PROFESSIONAL KNOWLEDGE IN EDUCATION AND HEALTH:
Restructuring work and life between state and citizens in Europe

Deliverable 6:
Crossprofessional Studies on Nursing and Teaching in Europe

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1 Introductions to research on professional knowledge and institutional restructuring

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During the last decades welfare state institutions in large parts of Europe have been in transition – indicated by changes in governing, by marketisation and consumer choice, as well as in reorganisation of work. Such transitions have their proponents among supranational organisations such as the OECD and in political parties as well as among researchers and intellectuals. But they have also a number of opponents in different camps such as professional organisations, as well as among intellectuals and political parties of different characters. In a word such restructuring of welfare state is debated on many arenas in Europe of today. In the PROFKNOW project – financed by the European Commission and by national research councils and universities – we have been carried out different studies of institutional restructuring in seven European countries in order to develop a more differentiated understanding of welfare state restructuring and professional work in education and health care.

The overarching ambition with the PROFKNOW project is to understand knowledge “at work” among professional actors situated between the state on one side and the citizens on the other side. This is a way to consider opportunities and constraints for change as well as a means to capture issues of social cohesion and integration in Europe of today. Our research is located in a period of ongoing restructuring in education and health care with implications for professional work. Thus, we are investigating professional work “in our time” in European welfare state institutions. We are focussing on the work life of teaching and nursing – how professionals deal with current changes in their work between state and citizens and how this is related to professional strategies and expertise.

1.1 Research objectives and focus

In our studies we focus on professional actors – their perspectives on ongoing work life transitions and ways of dealing with ongoing changes. Given this focus, our studies build on a design of national case studies, life histories and ethnographies as well as surveys to samples of teaching and nurses. We are working within the contexts of Northern (Finland and Sweden), Southern (Greece, Portugal and Spain) as well the Western (England and Ireland) European welfare states with their different trajectories, traditions, reforms and policies.

It is our ambition to reach the following objects:

1. To present comparisons of professional work and life in different European contexts within and between the professions of teaching and nursing.

2. To achieve a more developed view of professional knowledge in the fields of teaching and nursing as a basis for the development of organisational, professional and educational strategies by the professions as well as administrators and policy makers.

3. To describe, analyse and evaluate current restructuring in education and health in different parts of Europe from the point of view of teachers and nurses and their experiences from their interaction with clients.
4. To present a conceptual framework for analyses of professional knowledge in restructuring organisations.

In the current study we are summarising work carried out in previous work packages in the PROFKNOW project. We want to integrate previous studies in our project, using opportunities of comparative analyses in order to capture positions and professional knowledge in restructuring welfare state institutions and to further develop our analyses of professional work and life in restructuring welfare state institutions.

As presented above we are studying a limited number of European welfare state national contexts. Given the fact that our empirical studies are carried out in Northern, Western and Southern Europe we will expand our field of study to Continental and Eastern Europe using secondary data for analyses.

1.2 PROFKNOW organisation of work and deliverables

The PROFKNOW work is organised as a research consortium consisting of research teams from eight universities in seven European countries with a total of almost thirty researchers and research students in the consortium. Our activities are coordinated with the help of an extensive technical annex which is the basis for the contracted work in PROFKNOW as a European Commission funded research project. The research tasks are organised as workpackages over time as presented in figure 1.

Figure 1: Workpackages over time in the PROFKNOW project

The point to be made here is that PROFKNOW is a highly complex research project in its tasks and work organisation over different contexts – national and academic contexts, institutions and professions as well as research cultures. This means that PROFKNOW as an international research project is grounded in different settings and is by necessity based on a
communicative structure between these settings. In order to make this visible, the results of PROFKNOW research will be presented in relation to these settings.

A complex international project can be organised in different ways from a centralisation-decentralisation point of view. One way is a centrally directed project with detailed directives and instruments for doing and communicating research. Another way is to develop a more decentralised research project where tasks are mutually discussed with the frames of the contract and its technical annex. We chose the second approach based on considerations of differences in the objects we study and the under-determination of facts and interpretative fluidity in understanding of tasks and findings due to theory-laden observations and cultural differences. A potential drawback is variations in ways of working and reporting. A gain to be made, however, is the flexibility of work organisation and the use of different possible resources in different contexts – e.g. available data sources and cultural differences in communication. Furthermore, in both ways the production of facts and ways of work are flexible and the second approach has the advantage due to demands on communication over ways of work and their implications for the project progress.

This is the sixth main report from the PROFKNOW research project. The previous reports cover different aspects of the research problematic presented above. In order to facilitate access to these reports we have chosen electronic publication. The reports are presented at the PROFKNOW website www.ProfKnow.net where they also can be downloaded by the public. They are as follows:


In addition we have carried out a number of symposia and seminars about the PROFKNOW project in different national and international contexts and presented a large set of papers and publications from the project. These publications are presented in the appendix.

We are now in a process of exploitation of our research – e.g. in terms of presentations to different stakeholders and we are also taking action to publish two books and several articles in scientific journals – e.g. special studies on gender issues and on professional expertise in a knowledge society.

In sum – given the number of publications from the PROFKNOW project – it is not our ambition in this text to present extensive presentations of work carried out in the project. Instead, we will use these works in different ways and make references when so is the case.
1.3 Revisiting research reviews and their implications

Research on institutional restructuring can be regarded as part of a communication system on welfare state institutions in transition. In previous studies we have reviewed and analysed other studies in the field of research outlined above (Norrie & Goodson, 2005). We found a field of study characterised by asymmetries in terms of professions as well as national contexts. Considering professions much more research was carried out on teachers and their working life compared to research on nurses and their work. A second asymmetry concerned research in different national contexts. Here Anglo-Saxon research was much more quoted in the researched literature than e.g. research from Spain or Sweden, even if it was written in English.

Research on professional knowledge under restructuring is divided in three segments: First, we have a set of more general arguments on societies and institutions in transition. Here we find scholars such as Benedict Anderson, Pierre Bourdieu, Basil Bernstein, Anthony Giddens and others commenting and analysing ongoing changes in broad terms. Second, we have researchers working on issues of restructuring as policy changes or as travelling policies, referring to e.g. world movements, translations of policy discourses, as well as changes in governance. The approaches in the research literatures vary much, referring to internationally recognised researchers – e.g. John W. Meyer, Thomas S. Popkewitz, and Stephen J. Ball. The third segment has a focus on professional actors and professional knowledge, going back to classical profession theories, e.g. referring to Talcott Parsons, Amitai Etzioni, Dan C. Lortie, dealing with professions as an exclusive as well as an excluding social category, as well as more modern approaches in terms of an alternative logic to the market and the bureaucracy as developed by Eliot Friedson, or based on notions of power/knowledge, where professionalism is linked to the disciplinarisation of professions by e.g. Valerie Fournier, and their governing by reason and trust (Foss Lindblad & Lindblad, 2008).

Current research can be considered as presenting three general hypotheses on institutional restructuring. The first hypothesis is about innovation:

- Restructuring is producing innovative institutions. By means of deregulation, increased autonomy, and marketisation schools and hospitals will communicate more with their environments and will have increased possibilities to improve their performances.

The second hypothesis is about dissolution:

- Restructuring is building an iron cage around institutions such as health care and education, decreasing their space for action. A number of technologies, such as league tables, quality indicators and audits are used to regulate and discipline work processes in health care and education.

These two hypotheses are not quite contrary. In both cases they put forwards the making of communicative systems. The working of these systems is going in different directions, however. The innovative hypothesis underlines the possibility to learn by inputs from e.g. comparisons of performances or markets mechanisms. From the dissolutive hypothesis position restructuring is considered as a collapsing of institutional norms and virtues when opening the doors for market forces and commercialism. In sum, for both hypotheses there is an assumption that there is a transition in the communication system and that this change is causing an impact on education and health care.

- Given this working of communication systems in relation to restructuring we have to put forwards a null-hypothesis as well, stating that the causal processes of communication is not working – not functioning, or blocked or reworked or ignored in
different ways. Assuming that restructuring is functioning we can summarise this hypothesis in terms of de-coupling. This means here that restructuring measures are not communicative, isolated in relation to work processes.

When focussing on the professional actors we also can put forwards three main hypotheses can be put forwards:

- **Professionalisation**: Restructuring will improve the position and expertise of the professionals and their organisations. This means that the professional autonomy at the workplaces will increase as well as the professional authority and legitimation vis-à-vis clients. This is based on communication of expertise at work producing expected and valued outcomes.

- **Deprofessionalisation**: This is a contrary process built on the same dimensions concerning autonomy, authority and legitimation.

- **Professional reconfiguration**: This is an alternative hypothesis focussing on changing qualities in professional definitions implying that patterns in terms of professional governance are in transition. A main idea is that we would notice “new” workings of professions related to restructuring.

In the first two hypotheses we are focussing on the professionals with notions on social positions and professional closure in mind. In order to investigate into the dimensions of professionalisation and deprofessionalisation we focus on the organising of work on one side and on the interaction with clients on the other side. What are then the causalties at work here? In a word it concerns asymmetries in communication. Under the professionalisation hypothesis it is on one hand opportunities to closure from the professionals point of view, and on the other hand having an impact on organisational decisions as well as in accept and trust from the side of clients. Given the statement that expertise excludes we can state that increasing asymmetries in communication is basic in professionalisation and decreasing asymmetries is basic in deprofessionalisation, while notions on autonomy and authority are indications on outcomes of such processes.

The third hypothesis is twisting the notions of professionalisation-deprofessionalisation a bit. The point is that restructuring implies differences in institutional working and institutional relations. Given this, we might expect that the structure of professional characteristics might change as well. Thus the classical notions of closure, expertise and asymmetries might be turned around in other ways. Indications on this is the 1960s notion on “a profession for everyone” and analyses of the expansion of the profession concept during the last decades.

The first two hypotheses are focussing on positions and interaction. They are contrary in their workings, and we could also assume an outcome in between professionalisation and deprofessionalisation where little has changed in relevant aspects. The third hypothesis is pointing towards new constellations of professional work and life. This means that we need to identify such eventual constellations in different ways.

Going back to the PROFKNOW research review (Norrie & Goodson, op cit) little of research was devoted to the fact that restructuring is part and parcel of professional work life carried out by actors such as teachers and nurses with their orientations and experiences based on previous actions, interactions under given preconditions and boundaries. Thus, we focused our studies on the professionals and their ways of organising work in interaction with their clients. For such reasons, this turned out to be the focus of the PROFKNOW project.

With this focus – and its limits – we will learn about professions and restructuring from a specific point of view, that is the professionals and their experiences and strategies when
dealing with work life in change. We will learn about the meaning of restructuring from these actors’ perspective and their conceptions of how restructuring is working. We will also capture their strategies to deal with the tools and technologies of restructuring. What we will get is versions of restructuring from professional actors’ perspectives. This means that restructuring is dealt with as part and parcel of professional work life, where other aspects are integrated into the set of processes, resources and events that make up this work life. Stated otherwise, with this contextualising research strategy we will capture ongoing processes of institutional restructuring in their lived working, as experienced by central actors in these institutions.

1.4 On the study of organisational change and professional experience

As presented above the PROFKNOW project focuses on organisational change in terms of institutional restructuring with a focus on professional perspectives and experiences in different national and professional contexts. Given this we have the tasks of capturing discourses on restructuring on one side and professional experiences and ways of work under restructuring on the other. Here, below we present in short four theoretical and methodological issues of central importance to the PROFKNOW studies:

First, organisational restructuring is here not conceived of as an example of policy implementation with effects on professional work life. Instead it is conceived of as part of a cultural change in institutions and society at large which sometimes are translated into institutional life and professional work (c.f. Foss Lindblad, deLima and Zambeta, 2007). This means that we are mainly interested in such life and work, and not trying to capture policy effects as such. However, we need to be informed about policy discourses as contexts for professional work life e.g. in terms of directives, technologies and resource allocation procedures. We are naming such discourses system narratives as texts on restructuring welfare state institutions. By using the concept of system we imply that we are interested in ideas and practices on how to govern and frame professional work life as part of welfare state institutions. The notion of narrative does not imply that such ideas are arbitrary or illusory. It means that we are interested in them as stories on educational/health care restructuring – why it should be done, with what measures, and with what kind of implications (e.g. Lindblad & Popkewitz, 2001). Stated otherwise, to conceive of policy discourses as facts or as having direct implications for institutional work life is to provide them with transforming characteristics they do not have as such.

Second, we are capturing professional work life under restructuring from the professionals’ points of view – their experiences and how they organise these experiences. We call these professional work life narratives. The notion of narrative has the same implications as when dealing with systems. They are not assumed to correspond to what institutional work life actually is but as it is conceived of and handled by professionals – their stories, perspectives and strategies to deal with their work. The ambition is to capture such professional work life narratives in a strict and rigorous way. In the PROFKNOW project we are taking the stance of conceiving professional work life as the working of a professional habitus (c.f. Bourdieu, 1986) as incarnated positions and positionings. This means firstly that professional histories are part in the making of the present – that achieved dispositions to act are at work in a current contexts of restructuring work life – and secondly that our studies of professional work life narratives are regarded as the meaning making and acting of professional habitus.

Given these two considerations, we are designing the PROFKNOW studies as studies of system narratives and work life narratives. Of special interest is then the intersection between such narratives – of system narratives as stories on professional work life and work life
narratives as ways of dealing with welfare state institutions in an eventual transition. An idea is that such transitions will make it possible to more elaborated studies of professional habitus since it put demands on positioning in a more explicit way. The same can be said about system narratives that need to question established ideas on systems in order to make organisational change a reasonable enterprise.

A third notion deals with comparing opportunities developed in the PROFKNOW research design. When organising our studies around system narratives and work life narratives as basic fields of inquiry in the PROFKNOW we are working in different European contexts. This gives opportunities for comparisons, but is also a conceptual problem. To use national labels as bases for analyses and explanations is a doubtful strategy. On the other hand the fact that we are doing our studies in different contexts is a resource that would be a mistake to neglect. However, analyses of such variation must be conceptually meaningful, and that is a criterion we are working with in our studies. In a similar way teaching and nursing are professions that are differing over contexts. Thus, crossprofessional comparisons need to be carried out with caution as well. Given this notion comparisons over variables and cases demand conceptual frameworks. It was our ambition to develop such a framework.

A final notion is trying to deal with the simple fact that the PROFKNOW studies are developed by different research teams with different research socialisation and specialities coordinated by research plans, seminars and discussions. It has been the ambition to delegate responsibilities over research teams working in different contexts, to develop studies within a joint framework and doing analyses of their cases – being system or work life narratives over professions as well as generations. In a word we have tried to elaborate collaboration between autonomous research teams developing their work in communication with the other teams in PROFKNOW. A consequence of this is that we are presenting the comparative analyses of the different research teams. This we conceive of as a fruitful communicative strategy in the building of a European research area in education and health care.

1.5 Comparative analyses: A grid for comparisons

When dealing with research reviews and their implications we put forwards two sets of hypotheses – one set on restructuring and one set on professions. We are here trying to develop a more differentiated understanding of professional work life under restructuring based on the notions of system narratives and work life narratives over contexts, professions and generations. Here, we are making comparisons in four aspects:

Firstly, we need to understand the meaning of restructuring. What is restructuring about, e.g. in terms of marketisation, deregulation, etc. Why are restructuring measures carried out and what are they replacing? What are the experiences of restructuring measures and on what basis are these experiences achieved? Here, we have notions of travelling policies and translations of restructuring in different contexts.

Secondly, we are trying to capture how restructuring is working – by means of what work processes, technologies and competences? Here, we can use descriptions from our ethnographies and work life narratives in order to capture different instruments and technologies used to make restructuring work.

Thirdly, we ask what strategies the professional actors are using in order to translate e.g. policy discourses and restructuring technologies in their work life. This aspect deals with different kinds of studies – from professional organisations as well as individual professionals and teams. A main idea is that restructuring is something that professionals are actively dealing with and translating into their contexts.
And fourthly, what are the implications of the meaning and working of restructuring as well as teacher strategies for the configuration of the professions of teaching and nursing? To us simplistic dimensions of professionalisation and de-professionalisation are problematic. They are obsolete in their ways of understanding changes in the professions. And they are simplistic in their ways of capturing professional work life and discourses on professionalism and professionality. This we need to conceptualise in a proper way. At present we think we need the following bricks in the configuration analyses: (a) positions in relation to the organisation and its clients, (b) identities as references to actions, (c) expertise – its production and maintenance – as more or less scarce resources.

Given the notions about what is to compared in relation to the basic distinction between work life narratives and system narratives we are getting a grid – presented in table 1.1 for comparisons over professions and generations for work life narratives as well as system narratives.

*Table 1.1: Grid for comparisons*

<table>
<thead>
<tr>
<th>Narratives</th>
<th>What does restructuring mean?</th>
<th>How is restructuring working?</th>
<th>What are the professional strategies and responses?</th>
<th>What are the professional configurations?</th>
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<tr>
<td>System narratives</td>
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<td>Work life narratives</td>
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The policy discourses/system narratives are constructed on periodisations as well as on comparisons between national contexts. Thus, when dealing with national systems we need to deal with periodisations and we need to compare these over national contexts. Here, we need to identify similarities as well as differences in these narratives. Presumably, this is needed to be done in terms of thematics making up the discourses. What is distinctive in PROFKNOW is the design of capturing restructuring in terms of life histories. We need to identify basic elements in these histories as thematics. Structural gender configurations over the three generations are also significant in this report as primary teaching and nursing are predominantly female professions. When exploring the lives of women the life-history approach is useful as it encourages a holistic view of work that is arguably more consistent with women's lives.

The focus of this project is a comparison of changes in the professional knowledge of teachers and nurses. A wide conceptualisation of professional knowledge is used in keeping with the life history approach. So in this report no distinction is made between public and private learning (Voydanoff, 2001) and experiential knowledge and worklife issues are viewed as an intrinsic part of professional knowledge. No distinction is made between knowledge and learning (Blackler, 1995) highlighting lifelong learning and following the view of knowledge as socially constructed and as a dynamic concept.

1.5.1 **Professions**

We are doing comparisons between professions – that is nursing and teaching. The profession concept is here used in rather a fluid way. We are not going into discussions on what characterises a profession in contrast to laymen. We are neither dealing with distinctions between professions and semi-professions. Instead we are interested in professional work life in welfare institutions – in social as well as epistemic aspects. Of special interest here are notions of expertise and the working of institutional restructuring in professional work life.
Foss Lindblad & Lindblad (2008) dealt with the profession concept. In the beginning this concept was regarded as something unproblematic in the project – not delineating professions from other occupations and not bothering about distinctions such as between semi-professions and profession. However, when having a closer look on profession research and profession theories, such distinctions and especially their changes seem to be highly important from a performative point of view. The classical traits theories based on characteristics of the professions in law, medicine etc, as well as the functionalist profession locations a la Parsons actually provides some insights when putting them into a social and historical context, not only as trying to define the professionals as modern heroes but locating them into specific institutional characteristics in terms of trust, legitimation and scientific expertise as well as control systems. Ideas of professionalisation projects – such as those dealt with by Sarfatti Larson (1977) – as ways of obtaining social status as well as social enclosures – and notions of professionalisation as building monopolies outside markets are from that point of important notions of changing times. Besides that, recent approaches to capture professions are interested in the fact that there (a) an increase in occupations labelling themselves as professions, (b) that there are professionalisation tendencies coming from above rather than from within the professions themselves, and (c) that profession-languages are part of fabrications of managers or policy-makers as ways of building trust or disciplining a workforce. To us this holds true in the field of education and nursing – though the profession notion is translated in different ways in different contexts. This is – as far as we can see – an important aspect of professionalism and a needed part for an understanding of professional reconfiguration as discussed below.

The following theories of restructuring, professions and professional knowledge can be viewed as a background of possible conceptualisations of how society, professionals and professional knowledge are changing.

*Table 1.2: Society, professions and professional knowledge.*

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<tr>
<th>Society</th>
<th>Fragmented Society</th>
<th>Knowledge Society</th>
<th>Risk Society</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professions</td>
<td>Downgrading and de-professionalisation of public sector. Rise of part-time work and more social and spatial segregation.</td>
<td>Creators of knowledge would become the dominant social class. WC become white collar workers.</td>
<td>Government and scientific elites challenged. Counter-elites/experts emerge with increased power.</td>
</tr>
<tr>
<td>Professional Knowledge</td>
<td>Expert knowledge de-legitimized and challenged and swamped by mass culture.</td>
<td>Expert knowledge secure, trusted and increasingly variable</td>
<td>No knowledge certainty.</td>
</tr>
</tbody>
</table>

Adapted from (Goldblatt, 2000)

Elements of all the theories can be identified in the change of teachers and nurses from traditional to re-framed professionals over three generations.

Harvey (2005) argues the rising power of global capital and neo-liberalism are leading to public sector work being degraded and de-skilled with expert knowledge de-legitimised, de-professionalised and challenged. This theory is supported in some countries by the difficulties in recruitment and retention of both teaching and nursing suggesting the degradation of the work in the public's eyes. Expert knowledge is also being challenged as for instance can be demonstrated by the rising litigation bill of the English NHS where patients
seek recompense for medical accidents. The rise of mass culture can be seen in the decline of deference in society in general. Drucker (1993) contests this view and argues we are living in a knowledge society. Elements of the knowledge society are also highly visible in lifelong learning being necessary and especially visible in nursing where medical knowledge changes quickly and professionalism is based on discourses of evidence-based-practice. From this viewpoint, expert knowledge can be described as being more important than ever as increased specialisation means greater dependence on a larger number of professional roles. Beck's (1999) Risk Society examines how in an era of environmental uncertainty, life is measured by statistical risks. There is no knowledge certainty and scientific elites are challenged by counter culture epistemologies. Firstly the rise of benchmarking, evidence-based practice and research-based reforms could be seen as a growing part of nurses and teachers knowledge and part of a risk society. At the same time, the rise of counter cultures or alternative epistemologies is also a phenomenon. An English nurse for example described how she had re-trained in alternative medical therapies to help patients due to disillusionment with the limitations of elements of modern medicine. Evetts (2005) combines the above theories and writes of professionalism being increasingly used across the workforce while paradoxically the conditions of trust, discretion and competence which historically have been deemed to be necessary for professional practice are being challenged, changed or regulated. Employees in a wide range of jobs are encouraged to self-define themselves as possessing professionalism and this encourages self-motivation (and self-exploitation). Evetts coins this management appropriation of the term as ‘organisational professionalism’ and contrasts it to ‘occupational professionalism’ which is a discourse constructed from within professional groups.

An alternative conceptualisation of changing configurations of public sector workers and their knowledge is the growth of local professionalisms. Craig (2007) for example discusses the situation in relation to London teachers. With the decline of the meta-narrative, local identity and knowledge becomes more important. Evidence of this was found in one of the fieldwork schools whose identity was very much based around being in a government-designated area of social deprivation. The skills, knowledge, identity and approach of the teachers in this school offered a stark contrast to the other two schools where fieldwork was carried out.

1.5.2 Generations:

Another idea deals with notions of generations. Here, we have the notion of generation, derived from the work of Mannhein, that is further developed by Ari Antikainen and his co-workers. Ari Antikainen says that:

‘A generation consists of a group of people born during the same time period and who are united by similar life experiences and a temporarily coherent culture background'.

(Antikainen, 1996)

Likewise, Mannheim argues that the particular benefit of generational analysis is that it makes it possible for us to include a historical dimension in the analysis. The concept of generation elaborates at least to some extent on the characteristics of the processes in which historical and social time shape the life course of an individual (Karl Mannheim, 1952).

To identify generations means to capture periods of vital concern for the organising of experiences and the positioning in relation to certain events.

The PROFKNOW project aims to compare the lives of teachers and nurses belonging to different generations as a way of exploring relations between reforms, professions and knowledge. Exploration of differences in the personas, opinions and relationships between
teachers and nurses belonging to different age cohorts sheds light on the interaction between reforms and professionals over time.

The following generational characteristics have been outlined (Huber and Skidmore 2003). These were identified within the interviews. It was especially noted that several of the older generation members talked about the role of religion in their professional life, whereas this discourse was noticeably absent in the younger cohort. However these differences were not seen as part of a significant professional generational divide.

- Seniors (1930-1945) (aged 62-77) (collective society, austerity, interested in family and religion, dedicated to hardwork, duty, education appreciated)
- Boomers (1946-1960) (aged 63-47), (individualistic, liberal, consumption, interested in personal gratification, stability in jobs)
- Generation-X (aged 46-32) (individualists, experienced downsizing and redundancies (and divorces) of their parents' generation and consequently work to live, not live to work and value worklife balance; change jobs frequently)
- Millennials (under 32) (IT knowledge and confidence).

Edmunds and Turner (2005) combine Mannheim (1952) and Bourdieu’s (1990, 1993) work to argue that generations are engaged in a fight over resources and describe how trauma combined with opportunity and leadership can create “activist” generations that manage to secure resources for themselves. They suggest that the lack of a generational divide could be seen as the success of the 1960s cohort in monopolising social goods (especially pensions) for themselves, while ensuring that part of younger generations’ identity consists of political apathy and lack of will to fight themselves to maintain services.

In our studies, teachers and nurses from the older generation were seen as holding characteristics associated with the younger generations when they expressed their wish to find a good work balance. In nursing there was a historic discourse about younger nurses possessing insufficient practical training.

It has been argued that the biggest structural change in society over the past three generations has been the rise in education and employment of women, given for instance England as an example. In 1983 men filled 2.5 million more jobs than women. By 2003 the numbers were almost equal with men performing 13.0 million jobs and women 12.8 million, although almost half of the female jobs were part time (Babb et al., 2006). The gender capital of male and female teachers and nurses has been significantly remodelled over the three generations and this was reflected in the fieldwork. The interviews were suffused with references to gender. The older generation of female interviewees recounted how there were only two professional options open to women in the past due to their gender – teaching or nursing. Younger generation participants noted how their mothers had lost jobs due to pregnancy and how they themselves struggled with childcare and the guilt of leaving children in day-care. Male nurse interviewees discussed how their gender capital worked offering both preferential and discriminatory experiences.

Professions and their knowledge are also changing with increased global mobility (Castells, 1998). International mindedness or inter-cultural literacy is now part of teacher and nurse professional identities, knowledge and competence. A difference between nursing and teaching is that in nursing a large proportion of practitioners come from ethnic minorities. Data for 2004 estimated that 16.4% of qualified nursing, midwifery and health visiting staff were from ethnic minority groups (Buchan, 2004).
1.6 References


2 Considerations and practices concerning research design and data collection

Ivor Goodson and Sverker Lindblad
University of Brighton and University of Gothenburg

This report aims to describe, analyse and compare educational and healthcare restructuring and the professional lives and knowledge of three generations of teachers and nurses. This report is based on previous work packages (WPs) consisting of a literature review (WP1), a national case-study including statistics (WP2), surveys (WP3) and life-history interviews and mini-ethnographies with teachers (WP4) and nurses (WP5).

The ProfKnow project was concerned to compare public sector reform in Europe. Education and Healthcare were chosen as two key sectors in public service provision. Primary teachers and hospital-based nurses were chosen as key professional sub-groups within healthcare and education. Comparative analysis of education and healthcare sectors highlights how changes in teaching and nursing are related to local, professional, national or global contexts. As a strategy for exploring how reforms interact with professionals over time, inter-generational analysis was used. Exploration of the personas, experiences, opinions and relationships between teachers and nurses belonging to different age cohorts sheds light on the interaction between reforms and professionals over time. This work will focus on reforms that have occurred over three generations of teachers and nurses but will focus mainly on the most recent periods.

2.1 System narratives

In this report, the systems narrative analysis (based on WP1-2) examines the restructuring of education and healthcare over the past years and aims to describe and analyse influential narratives of reform within the multifarious discourses competing for resonance. A narrative approach focuses on the discourses that accompany, justify, sustain or contest policy changes. So concepts such as marketisation or choice are focused on as discursive narratives as well as concrete processes. Data is based on academic literature and internet resources such as governmental and non-governmental policy documents, websites and statistics.

System narratives were constructed on basis on available information and policy documents in the national contexts. It is based on cases built on national statistics and document analyses from each partner, and analysis of information from international organisations. It concerns besides policy texts information about:

a) transitions in the work life organisation of education and health,

b) the education and training of teachers and nurses related to notions of tasks and professional knowledge

c) relevant national statistics concerning the provision of welfare, and relevant statistics on education and health care professions, gender, recruitment, work life problems etc.

The main PROFKNOW report on system narratives is the case study report edited by Beach (2005). The ambition of this report was to portray the national cases as it was presented in such documents. The national case studies were in sum based on more than 500 documents used as sources to define and describe the national cases in PROFKNOW. It is a mix of policy documents, commission texts as well as research reports. In sum they present sets of positions
in relation to the PROFKNOW research problematic and how these positions are supported by a number of actors – national as well as international – in a multi-voiced way. Thus, the system narratives are neither homogeneous nor uni-vocal.

To some extent the same voices are heard in the PROFKNOW research review (Norrie & Goodson, 2004). The overlap is most visible when considering research publications, but the different texts are also referring to same – or similar – policy documents. In addition, the national research teams presented in their contributions to the workpackage 6 their presentations of system narratives as will be shown in this report.

Taken together, the system narratives are based on a number of sources in different national, international and supranational contexts. Their construction is based on extensive research and is assumed to portray relevant narratives on restructuring and professional work from different points of view.

2.2 Work life narratives

The main work in PROFKNOW was to develop work life narratives based on studies on nurses’ and teachers’ experiences and perspectives. Thus, we are describing notions on design and data collection more in detail compared to work on system narratives.

2.2.1 Surveys: Samples and background variables

This data collection was carried out in work package 3. The presentation here is quoted from Sohlberg et al (2007). The initial idea was to carry out the survey in all participating countries, but due to some grave technical and practical problems we had to be satisfied with four countries, that are Finland, Ireland, Spain and Sweden. Furthermore, we had to drop Spain from the survey data-base because the quality of the survey, carried out by a hired independent agency, was not scientifically high enough for comparison. The initial samples were 1,100 nurses and 1,100 teachers in each country. The survey consisted of 50 questions and 121 variables covering main themes relevant for the PROFKNOW-project and dealing with topics as e.g. work-description, education, unemployment, working-conditions, work-organisation and attitudes.

A majority of the items were construed specifically for the PROFKNOW-project. However, in order to make relevant comparison possible some items were replicated from other studies (Wright, 1997; European Social Survey). Some central characteristics of the sampling procedure are illustrated in Table 2.

Table 2.2: Construction of samples and response rates.

<table>
<thead>
<tr>
<th></th>
<th>Initial sample (f)</th>
<th>Not actively work in profession (f)</th>
<th>Final sample (f)</th>
<th>Responses from active (f)</th>
<th>Response rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>Finland</td>
<td>1100</td>
<td>91</td>
<td>1009</td>
<td>784</td>
</tr>
<tr>
<td></td>
<td>Ireland</td>
<td>1100</td>
<td>75</td>
<td>1025</td>
<td>635</td>
</tr>
<tr>
<td></td>
<td>Sweden</td>
<td>1100</td>
<td>77</td>
<td>1017</td>
<td>787</td>
</tr>
<tr>
<td>Teachers</td>
<td>Finland</td>
<td>1100</td>
<td>128</td>
<td>972</td>
<td>730</td>
</tr>
<tr>
<td></td>
<td>Ireland</td>
<td>1100</td>
<td>24</td>
<td>1076</td>
<td>757</td>
</tr>
<tr>
<td></td>
<td>Sweden</td>
<td>1100</td>
<td>42</td>
<td>1054</td>
<td>817</td>
</tr>
</tbody>
</table>
In relation to what is now standard for postal-surveys the response rate must be considered as rather high. There are however quite large differences between the national cases. Even the degree of internal non-responses was small in most cases. The response rate is of course a crucial factor, but not the only factor essential for the validity of the results, and thus for a possibility to draw generalisation to the populations of nurses and teachers. The occupations of nurses and teachers are strongly feminized, and they consequently deviate from the average sex-distribution of the population. If the sex-distribution in each sample is approximately the same as the sex-distribution of the population of teachers and nurses in respective countries, it is one indication that the study is representative in this respect.\(^1\)

Table 2.3: Division by professions, country and sex

<table>
<thead>
<tr>
<th>Professions</th>
<th>Countries</th>
<th>Men (%)</th>
<th>Women (%)</th>
<th>Total (♀)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>Finland</td>
<td>6</td>
<td>94</td>
<td>783</td>
</tr>
<tr>
<td></td>
<td>Ireland</td>
<td>8</td>
<td>92</td>
<td>635</td>
</tr>
<tr>
<td></td>
<td>Sweden</td>
<td>8</td>
<td>92</td>
<td>787</td>
</tr>
<tr>
<td>Teachers</td>
<td>Finland</td>
<td>29</td>
<td>71</td>
<td>731</td>
</tr>
<tr>
<td></td>
<td>Ireland</td>
<td>26</td>
<td>75</td>
<td>757</td>
</tr>
<tr>
<td></td>
<td>Sweden</td>
<td>30</td>
<td>69</td>
<td>817</td>
</tr>
</tbody>
</table>

When looking at the table 3, we see that the nurses are mostly women in every country. Every further division of this category is therefore not statistically justifiable. In consequence, it is not possible to analyse men and women separately. Even the teacher-category is strongly feminized as approximately three of four teachers are women.

Compared with their parents, both teachers and nurses have higher educational qualifications than their biological mothers and fathers. This of course indicates the general increase in educational level. There are, however, differences between the countries and professions. To take some examples: Between 51 and 64 % of nurses’ fathers had primary education. More than 50% of the father’s of Swedish nurses and teachers had primary education. It was more common however for the fathers of Finnish and Irish teachers to have secondary and tertiary education. Best educated were the fathers of Finnish teachers. Almost 30 percent of them had college education. The education of nurses and teachers mothers follows the same pattern with two exceptions: Mothers to Irish nurses and teachers were better educated than their fathers.

The complex qualitative differences in the educational systems of nurses and teachers in three countries make the comparisons difficult in one-dimensional terms. This means that it is difficult to find simple correlations between structural conditions of education and effect-variables. For instance, should we interpret additional university education as an indication of aspiration to a professional growth? Then, should we also take into account the formal status of the original education and its length as well as the demands on the employees.

One major factor to be considered at the outset of our analysis is nurses’ and teachers’ professional position in the national labour-market. Both teachers and nurses seem to have a rather stable position on the labour market. The majority of nurses (80 %) and teachers (85%) were never unemployed.

\(^1\) The distribution of sex in the samples and respondents in Finland, Ireland and Sweden correspond with the sex-distribution among teachers and nurses in the population.

20
2.2.2 Life histories

Major efforts in the PROFKNOW project was to capture professional work life histories in restructuring welfare state institutions. The worklife narrative analysis is based on such life-history interviews and mini-ethnographic observations (WP4 and 5). Two life-history interviews and observations (of 2-3 days) were carried out with 3 primary teachers and 3 hospital-based nurses of different generations based in one school and one hospital. The aim was to explore restructuring and the different professional personas and professional knowledge of nurses and teachers of different generations. First interviews were unstructured and second interviews explored themes arising from the first interviews. These themes were then further explored in focus groups with nurses and teachers and additional thematic interviews and observations in the hospital and in two other schools. In all, the views of 15 teachers and 8 nurses are included in this report. The observations were useful in contextualising the worklife narratives presented by the interviewees. They also offered an opportunity to discuss working conditions, practices or incidents witnessed.

*Table 2.4: Themes of life history analysis*

<table>
<thead>
<tr>
<th>Themes of the life history analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Socio-economic position, family relations</td>
</tr>
<tr>
<td>1.1. Childhood</td>
</tr>
<tr>
<td>1.2. Present-day</td>
</tr>
<tr>
<td>2. Education</td>
</tr>
<tr>
<td>2.1. Basic education</td>
</tr>
<tr>
<td>2.2. Professional education</td>
</tr>
<tr>
<td>3. Friends and social networks</td>
</tr>
<tr>
<td>4. Personal interests and activities</td>
</tr>
<tr>
<td>5. Professional career and present tasks</td>
</tr>
<tr>
<td>6. Working conditions</td>
</tr>
<tr>
<td>6.1. Organisation</td>
</tr>
<tr>
<td>6.2. Community</td>
</tr>
<tr>
<td>6.3. Decision making</td>
</tr>
<tr>
<td>6.4. Management</td>
</tr>
<tr>
<td>7. Colleagues and cooperation</td>
</tr>
<tr>
<td>8. Professional status and position</td>
</tr>
<tr>
<td>9. Professional skills, knowledge and expertise</td>
</tr>
<tr>
<td>10. Professional ideals, values and motivation</td>
</tr>
<tr>
<td>11. Structural changes</td>
</tr>
<tr>
<td>12. Emergent themes</td>
</tr>
</tbody>
</table>

The life history interviews were investigated for individual, professional, local, national and international stories, themes or motifs. The function of these stories was investigated with some being interpreted as symbolic motifs or mantras. Other narratives were investigated to see if they acted as sense-making or identity-reinforcing mechanisms. What was not spoken was also explored and viewed as relevant. The concept of narrative capital (Goodson, 2006) problematises how different individuals have varying capacities to story their lives for an outsider or for themselves. This can depend on their age, reflexivity, social or cultural capital. Some participants appeared to be re-telling familiar, well worked, self-presentations or performative events. Other participants noted they were surprised to find the interview process was a useful reflective experience. Both the system and individual narratives can be
viewed as part of a hegemonic or legitimatory process while other discourses may be more rhetorical or mythical in character.

The structural analysis of change is based on a combination of WPs 1-5. It explores the restructuring of professions and their knowledge by comparing the systems narrative with the worklife narrative. This approach highlights the voice of professionals acting as intermediaries delivering services and situated between the state and the citizen. So this report will explore the gap between official government discourses and individual and professional narratives.

2.3 References


Goodson, I. (2004). Narrative capital and narrative learning. Paper given to a workshop at the University of Viborg in November. This paper was considerably extended in doctoral classes given at the University of Barcelona in a course on life stories during the period January to July 2005.


## Appendix to chapter 2:

### Working with Teachers

<table>
<thead>
<tr>
<th>Country</th>
<th>Life history (each was interviewed twice in all countries)</th>
<th>Shadowing</th>
<th>Group interview</th>
<th>Comments</th>
</tr>
</thead>
</table>
| England | 1) Maria, late 50s, 40 years of experience. Always wanted to become a teacher  
2) Jane, age 34, 10 years of experience. Always wanted to be a teacher, in- and out of job  
3) Susan, mid 20s, 3 years of experience, self-made professional, in part for secure job, in and out of her job. | 2-3 days with each teacher | 12 teachers from two other schools | (unclear if all 12 have participated in a group interview, could have been individual interviews as well) |
| Finland | 1) Sirkka, age 59, 33 years of experience Teaching as first choice of career  
2) Tuula, age 46, 16 years of experience. Teaching as first choice of career, difficult family situation  
3) Martti, age 38, 11 years of experience, third choice teaching  
4) Niina, age 31, 4 years of experience Teaching first choice of career, first child with 22 | 3 days with each teacher | - | Group interview not possible |
| Greece | 1) John, age 58, 30 years experience. Poor rural family background, economic needs and escape from land-life.  
2) Mary, age 41, 17 years experience. Tried Medicine but did not have the grades, teaching as second choice.  
3) Helen, 32 age, 3 years experience. Tried different other professions, teaching actually third choice. | 3 days with each teacher | 7 teachers | |
| Ireland | 1) Teresa, ~ 53 age, 32 years of experience. Urban upbringing. Had ideas to become a teacher, out of teaching 1980-7  
2) Sarah, ~ 26 age, 5 years of experience. Middle class, always wanted to become a teacher, made a career break for traveling, now back in teaching  
3) Conor, ~ 22 age, 1 year of experience. Rural, upbringing good working conditions, good memory of his time in school and secure job in the end. | 3 days with each teacher | A focus group was conducted with the three interviewees so as to discuss issues that arose during the process of analysis and to lend ‘trustworthiness’ | |
| Portugal | 1) Maria, 32 years of teaching. Poor villages  
2) Victoria, 18 years of teaching, poor family background  
3) Carlos, 2 years of teaching, lower/middle class, finding a job main concern, teaching as second choice. | 3 days with each teacher | 5 teachers | |
| Spain | 1) Maria, ~ 50, 30 years of experience, always worked with children, strong inclination to knowledge  
2) Rosa, ~ 40, 15 years of experience, First choice math, then “downgrade” to teaching math.  
3) Sophia, age 25, 5 years of experience, music primary, teaching a possibility to pursue it. It is a job | 3 days with each teacher | 3 teachers | |
| Sweden | 1) Tina, age 65, 40 years experience. Clear vocation, care for children, but not a direct entry into profession  
2) Tide, age 46, 16 years of experience. Worked in different jobs, teaching as second choice  
3) Tea, age 38, 1 year of experience. Had an early interest in teaching but started working in other jobs. Late entry into job. | 3 days with each teacher (9 days) | 4 primary school teachers and 2 leisure time teachers | The six teachers in the group interview were organised in a teachers’ team |
## Working with nurses

<table>
<thead>
<tr>
<th>Country</th>
<th>Life history (each was interviewed twice in all countries)</th>
<th>Shadowing</th>
<th>Group interview</th>
<th>Comments</th>
</tr>
</thead>
</table>
| England | Laura *(the experienced nurse)*, aged 52, with 27 years of nursing experience works in an administrative and management position with some consultation with the patients.  
Bridget *(the mid-career specialized nurse)*, aged 36, treats patients and has some administrative and management duties. She has worked in the current hospital for 2 years and a few years elsewhere before.  
Steven *(the early-career nurse)*, aged 23, He works at a general ward, and has been nursing for 9 months. | 2-3 days with each nurse | 6 nurses | Additional interviews and observations |
| Finland | Helga, 50, works as a consultation nurse at a health centre. She has worked in health care for 25 years, but she started as a nurse assistant. Now she has 20 years of professional experience as a nurse.  
Lena, 42, works as a consultation nurse at a health centre with some 4 years of nursing experience. She, however, has health care related work experience for about 10 years.  
Jenna, 33, works as a consultation nurse at a health centre as well. She has about three years of professional experience. | 3 days with each nurse | - | Group interview not possible |
| Greece | Despina, aged 58, works at Outpatient Services, and has 27 years of working experience in nursing.  
Konstantinos, aged 38, works at a blood donation unit. He has been working there for 14 years.  
Rebecca, aged 28, works at a women’s ward with 1.5 years of experience as a nurse. | 3 days with each nurse | 6 nurses |
| Ireland | Aideen is a divisional nurse manager with 18 years of experience.  
Ellen is a specialist nurse who works predominantly off the ward. She has 11 years of experience as a nurse.  
Nora is a staff nurse working in a surgical ward with 3 years of experience.  
About group interview: “It was also intended to carry out focus groups and thematic interviews with additional participants so as to further “test” our findings. However, given the considerable wait (3-4 months) to secure ethical approval we feared that to do so would significantly delay our report and ultimately our European partners in their process of comparative analysis. Hence, the focus groups did not take place. However, we are confident that with regard to both teachers and nurses that our account has been ‘validated’ by the participants themselves, thus lending significant credibility and dependability to the accounts in the cases.” | 3 days with each nurse | Focus group not possible |
| Portugal | Ana, aged 54, has been as a staff nurse in a blood donation service for 25 years.  
Paula, aged 36, works as a staff nurse on a medicine ward, and has been working in a same institution all her career.  
Alexandra, aged 24, works at oncology inpatient ward, which joined immediately after getting her degree and finishing her training at the same ward. | 3 days with each nurse | 5 nurses |
| Spain | Jenny has been working as a nurse for 30 years. She also lectures at a University, and has been involved in administration, strategic planning, building up nursing services and exploring new terrains for nursing.  
Flor works in an administrative position, which she gained | 3 days with each nurse | 4 nurses |
recently after 15 years as a nurse. Maite is a nurse who works as an interim with a part-time contract of 21 hours in a post-surgery ward. She has 5 years of professional experience.

| Sweden       | Nora, 60, works as a nurse at a health centre. She has worked in Sweden, Afghanistan and Tanzania. She has got a three-year long nurse education in the 60s, and has various specialisations. Nancy, 56, is a nurse at a health centre. She has been working also at hospital wards and clinics, as well as in a managerial position. She has had a five semester long initial nurse training. Nina, 36, has been a primary health care nurse for 4 years, but she has 15 years of experience as a registered nurse. | 3 days with each nurse | 4 nurses | No younger nurses were employed at the studied health care centre |

Guidelines, interview

1st area: **Working conditions**
Professional status and autonomy, employer, place of work and site, work organisation or unit and setting, job title, official rank, hierarchical position in the work organisation or unit, main tasks, duties and responsibilities, skills and knowledge at work, degree and content of independent decision-making, supervision and control of work, instructions, orders and regulations, interaction with colleagues and other staff, patients and other people’ how positions oneself, i.e. how sees oneself relative to others, use of machines, instruments, tools, materials and other artefacts

2nd area: **Historical content**

3rd area: **Work life balance**
- family relations (spouse, partner, children, relatives at home)
- housework, duties at home
- atmosphere and support at home
- free time, hobbies, interests, friends
- way of life, rest

4th area: **Key experiences – critical incidents**
- in any area of life and activity, not only at work
- turning points in life, problems, crisis
- solutions, lessons, effects and significance in the life course

5th area: **Gender**

6th area: **Knowledge sources** (opportunities to learn)
- in any area of life and activity, not only at work or at formal education and training
- shortcomings and needs
- significant other people

7th area: **Relation to clientele/people, sense of their professional mission**

8th area: **Job satisfaction**
- satisfaction with various aspects of work, such as tasks, autonomy, salary, atmosphere etc.
- good and bad features and things
- has ever considered changing occupation, work place or unit
- has ever regretted the choice of a career or profession

9th area: Important to consider “knowledge at work” in all areas and in relation to restructuring
- knowledge is defined broadly (not only technical and functional knowledge), but also knowledge about values, norms, people, symbols etc.
- knowledge at work is often tacit and situational, therefore difficult to convey
- try to keep in mind the country specific restructuring processes and events, such as major changes in policy, regulations, laws, economy, education, work organisation etc.

10th area: **Other information**
3 The PROFKNOW research in European contexts
Sverker Lindblad and Gun-Britt Wärvik
University of Gothenburg

3.1 Introduction
In focus for the PROFKNOW research presented here is professional work life in important welfare state institutions in different national contexts. The welfare states in Europe are in transition during the last decades – manifested among other things in the breakdown of the Eastern Europe economies and increasing neo-liberal tendencies in terms of marketisation and privatisation of welfare services and re-regulation in terms of governance as well as new public managerialism. As noted by Esping Andersen (1996, p 10 ff) the welfare states are taking different routes;

- The neoliberal route by means of deregulating (or rather re-regulating) and market-driven strategies such as in the UK.
- The Scandinavian route of welfare state expansion and social policies maximising employment and gender equalisation.
- The labour reduction route with a developed social insurance system and underdeveloped social services subsidising exclusion of elderly people and women.

To our understanding the PROFKNOW countries ten years ago exemplify a neo-liberal route by England and a Scandinavian one by Sweden and Finland, the others a bit less clear cut examples in the distinctions made by Esping Andersen. To us it seems that we are missing cases following the labour reduction route.

These different routes are perhaps not as distinct today – given globalisation forces and international community building such as by the European Union. On the other hand we are dealing with old welfare state institutions that are stabilising work practices as well as traditions and cultures.

The PROFKNOW studies are situated in seven national contexts: England, Finland, Greece, Ireland, Portugal, Spain and Sweden. Considering their geo-political contexts these cases belong to the Northern, Western and Mediterranean parts of Europe. Given this, we are not representing Continental and Eastern European cases in our studies. Thus, large parts of Europe are missing in our ways to capture professional knowledge under restructuring. Furthermore, as will be shown below, there is a large variation among the PROFKNOW countries in several respects, and international statistics will also be used to deal with this variation in PROFKNOW.

3.2 On national contexts and international comparisons
In this chapter we will shortly present and discuss different European contexts in education and health care and implications of this for our studies in PROFKNOW. Here, we will use the ways a number of European countries are presented in international statistics, mainly from the OECD. Everyone familiar with comparative studies and international statistics knows about the problems connected with overall comparisons over single variables (e.g. Ragin, 1987) and the abuse of measurements in order to make “quick and dirty” conclusions on measurements
of characteristics and performances of “nations” or institutions (e.g. van Raan, 1996). Based on such considerations we will use more general and less sensitive information about different national contexts as listed below:

- Gross Domestic Product (GDP) is the standard measure of the incomes generated from productive activity in a country per year. Here it is used in US dollars.
- GDP per capita is the GDP for a year divided by the average population for this year.
- Total expenditure on education in percent of GDP is the sum of general government expenditure on health and private expenditure on health in a given year.
- Total expenditure on health in percent of GDP is the sum of general government expenditure on education and private expenditure on education in a given year.
- Nurses includes professional nurses, auxiliary nurses, enrolled nurses and other nurses such as dental nurses and primary care nurses.
- Teachers are here limited to primary school teachers – which are the focus of PROFKNOW studies – and are defined as in Education at a Glance 2006.
- Teachers’ salary refers to average pay after 15 years of work and is defined as in Education at a Glance 2006, Annex 3.
- Nurses’ salary is an unstable classification as defined in Health at a Glance 2007 and not possible to compare. There is a lack of data from most European countries.
- Foreign-born individuals refers to long-term migration and are measured in relation to population censuses (International Migration Outlook Annual Report 2006 p 44 and 260) representing first generation migrants.

The list presents ways of dealing with complex definition problems. We have chosen the simple way to rely on practices at supra-national organisations, predominantly the OECD. This is the reason why much of the presentations are referring to the GDP as an indicator of importance to characterise countries as well as education and health systems.

A most problematic definition refers to Foreign-born individuals which will be used as an indicator of migration issues. The indicator chosen is referring to place of birth – and is calculated in relation to the whole population. This is a bit misleading in two ways: Firstly, notions of foreign-born differ in relation to social and cultural determinants which make this simple characteristic somewhat problematic. Second, in PROFKNOW we have chosen to do large parts of our studies in multi-cultural urban settings, which is distinctly different from average percentages in different countries.

### 3.3 The national contexts in terms of economic indicators and expenditures

In appendix 3.1 a selection of European countries are presented in a table concerning GDP per capita, migration and expenditures on education and health as percent of GDP.

Starting with the GDP per capita as an indicator of economic wealth in the selected countries, the outcomes are presented in figure 2. Here, we can note that countries belonging to the former Eastern Europe are less well off compared to continental, northern and western countries. We can also note that the PROFKNOW countries are distributed rather well over the national contexts outside Eastern Europe, having Ireland on second position – after Norway, UK (representing England) on the ninth, Sweden at the tenth, Finland at the twelfth and Spain, Greece and Portugal at the bottom part. Based on the same observation we note considerable differences between the PROFKNOW countries in this specific European context.

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The next step in our analysis is to have a closer look on the expenditure on education and health in the selected European countries. The indicator here is the total expenditure as percent of the GDP. In the figure 2 we have ordered the countries based on their GDP per capita as presented earlier. Thus, Norway is given the highest position and Poland the lowest one.

In figure 3 we find considerable differences in expenditures between countries using the chosen indicators. Greece, Slovakia and Ireland are spending rather small shares of the GDP on education compared to the other countries, while Iceland, Denmark, Norway and Sweden are taking the lead positions. Finland, the UK and Portugal are positioned in the middle together with France, Austria and Hungary. In a word, there is no one-to-one correlation between wealth and education expenditures by these measurements. Furthermore, the variation within the PROFKNOW countries is considerable here.

Going over to health expenditures we are getting a somewhat different picture. In the top in terms of expenditures we find the UK, Switzerland, Germany and France while we at the bottom observe the positions of Slovakia, Poland, Ireland, and the Czech Republic. In the middle we find Italy, Denmark, Sweden and the Netherlands. We are noting large differences between the countries to which we can add differences in GDP as such. Furthermore, the PROFKNOW countries cover almost the whole range of positions by means of this measurement.
In figure 3 we can also observe large differences between expenditures for health care and education, the former being much higher than the latter as a rule, but also that there are large differences between the differences, showing the UK and Greece among those countries, while Denmark, Finland and Sweden are presenting rather small differences in expenditures. These indicators on economic wealth and expenditures on education and health care are of course too general to do more precise comparisons between different European countries. But taken together three conclusions are possible to draw:

1. Not surprisingly the former Eastern European countries are significantly less well off compared to the other European countries using the GDP as an indicator.
2. The PROFKNOW countries are not significantly different from the European countries outside Eastern Europe.
3. There are large variations between the PROFKNOW countries within the current frames of European countries and their GDP.

So far, with the reservations presented above, the PROFKNOW countries are not very special in European contexts outside Eastern Europe. Thus, our work is at least to some extent compatible with e.g. Continental European contexts.

### 3.4 Migrations in European contexts

Migration issues are highly complex. Immigration flows are presenting quite different tendencies in terms of social and cultural issues. Thus, it is not surprising that they are dealt with in quite different ways in different national contexts and that international statistics are in front of quite serious problems in terms of categorisations and measurements of e.g. unauthorized immigrants in different national contexts. Furthermore, the ways migration issues are dealt with are often related to critical and contested areas in societies, such as language politics, citizenship as well as social inclusion/exclusion.

The OECD is presenting data and analyses of migration issues in relation to policy agendas, labour markets and eventual selection of migrants as well as to international cooperation (see e.g. the OECD annual report from 2006: International migration outlook).

**Figure 3.3: Migration.**

The percentages in figure 4 are based on the national censuses in the different countries. To our understanding it means that unauthorised immigrants are to a large extent excluded in the estimations presented in figure 4. There are different ways to capture these immigrants – showing that unauthorised immigrants are around one percent of the population. An exception is Greece who have around three percent unauthorised immigrants, according to the OECD (International Migration Outlook, 2006 edition, p. 46).

According to figure 4 there are large variations in the share of foreign-born individuals in the selected European contexts – where Switzerland has a very high share and Poland a very low share. The PROFKNOW countries cover a high share of the variation, with Sweden as a high proportion of foreign-born and Finland a low share. However, given these figures and current variation in unauthorised immigration a reasonable conclusion is that the PROFKNOW countries have a somewhat higher share of foreign-born inhabitants and are in that sense a bit un-representative to the rest of Europe. On the other hand, we have reason to expect that migration flows are increasing in Europe and in that sense our national cases can be regarded as more representative in the future.

In the PROFKNOW project it was regarded as strategically important to capture issues of migration in our studies and we selected sites for our ethnographic studies in areas characterised by large shares of foreign-born inhabitants. Thus, our work will be special in that respect.

3.5 Salaries

When considering international statistics over countries and professions we find that the pictures on teachers are more distinct than those of nurses, e.g. in terms of classifications but also about what kinds of statistical information that are provided e.g. from the OECD. One aspect of this asymmetry concerns salary. Though recruitment of nurses is a vital point of discussion today we find little of stabilised information on their salaries today. The data available from OECD refers to nurses who work in public or private hospitals only. Registered/certified nurses and associate/practical/vocational nurses are accounted for as one and the same category.

In appendix 3.2 more detailed information on the salaries of teachers, and to some extent for nurses in appendix 3.3, in different European countries is presented.

A more relative – and perhaps more telling information is provided when we put salaries in relation to the Gross Domestic Product per capita, as is shown for primary school teachers in figure 5. Here we note that the Nordic Welfare states Finland and Sweden are having rather low salaries compared to Portugal, Spain and also England and Greece. The Swedish teachers are earning less than the GDP/capita while the Mediterranean are earning far more than their average countrymen and women. The basis is the OECD publication Education at a Glance from 2006. It must be underlined that we are referring to teachers working in the public institutions, whose salary pattern might differ very much compared to teacher salaries in private schools. We can note that the former Eastern Europe countries Poland, Hungary and the Czech Republic are clearly below the other European countries in the table, where Germany and Switzerland takes a lead considering entry salaries as well as salaries after 15 years of work in the occupation. The PROFKNOW countries are distributed fairly well with Greece and Sweden as those having the lowest salaries and Ireland and England the highest salaries among primary school teachers.

---

2 Mean: All countries 8.42 %; ProfKnow countries, 7.73 %; ProfKnow countries excluded, 7.78 %
Figure 3.4: Primary public school teacher salaries over GDP per capita.

Given these figures the PROFKNOW countries are having salaries that are fairly well comparable with other Continental, Mediterranean and Western European primary school teachers. Furthermore their economic status differ – primary school teachers in the Nordic welfare states are comparatively less paid than teachers in the other PROFKNOW countries, and especially in comparison to Spanish and Portuguese teachers.

Figure 6 illustrates some corresponding comparisons for nurses and the basis is the OECD publication Health at a Glance from 2007. There is no data available from Spain and Sweden.


^Mean: All countries, 1.1; ProfKnow countries, 1.3; ProfKnow countries excluded, 1.1.
It is also difficult to draw any comparing conclusions since the unstable base of the data presented.

**Figure 3.5: Hospital nurses’ salaries over GPD per capita.**

[Graph showing hospital nurses’ salaries over GDP per capita for various countries.]


It must be noted that the data from OECD about nurses’ salaries is very unstable and there is a lack of data from most European countries, including ProfKnow countries. Portugal appears to have better paid hospital staff than the rest of the countries in the table. However, we don’t know which hospital staff categories are included in the data and it is therefore not possible to draw any conclusions from this diagram.

### 3.6 Concluding comments

In this short review we have presented the PROFKNOW national contexts in relation to other European contexts by means of international statistical material – mostly derived from the OECD. Given the premises of such construction of national similarities and differences by means of negotiated and harmonised categories and data-collection we are getting a picture where the differences within the PROFKNOW countries are more significant than the differences between the PROFKNOW countries and the other European countries. However, countries from the former Eastern Europe are at present distinctly different from those in northern and Western Europe. Thus, for this reason we should be a bit restrictive in our translations of the PROFKNOW findings to these national contexts.

### 3.7 References


Appendices to chapter 3

Appendix 3.1: Basic social indicators in a selection of European countries

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP/capita</th>
<th>Education percent of GDP</th>
<th>Health percent of GDP</th>
<th>Foreign-born population as percent of total population</th>
<th>ProfKnow country</th>
</tr>
</thead>
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<tr>
<td>Slovakia</td>
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<td>4.21</td>
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<td>Poland</td>
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<td>6.5</td>
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<td>3.4</td>
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<td>6.2</td>
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</tr>
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<td>10.1</td>
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<td>12.9</td>
<td>-</td>
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<tr>
<td>UK</td>
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<td>5.90</td>
<td>15.3</td>
<td>9.7</td>
<td>+ (England)</td>
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</tbody>
</table>


Mean: Education percent of GPD
All countries: 5.69
ProfKnow countries: 5.41
ProfKnow countries excluded: 5.84

Mean: Health percent of GPD:
All countries: 9.25
ProfKnow countries: 9.59
ProfKnow countries excluded: 9.08
Appendix 3.2:
Annual statutory teachers’ salaries in public institutions at starting salary, after 15 years of experience and at the top of the scale, by level of education, in equivalent US dollars converted using PPPs (in short related to differences in costs of living in different countries).

<table>
<thead>
<tr>
<th>Country</th>
<th>ProfKnow country</th>
<th>Start salary</th>
<th>Salary after 15 years</th>
<th>Ratio 15 years salary and GDP/capita</th>
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<td>10023</td>
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<td>Spain</td>
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Source: Education at a Glance 2006 edition, OECD.
Appendix 3.3
Remuneration of salaried hospital nurses, USD PPP

<table>
<thead>
<tr>
<th>Country</th>
<th>1999</th>
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<th>2002</th>
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<td>14 436</td>
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<td></td>
</tr>
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<td>Denmark(^b)</td>
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<td>38 747</td>
<td>39 814</td>
<td>41 129</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finland(^c)</td>
<td>25 088</td>
<td>26 395</td>
<td>26 255</td>
<td>27 712</td>
<td>28 405</td>
<td></td>
</tr>
<tr>
<td>Hungary(^d)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13 574</td>
<td></td>
</tr>
<tr>
<td>Ireland(^e)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>40 739</td>
</tr>
<tr>
<td>Norway(^f)</td>
<td>31 005</td>
<td>33 718</td>
<td>33 729</td>
<td>34 292</td>
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<td>Portugal(^g)</td>
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<td>36 982</td>
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<td>36 890</td>
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<td>UK(^h)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>47 554</td>
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</table>

\(^a\) Includes wages for paramedical personal.
\(^b\) All levels of registered nurses working in hospitals. Overtime included.
\(^c\) Nurses who work in health care centres and hospitals. Public health nurses, specialist nurses, and chief nurses not included. Overtime included.
\(^d\) Hospital nurses.
\(^e\) Nurses working in publically funded hospitals. Overtime not included.
\(^f\) Nurses with three years of training but no specialist training. Central government maintained hospitals.
\(^g\) All categories and scales of hospital nurses. Overtime not included.
\(^h\) NHS-nurses in England.

Source: Health at a Glance, 2007 edition, OECD.
4 England: National report

Caroline Norrie and Ivor Goodson
University of Brighton

4.1 Introduction

The aims of this research report are stated in the ProfKnow project proposal (Lindblad, 2004)

- To describe, analyse and evaluate restructuring in education and healthcare from the point of view of teachers and nurses and their experiences from their interaction with clients.
- To present a conceptual framework for analysis of professional knowledge in restructuring organisations.

This report aims to describe, analyse and compare restructuring of education and healthcare in England and the professional knowledge of teachers and nurses. The conceptual framework to be used is a combination of 1) a systems narrative, 2) a worklife narrative and 3) a structural viewpoint. The systems narrative will discuss reforms at a national level. The worklife narrative will examine reforms at a grassroots level using data collected from interviews and ethnographic observations. The structural analysis will explore global and societal trends interacting with teachers and nurses' worklives. Within this report, a systems analysis perspective will highlight how all changes and reforms are inter-connected, constantly influencing and interacting with each other. This approach will be combined with narrative analysis which will explore how competing discourses resonate at different levels within the system. A main aim of this work will be to make cross-professional comparisons.

The argument posited in this report is that the progressive narrative of the 1960s and 1970s ‘consensus years’, when labour and capital worked together in harmony rebuilding England after the Second World War, broke down at the end of the 1970s in economic stagnation, de-industrialisation and subsequent labour unrest. Margaret Thatcher capitalised on this moment to break with the social democratic narrative tradition and introduced the New Right ideology of ‘the market’ into England with its emphasis on supply, demand, choice and citizens’ self-reliance. In this era public sector professionals were viewed by government with suspicion and berated for being unproductive and money-wasting. Conservative governance ended in a mire of political sleaze and New Labour swept to power in 1997 on a wave of popular euphoria. Many professionals hoped for a return to left-wing politics but there was to be no going back to Old Labour socialist narratives. The new dawn meant the introduction of ‘third way’ (Giddens, 1988) narratives - socially democratic policies combined with economic prudence. This approach was designed to fit an increasingly globalised and service-based economy. Jobs in the service industries increased by 45% between 1978-2005, while those in manufacturing fell 54% in the same period (Babb et al., 2006). Old Labour principles of a planned economy were jettisoned and capital was free to pursue its goals without political interference. In this new context, there is greater freedom for professionals to pursue varied careers and goals within a more flexible labour workforce. However, in this new wealthier society ideology and an over-riding, collective, meta-narrative have withered. (Or as Lyotard (1979) sees it, post-modernity is defined by 'incredulity towards meta-narratives'). In place of ideology is a cacophony of local, individual, micro-narratives played out in an increasingly marketised and consumerist society.
This research will argue that within the periodisation above, the role of professionals and their knowledge has changed. Teachers and nurses have reconfigured from traditional professionals to contested professionals to reframed professionals. Traditional professionals in the 1960s and 1970s were enmeshed in the progressive narratives of the post-war reconstruction era. Narratives of religious duty and long-term service were part of professional personas. Traditional professionals were deferred to by the public on the grounds of their status and expert knowledge. Under Thatcherism the ideological battle between the Old Left and New Right led to contested professionals with their ideals, ethics, authority and commitment becoming publically disputed areas. In the last 10 years, under New Labour professions have been re-framed. Teachers and nurses are now more flexible professionals, their authority has to be earned through team-working, collaboration with clients and life-long learning. Meanwhile increased regulation has been introduced in order to 'protect' the rights of the citizen.

It will also be argued that reform of professionals is related to structural changes taking place in society. These changes include the spread of ICT (and availability of knowledge), increased mobility and the changing roles of women resulting in a care deficit. These global changes including Neo-Liberal discourses interact with the re-configuration of the teaching and nursing professions. Discourses associated with structural change can be conceptualised as being refracted at different systems levels in different countries according to a multiplicity of factors including the positionality and power of professional groups (Norrie and Goodson, 2005).

4.2 The national case presentation

The argument that teachers and nurses have evolved from traditional to contested to re-framed professionals accompanied by associated changes in professional knowledge will be expanded in this report. This conceptualisation however is not meant to over-simplify the important differences and specificities of the two sectors which will be explored throughout the report. The systems and worklife analysis will be explored according to the ProfKnow consortium agreed guidelines presented in chapter 2. This will be followed by the structural analysis.

4.2.1 System Narrative:

A systems narrative approach will be used to compare educational and healthcare reform in England over three generations of teachers and nurses. This analysis is based on previous workpackages 1-3.

4.2.1.1 What does restructuring mean in the English context?

This section will compare periodised descriptions of education and healthcare reform in England. It highlights how teachers and nurses in England have moved from traditional professionals working within a progressive narrative to contested professionals in marketised narratives under Thatcherism to re-framed professionals under New Labour. England can be seen to have changed as a country from one where a progressive rhetoric of improvement has dissolved into more materialistic, localised and individualised narratives.

The following table represents the main changes over time effecting Acute Healthcare and Primary Education in England.
### Table 4.1: System Narratives in England

<table>
<thead>
<tr>
<th>Systems Narratives</th>
<th>Education Reform</th>
<th>Reform of Primary teachers and training</th>
<th>Healthcare Reform</th>
<th>Reform of Nurses and training</th>
<th>Professional Re-configuration of Teachers and Nurses</th>
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<tbody>
<tr>
<td>1960-1979</td>
<td>Piece meal</td>
<td>Primary teacher training colleges move</td>
<td>Increases provision</td>
<td>Nurse education based</td>
<td>Traditional Professionals –</td>
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<td></td>
<td>comprehensivisation</td>
<td>into universities</td>
<td>of services.</td>
<td>in schools of nursing.</td>
<td>Secure in their professional knowledge in hierarchal system</td>
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<td></td>
<td>of the secondary</td>
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<td>Organisational and</td>
<td>Push to increase status of</td>
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<td></td>
<td>education system.</td>
<td></td>
<td>clinical optimism.</td>
<td>nurses re doctors – focus</td>
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<td></td>
<td>of the National</td>
<td>stipulated course criteria. Over the</td>
<td>Service and</td>
<td>more competency based.</td>
<td>Conflicting voices and contestation over the role of the professionals in a more marketised public sector.</td>
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<td></td>
<td>Curriculum, Ofsted</td>
<td>80s and 90s courses reformed to include</td>
<td>Community Care Act</td>
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<td></td>
<td>testing at 7.11 and</td>
<td>student competencies.</td>
<td>introduced the 'internal'</td>
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<td>14 and league tables.</td>
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<td>market'. Tendering out</td>
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<td></td>
<td>the National</td>
<td>focused on 'standards'. A 'national</td>
<td>Healthcare Commission, NICE</td>
<td>in 1998. Nursing education</td>
<td>New definitions of professionalism based on –</td>
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<td></td>
<td>Literacy and</td>
<td>curriculum' for teacher education in</td>
<td>and increased use of</td>
<td>moves into universities.</td>
<td>teamwork, collaboration with citizens, public scrutiny, increased regulation and accountability.</td>
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<td></td>
<td>Numeracy Strategies</td>
<td>force from 1997-2002. But later</td>
<td>targets and</td>
<td>Courses become more</td>
<td>Respect is earned not conferred, expert status through experience and lifelong learning and reflective and evidence-based practice.</td>
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<td>dropped. Delivery of the Numeracy and</td>
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<td>Literacy Strategies and now the Creative</td>
<td>Increased ICT.</td>
<td>Nurses accused being too technical and having lost practical caring skills.</td>
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<td>Curriculum key.</td>
<td>PFIs</td>
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<td>Introduction of</td>
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<td>Increase in HCAs.</td>
<td>2005 – Project 2000 courses</td>
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<td>Foundation</td>
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<td>Introduction of new</td>
<td>replaced by more practical</td>
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<td></td>
<td>hospitals.</td>
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<td>competition through</td>
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<td>alternative providers.</td>
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<td>Foundation hospitals.</td>
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- **1960-75 – Progressivism and Expansion of welfare**

The period of the 1960s-1970s is considered as a time of progressive narratives and expansion in education and healthcare in England. Within this time period teachers and nurses were part of a profession-led, hierarchical, bureaucratic, planned welfare system. Professionals were self-directed and their knowledge and opinions were accepted as expert in a more class-defined society. Debates rage about the degree of *golden ageism* in this conception (Dingwall and Allen, 2001, Whitty, 2005). However, despite these reservations, this era can be viewed as one where professionals did command greater respect. In education, this was the era of comprehensivisation driven by a narrative of social justice. Teachers were encouraged to innovate in schools and there was a decline in the surveillance role of Her Majesties Inspectorate (HMI). In healthcare during the 1960s and 1970s clinical and organisational optimism prevailed and the belief that increased spending and new treatments could meet the population's needs. Matrons were closely regulated by doctors. Matrons in turn held power over their nursing staff in a hierarchical hospital structure. Teachers and nurses were *traditional professionals* and had autonomy over their own spheres of influence — the ward or the classroom. During this period nursing education was characterised by its practical nature. Nursing colleges were attached to teaching hospitals. Training led to qualification as either
an enrolled nurse (after 2 years) or as a state registered nurse (after 3 years). In contrast to nurses, professional training for primary teachers changed during this period as their practical training colleges were amalgamated into polytechnics (later incorporated into the university system) starting in 1965. This change meant that the practical courses of the colleges became more academic and based on subjects such as sociology, psychology or history.

- **1979-97 – Welfare reform - Thatcherism and the Conservative years**
  Margaret Thatcher stormed to power in 1979 pledging to end economic stagnation, de-industrialisation and labour unrest. The Thatcherite narrative was of economic renewal via the introduction of the ‘market’. This period was an era of conflicting ideological discourses between Old Labour and the New Right where the positionality of professionals became contested. Under Thatcherism professions were viewed sceptically as self-serving monopolistic bodies, which were wasteful of public money and acted against the citizens. Teachers in particular were attacked in this ideological battle and vilified in the media for their allegedly 'trendy lefty' beliefs and pedagogies which were seen as failing children. Despite protracted industrial action from teachers over two years, the 1988 Education act was passed. This act led to the National Curriculum, testing at ages 7, 11 and 14, publication of school league tables and intensified inspection and dissemination of results by the newly formed inspectorate Office for Standards in Education (Ofsted). In healthcare, efficiency drives and general managers were brought in, while non-clinical services (portering, catering and cleaning) were contracted out. Dentists and opticians were also privatised. Long-term care for the elderly and chronically ill was transferred from the NHS to Local Authorities who were now in charge of contracting services out to private companies. Nurses went on strike in 1988 calling for better pay and conditions but little was achieved apart from disillusionment. The 1990 National Health Service and Community Care Act under Prime Minister John Major introduced the ‘internal market’ in an effort to make the NHS more economic with Primary Care purchasers commissioning services from hospital Trust providers. A new Citizen’s Charter introduced standards for public services, which although received sceptically at the time by the public, can be seen in retrospect as psychologically significant as it increased expectations. During this period nurse education changed radically as nursing school were now, like teaching colleges 10 years earlier, amalgamated into universities starting from 1989. New 'Project 2000' courses lasted 3 years and either led to a diploma qualification or a degree. Trainee nurses were now however supernumery and spent more time in university than before leading to a shortage of staff on the ward. This has led to the introduction of large numbers of Healthcare assistants (HCAs) to cover their work, a trend that has continued.

- **1997 – 2005 – New Labour – the third way?**
  New Labour came to power in 1997 under the slogans "education, education, education" and "only 24 hours to save the NHS". Public sector workers enthusiastically welcomed the new rhetoric of 'partnership and performance'. However Labour have not repealed previous conservative policies and have instead introduced a plethora of legislation affecting teachers and nurses. During Labour’s first two years in power they were committed to the spending plans of their predecessors. However after this period funding in health and education has increased hugely. The Labour government has increased the proportion of GDP spent on public services by 3.3 per cent since 1997 (Pearce and Margo, 2007). Since 2000, funding of the UK NHS has more than doubled (Manel, 2007). Increased funding has been accompanied by a barrage of new targets. In primary education Labour introduced the National Numeracy (1998) and Literacy (1999) Strategies dictating classroom pedagogy. In healthcare nurses’ work was now monitored by increased managers and new quangos developed to monitor and publish standards in hospitals. However, Labour were disappointed with their ability to raise
standards and have now moved to a new approach of *personalised* provision of public services (Leadbeater, 2004). This new narrative focuses on clients exercising choice and being co-producers, designers and deliverers of their own *personalised* services. It also states that the private sector should have a larger role in provision of services. In secondary education Foundation, Trust and City Academy schools are being expanded. In primary teaching the focus has changed with a new *Primary National Strategy, Excellence and Enjoyment* which has introduced a more flexible creative curriculum and individualised learning (DfES, 2003). There is a strong creativity agenda in schools which accepts that in today’s fast moving society, facts are irrelevant as they are constantly changing, instead children need to be educated to be lifelong learners able fit to work in the new global, knowledge economy. In healthcare New Labour have been more radical with the creation of alternative providers and Foundation hospitals (Secretary of State for Health, 2000). “The Government has set out a new vision for the NHS where instead of being a monolithic structure that both commissions and provides care, it is to be a set of rights to treatment, at specified and assured standards, from a widening base of diverse suppliers, public and private” (Whitfield et al., 2005:11). The NHS is currently undergoing a funding crisis and for the first time in 20 years, nurses are being made redundant as Trusts struggle to save money. Despite the extra money many hospital Trusts have run up deficits and been plunged into debt. The Labour government is now lambasting Trusts accused of mismanagement and overspending on their budgets. *Turnaround teams* from international consultancies have been rushed into hospitals to make savings. These have been made by cutting staff including nursing jobs. Reasons for this situation are stated to be increases in staff wages, Trust debt due to Private Finance Initiatives (PFIs), and increased costs of litigation (The King's Fund, 2005). Other writers also blame the increased use of management consultants in the NHS (Craig and Brooks, 2006)

4.2.1.2 How is restructuring working?

This section will compare national policy narratives of restructuring in healthcare and education. The following system narratives will be explored – governance, choice, marketisation and privatisation. It is within this context that the re-configuration of teachers and nurses has occurred from *traditional* to *contested* to *re-framed* professionals with accompanied changes in knowledge.

Various narratives around governance changes in education and healthcare have surfaced over the lives of three generations of teachers and nurses and their various manifestations have been greatly debated. Narratives associated with New Public Management emerged in England during the Conservatives and have continued under New Labour and involve de-centralisation, de-regulation and governance-by-results. In education, power has been devolved from Local Education Authorities to individual primary schools – empowering parent-ocracy at the expense of local democracy. In healthcare reorganisations have been prolific and power has been devolved from Health Authorities to smaller Trusts or Foundation hospitals. However the process of devolvement of power and de-regulation is a contradictory process as new technology means central government has also increased its power to monitor and control. The spread of ICT facilitates data collation and benchmarking and leads to a quality agenda. This agenda and the associated narrative of ‘standard setting’ started under the Conservatives. New Labour extended this agenda in education with extended SATS tests in schools, intensified Ofsted inspections, school league tables and targets. In healthcare Labour introduced the narrative of clinical governance (Department of Health, 1998). The meaning of this discourse is contested. It encompasses many voices including raising standards via benchmarking and auditing via newly established organisations - the National Institute for
Clinical Excellence (NICE) and the Healthcare Commission (HCC) as well as the use of National Service Frameworks (NSFs). The role of the HCC is to set targets, regulate, publish and enforce standards of care. Clinical governance also includes discourses around patient and public involvement, lifelong learning and evidence-based practice. Over the years data collection, analysis and targets have become more sophisticated for example the use of Value Added data. The standards agenda however, has not raised performance as quickly as Labour hoped and they have now turned to more radical market-inspired plans to stimulate improved public services.

The 'choice' narrative is key to how restructuring is working. Under the Conservatives, the raising of standards through competition and choice was justified ideologically. However under New Labour ideology has been abandoned and choice is justified as a way of defending public services by maintaining their popularity in a consumerist society (Cabinet Office, 2007). Under the Conservatives choice in public healthcare and education was more rhetorical than practical. New Labour however have made efforts to introduce choice more concretely. In education all parents now have the right to express 3 preferences of which primary and secondary school their child will attend. However, there are no guarantees the child will be placed in the school of their choice. Parents have the right to appeal if they are not happy with the school their child is allocated to. In healthcare, since December 2005, Labour introduced the right for a patient to choose in which hospital they will receive treatment out of a selection of 5 including private providers. This policy is connected with the introduction of 'Choose and Book' under the Connecting for Health ICT modernisation. This means patients visiting their GPs can view their options to be seen in different hospitals on-line and choose where to be treated according to waiting lists, proximity or hospital reputation. Oppositional narratives to Labour's choice agenda are current with the popular critical discourse that the public are interested in high standards of services locally rather than choice. When accused of creating greater inequality by pursuing a choice agenda, New Labour defend their policies by stating public sector capture by the middle classes means that in the past inequalities were rife. By introducing choice, Labour argue rather than presiding over a postcode lottery, they are offering the less privileged greater opportunity to access a wider range of public services (Cabinet Office, 2007).

Restructuring of healthcare and education is working as narratives of marketisation have become increasingly normalised. An over-arching discourse during the Conservatives years was the marketisation and privatisation of services on ideological grounds. Under New Labour, private providers are being encouraged into the public sector. As Tony Blair recently stated when announcing that primary schools would soon be incorporated into the business-sponsored Academy schools, "business and education will move even closer together and rightly so." (Cabinet Office, 2007) In healthcare, the drive towards introducing private provision is more advanced. Labour has aimed to reform the NHS with the target of 15% of services to be provided by the private sector. Independent sector treatment centres (ISTCs) have been introduced to compete with the NHS treating specific areas such as orthopaedics, elective surgery and pathology. High performing hospitals have been given independent status and re-named Foundation Trusts and regulated by their own newly created quango Monitor. Foundation hospitals are allowed to enter into joint ventures with private healthcare companies like the American UnitedHealth Group, South African Netcare or BUPA (Pollock, 2005). Payment by Results was introduced in 2003 and full implementation is expected by 2007. Under this scheme costing and payment for patient's treatment has to be calculated against government benchmarks for procedures. Whispers of previous more

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4 A private company known in the USA for a ‘catalogue’ of offences and fines in various States including defrauding the government insurance system and cheating patients (Pollock, 2005: 14).
socialist, anti-marketisation narratives can be captured for example in current debates over cutting television junk food advertising aimed at children or in complaints about the high costs of hospital parking which has been contracted out. But discussions are based more on particular cases or local issues and divorced from collective ideological moral arguments of social justice.

Private Finance Initiative schemes (PFIs) in healthcare and education are another demonstration of how restructuring is working under New Labour. Under PFIs, private companies are contracted to build (and sometimes run) schools and hospitals. Government narratives on the use of Private Finance Initiative schemes (PFIs) emphasise their cost-effectiveness as vital mechanisms to renew and rebuild public sector infrastructure after years of underfunding under the Conservatives. However, critics voice severe misgivings about the economic competitiveness of PFIs due to higher costs of private rather than public borrowing and additional contractual legal costs. PFIs are also criticised for tying up public money in contracts for up to 30 years without any idea of demand in years to come (Gaffney et al., 1999, Edwards and Shaoul, 2002). This is especially controversial in healthcare where the central push is increasing for care to be carried out in the community.

The picture presented so far of how restructuring is working under New Labour has been of the continuation of broadly Neo-Liberal and Conservative policies combined with re-modelled narratives of justification. However, this would ignore the socially democratic nature of many of Labour's less publicised initiatives such as the setting up of SureStart programmes and Children's Centres in areas of disadvantage which provide childcare services and support for parents.

4.2.1.3 Professional strategies

This section will compare what national professional strategies have been used by the teaching and nursing professions at a national system level in the face of recurrent reform. The movement of nursing and teaching from traditional to contested to re-framed professionals is not seen as a fait accompli but rather a continuous, evolutionary process. In the 1960s and 1970s, teaching and nursing were traditional professions who maintained public support due to their exclusive knowledge, long training and ethical relationships with clients based on self-regulation by a professional body. This approach was sufficient in a more class-based society. However, this conceptualisation became contested in the 1980s with some public sector workers, especially teachers, attacked by the government. Today's re-framed professionals maintain public support through new strategies. Massification of education and access to professional knowledge via the internet means power has shifted towards the public vis a vis professionals. Teachers and nurses now have to gain public support through communication, sharing knowledge, reflective-practice, user-involvement, ethical practice and stricter regulation. (These issues will be examined in more detail in the next section on professional reconfiguration.) Strategies open to professions aiming to retain or improve their status, pay and working conditions are winning public, government and media support or increasing their collective power through unionisation. Support may also be gained through mythical narratives of self-justification.

Nurses and teachers can be seen to be successful in their strategies of retaining public support. A recent survey found 94 per cent of the public trust nurses compared with 83 per cent who trust teachers. (Doctors also retain high levels of public trust at 91 per cent, whereas politicians only score 7%) (Lifestyle Extra, 2007). However, this only tells half the story. Closer investigation of data reveals that patients' surveys report dissatisfaction with many areas such as shared decision-making, self-management plans or support in accessing information (Coulter, 2005). This demonstrates that NHS professionals' strategies
maintaining public support need work in the area of greater user-involvement. Giddens (2007) describes this change as a move from *passive trust* by the public in the past to a situation today of *active trust*. Professionals now have to work *with* clients to gain trust in a collaborative exchange rather than it being simply conferred (Giddens, 2007). Giddens conceptualises this as a positive change to a more democratized society.

The battle to retain popular support as a strategy of professions is also fought through the media. Appalling examples of professional criminality have been accompanied by huge media interest. Narratives about GP, Harold Shipman’s murder by injection of several hundred pensioners or Children’s Nurse, Beverly Allitt’s killing of several infants are part of collective public memory and have affected perceptions of professions. Public discourses about teachers and nurses can be compared and they reveal that both sectors have experienced their share of profession-bashing. In the case of teachers, these attacks are remembered as being government inspired and starting in the 1980s. However bad media publicity has also affected nurses over the last ten years. Nurses are now accused in the media of being ‘too posh to wash and too clever to care’ and letting patients fester in filthy wards where the superbug MRSA is rife. In contrast to teachers, nurses also continue to experience an exploitative, sexualised image in the media (Gordon, 2005).

Another alternative for professions as a strategy to improve their circumstances or resist reforms is through unionisation. In comparison to teachers, nurses work in a more diverse and stratified environment making cohesive union organisation harder. The failure of teacher and nurse industrial action in the 1980s to achieve their aims highlights how the public embraced the state’s anti-professional narrative. In the case of the teachers it was also followed by a 1988 Act abolishing the national teacher unions negotiating machinery and in 1991 the School Teachers’ Pay and Conditions Act determined that the Secretary of State for Education and Skills, would now set teachers’ pay and conditions. On closer investigation, however while unionism has declined overall in England with the demise of the manufacturing industry, it is the big public sector unions including teaching and nursing that have retained their members. There are more women in unions today than there are men (Babb et al., 2006). However the nature of unions has changed and it is the unions who have non militant, anti-strike pledges that have gained the largest numbers of new members (Redman and Snape, 2006). This moderate “new unionism” is part of professional identity today. It also reflects the individualised, affluent society where capturing an overarching meta-narrative with which to inspire would-be strikers is difficult. Despite the wide changes to the NHS there appears to be little public discussion about the direction reforms should take and especially little conceptualisation of the broader issues at stake. There are currently national campaigns involving all the NHS unions fighting against further privatisation of the NHS e.g. (Keep Our NHS Public, 2007) however these have not made large inroads into public narratives.

Professional strategies also include appeals to ‘mythical’ narratives of professions. Dinwell and Allen (2001) argue nursing has always consisted of the jobs doctors do not have the time or inclination to carry out. Nursing leaders and dominant professional discourses however focus on emotional labour, holistic care and therapeutic-use-of-self as devices to gain more public support and to demarcate nurses from doctors and other allied health professionals. Dingwell and Allen (2001) argue for nurses to drop the myth and advertise the reality of their jobs as increasingly technical. The caring narrative can be seen as particularly important in a context where nursing has historically had to fight for power against male, medical discourses. Nurses are often seen as being hampered from progressing as a profession due to their gender. However Dinwell and Allen (2001) also argue this is a myth that needs jettisoning as today in medicine, women doctors make up nearly half the profession. In
contrast it is harder for the teaching profession to retain mythical idealised conceptualisations in the eyes of the public as the experience of schooling is universal. Nurses have the opportunity to maintain more professional mystique and prestige. It has been argued however that in today's 'interview society' (Atkinson and Silverman, 1997) (where no corner of society is left un-intruded into) it is only a matter of time before remaining occupational mystique is broken down.

One strategy teachers and nurses have pursued with success under New Labour is their striving for increased wages. Under New Labour, teachers and nurses' wages have increased. In nursing this has been more controversial than in teaching. In fact, Agenda for Change and the new doctors' salaries are one of the reasons that the NHS is in its current financial crisis (Manel, 2007). Agenda for Change has re-organised of the pay structure for all NHS employees (excluding doctors) and wages are now linked to a new skills and knowledge framework. One aim of this reform is to link competency and performance more closely to pay, and as such can be viewed as part of a performativity agenda. Another aim is to allow more flexibility and career progression within the NHS and to break down hierarchies. Pay deals can also be seen as a way of paying off professionals so they will not criticise restructuring.

Another strategy for professions aiming to improve their status or material benefits is controlling their supply. In the past, as part of a planned economy, university places were allocated based on an estimation of future demand for professionals. Higher education has been de-regulated however and in many disciplines operates in a more marketised fashion. In education and nursing however, there are still mechanisms for control by way of the fees and bursaries offered to trainee teachers (introduced in 1998) and also for nurses. So for example, due to the current funding crisis in the NHS, Health Authorities have cut back funding for nurse education. For the first time in many years, there are more UK trained doctors and nurses than required by the NHS. This is in contrast to the last 15 years in teaching and nursing when there have been staff shortages and retention problems. In contrast with teaching, the nursing shortfall was so severe that international recruitment was seen as the only (or cheapest) solution. National agreements were formed for example with the Philippines, Spain and India to encourage more nurses to work in the UK. Now however international nurses lower grade nurses have been taken off the Home Office 'shortage occupation list' meaning work permits will be granted only if a job cannot be filled by British or EU applicant.

Professional strategies of the primary teaching and nursing professions can also be compared in their success in attracting and retaining men. While the numbers of men entering nursing are rising (currently 10% in the workplace and 15% in training), primary teaching is a feminising profession (Hutchings, 2002). This could be seen as evidence that the professional status of nursing is rising in line with their increasingly technical roles and the profession is attracting more male members, while that of primary teaching is falling. Within both professions male teachers and nurses are stratified within certain areas and in higher management level positions.

4.2.1.4 Professional Configuration

This section will compare the re-configuration of teachers and nurses and their professional knowledge. It will explore how teachers and nurses have re-configured from traditional to contested to re-framed professionals over three generations. The use of this conceptualisation is not however to over-simplify the important differences and specificities of the two sectors. The remodelling of professions is a widely discussed discourse in academic and professional literature as well as in the media. In England in both teaching and
nursing there is a continuing debate about what it means to be a 'new professional' in the new millennium e.g. (Davies, 1995, Whitty, 2005). The Definition and conceptualisation of professions is a long contested area (Etzioni, 1969, Freidson, 1983, Larson, 1977, Lortie, 1975, Talcott Parsons, 1968). Professions can be viewed as occupational groups on different evolutionary pathways in possession of varying amount of power according to their historic and characteristic features. Early approaches to the study of professions involved the listing of characteristics of the big four (Law, Medicine, Clergy and Academia) with the aim being for the semi-professions to raise their status by acquiring the same attributes. This is now seen as a dated approach and professions are viewed more critically as complex systems constituted of a plethora of voices. The view of professions as monopolistic organisations engaged in pursuing turf wars to maintain their occupational 'closure' (Weber, 1968) is also generally acknowledged. However in order to describe and analyse change it is possible to generalise that traditional professionals can be conceptualised as more associated with certain qualities. These include self-regulation via a professional body and an ethical code, a long training and an exclusive body of knowledge. Associated with traditional professionals are paternalistic attitudes, autonomy, control, power, mastery, elite knowledge and privilege. In contrast re-framed professionals are characterised by stricter regulation, lifelong learning and CPD, reflective practice, evidence-based practice and team-working. Associated approaches include public accountability, collaborative practices, client and public involvement and research-based practice. This section will explore government policies and reconfiguration of professionals by focusing on – professional regulation, professional education, teamworking, professional knowledge, lifelong learning and user-involvement.

Professional regulation has been reconfigured differently in teaching and nursing. While nurses have been registered since 1917, teachers have only been obliged to register since 2002 with the formation of the General Teaching Council (GTC) (legislated for in 1997). The creation of the GTC can be viewed as status-raising and increasing the accountability of the teaching but it can also be seen as extra surveillance and a response to the public's fear of paedophiles and mistrust of teachers. (All adults working with children now have to pass criminal record police checks to confirm they are not on national list of paedophiles). Teachers had campaigned for a professional body for 100 years but they have only gained the GTC at a time when the bodies losing power. It is not seen as a self-regulatory professional body as it contains non-teaching board members. Teachers are required to register their identity and teaching location with the GTC. This situation is also demonstrated by the reforms that have taken place in nursing regulation. In the light of high profile media cases the government felt the need to restore public trust with greater regulation. The United Kingdom Central Council of Nurses (UKCC) was re-organised to form the National Nursing and Midwifery Council (NMC). The privilege of self-regulation was ended as this new organisation was compelled to involve lay people in decision making. The NMC introduced a system of nurse re-registration every 3 years and practitioners may be required to produce evidence of CPD. The NMC has greater powers to investigate cases of nurse incompetence and fitness to practice. This shows the profession's need to demonstrate members' competency and knowledge. This is evidence of how the public demands greater scrutiny of professionals. The stricter regulation of teachers and nurses is demonstrative of the move to re-framed professionals and is also occurring in other professions including medicine and pharmacology (Secretary of State for Health, 2007). Possessing an ethical code was seen in the past as part of traditional professions. This alone is no longer viewed as sufficient robust for professionals. Benner (2007) highlights how the education and creation of ethical practitioners is a growing part of the narrative around professional reconfiguration. In a recent study she has explored the professional training of five professions including nursing,
the clergy and accountants in the United States in the light of the Enron scandal. Benner posited the need to educate 'civic professionals'.

The reconfiguration of nursing and teaching can be compared in terms of their changing professional education. While primary teacher training moved into universities in the 1980s, nurse education was not to move into universities until the early 1990s. In both teaching and nursing, university courses became more based on traditional academic subjects of psychology and sociology and distanced from practical professional knowledge. Teacher training was attacked as irrelevant by the government in the 1980s and reformed becoming more school-based and focused on competencies. Nursing also faced criticism from within and outside of the profession for being overly academicised and theoretical. This has led to the dropping of Project 2000 and its replacement with courses where more time is spent on practical skills. Students now go on the wards earlier in the course and for longer periods, they have a "home" hospital and the practice part of the course now has to be at least 50% of the student experience. In initial teacher training universities have also faced competition from a small number of newly created school-based ITT providers (SCITTs). Meanwhile nursing has opened its doors wider with increased Accreditation of Prior and Experiential Learning (APEL) courses.

Increased inter-professional and team working is a key part of re-framed professions. Greater specialisation of jobs over three generations of teachers and nurses means more multi-agency working. In education the creation of extended schools as well as the increased number of special educational needs (SEN) children in mainstream schools has led to increased inter-agency working for teachers. Schools have become more specialised places with the creation of new roles, for example school bursars and business managers. Non-teaching professionals are employed full-time especially within some challenging schools, for example social workers, youth workers, family therapists or nurse managers. Team-working is now seen as an integral part of the teaching role. In healthcare increased medical specialisation has created a need for more multi-disciplinary team-working. Nurses' roles themselves have also changed hugely and been extended and become increasingly specialised. A 1992 document *Scope of Professional Practice* (UKCC, 1992) led to nurses taking on new responsibilities without needing a certificate of extended roles, 'as long as they were deemed competent'. The Nurse Prescribing Act was also passed in 1992, and Specialist Practitioners were introduced. Under New Labour, in 2000 Nurse Consultants and Modern Matrons were created. Extended roles were expanded with 10 areas of potential responsibility that nurses could be take charge of including ordering diagnostic tests, making and receiving referrals, admitting and discharging certain patients, managing a caseload, running clinics, prescribing treatments, carrying out resuscitation procedures, performing minor surgery, triage and running of local health services. It is argued that these roles take advantage of nurses as 'cheap doctors' brought in due to fill a skills and labour shortage created by the EU Working time Directives (1989 and 1992, 1998, 2004) which reduced doctors hours. Other commentators view them as empowering nurses' career development and inspired by a wish to make the best use of nurses' skills and knowledge. Career structures for teachers have also widened with the introduced under New Labour with the introduction of Threshold pay and Advanced Skills Teachers' (ASTs). This reflects the government's narrative of recognition of public sector professionals as knowledge workers who view career progression as personally important (Cabinet Office, 2007).

Teachers and nurses' roles are being reconfigured as they increasingly work in teams managing less qualified staff - changing their own positionality. Healthcare Assistants (HCAs) represent the most rapidly growing group within the NHS. HCA numbers in England almost doubled in the six years from 1997 when 16,190 were recorded (Buchan and
There has also been a large increase in teaching assistants (TAs). Between 1997 and 2005 the number of teaching assistants almost trebled – from 35,500 to just under 100,000. During this time special needs support staff doubled to 48,000. By comparison, the number of full time equivalent (FTE) ‘regular’ teachers in the nursery and primary actually went down by 200, to 196,000 (Whitty, 2005). Teaching assistants can now train to be advanced teaching assistants (ATAs) who can teach whole-class groups. The National Union of Teachers (NUT) - has warned that teaching assistants only results in larger classes and unqualified people substituting for properly trained teachers. The National Foundation for Educational Research (NFER) review of literature on the impact of teaching assistants in schools found TAs do not necessarily lead to any reduction in teacher workload or allow extra time for them to concentrate on planning or preparation. Instead, they give teachers additional responsibilities as they now need to manage and plan the TA's work (Lee, 2002). In nursing, research has found that higher proportions of unqualified nursing staff correlates with worse standards of patient care and higher rates of patient morbidity (Aitken and Patrician, 2000). New Labour discourses around the increases in HCAs and TAs celebrate the extra support they have introduced for teachers and nurses (Cabinet Office, 2007).

Institutions are currently being re-organised according to the Every Child Matters Agenda (Department of Education and Skills, 2004). The aim of this reform is that professionals working with children should work together to ensure child protection and holistic care for all children. This agenda involves the re-organisation of Local Authorities, the introduction of joint ICT networks between social services, healthcare and education providers and the establishment of 'lead professionals' for at risk children (Department of Education and Skills, 2004). Under this initiative new core competencies for the children's workforce have been introduced with the expectation that teachers, children's nurses and social workers (and TAs or social worker assistants or early-years workers) might in the future have transferable qualifications and be able to cross disciplines. Some universities have already started courses where first year students follow a common curriculum and chose which profession they wish to join in the second year. By 2010 an Integrated National Qualifications Framework is to be established. This agenda obviously offers huge challenges to professionals and huge potential demarcation issues. However it is evidence of how the government is trying to break down inter-professional barriers and knowledge (Cabinet Office, 2007).

The professional knowledge needed by re-framed professionals has also changed and can be compared in teaching and nursing. Traditional professionals relied on an exclusive body of knowledge that provided them with status as experts. Re-shaped professionals work in an environment where there is greater access to their professional knowledge via the internet giving clients more power. Professionals are no-longer automatically seen as "knowing best" (Coulter, 2002, Muir-Grey, 2002). Greater access to knowledge means that professionals' legitimacy is questioned so CPD and lifelong learning becomes more important for re-framed professionals. The reliability of the professional knowledge is also now more debatable, leading to the rise of evidence-based practice as an attempt to keep up with new, more rapidly changing developments. In nursing especially, since the 1990s the growth of evidence-based practice discourses has been explosive including evidence-based decision making, evidence-based nursing or evidence-based healthcare. This outlook can also be seen as a justification for cost-cutting and the rationing of treatment. French (2002) argues that 'evidence-based practice' is a euphemism for information management, clinical judgement, professional practice development or managed care. He notes that 'the term adds little more to the existing traditions of quality assurance and research-based practice'. Estabrooks et al. (2005) argue that nurses are encouraged to take responsibility, and make decisions backed by
evidence-based practice, however in reality much of their practice is actually founded on embedded tacit knowledge. In education the teacher-as-researcher movement has also become a feature of professional knowledge. Schon (SCHON, 1992) argues that professionals and their knowledge is in crisis. Professionals justify their authority based on evidence-based practice but in reality they should be focusing on reflection-on-practice. The rise of the reflectivity discourse can be seen as an important element in nursing and teaching knowledge and professionality. It could be seen as linked to the necessity for today's teachers and nurses to be personally accountable and self-monitoring in a less hierarchical society where religion is no longer the controlling and self-regulating mechanism is was a generation ago.

The development of increased user-involvement as part of professional knowledge can also be seen as progressing in both nursing and teaching in line with their re-configuration from traditional to re-framed professionals. In nursing, discourses such as holistic nursing and patient advocacy are an important facet of their distinctive professional knowledge and commitment to the patients. It is argued that these discourses also represent oppositional positions to the dominant positivist narratives of traditionally male dominated medicine (Dingwall and Allen, 2001). The fight of nurses to be viewed as autonomous professionals in possession of their own body of knowledge is not a battle that teachers have had to engage in. In teaching, user-engagement has also increased with the re-emergence of 'student voice' discourses (Fielding and McGregor, 2005), school councils becoming more widespread and increased parent participation.

4.2.2 Worklife Narrative

This section aims to explore the reform of education and healthcare from the point of view of teachers and nurses using a worklife narrative approach. This section is focused data collected during ethnographies and life-history interviews with teachers (WP 4) and nurses (WP 5). The worklife narratives support the argument that over three generations, the professionals have moved from traditional to contested to re-framed professionals although each in their own distinctive manner.

Whereas the system narrative focused on national discourses of reform, this section analyses and compares teachers and nurses' personal life stories and experiences of working in education and healthcare. Giddens (1991) writes that in 'high modernity' the self is a 'reflexive project' with citizens engaged in constant re-invention and re-storying of their identities. The rise of the micro-narrative means individuals' lives are no longer automatically scripted but involve choosing identities. In this context narrative capital (Goodson, 2006) becomes increasingly important. The reflexivity of the nurses and teachers was in evidence during the interviews. Some participants appeared to be re-telling well worked stories whereas others mentioned that the interview process had drawn out newly discovered issues. Discourses were identified around changes in professionalism and knowledge running through the discussions with teachers and nurses, for example, global (references to IT, mobility, gender and multiculturalism), societal (changes in social structure) political (references to Thatcherism and New Labour), mythical (references to idealised professional conceptions or golden ageism) professional (references to autonomy or competence), empirical (references to best-practice and research-based practice) local (references to local communities), or personal (references to worklife balance).

4.2.2.1 What does restructuring mean (including working conditions)

The grid below illustrates what restructuring means for teachers and nurses from a bottom up perspective by examining individual and collective narratives arising from the fieldwork.
Table 4.2: Narrative Motifs among Teachers and Nurses

Summaries of worklife attitudes of teachers and nurses interviewed and observed

<table>
<thead>
<tr>
<th>TEDS' Narrative motifs</th>
<th>NURSES' Narrative motifs</th>
<th>Shared professional narratives of all teachers and nurses (n = 23).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Older generation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1</td>
<td>Committed educationalist. Despite disliking recurrent reform, still finds job enjoyable.</td>
<td>N1 Dedication to the job but disillusioned with working in the NHS and constant change. Looking forward to retirement.</td>
</tr>
<tr>
<td>N1</td>
<td></td>
<td>&quot;We work to live, we don't live to work&quot;……</td>
</tr>
<tr>
<td><strong>Mid generation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T2</td>
<td>Views change as part of the job and is a-political. T2 is representative of a globally mobile professional as she has gone to work in NZ.</td>
<td>N2 Struggling to enjoy work due to high responsibility, job cuts, staff shortages and uncertainty over job security.</td>
</tr>
<tr>
<td>N2</td>
<td></td>
<td>&quot;Patients/relatives, Children/parents have become more demanding...&quot;</td>
</tr>
<tr>
<td><strong>Younger generation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td>Representative of younger generation where there is a wide career choice. T3 tried work outside teaching but found it was also competitive. T3 feels although her job is currently tough it will get easier and offers a stable career.</td>
<td>N3 N3 finds work stressful due to staff shortages and she has chosen to work part-time in the NHS hospital and a private hospital to avoid stress. N3 puts her social life before her work.</td>
</tr>
<tr>
<td>N3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comparative Professional narratives</strong></td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>&quot;Everything has speeded up.&quot;</td>
<td></td>
</tr>
</tbody>
</table>

This research found when teachers and nurses talked about reform, the major narrative motif they continually came back to was the alterations in attitudes of children, parents, patients and relatives over the years. The phrase that clients "are more demanding" is symbolic of the interaction between various trends that have occurred over three generations of teachers and nurses. Society has changed from a class society to an under-class society reflecting the economic restructuring and de-industrialisation that has occurred in England. At the same time there is increased marketisation and public expectations of their entitlement to services has risen. The breakdown of class barriers in society, the rise of consumerism and individualism (Beck, 1999, Giddens, 1991) and the decrease of deference in society (Sennett, 2003) are experienced by the teachers and nurses in the frontline. The following quotes about changes in children and parents demonstrate the situation in education.

**T1:** Children are not as nice. [...] And talk to anybody, and they'll agree with you, anybody who's been in school. Children are more difficult, and they're actually not as nice because they don't have any kind of self-discipline, on the whole. There's a lack of boundaries, a lack of parenting, and it's actually meaning that the children are just not so nice to deal with. [...] Nowadays children are kept in, they're not given freedom, they are like pressure-cooked, you know, so that they come to school like they're little things wanting to burst out, you know, and, and yet, they don't know rules and boundaries, so they don't learn self-discipline, [...] it was just accepted in the past. (T1, experienced teacher)
T1: Most parents are really wanting help, [chuckles] which is different. They're also stroppy with you, which they never used to be, because I mean, in the past parents weren't involved with school, they just handed their children over and that was it. And they didn't really know very much about what went on, so all that kind of aspect of parents being involved and the fact that reading books go home for the children to read at home every day, and all of that kind of thing is great. But, again it's, somehow we've, almost moved a bit too far in terms of, well it's the classic thing, people know all their rights without their responsibilities, it's that kind of phrase, isn't it? [...] now parents question everything. And they molly-coddle their children, they don't kind of accept that children actually have to learn to find out things for themselves and stand on their own feet a bit, and...[...] it's society generally, it's not just with teachers. People question more. People are less submissive, they will, you know, the class structure is not as strong as it was. (T1, experienced teacher)

The following comment highlights changed relations nurses experience between patients and relatives.

N8: They're much more demanding than they were. And that's because they've been given the wrong impression of the health service. I think that comes from the very top, it's about these targets and 'you can have this and you can have that' [...] But there's a small minority and there is an increase in verbal abuse to staff. Yeah, and I've certainly noticed that. And it's not just your usual, 'I don't like you'. It's assault. It really is. (N8, experienced nurse)

4.2.2.2 How is restructuring working?

This section aims to use evidence collected in observations and interviews to explore how restructuring is working from the viewpoint of teachers and nurses. The primary teachers' over-riding collective narrative was that their work had "come full circle" – but importantly now practice also included accountability measures. Under Thatcher the introduction of the National Curriculum, testing Ofsted and league tables affected the autonomy of primary teachers. The compulsion to teach science in the curriculum was also noted as an important change. Under New Labour, the introduction of the National Literacy and Numeracy Strategies with their highly prescriptive pedagogy again changed teachers' practice. However the teachers were not overly critical of the Strategies in retrospect and they noted they were well-conceived and had raised standards. The interviewees noted the most recent changes (DFES, 2003) brought teaching 'full circle' with the focus on creativity in pedagogy. However the pressures of SATs tests and Ofsted had not been removed and the teachers' practice is still vastly more prescribed than it used to be in previous generations. The existence of this very strong collective 'full circle' narrative suggests there is consensus over changes and cohesiveness of the profession - possibly as a result of having to undergo constant reform. This discourse could also represent a professional collective attempt to gain emotional equilibrium when faced with recurrent reform. The phrase "we've come full circle" is a short cut for teachers to bolster their collective self-esteem psychologically and note to each other and outsiders that despite reforms teachers knew best all along. This can therefore be seen as a symbolic narrative motif or mantra of passive resistance.

Meanwhile for the nurses their first concern when discussing working conditions and change was the security of their own jobs in a period of redundancies where some were being asked to re-apply for their positions. When nurses talked about restructuring they mentioned a more disparate number of factors compared to the teachers, reflecting their more dispersed roles. Nurses told a collective story of work "speeding up" over the generations. This was due to increased through-put of high dependency patients, making work more stressful and demanding. In nursing the story of loss of nursing control over cleaning, catering and
portering reverberates and was evident during observations. For example, cleaners were noted doing an extremely poor job despite high levels of MRSA in the hospital. Although this reform happened under Thatcher it is still a current theme as its ramifications are evident in nurses every day working lives. The older nurses also highlighted the discourse of the increase of hospital managers and this was noted by the older generation as impacting on their work and autonomy.

Some discourses were noted across nursing and teaching. For example both teachers and nurses noted how their work is controlled by governance by results. From the teachers and nurse perspectives on the ground, this was experienced by pressure to meet targets and comply with nationally set regulations. Nurses and teachers also complained about the increases in paperwork this created. Nurses discussed having to comply with Care Frameworks and Care Pathways laid down by NICE (National Institute for Clinical Excellence) and Essence of Care, benchmarks which were first introduced in 2001 by the Department of Health Modernisation Agency to try to ensure the fundamentals of nursing care are covered. Areas covered include personal hygiene, food and nutrition, privacy and dignity or record keeping. Teachers discussed complying with regulations in all areas of their work. In the words of T1, ‘I used to say, if it moved in school you had to write a policy for it. Well, now we’ve done that, we’ve been there, we’ve written policies for everything...Now, people are writing action plans for everything...now you’ve got an action plan about how you’re going to improve it!’ For both teachers and nurses, the need to document work was seen as both good practice aiding accountability and also increased surveillance and work.

The role of ICT in controlling work was mentioned by some of the participants, for example one teacher explained how weekly lesson plans had to be placed on the school computer network for the head to sign off. Another nurse described the computer programme used to work out the nurse-to-patient ratio.

4.2.2.3 Professional Strategies

This section aims to compare teachers and nurses’ responses from the bottom up when faced with this relentless reform. This report argues that in the face of recurrent reform professionals have taken refuge in the symbolic motif or mantra of ‘working to live, not living to work’. This mantra demonstrates how professionals have internalised lessons from the downsizing experienced by the private sector in the 1980s. Jobs are now viewed as unstable and unreliable so psychologically self-emersion and identification with your job or career is no longer an emotionally safe bet. Professionals want to place their emotional energy into their own outside interests rather their work. Older professionals noted how the younger generation behaved in this manner, although they did not see this as a sign of their lack of commitment. Rather the older generation of professionals admired this as a good approach and aimed to ape it themselves. The fact that this is such a strong motif within the interviews points to worklife balance being an area of concern and stress for the professionals. Teachers and nurses are continually required to repeat their mantra in an attempt to distance themselves from their work environment and remind themselves of where their real values lie. The following quotes demonstrate the pressures of working.

T7: I think the pressures are huge. I think it’s, one of the problems with teaching is knowing when to shut it out, knowing when to draw a line under it, we’re talking about the worklife balance, you can start a term with clear ideas in your mind about how many hours you’re prepared to do and what tasks you are prepared not to do but as, you know, people come to


5
you with, with more demands, increasing demands as the term goes on, and as you become
tired-er which you do, so that by this stage in the term we are incredibly tired, it becomes...
you become less effective in managing tasks and you become less effective in saying no or
shutting out the thoughts or the worries or the anxieties, because you've lost the energy to do
that. [...] I think a lot of people outside teaching, work very, very hard, I know they work
long hours, but I wonder how many of them actually work probably fifty percent or more of
their weekend as well, and, put in, you know, two hours minimum an evening, beyond the
working day. That is, that's a heavy load so what happens is you end up like I am having had
a little more sleep but not necessarily rested mentally or emotionally because you've still been
living and breathing and thinking about work that you've needed to do. Erm, and then if you
have a house to run as well, [...] I do find that hard. (T7, mid-career teacher)

N3: [...] it is good. I mean, I'm happy with what I can do here. But I worked on
units that were great in [town 1], and the nurse in charge, I mean, just lived and breathed
the ward, the, you know, working seventy hour weeks, which is fine for them, but it isn't for
me. I mean, I don't, I think I'm more.... I work to live, I don't live to go to work. (N3, early-
career nurse)

Representatives from both nursing and teaching sectors discussed dealing with work stress
and worklife balance and how excessive work stress can lead to bullying in the work place
and how destructive this can be.

Professional strategies available to teachers and nurses range from enthusiastic compliance to
resistance. Importantly, without the support of the larger proportion of teachers and nurses
on the ground, reforms would be impossible to implement. During fieldwork, examples of
resistance were identified. T3 and T2 noted how they disagreed with testing for young
children but for example tried to make the experience fun and non-pressurised while still
falling in with regulations such as covering material on the classroom walls that could help
pupils. Teachers and nurses also offered examples of how they worked with reforms. Nurses,
for example explained how they now worked in extended roles; teachers discussed pleasure at
being made Advanced Skills teachers. In the past these roles would have been viewed as
breaking professional solidarity; today however these socialist discourses are silenced. This
is not to say there was no discussion or friction around the changes, especially in nursing, but
it is not vocalised in ‘Old Labour’ terms. It might be expected that teachers and nurses would
have misgivings about TAs or HCAs undermining and blurring their professional boundaries.
Again, this approach was not vocalised in terms of professional ‘closure’. Nurses and
teachers did discuss their personal relationships with individual TAs and HCAs (sometime
problematic, sometimes rewarding). Nurses mentioned worries about patient safely when
increasingly basic care was being carried out by HCAs, but implications for the profession
were not voiced. This suggests that teachers and nurses have taken on board the atti
dtudes from the private sector about working in different ways for the good of patients and children
and have accepted the changes. Alternatively, especially in the schools, an atmosphere was
sensed that it would be ‘un-reconstructed’ and non politically correct to voice this opinion.

The teachers and nurses demonstrated no evidence of any militant attitudes. When
mentioning the teaching strikes of the late 1980s, all the teachers viewed them as a failure and
as (T4) noted of the period, ‘We lost a lot of public sympathy and I don't think that we've ever
regained that in the public's eyes.’ In contrast, the nurses did not mention strikes that had
been held in the 1980s. Nurses' strikes were less protracted and well supported at the time
and left less of a mark on the professional collective consciousness. While the transition to
re-framed professionals was, in the case of teachers carried out in the public eye, for nurses,
the contestation appears to have occurred more privately within the profession. However in
contrast to the teachers, it is the nurses who are currently facing calls to protest and support
industrial action. The views of the nurses interviewed were that restructuring of the NHS
would continue as neither the Conservative or Labour parties want to stop the marketisation process. Nurses stated that the NHS could be broken up and replaced by an insurance system or privatised providers under the NHS umbrella. N4 noted how this process appears to be happening without political or public discussion. She felt that the public were lulled into a false sense of security by it being a Labour government who was carrying out the changes, while the Iraq war also acted as a distraction. Nurses across the generations appeared to be resigned to this and unwilling to fight it. During the observation period, a demonstration was called in the hospital by the group Keep our NHS Public. It was not however a huge success, demonstrating the failure of the Left to find a collective meta-narrative to resonate with either NHS professionals or the public.

N8: I think there was only about fifteen people there, I heard.
I: Oh, really.
N8: Yeah, Let's just get on with it. We're here to look after patients, and we've got to do what's right for them. As long as they don't suffer, I don't mind people protesting, but...
N7: [...] I said ‘Well, you're all fighting that you don't want any more redundancy and 'scuse me I've just been taken on full time permanently.’ I said 'I'd be a bit of a hypocrite to come down to your rally, I feel'. Erm, and when I thought about it afterwards I thought, 'Oh, that's a bit pious, really wasn't it, you know.' I don't care about anyone else now, it sounds like, you know, I've got my job, so, you know, bless them all, but...
(N8, experienced nurse, N7, early-career nurse)

Since this research was undertaken, job cuts have continued and wards have been shut down to save money. In fact, rumours on the internet now state that a key department is to be handed over to be run by a private company due to the hospital debt.

4.2.2.4 Professional reconfiguration

The teachers and nurses narrated how they saw professional reconfiguration over the generations from the bottom up. Teachers and nurses’ views demonstrated how they had changed from traditional to contested to re-shaped professionals. Many of the changes in professional reconfiguration that were discussed by the teachers and nurses have already been noted in this report. These include changes in initial training, increases in inter-professional working, more demanding clients, changes in governance (via regulation, ICT, targets, and national policies), rise of discourses of reflective, evidence-based practice and lifelong learning.

One area that has not been discussed and that the professionals discussed at length and is of interest when discussing reconfiguration are changes in status as felt by the different generations. Teachers and nurses ruminated over the extent to which their status had changed over the three generations. Although pay has improved, practitioners felt their status had not risen.

T4: I don't think teachers are held socially, if you like, erm, and I use the term fairly loosely, I don’t think they're held in the esteem that they once were, you know, because, you know, ‘he/she is the teacher’. That was felt to be a really good job. (T4, experienced teacher)

In comparison with teachers, the status of nurses is more complicated due to the variety or roles and the particular professional image. The following quote highlights how the knowledge of nurses can be undervalued in society. N2 explained when her father went into hospital he gained a greater insight into the skills of his wife, who had been a nurse for 30 years.
So he said to her when he came out when he was much better, and it was a real opening for them, actually, real, quite a big, major thing, he said, ‘I'm so sorry, I had no idea how clever you were or how much responsibility you had’. And he really didn't, he just thought she was just, used to go along and wash bottoms and.....(I: That's heartbreaking isn't it.) Yeah. And they were both hurt and elated by it at the same time. Yeah. (N2, mid-career nurse)

Compared to teachers, nurses' positionality within the hospital hierarchy means their status is effected by the identities of doctors, managers and some other allied healthcare professions. While nurses’ identity has been reconfigured, some of the other professions were less evolved. Nurses particularly felt that some of the older generation of doctors continued to behave more like traditional professionals.

I mean, you see the junior doctors and the critical care sisters, and you know that the sister, her knowledge or his knowledge just exceeds the junior doctors' just outrageously, and yet they still have to say, you know, ‘I think you should prescribe this’, there's a certain amount of you know, yeah, which is madness. [... you know, you're still playing it in this, 'you're the doctor, I'm a nurse', kind of bullshit. (N6, early-career nurse).

4.3 Analyses of structural changes with special reference to restructuring

This section aims to compare structural changes related reform of teaching and nursing. Cross-professional comparison sheds light on the interaction of structural changes in the evolution of teachers and nurses from traditional to contested to re-framed professionals.

4.3.1 Comparisons over Regions and settings

Comparisons between national, regional and case-study settings sheds light on the typicality of the case study schools and hospital used during fieldwork. Obviously drawing conclusions from the views of 15 teachers and 8 nurses would be erroneous. However, the question of how representative the case-study research sites were compared to other schools and hospitals in the country is of interest. Statistical data taken from the Ofsted and Health Commission web sites give an idea of how representative these cases were. Indicators of hospital performance show the Trust was graded in 2005/2006 as weak for use of resources and fair for quality of services. This places the Trust in the bottom half of results in England. The 0-3 star system of grading hospitals has been modified, however according to this previous system the hospital was in the bottom 20% percentage of national hospitals having been awarded 0 stars. The hospital has received poor media coverage and has a bad record on MRSA rates. As to the schools, one was based in an area of deprivation and so was in receipt of specifically targeted funding which meant many national initiatives were carried out in the school. These included Leadership Development for school managers, Playing for Success (PfS), a study support scheme based at sports grounds and Extended school Programme - childcare from 8am-6pm, all year round. At this school, over 20 different languages were spoken by the children and high percentage of them also came from families without work. SATS results for this school were below the national average. The other two schools involved in this research are referred to in their Ofsted reports as 'typical" and their SATS results were average. However, it is surmised that schools where the head is willing to host researchers freely tend to be outward looking, more confident schools.

4.3.2 Comparisons of System narratives and life work narratives

Comparison of the systems and worklife narratives investigates teachers and nurses as key professionals acting between the state and the citizens. Teachers and nurses have always
occupied this liminal positionality. However within the 1960s and 1970s progressive narrative, professionals and the state had a shared mission and this positionality was less problematic. Under Thatcherism, teachers and nurses often offered an opposing voice of contestation against government changes by way of socialist oppositional narratives. However, in the current situation, without a meta-narrative, there is confusion and dissatisfaction among professionals around their over-arching aims. On the one hand professionals see targets for example as a waste of time, however, on the other hand, they too agree with the government that DNAs (patients who did not attend an appointment) or poorly behaved children are problematic and need addressed. Another example would be the positive rhetoric that surrounds the increase of SEN children into the classroom and the reality of working with children who may be disruptive to a whole class for 4 years. In healthcare the rhetoric of raising standards through targets can be confronted with the reality of data manipulation and patients being seen for first appointments quickly to meet targets then languishing on waiting lists for months. Professionals are called to be child or patient advocates while at the same time, they also have to ration services. Policy makers understand this contradiction and try to address it at a national system level with a narrative around citizens’ ‘rights and responsibilities’. In the past, this was a right wing narrative, but it has been taken by New Labour and sums up the situation as seen by the government that citizens cannot expect rights without taking some responsibility for the collective society. For professionals this dilemma is expressed by their feeling that their clients are too ‘demanding’. Price (2007) has conceptualised this paradox as a philosophical clash between Bentham versus Kant in which teachers and nurses are involved in an emotional tug of war over economic rationing versus client-centred, holistic practices and identities. In this way teachers and nurses are trapped in the gap between government rhetoric and political narratives about choices and entitlements and the reality of the classroom or the hospital situation. The interviews highlight the unease of professionals with over-riding national policies. Using choice and competition as methods of raising standards in public services is seen as intrinsically contradictory and causing greater inequalities in society and taking professionals away from their aims of putting clients first. However the lack of a national underlying oppositional ideology (with socialism having been dropped by the Labour party) leads to inward looking motivations and increased professional localism. This underlines the argument that the lack of a convincing meta-narrative means that professionals are relying on their own individual professional personas rather than any larger motivations.

4.4 Concluding comments

This report has compared the restructuring of healthcare and education from a system narrative viewpoint and a worklife narrative viewpoint. It has also explored reform from a structural, societal viewpoint. It has outlined how the progressive narratives of the 1960s became contested in England due to recession and poor economic performance in the mid 1970s. Traditional professionalism was contested under Thatcherism with the rise of market narratives and socialist discourses were silenced to a great extent during this period. Under New Labour a new society has emerged with greater numbers of people employed as knowledge workers in the service industries while a hard to reach underclass or excluded 20% of the population are increasingly challenging for professionals (Todd, 2003). Under New Labour, teachers and nurses have become re-framed to work in new circumstances. This report has aimed to compare restructuring of education and healthcare by exploring professionals who are conceptualised as positioned between the state and the citizens. The comparison of system narratives with worklife narratives has demonstrated the gap between the rhetoric of change as conceptualised by successive governments and the reality for professionals at the frontline of services who are torn between narratives of choice and
marketisation versus rationing and *increasingly demanding* clients. Inter-generational analysis highlighted the structural and societal changes in society over time interacting with professional reconfiguration. Those of particular importance are changes in gender capital, increases in ITC and increased mobility. Inter-professional comparison has brought to the fore the differing sectors’ interaction with global, national, local and collective discourses. The comparison of primary teachers and nurses has demonstrated while reconfiguration is profession-specific and connected to historic and intrinsic issues, it is at the same time, useful to identify shared patterns of reconfiguration.

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5 Finland

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5.1 Introduction

This report offers a general description of the restructuring of the Finnish welfare society and its implications for nurses and teachers professional work. I explore the meanings and workings of welfare state restructuring by comparing nurses and teachers in terms of professions and generations. Moreover, I juxtapose system narratives with life world narratives in order to highlight professional strategies and configurations. Finally, within this framework, I address to several themes, such as professional autonomy and accountability.

The empirical material that is referred to in the text comes from the national survey of the teachers (N=730) and nurses (N=), and life-histories, thematic interviews and observations for three working days of four primary school teachers and three nurses with their own consultancy in a public health clinic. More detailed account of these materials is given in work-packages 3, 4 and 5 of the ProfKnow project.

The structure of this national report is based on the guidelines presented in Chapter 2. However, the order and titles do not exactly follow the guideline, but the required issues are sometimes discussed under different headings and in different sequences than suggested in the guideline. Section two presents the publications based solely on national data and written solely by national authors working in the project. Section three is an account of structural changes in the Finnish welfare state. It is also a narrative of the system divided into three periods. Section four is an analysis of structural changes with reference to professions and generations. The focus of the analysis is on both the national survey and life-histories of nurses and teachers. It is also a life world narrative. The various themes that emerge from the data, such as autonomy, accountability and working conditions of these professions, are discussed within this chapter. The report ends with comments on the implications of the research project at the national level.

5.2 The National Case Presentation: System Narrative

In Finland, as in other Scandinavian countries, all citizens are entitled to a wide range of welfare services that are publicly funded by the state and municipal tax revenue. Thus high employment levels, growing national economy and high taxes per GNP are necessary preconditions to finance the Finnish welfare system. In most cases, for instance in primary and secondary education, social services and health care, municipalities are the main providers of provision of welfare services. Municipalities finance the services by collecting local taxes and receiving state subsidies. The state financing is based on unit costs instead of previously common ‘ear-marked’ money. Thus the decisions about the allocation of resources are made at municipalities. This means, that local authorities are basically free to decide, within the legal framework, how to allocate the per capita determined government transfers into various services sectors in so far as they can provide the basic services with appropriate quality. This state of affairs often leads to a confrontation between the representatives of various service sectors and the professional bodies and the municipality.

The build-up of the Finnish welfare state began during the post Second World War reconstruction period and intensified during the 1960s. The heyday and culmination of the
Finnish welfare state was probably the 1980s when the national economy was booming. The period that began in the 1990s meant the end of the expansion of the Finnish welfare state. The early years of the 1990s were a time of very serious economic recession. It suffice merely to say that while in 1990 the unemployment rate was 3.2%, then it rocketed up to 16.6% in 1994, and it has only gradually went down, being 8.4% in 2005. In those circumstance municipalities were in trouble to provide welfare services as the demand for services increased at the same time as the tax revenues and state subsidies declined. The eastern and northern regions of Finland, being already in an economically disadvantaged position, suffered most from the effects of the recession. Their recovery has also been the slowest. These regions had already lost much of their able work force to Sweden and Southern Finland during the Great Migration in the 1960s and 1970s.

Though the national economy has recovered from the economic recession of the early 1990s, the resources for the welfare services have been precarious in many municipalities. The differences in tax revenue are equalised through the government transfer system. However, the greyling population, falling birth rates and migration of young people cause troubles for the already underdeveloped periphery regions because of increasing health care and social costs and decreasing number of school-aged children. In addition, the legacy of the recession seems to be rather persistent among some social categories. For instance, the long-term unemployment and youth unemployment figures have remained very high. Youth unemployment among the 15 to 25-year-old was 20.1% in 2005, and 23.5% of all the unemployed were long-term unemployed, that is, they had been unemployed for a year or more. The recovery has been much more intensive and faster in few growth centres in the southern and western Finland than in poorer areas in the northern and eastern Finland. However, there are differences in the capabilities of municipalities to provide services and moreover to attract qualified professional workforce. Southern regions, especially the Helsinki area have a lack of qualified teachers and nurses, whereas small municipalities in the north and east have a lack of qualified medical doctors.

The restructuring of the Finnish welfare state began in the late 1980s when the coalition government formed by the Conservative Party and the Social Democratic Party adopted the discourse of New Public Management. Since then the catchwords of ‘efficiency’, ‘effectiveness’, ‘quality’, ‘accountability’, ‘control by goals and results’ and ‘evaluation of outcomes’ has change not only the language but structures and processes of state administration and public policy. Some researchers have argued that Finland has transformed from a national welfare state to a national competition state, due to intensified influences of globalisation and neo-liberal doctrine. In the past, the welfare state was based on belief in the circle of good between equality, economic efficiency and solidarity, which was a compromise of class conflicts between peasants, bourgeoisie and workers. Today, the institutions of the welfare society are thought of forming the infrastructure for the innovative and competitive community. The justifications for this infrastructure is often backed up by referring to the various international comparative assessments, such as the Global Competitiveness Report by the World Economic Forum or OECD’s PISA study, were Finland has thrived. (Heiskala and Luhtakallio 2006.)

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6 According to the latest Global Competitiveness Report (2006-2007), released by the World Economic Forum, an independent international organization based in Geneva, Switzerland, in September 2006 Switzerland, Finland and Sweden are the world’s most competitive economies. PISA, or OECD’s Programme for International Student Assessment, is a survey carried out in 41 countries, 30 out of which are OECD countries. Finnish 15-year-old students were among the best in all tested areas, mathematics, science, reading literacy and problem solving.
I will describe the history of the Finnish welfare state in three phases, which are the Preparatory phase of the welfare state (ca Second World War – 1960s), the Golden age of the welfare state (ca 1970s-1980s), and the Restructuring of the welfare state (ca 1990s-). This periodisation is based on the major changes in the administrative and policy ideology and practice which are manifested in the enactment of particularly important legislation concerning educational and healthcare services. These periods are also important if we want to make distinctions between various generations of teachers and nurses. Because education and health care sectors have been governed within a larger framework of the social policy the changes in these two sectors have been parallel.

5.2.1 Preparatory phase: From the WW II to the end of the 1960s

The major change in the Finnish health sector after the Second World War was the modernisation of the hospital system organizing them around central hospitals in the 1950s. In addition, the 1964 National Health Insurance Act introduced a social income during sick leave and reimbursement for private outpatient health services and pharmaceuticals. These services have remained until today, though amount of reimbursements for the private medical care have not followed the increase in costs. The major social policy concern behind the reforms was the regional and social differences in the availability of various health services. Thus the change aimed at social and regional equality. The expansion of health care services meant also more demand for the professional health care staff and consequently the number of student medical doctors and nurses was increase. During that period the Education of nurses was arranged in Educational Institutions of Nursing and the program lasted for two and a half years. Nurses were clearly a subordinate occupational group in relation to the profession of medical doctors in terms of educational level, material rewards and social prestige.

There were no similar changes in the field of education as in the health care sector in the 1950s and 1960s. Indeed, up to the comprehensive school reform in 1970s there was so called parallel school system in Finland. Children could either proceed from a four-year-long elementary school to a grammar school. Or, they could stay for two more years at the elementary school and after that go to a more practically oriented two-year extension school. In the 1960s the extension schools became secondary modern schools. The grammar school was divided into a lower and an upper school. The latter led to matriculation examination and then to academic education. From the secondary modern schools and from the lower levels of grammar schools pupils entered into vocational schools, colleges and training courses. Thus, university education was a privilege meant for the few, that is, mainly for the boys of the upper social class.

Also the education and professional position of teachers were divided into grammar school teachers and elementary school teachers. The education of elementary school teachers was at so called teacher seminars and the education of grammar school teachers at universities, where the teacher training occurred after the acquiring the subject degree at the subject faculty. Thus the educational system was strictly divided into two hierarchical tracks, one leading into the positions of societal power and the other leading to the world of manual work.

The Finnish economy grew and rapidly became more industrialized after the Second World War. In addition, the services and public sectors were enlarging. Related to this was a great migration from the rural areas to the southern urbanized growth centres and Sweden. Consequently, there was increasing demand for skilled and educated labour force and more widely spread willingness among the political and social elite to exploit the reserve of talented people. People strived for social mobility and in the context of expanding job opportunities even minimal educational investments returned excellent profits. This strengthened people’s
believe in education as an instrument for success in the labour market and social advancement (Antikainen and Kauppila 2005, 219; Antikainen et al 1996). Consequently, the parents were very motivated to educate their children and there was an increasing pressure for the educational system to expand and to become more inclusive. Also the state was motivated to reform the educational systems, because the expanding economy needed skilled workforce in factories and offices. The pressure was intensified by the fact that especially the generation of the baby boomers who were born between 1945 and 1950 was exceptionally big. It has been estimated that about 7000-8000 young people moved to Helsinki each year during the 1960s. Already half of the age group was studying at the lower level grammar schools at that period. It was quite obvious, that the idea of the comprehensive school for the whole age group was introduced in the 1960s. The idea was especially backed by the Social Democratic Party and the Centre Party and opposed by the political right and private grammar schools.

Socio-historically the period 1945-60 was a time of reconstruction after the Second World War. It meant the building of the social consensus, economic base and legal infrastructure for the coming of the Finnish welfare state. Finland turned during that period from an agricultural society to a modern industrial economy. There was strong internal immigration and the regional differences in growth and prosperity within the country increased. Culturally the country became more modern and individualised. As the economy grew and people moved from small farms to factories and bureaus in the towns it had also a profound effect on their way of living. People had more free time and money to consume various goods, services and entertainment increased. In the international politics Finland tried to be neutral in the competition between the Soviet Union and USA. In addition to the Soviet threat there was also an internal instability caused by the extreme left. The welfare state can be seen also as an effort to build national consensus against external and internal threats.

5.2.2 Golden age: From the beginning of the 1970s to the end of 1980s

In Finland, as in other Scandinavian countries, all citizens are entitled to a wide range of welfare services that are publicly funded by state and municipal tax revenue. The Finnish welfare system continues to be publicly funded though, for instance, in the health care sector, the proportion of costs to households and health insurance premiums have increased. The state regulates the health care and educational system and pays subsidies to municipalities, which are the main service providers. Thus, it is the municipalities and the Federations they have organized that hire educational and medical staff and purchase additional services from the limited private sector, particularly in health care, if necessary.

Much important legislation contributing to public welfare services were enacted in the 1970s. In the health care sector the Public Health Law enacted in 1972, leading to the creation of a system of primary health care centres in municipalities and the strengthening of specialised care in central hospitals. In addition, Occupation Health Act was enacted in 1978. In the 1980s The Ministry of Social Affairs and the Ministry of Health were unified, administration and planning was rationalised and centralised, and health care and social services were put together into the same national planning and financing system (“five-year-planning”). In addition, so called population responsibility and system of personal doctors were introduced in the 1980s.

In 1960s nurses were educated in Nursing Schools which were later transformed into Educational Institutions of Nursing, and again were re-named in the 1980s as Educational Institutions of Health Care. Education consisted of 2.5 years of general education and after some practical work experience nurses could take one-year specialisation studies in a chosen area of concentration. In 1980s the training was changed so that it took place in the upper secondary level lasting 3.5 years and including a specialisation. Public health nurses and
midwives had their own educational track, and were also educated at the upper secondary level.

Social and regional equity in access to health care services were emphasised as an official policy in the 1970s. This general objective is continued today, though there is an addition strong emphasis on the aspects of efficiency, quality and standardization of care. In the late 1980s the two-pillar management structures emerged at hospitals, which strengthened the nursing profession in relation to the medical doctors. Just about the same time nursing science was introduced at the university, especially for those who wanted to take the managerial roles in nursing. Though the period started with a striving for centralisation, already the end of the 1980s witnessed the early signs of deregulation and decentralisation in health care and social services sector.

In the educational sector, the comprehensive school reform of the 1970s (1972-77) was similarly accompanied with the intensification and further centralization of educational administration. Education became under a stricter control of the Ministry of Education and the semi-autonomous governmental agency, the National Board of Education. School reform meant that all children would study in a single comprehensive school. Children would normally start their school at the age of seven in the lower level classes (1-6) and then continue in the upper level classes (7-9), which would fulfil the compulsory education requirement. However, the lower and upper level schools were administratively united as a single comprehensive school only recently. After the compulsory education pupils can apply for either the general secondary high school, or the vocational school. So called 10th grade was later added for those who needed to improve their skills and knowledge.

Nowadays there is an increasing demand for general secondary school education and matriculation certificate. About 60% of the age-group enters into general secondary education, and about 50% make it to the matriculation examination. More than half of the secondary school graduates are females. After the matriculation examination students apply either for the polytechnic or the university.

Secondary vocational education after the comprehensive school is relatively broad and long compared to many other countries. Programs, which combine theoretical and practical learning last three years, and the apprenticeship system is used only slightly. Previously, before the establishment of the polytechnics, there used to be also programs for those who had obtained a matriculation examination.

In parallel to the comprehensive reform teacher education was modified so that the university faculties of education were established and thus also the class teacher education was transferred from the seminaries into the universities in the 1974. From the old grammar school teachers became subject teachers and from the former elementary school teachers became class teachers. Subject teacher students, as did the grammar school teachers, enter first the subject departments and take their teacher training at the faculty of education during their studies. Class teacher students enter the teacher education programmes, which have their roots in the teacher seminaries at the faculties of education. Special teacher students enter the department of special education for a five-year program, or they take one-year course after their initial teacher degree and with some work experience at school.

The expansion of the welfare state was backed up by prosperous national economy, except the relative slight and brief economic stagnation cause by the international oil crises. However,

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7 For instance, in 2005, the Faculty of Education and the teacher training program at the University of Joensuu celebrated the 125th anniversary of the teacher seminary in Sortavala, a town that was annexed by the Soviet Union after the Second World War.
the Finnish economy was not hit so severely than the Swedish economy for instance because it was backed up by the cheap Soviet oil and export of consumer goods to Soviet Union.

The period between about 1975-1990 can be called the golden age of the Finnish welfare state. The administration and finance in sectors of education and health care was quite centralized, regulated and controlled by the detailed norms and rules issued by the state. For instance, schools and teachers were guided by the national curriculum and the inspections at schools were carried out by regional state administrators. Yet, municipalities have had historically rather much local autonomy, which is this context meant a legal obligation to arrange welfare services to their residents. The internal migration continued from the Eastern and Northern parts of the country to the Southern Finland, but not being as large as in the 1960s. In addition, Finland began to change into a service economy, meaning that the period of industrialised economy remained relatively short compared with many other western capitalist countries.

The internal and external political threats diminished as the Soviet Union weakened and the extreme leftist groups also disintegrated due to lack of political support. The collapse of the Soviet Economy together with the unintended negative consequences of the rapid deregulation of the financial markets caused severe crisis for the national economy which almost ruined the Finnish welfare state. Moreover, Finland opened more up to international and European influences and integrated more tightly into the world economy. The first initiatives of restructuring, at least in a sense of decentralisation and increased local discretion, of the Finnish welfare state were introduced already in the end of the 1980s. Then the economic recession of the early 1990s became entangled with the initiation of restructuring, and thereby left its marks to the measures of restructuring.

5.2.3 Restructuring: From the 1990s onwards

Pressures to increase efficiency the system of health care and social affairs became very prominent at the early 1990s and was took even more emphasis in the context of the severe economic recession. It was believed that efficiency and thus savings could be achieved by deregulation (or re-regulation) and increasing the autonomy and discretion of the municipalities and the federations of municipalities. In 1993 the reform in the state subsidy system was executed. The allocation of subsidies, which was previously based on the actual costs, was now organized according to some needs criteria such as demographic indicators. This change was a part of an overall reform in state administrative and financing system, which therefore also touched educational sector. In health care sector the consequences of the change of the financing system have been perceptible. From the 1980s to the beginning of 2000 the share of the state in financing health care has steadily decreased from 38.2% to 17.6%, whereas the share of the municipalities has increased from 28.9% to 42.4%. This means that health care is more and more financed by municipal tax, which is not based on a progressive tax as the state income tax, but it is based on equal tax percentage that is decided by the municipal council. In addition, households and social insurance premiums have increased their proportion of the health care financing. Furthermore, nursing education was upgraded and transferred to Polytechnics in 1990s. Number of nurses increased from 20,000 (1970) to 60,500 (2004). Most of the nurses work in the public sector, they particularly employed by municipalities and the federations of municipalities. Only about 9% of the work in the private sector and 0.5% are entrepreneurs.

Although the health care system was hit hard by the economic recession the services could be maintained at fairly good level. Recession did not either cause major changes in the population health indicators, although the higher social strata consumes doctor’s services, especially occupational health care and private practitioner’s services, slightly more than the
lower social strata (Häkkinen 2002; Häkkinen and Lehto 2005). However, many municipalities, and not only the ones in the less prosperous regions, have been struggling to keep the increase in expenses in control, especially in the specialized health care, in the context were tax income seems to be constantly precarious. Although, there has been a heavy emphasis on efficiency in health services it would be unfair to claim that the questions of equal access and quality have not been also in the forefront of health care policy. Most important ways of steering the health care system are means of In addition to legislation and regulation health care system is steered by extensive information gathering and projects organized mostly by STAKES, the National Research and Development Centre for Welfare and Health. Programmes of evidence-based medicine, local auditing and quality control are also widely used.

The division of labour between the nurse and the medical doctor and broadening of the nursing functions have much discussed in the early years of the 21st century. Nurses have been given new tasks on the grounds of more flexible and effective caring in the context of shortage of medical doctors and increasing demand for services. At present nurses have also been given their own reception where they treat, guide and follow-up patients’ with some common national deceases such as arterial hypertension. In addition, so called doctor-nurse work-teams have been established. Finally, the Ministry is considering allowing nurses a right to prescribe certain pharmaceuticals. In the background of these changes is the shortage of medical doctors, especially in the remote areas and an official policy for quick and equitable availability of health related services, which has culminated in a recent statue of about guaranteed access to treatment.

The latest reform initiative in Finland is the National Project on Health Care launched by the Council of State in co-operation with municipalities in 2001. The aim of the project is to secure the future of the system and provide quality health care in terms of regional and social equality (Decision 2006). The project has several aims: (1) to improve efficiency and productivity by re-organizing the operational and administrative structures, (2) to ensure quick access to treatment, (3) to maintain the quality and quantity of health care staff and improve working conditions and the division of labour, and (4) to secure the financing of the system. In addition, particularly so called Health 2015 -program promotes health and welfare in all spheres of life of the Finns and deals with some persistent national health problems.8

These administrative and policy developments and new requirements contribute to demand for further education of nurses. For instance, the current state of education of nurses is criticized as being too theoretical and not always in touch with the practical skills needed in primary health care. In addition, there is not a centralized curriculum for nurse education, but each Polytechnic is responsible for developing own curriculum, so that graduates do not have skills at the equal level.

Today the most of the registered nurses work on wards in primary health care or in specialized health care: 82% in 2000. In 2001, according to Statistics Finland, 45% of nurses worked in hospitals, more than third in institutional long-term care, and nearly one fifth in primary health care (out-patient care). 48% of them worked as public health nurses and midwives and 47% as practical nurses. A great portion, 80-85% worked for municipalities and municipal federations. (Moore et al. 2005, 169)

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8 There are even more specified aims: Clinical guidelines for treatment and evidence-based health care, in-service and management training programs, increasing the proportion of result-based bonuses in salary, regional re-organization of primary health care and intensification of co-operation between hospital districts, and initiating electronic patient records.
The structure of education and teacher training has remained virtually the same since the 1970s. However, there has occurred de-centralisation of educational administration and increasing local discretion and decision-making power in municipalities, at schools and in class-rooms. This type of restructuring has meant for instance the imposition of the national framework curriculum that obliges municipalities, schools and teachers to prepare their own curriculum based on the national guidelines. Furthermore, financing is now based on unit costs instead of “ear-marked” money and it was related with the allocation of decision-making power at the local levels, municipalities and schools. Finally, the overall management of the educational system was organized in terms of goal steering, evaluation and accountability, at least in rhetoric, if now in reality.

It should be mentioned that the economic recession caused the universities make budget cuts, which also affected the teacher education at the Faculties of Education. Yet, teaching has remained very popular choice among the secondary school graduates (Simola 2005, 459). But in some subject areas there has been insufficient number of application for subject teachers whereas the class teacher education has continued to be very popular (Webb et al. 2004a, 177). The number of teachers in comprehensive schools and upper secondary general schools has increase from about 45,750 in 1996 to about 51,000 in 2004. Teaching has been quite secured, except for the early 1990s when there were short temporarily dismissals in many municipalities due to economic recession. Compared to many other public sector jobs teaching is relatively well-paid.

Teachers as a profession are generally respected by the public, both at lower and higher ends of social spectrum (Simola 2005, 458). Consequently, teachers enjoy the social trust granted by the general public as well as the political and economic elite (Simola 2005, 459). However, Webb et al. (2004a, 180) in their qualitative study report about the decline in public respect for teachers. They relate the issue to the fact that the latest educational reforms have given parents a greater role in the decision-making of school-related matters, such as curriculum development and evaluation. Teachers report that parents are increasingly critical towards to schools and teachers and teachers’ see these negative views sometimes very uncomfortable or even threatening. Teachers see that parents do not appreciate their work as much as in the past (Webb et al 2004a, 181). In addition, Kiviniemi (2000) reports teachers perceive that the valuation of schools and teachers is decreasing.

Historically there has been strong upward social movement and striving for professionalism among the teachers in Finland. Teachers tend to identify themselves with the upper middle class, which belief is supported by the general social trust and high social status that they enjoy among the public (Simola 2005, 460-461, 465-6).

According to Simola (2005, 459-460) teachers have traditionally held rather conservative political opinions and at work teachers believe widely in their traditional role. He continues that that the teachers at the Finnish comprehensive schools appear to be pedagogically rather conservative and have more reserved and rather remote relations with the pupils and their families than their colleagues in many other European countries. According to Simola (2005, 461-3) teaching and learning seems to be traditional and teacher-centred, mainly frontal teaching of the whole group of pupils. Individualised and pupil-centred teaching is lacking (see also Norris et al. 1996, 29, 85). Regardless of this one observation, it is more realistic to situate Finnish school teaching somewhere between ideal types of authoritarian and pupil-centred teaching. Indeed, class teachers have to participate often to various issues related to pupils’ welfare that are strictly speaking outside teaching. Class teachers that we interviewed emphasized also that their work motivation stems mainly from caring and helping children rather than teaching them intellectual skills and knowledge. Finally, also Webb et al. (2004a,
180; 2004b, 94) have observed that class teachers consider that they have adopted new roles of a social worker, mother or father, alongside teaching.

The situation could be given a more positive interpretation as well. For instance, Norris et al. (1996, 39) observe that Finnish school are calm and secure places for pupils to work. Pupils behave well, there is concern and respect for others and property and only few problems of order and discipline. However, Simola (2005, 465-6) argues that the respect for teachers and acceptance of their own position supported by authoritarian Eastern culture accompanied with the mentality of obedience. Yet, according to Kiviniemi (2000) teachers perceive that there is a general breakdown of authority of schools and teachers. And there is growing anti-school culture intensified by pupils’ personal problems and parents’ problems due to social exclusion. One explanation for pupils’ respect for teachers and schools may relate to the cultural belief in education and the idea of learning society in Finland (Antikainen 2005).

Restructuring, coupled with the recession, was the end of the expansion of the Finnish welfare state. The economic resources are not growing rapidly anymore and therefore restructuring signifies a new way to allocate the existing resources. The national economy and most Finnish companies, families and individuals have fully recovered from the economic troubles of the early 1990s. However, some regions, families and individuals still seem to carry the legacy of the economic recession in the form of various “social problems”, such as unemployment, alcoholism, divorce etc. In addition, some service sectors, obviously the ones that were already in a vulnerable position before the recession, such as services for the aged and mentally ill, have a lack of resources. Although the material difficulties have been fixed in most cases the experiences of the recession has been significant, so that the phenomenon is often present in the discourse as a category to perceive, experience and explain social events and situations in Finland.

The administrative slogans of today are efficiency, effectiveness, quality, control by goals and results, and evaluation of outcomes and processes. The collapse of the Soviet Union and the emergence of the new international scene were later followed by the Finnish membership for European Union, which introduced the “European standards” in various sectors of society. In addition to the administrative changes and macro-economic conditions, the welfare system is influenced by other intertwined factors and trends, which are actually used to justify the reforms. First, globalization has intensified economic competition and the circulation of goods, services, money and people. Second, the regionally differentiated aging of the population has increased the demand for social and health services. Third, technological innovations change work procedures and techniques and thus require new aptitudes and skills. All these factors may have an additive or an interactive bearing on conditions, institutions and professional practices.

Lately some researchers have argued that Finland is transforming from a national welfare-state to a national competitive community, or a welfare society, due to intensified influences of globalisation. In the past, the welfare state was based on belief in the circle of good between equality, economic efficiency and solidarity which was a compromise of class conflicts between peasants, bourgeoisie and workers. Today, the institutions of the welfare society are thought of forming the infrastructure for the innovative and competitive community (Heiskala and Luhtakallio 2005; Kettunen 2001). The justifications for these institutions as a foundation of competitiveness is often backed up by referring to the various international comparative assessments were Finland has thrived.
5.3 Analysis of Structural Changes with Special Reference to Restructuring: Comparing across Professions and Generations

In order to compare professions and generations, the responses made by the participants of this research to various structural changes are examined as socially conditioned practices, which bring ―embodied history” and “objectified history” together (Bourdieu 1981, 305). The objectified history is accumulated over time into procedures, regulations, job descriptions, rooms, instruments and so on, that are for the worker the external reality of the work. The nurses and teacher interact with these objects, that may be tangible, such as spaces, people, documents, instruments and machines, and also intangible, such as ideas and regulations. The changes in administrative and regulative measures of professional work change the objectified history because it introduced new requirements and abolishes the old ones. For instance, at schools the external control by regional school inspectors was replaced by self-evaluation conducted by the teachers, schools, and municipalities.

The nurses and teachers differ in their tendency and style to interact with the external objects that belong to the sphere of objectified history. This difference is approached here as looking at them as carrying, or being carried by, different habitus. The habitus is a set of dispositions which incline agents to act in a distinguished manner. The habitus consists of dispositions, capabilities, aptitudes, interests and preferences that agents have concerning different objects. These dispositions are acquired in past practices in various conditions and settings, particularly in professional education and training. For instance, there might be measurable differences in various age groups of teachers and nurses with relation to their understanding of proper professional conduct.

By the virtue of habitus, the nurses and teachers differ in the extent to which they may appreciate and accomplish particular tasks. The new demands introduced by the changes in the administration and regulation of welfare state provisions, such as, increasing need for evaluation and detailed documentation could be seen as an interesting challenge or as a stressful additional burden on an already too heavy workload.

5.3.1 Professional Autonomy

One of the most important aspects of professionalism is the extent of professional autonomy and independent decision-making power at work. We asked the nurses and teachers to estimate the extent to which particular factors influence their everyday work. 94.7% of the nurses argue that their own conceptions influence their work ‘very much’ or ‘rather much’. Teachers think slightly more often (98%) that their own conceptions about how the work should be done influence ‘very much’ or ‘rather much’ to their everyday work. There are not any significant differences between various age-groups of teachers. Instead the older nurses tend to choose the option ‘very much’ more often (68.7%) than the younger ones (54.6%).

The result could be due to the fact that the older and more experienced nurses exercise relative strong control over the young and less experienced nurses. Indeed, this finding emerges in various national qualitative reports on the nurses. Yet, this is not true in the Finnish case study on nurses, though, because the cases worked as consulting nurses with their own rather independent consultation where they follow the basic national diseases such as arterial hypertension. The autonomy of this particular and rare type of nursing work is illustrated in an interview.

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9 Age groups were divided in this analysis into four according to the year of birth: ‘oldest-1949’, ‘1950-59’, ‘1960-69’, and ‘1970-youngest’.
Interviewer: How do you see your work is monitored and controlled?

Lena: Well, here it's mostly up to yourself, I mean, there's nobody to watch the way I treat the client who comes here. So you've got a big responsibility. Of course the clients may complain then, and we do get supervision or control from our supervisors. So it's very much about you yourself being sure that you know this thing, and you're saying the right thing to the client. You need to be sharp with yourself.

Actually, the example above illustrates the difference in the possibility of group control between the two professional groups. Nurses usually work in teams and/or in the same physical setting which makes the exercise of control possible whereas the teachers work independently in the class room. However, it is also interesting to see that teachers consider that their own conceptions influence so much because in reality they have to take plenty of things as given, such as the children, the curriculum, the classroom, the schedules, and the text books. The teachers that we interviewed and observed argue that their work is very independent. The teachers do much co-operation with their colleagues, which depends, however, on how well the teachers get along. In addition, colleagues and parents are considered also as an external control of work. The oldest teacher informant notes that during her 30-year-career the supervision and control has become less stringent. According to teachers this relative autonomy requires, as in the case of nurses, strong working morale.

Makes you feel that every teacher should have a very strong working morale to take care of all the duties then. If someone doesn't, it's not much we can do about it. It easily sort of goes to a situation where people accept that someone just isn't taking care of their duties. And that's just the way it is then. (Male teacher, born in 1967, 11 years of work experience)

We also asked the respondents to estimate how much the control of supervisor influences their everyday work. For the nurses the dispersion was the following: ‘very much’ (4%) – ‘rather much’ (22%) – ‘a little’ (39.5%) – ‘not at all’ (14.1%) – ‘not relevant’ (0.4%). There were significant differences between the age categories as the younger nurses felt more control by supervisors than the older ones. This finding relates to the previous one so that the older nurses are more often in the positions of supervisors When we cross-tabulate occupational titles and age categories the results show that the oldest are overrepresented in the category ‘other’, which includes also the heads and supervisors, and most of the ‘general nurses’ come from the youngest age category (.000).

The supervision of the nurse consultancy is based on the control from the distant. One of the nurses describes relationship between the nurses and the management in terms of trust.

[Of] course the management monitors us, but the management here doesn’t mean that there would be someone standing behind our shoulders all the time, the head nurse or someone. We're quite, you know, they trust us, I'd say that, for that's how I see it.

Among the teachers about 1.1% say that supervisor control influence ‘very much’ on the everyday work as a teacher, 10% say it influences ‘rather much’, 61% say it influences ‘a little’ and about 27% say that is ‘does not influence at all’. There are no significant differences between the age groups. The results clearly show that more nurses than teachers feel that the control by their superiors is rather influential.

Parallel to the previous items was a statement presented in the survey concerning how often does someone in authority check your work. The following distribution was observed among the nurses: ‘Never’ (23.6%) – ‘less than once a week’ (59.6%) – ‘about once a week’ (6.8%) – ‘several times a week’ (4.1%) – ‘about once a day’ (3%) – ‘almost constantly’ (3%). There was also a significant (.011) differences between the age groups so that the younger ones tend to feel that their work is more often checked by superiors. Again, the interpretation could be
that younger and more inexperienced nurses are monitored and controlled more quite overtly and that the old nurses occupy superior positions within the hierarchy of nurses.

Of the teachers about 40% choose ‘never’ and 54% choose ‘less than once a week’ in the statement mentioned above. The result shows that nurses conceive more often that they are controlled by superiors than teachers. However, there are significant (.000) differences between women and men (‘never’ 42% vs. 26% and ‘less than once a week’ 49.5% vs. 66% respectively) and occupational titles so that subject teachers’ work is rarely checked by some in authority than the others.

Our qualitative data does not make much, if any, difference in terms of issues of professional autonomy among the studied cases. So, when we compare the qualitative data and survey data we get somewhat different picture, particularly in the case of nurses. We may be able to generalize the results based on the analysis of the qualitative data to such settings that have similar working conditions as our cases. Thus, we may expect to find similar results in class-teachers working mid-size primary schools and nurses working in independent nursing consultancies in public health clinics. These results indicate that all the studied cases appear to carry out their daily tasks in comparatively independent fashion. There is not overt management control at work and the continuous peer-control is possible only if the cases work in co-operation with their peers. There is however, lots of co-operation and information exchange among the teachers and the nurses. Shared discussions, meetings and information exchange opportunities are frequent in the course of work. Nurses in their usual working conditions co-operate more than teachers because the real conditions of work are such that co-operation is required. Instead, the class-teachers can manage their class of pupils quite independently. Yet, class-teachers co-operate, especially with their parallel class-teachers if they share an understanding about what and how should be taught.

Participation in decision making is also an important aspect of autonomy. According to the survey only 5.6% of the nurses participate ‘directly’, 22.2% ‘give advice’ and 72.1% don’t participate at all in decisions about distribution of funds. The younger the nurses are more likely they do not participate in decision making. This is illustrated by the figures 68% and 80.5% for the group of ‘oldest to 1949’ and ‘1970 to youngest’ nurses respectively. Yet, the group of ‘1950-1959’ is most intensively involved in the decision-making. However, the figures are not statistically significant, but they show that the decision-making power among the nurses is concentrated in the hands of the few. In contrast to the survey, our qualitative data shows that the nurses participate a lot in decision making. The public health clinic where we observed the nurses they had organized a new form of management, so called common meetings. The nurses had differing view on their status in the common meeting. Jenna sees that the views of nurses are well taken into consideration.

They do listen to the nurses, too, and their opinions are taken into consideration, so I feel that the decisions could be made together as well. We, nurses are important in delivering information to the upper level, reporting what goes on here in practise, relaying the constant feedback from the patients. They do listen to us, and try to make the decisions on the basis of the feedback the patients give us as well, yes.

Lena holds an opposing view claiming that there has been resistance on doctors’ part. According to her, some doctors feel that the nurses are stepping on their toes. She states that, as they are used to working independently, they have difficulties in working in teams. Helga sees decision-making rather as a process:

[W]e make decisions together on, like, well, the guidelines. Like at the moment the meetings are mostly about the change. I mean, we need to think about the solutions together, how to
We do discuss things, and sometimes we leave the decisions open, continue pondering, and try to collect our thoughts.

Of the Finnish teachers about 20.6% participate ‘directly’, 29.4% ‘give advice’ and 50% ‘don’t participate’ in general policy decisions about the distribution of funds. In addition, seniority is much more important factor that separates decision-makers among nurses than among teachers. There are no significant differences among the teachers between the age groups, though the middle age groups seem to participate more often directly in general policy decisions than especially the youngest age group.

Our case study at the local primary school shows rather open decision making process. It is not formally democratic though, since the headmasters have all the formal decision-making power in the Finnish schools. Yet in this particular school the headmaster does not give orders from above and all the things, such as purchasing, division of lesson hours and combination of classes, are thoroughly discussed and negotiated so that all the teachers have an opportunity say their opinion. Niina states that,

[well, what we do here is that the headmaster presents a lot of issues [s]he could decide alone, too, [s]he presents them to us on the field, in teachers' meetings, asking for our opinions, and sometimes we've even voted on them to see what the majority thinks, and decided on the basis of that then. [S]he's really quite flexible and lets us to be heard, too.

Also Tuula feels that she has enough opportunities to participate in the decision making processes. She finds the school functional in a sense that everybody can influence the matters there.

We discuss a lot of things in meetings. I mean we have quite a functional school, everybody can influence here if they just want to. We discuss and... I mean we don't have a dictator here to rule from the top. Of course it's needed in some issues, but anyhow, we have a possibility to influence the matters here in our own school, and we manage to do that in quite a positive atmosphere.

To conclude, restructuring has meant the increasing professional autonomy of nurses and teachers at the local level. This implies that these professionals have to maintain self-control and assume responsibility of their work. Nurses’ work is more controlled because many of their work procedures are formalized and standardized. In addition, nurses working conditions are such that their work is easier to control by the peers. Indeed, the younger nurses tend to perceive that their work is more controlled than the older nurses. The greater formalization and codification, and hence control, of nurses’ work could be understood as a particular instance of a more general phenomena of control of situations that involve great dangers and risks.

5.3.2 Working Conditions

The qualitative data shows that the working days are structured by time and space for both professions. Yet this structuring follows different patterns. Primary teachers’ typical work day begins at eight o’clock, is divided into 45-minute lessons and 15-minute breaks, and ends in the afternoon usually about at one or two o’clock. During the breaks the teachers arrange their things, talk to parents through the phone, discuss with the colleagues in the staff room, or have to oversee the kids during the lunch hour or the break. The nurses who have their own consultancy work from eight a.m. until four p.m. They have two fifteen minute coffee breaks and one half-hour lunch break. Typically the visit of the patient lasts about 10 to 15 minutes.

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10 The position of headmasters has become managerial and powerful since the beginning of the 1990s especially due to increasing demands for school-specific curriculum, development work, evaluation and financial administration.
However, the nurses have to help sometime the doctors in various operations, and they also have to do some paperwork and they arrange the instruments and other supplies.

Both the school and the public health clinic were quite modern and clean, though there was a major renovation and extension carried out in the clinic. The school was clean, peaceful and relaxed place, whereas in the health clinic was more restless because people where coming and going all the time, and due to the renovation the nurses had to decide the allocation of the room every morning because no-one had their permanent consulting room. Moreover, the nurses had to look for the supplies from their colleagues’ rooms.

Both teachers and nurses basically told that they had a good atmosphere at work. The teacher complained mostly about the too large teaching groups and that they have to be in hurry all the day. In addition, teachers said that some parents and pupils had been problematic, but these constitute a small minority. All in all, the general working conditions seem to be rather good for both professional groups, but the teachers perceive the rush and its consequence, tiredness, as being one of the most negative aspects of their work. In addition, all seven cases considered their salary being too small.

In the survey looked at the working conditions from various perspectives. One battery of questions dealt with the potential obstacles at work that the teachers and the nurses may encounter. About 38% % of the nurses and about 40% of the teachers say that they do not meet serious obstacles in realising their ideas in work. In both professions it is the younger professionals, who meet most often obstacles, but these differences are significant only among the teachers. Of teachers 12% say that they meet serious obstacles ‘at least once per week’, 18.3% ‘several times per month’ and 29.7% say ‘at most once per month’. The intensity of the obstacles is lowest in the oldest age group and 53.3% of them meet obstacles seldom or never. Could it be that the younger age groups have not yet been adapted to the realities of school life? Or is it that they still carry with them the ideas that they have acquired in the intensive university education which provides them with models that are good in paper but that have not been yet tested in the real conditions of practice? Or, are they not allowed to realise their ideas because of the informal professional control exercised by the older colleagues? We do not have other information for the interpretation of these results.

The Finnish case studies do not show that there would be a confrontation between the new academic nurses/teachers and the old practical nurses/teachers. However, some other national reports show that such confrontation exists. However, the Finnish survey shows that the obstacles that the teachers experience are mostly about the lack of economic and time resources, or poor work organization of work, in addition to some difficult pupils and parents, but not the colleagues or superiors. The survey of the Finnish nurses shows that their main obstacles are also economic and time resources, but patients or their family and relatives do not cause much trouble.

To conclude, both the survey and the qualitative case studies show that the main insufficiencies at work are the lack of economic and time resources. There are not many differences between the two professions regarding this.

5.3.3 Professional Knowledge

Both teachers’ and nurses’ knowledge can be regarded as composing of two main areas of knowledge, which a connected to the main tasks of teachers and the nurses. Teachers’ knowledge areas and tasks consist of teaching and education the pupils. Teachers try to teach pupils substantive knowledge and they try to educate pupils into the moral order. Teachers emphasize particularly two things: they are motivated by helping children and their personality is the main instrument in their work. It is rare that we see an inner dedication to
knowledge of substantive disciplines, though there are obviously differences between class teachers and subject teachers in this respect. These differences can be seen in the qualitative data and survey results.

Nurses’ knowledge areas and tasks consist of curing and caring the patients. Curing refers to biomedical and technical aspects of nurses’ work, whereas caring refers to the psycho-social support of the patient. Nurses also argue that they are first and foremost there to help the patients and in this respect personality is their major asset. Thus, both professions require people-skills because the work tasks are mostly directed towards the clients. Moreover, both professions require a space for professional judgement as the professional ‘theory’ is put into practice.

Although the client is an important aspect for both professions, it is particularly for nurses that the patients are the main point of reference of their professional self-perception. This is quite clearly seen in each national case reports where the nurses discuss about the importance of caring and the relations with patients. This does not mean, however, that the professional and practical significance of bio-medical and technical aspects of the nurses’ work is unsubstantial. It is just that the data suggests that the caring aspect of nurses’ work seems to be much more salient for their professional identity. Restructuring measures that demand for more efficiency in the context of often scarce resources seem particularly to undermine that aspect of nurses’ work, because nurses do not have time to relate with and care the patients.

Yet, demands for efficiency and scarce resources often make it impossible to live up to idealized medical standards as well. Moreover, the concept of caring is seen by some national informants more as an abstract knowledge structure than a personal and internal attribute. The former conception is often specified with an emphasis on the professional relations to patients with no personal emotional bond. This perception, that is minority, however, among the informants, implies that the caring aspect might not be perceived only as an innate quality of a person, but something that can be formalized and formally transmitted to the students of nursing science. Then sympathy and emotions could be played as a part of the professional role without putting the ‘real self’ at risk (Hochschild 1983; Lopez 2006). It would be interesting to elaborate further in the subsequent studies how professionalisation, standardization and commercialization together with other restructuring measures changes the idea of emotional labour and particularly authentic emotions.

Patients’ opinions influence on everyday work of nurses more than pupils’ opinions on everyday work of teachers. 28.8% of nurses say that patients’ opinions influence ‘very much’, 47.9% of nurses say it influences ‘rather much’, 20.15% say it influences ‘a little’ and only 2.7% say that it ‘does not influence at all’. On the other hand of teachers 43.8% say that pupils’ opinions influences ‘rather much’ and 44.6% say that influences ‘a little’, 7.6% say it influences ‘very much’ and 3.6% say it does ‘not influence at all’. From this we can conclude that clients’ opinions influence much more on nurses’ everyday work than to teachers’ everyday work. Again, I urge to think the social conditions of work. Nurses’ usually meet their clients as and individual patient whereas teachers’ meet their clients as a group of pupils. But these ‘facts’ are not only instituted in things, procedures and work conditions, but also in the minds of nurses and teachers.

In our survey we asked the respondents to estimate the degree they use various knowledge sources in their everyday life. Scientific journals or books are sources of knowledge ‘at least once per week’ for 27.5%, ‘at least once per month’ for 47.2%, ‘at least once per quarter’ for 16.4% and ‘seldom/never’ for 8.9% of the nurses. Teachers in our sample use scientific

11 About the concept of ‘emotional labor’ see the above references. Emotional labor is defined by Hochschild (1983, 7) as “the management of feeling to create a publicly observable facial and bodily display”.
journals or books slightly more intensively (40% once ‘at least once per week’, 35% ‘at least once per month’, ‘at least once per quarter’ 17.4% and ‘seldom/never 7.7%) than the nurses. Older age groups of the teachers use these sources of knowledge significantly more often than the younger teachers. The older nurses use more scientific journals and books, but the difference is significant only at the level of 0.05. We should look at closer what do those journals and books actually contain, that is, what is considered as ‘scientific’ journals and books in these professions.

For nurses the colleagues at work are very important sources of knowledge: ‘At least once per week’ (81.1%), ‘at least once per month’ (14.8%), ‘at least once per quarter’ (2.8%), seldom/never (1.3%). For teachers the colleagues at work are somewhat less important source of information since 65.6% use them ‘at least once a week’, 18.8% use them ‘at least once a month’, 9% use them ‘at least once per quarter’ and 6.7% use them ‘seldom or never’. These figures indicate the difference between the conditions of teachers’ and nurses’ work. Usually an individual teacher is responsible for her class by himself while a nurse is responsible for patients as members of a caring team. Furthermore, this state of affairs is not only institutionalised in the social conditions and organisation of work, but also to the teachers’ and nurses’ practical understandings of the requirements of their work. Our qualitative data is parallel with the survey data in that there is lot of co-operation and discussion about the organization of work and the exchange of information and tasks relating to various patients among the nurses. In the case of teachers, we find that there is also lots of co-operation and information exchange, but this occurs usually between the teacher of parallel classes, and only if their ‘teaching philosophies’ match well enough together. The younger nurses use more intensively the colleagues at work as information source than the older nurses do (p = 0.016). Among the teachers the picture is the same: the young teachers use colleagues more than the old ones, but the result is not statistically significant.

In addition, class teachers, special teachers, special class teachers and headmasters get much more often information from the colleagues than subject teachers and other teachers. The same difference occurs between schools types naturally, so that upper we go at the level of education the more important is the information from books and less the information from the colleagues. We could speculate here that the information used and needed by subject teachers and other teachers is attached to their books whereas the information used and needed by other categories of teachers is more attached to their pupils. This interpretation gets support from the fact that these latter two groups are the most intensive users of scientific journals and books (.037). Thus, there could a genuine difference in expertise culture here between different fractions of teachers. Among the nurse types there are not significant differences in the intensity of use of colleagues as an information source. However, those nurses who work in hospitals use this source of information more intensively than the other nurses. This could indicate that nurses work often in teams in hospital wards.

Internet is nowadays and important source of knowledge. Nurses are slightly less intensive users of the internet as an information source than teachers. Of nurses 54% use it ‘at least once a week’, 24.8% use it ‘at least once a month’, 12.8% use it ‘at least once per quarter’ and 8.4% use it ‘seldom or never’. Most of the teachers use internet as a source of information ‘at least once a week’ (64.5%) or ‘at least once a month’ (20.7%). But there are significant (.000) differences in how frequently different age groups use internet: of the youngest 75.4% use internet at least once a week compared to the 56.3% of the oldest. In addition, in the oldest age group 14.3% use internet seldom or never, whereas the figure for the youngest is only 3.1%. Furthermore, men use internet more often than women (.001). There are not significant differences between the age categories of nurses.
However, the case studies show that actually nurses rely much more on computers and information technology than the teachers do. For instance, the electronic appointment book, which is maintained by the centralized phone service, nurses and doctors, structures the workday of the observed nurses. The appointment book contains other time-related information too, such as the professional training periods and sessions, and meeting schedules. In addition, nurses communicate through the computer network sharing messages and patient records with their colleagues. Finally, the observed nurses used the digitalized nursing and medical data-bases heavily in their work. This observation when compared to the survey result indicates indirectly that there is a vast variety of nursing positions and working conditions. Working as nurse at the elderly care home is very different from working as a nurse at a special ward of a university hospital, yet both positions belong to nursing profession.

We also asked in the survey the extent to which nurses and teachers use colleagues and partners from other workplaces as their information sources. Nurses’ answers are quite dispersed: ‘at least once a week’ (17.3%) – ‘at least once a month’ (33.5%) – ‘at least once per quarter’ (25.4%) – ‘seldom/never’ (23.8%). There are no significant differences between the age groups. The case studies show that the nurses co-operate also rather much with outside partners of their immediate work context, such as doctors, laboratories, and x-ray and other units. This co-operation occurs because of the patients, their illnesses and other matters. But the nurses seldom co-operate with the agents outside the local health care system. The dispersion implies again that nurses working conditions vary internally.

Teachers’ answers to the statement mentioned above had also quite a largely spread: ‘at least once a week’ (13.2%) – ‘at least once a month’ (30.3%) – ‘at least once per quarter’ (25.1%) – ‘seldom/never’ (31.4). This implies that teachers’ working conditions and tasks are differentiated. Think for instance the tasks of a special teacher who often has to co-operate with a school psychologist, a doctor and a social worker, and even a police. The oldest age group stands out in both extremes (16.3% and 41.1%). In terms of school types lower level comprehensive school teachers are the most frequent users of outside colleagues and partners, perhaps because most of the special teachers, special class teachers and headmasters, who have to co-operate with extern agents, are dominated in this category of schools. Subject teachers use much less colleagues and partner from other workplaces as sources of information than special class teachers, special teacher, class teachers and headmasters.

We get an additional insight of the nurses’ and teachers’ relation to knowledge when we examine how they perceive the relative value of formal training respect to work experience. Nurses tend to emphasise the importance of work life experiences more than formal education as they answer to the statement that work life experience is more important than formal education in the following manner: ‘not at all true’ (6.4%) – ‘a little true’ (25.5%) – ‘quite true’ (35.3%) – ‘very true’ (32.7%). In addition, they tend to emphasise experience more than teachers do. The teachers’ responses are nicely spread out, although most of the teachers think that work life experience is more important than formal education: ‘Not at all true’ (10.9%) – ‘a little true’ (30.4%) – ‘quite true’ (31.8%) – ‘very true’ (26.8%). An interesting observation is that the older teachers emphasise work life experiences significantly (.000) more than the younger teachers do. We could argue that they make “virtue out of necessity”, because they indeed have longer experience, and often less education compared to the younger teachers. This is particularly the case when the older teachers are class-teachers and their education occurred in teacher seminaries. We can see here also a competition about the definition of the value of different currencies (experience vs. education, and, practice vs. theory). This interpretation is backed by the observation that upper level comprehensive school teachers and especially general secondary school teachers emphasize formal education over experience.
Bear in mind that they also used more scientific journals and books as sources of information. In addition, teachers in other schools alongside with lower level comprehensive school teachers tend to emphasize experience over formal education, which is quite unambiguous finding because most of them teach at vocational schools or music institutes where the goal is to teach something practical and applicable. Finally, men tend to emphasize more the experience than women (.001).

Our case studies suggest that both the teachers and the nurses value the practical experience more than academic education although they acknowledge that the academic education is a necessary theoretical base and a sort of driving licence (Kauppila et al. 2005, 5) to get the job in the first place. Based on the Finnish Adult Education Survey (N = 3,422) Moore et al. (2005, 310-311) show that Finnish workers tend to underline the importance of work experience in the formation of skills and knowledge. However, directors, chief officers and experts are likely to perceive above the average that their knowledge and skills are based also on formal education. By contrast, in male dominated manual industries workers tend not to agree that their knowledge and skills are based on formal education.

Quite closely related to the previous statement we also asked the respondents to assess to extent to which their authority is based on professional education. 33.3% of nurses said ‘not at all true’, 43.1% said ‘a little true’, 20.5% said ‘quite true’ and 3.1% said ‘very true’ for the statement my authority is mostly based on their professional education. 54% of teachers say ‘not at all true’, 33.4% say ‘a little true’, 9.8% said ‘quite true’ and 2.8% said ‘very true’. There are no significant differences between the various age groups of nurses, but among the teachers the younger ones tend to emphasise more professional education than the old teachers (.016). As a group nurses tend to underline more professional education than the teachers, which bears to the fact that their work is more based on more explicitly stated scientifically based plans and standards of action.

While Teacher as researcher movement and the emphasis on research based teaching and teacher training are well established, and the teachers regard themselves as highly educated professionals, the slogan personality is the most important instrument of work is predominant among the Finnish teachers. Indeed, the practicing teachers emphasize that the long science-based teacher education, except practical training periods, provides only a theoretical foundation for professional work. For them the more important source of knowledge is the practical activities, common sense, everyday experiences and learning by doing. In addition, personal hobbies and activities outside the school are valued as well. Indeed, according to some recent studies the opportunities to draw on personal interests and to exercise independent judgement are among the most important motivations for being a teacher (Kiviniemi 2000; Webb et al 2004a, 182; Väisänen 2001).

Teachers’ relation to knowledge seems to be very practical, and the attitude towards systematic and conceptual knowledge could even be somewhat hostile. Indeed, all sorts of theoretical speculation are regarded useless, and thus the ultimate criterion of value of knowledge depends on its immediately perceptible social function and applicability at work.

This emphasis on personal and practical aspect of knowledge and identity is summarized by the following statement of an old-timer teacher and a teacher student instructor:

Good teacher-hood is a personal quality, not a skill learnable by heart. Already at the classroom door one could see if the teacher trainee had enough charisma, enthusiasm, aura and know-how. That was completed by an easy and respectful attitude towards the pupils. Theory could not help if the sentiment was wrong.

Another case in point is the recommendation that Teacher Student Union of Finland made for the arrangers of teacher education entrance examinations. It argues that good and
achievement-centered grades in studies are not the same as skills of hands-on pedagogue, or a guarantee for aptitude for teaching. Moreover, the applicants should be assessed in terms of personal characteristics, abilities for interaction, motivation, and commitment, and skills to absorb and apply theoretical knowledge. So, there is nothing, for instance, about creating or criticizing knowledge, which both are crucial aspects of researcher’s relation to knowledge.

Finally, one of our informants in the project mentioned above\textsuperscript{12}, Niina, states that:

\textit{Well, of course the education, I mean, it offers the basis for the job, but I think it's the practice that teaches a lot more, or at least helps you to apply the learned things. All along the way you notice that there are so many things here, like planning the curriculum for example, one of those main issues, for which you're not given any tools whatsoever in the university, or encountering the parents, so yes, there's a lot this job itself teaches. You learn here by doing.} (Female teacher, born in 1976 with 4 years of experience)

These results also tell me that practical knowledge, as it is very individual and ignorant of the material and metal preconditions that support it and make it possible cannot see how the institution actually grants the authority to its representatives. Without the degree, official title and classroom provided by the institution a teacher would just be the man in the street without any special justification to teach.

Younger age groups tend to judge more often than the older ones that their authority is based on professional education. This is quite natural because they cannot boast with long experience where as the oldest age group cannot boast with fancy university degrees. In addition, women, subject teachers and general secondary school teachers (all about .05) tend to emphasize more the authority based on professional education.

5.3.4 Professional Accountability

Professional must be accountable for their work in order to achieve trust and legitimacy in the eyes of the authorities and the public at large. Most of the teachers say that the control of their supervisor influence on their everyday work ‘a little’ (61.1%) or ‘not at all’ (26.7%), only 1.1% say that it influences ‘very much’ and 10.2% say that influences ‘rather much’. There are not significant differences among the categories of teachers. This is contrary to nurses who tend to see that supervisor’s control influences their everyday work ‘very much’ (4%), ‘rather much’ (22%), ‘a little’ (59.5%) or ‘not at all’ (14.1%). There are significant (.000) differences also between the age categories of nurses: the members of the youngest age group tend to feel supervisor’s control stronger than the members of the older age groups. This result confirms the observation that in nurse’s work the control by superiors is experienced more intensive than in teachers’ work, and particularly so by the young and inexperienced nurses. In short, they cannot escape the direct control easily, first, because the work is usually done under the eyes of the other medical staff, and second, because it is quite often documented in casebooks and registers while teachers can always escape inside their classrooms. Health care as fields of professional practice are much more strictly regulated than education, obviously because the consequences of malpractice are considered to be graver. Moreover, the procedures and guidelines are standardized than in teaching profession.

Our case studies show that class teachers and nurses, at least those with their consultancy, work very autonomously and there is not direct management monitoring during the working day. Both professional groups acknowledge this and add that this requires self-restrained and responsibility. However, both professional groups are strongly regulated regards to the entrance to professional education and certification. Thus, we may argue that the rather loose

\textsuperscript{12} We observed and interviewed only four class teachers who work in a primary school for our project. The main part of the project’s research data came from a national probability sample of primary and secondary teachers.
external control of teachers’ and nurses’ work is possible if the certification of who does the job (cf. Weick 1976, 11-2) is strictly controlled. This also presupposes strong professionalism with internal norms and ethical requirements.

Nurses are prone to believe more often than teachers that there are procedures for checking their professional competence: ‘not at all true’ (5.5%) – ‘a little true’ (36.2%) – ‘quite true’ (35.5%) – ‘very true’ (22.8%). Teachers break up into subgroups when answering the statement “there are procedures to for checking my professional competence at my job”: ‘not at all true’ (18.8%) – ‘a little true’ (47.3%) – ‘quite true’ (25.2%) – ‘very true’ (8.6%). There are significant (.001) differences among the age groups of teachers but it is rather difficult to extrapolate a clear general trend here, although the oldest age group tends to believe more on the existence of the procedures.

These dispersions in answers between the nurses and the teachers indicate the real differences in the control of their work, namely documentation and explicitly stated guidelines. Nurses are required to document the visits of patient and the treatments and procedures that are realized at the consultancy, whereas the teachers are not required to keep a diary as they did before the administrative reforms. Furthermore, health care is more standardized than education by various kinds of recommendations, guidelines and prescription.

Evaluation of work is considered as one of the most important measures of governance of welfare service providers and professionals. Basically, administrators provide the general goals and providers and professions are held responsible for achieving those goals. Then evaluation is a sort of ex post facto control that checks how well the providers and professionals had achieved the goals. Evaluation does not seem to influence very much teachers’ everyday work: ‘very much’ (4.8%) – ‘rather much’ (30.1%) – ‘a little’ (51.5%) – ‘not at all’ (11.5%). The same tendency, if only as slightly more intensive, is seen among the nurses: ‘very much’ (8.9%) – ‘rather much’ (35.8%) – ‘a little’ (44.2%) – ‘not at all’ (10.3%). There are no significant differences between age categories of both professions. Even though the idea and practice of evaluation is introduced as a part of the new governance by goals, it does not seem to bother much the everyday work of the nurses and the teachers. Perhaps the evaluation is organized so that it is mostly carried out by the administrative stuff, or the evaluation process is rather light. Actually some studies show that the abandoning of the national inspection system of schools and establishing the self-evaluation done by the provider of education has lead to many local evaluation practices with varying quality of data and methods (Laukkanen 1998; Moore et al. 2005; Rajanen 2000)

When seen parallel with teachers’ relatively autonomous work and the observations made in the qualitative case studies, we may conclude that evaluation and other paperwork does not take much teachers’ time and energy even though it is sometimes highlighted in the public discourse and individual interviews as the biggest evil. It is more like these tasks are regarded irritating and not belonging to proper tasks of teachers. When we look at the question according to occupational title it seems that evaluation does not such a big influence especially on subject teachers and special teachers. We could infer that evaluation influences especially at the lower levels of comprehensive school and in other schools (vocational schools). This is indeed what the figures show when we cross-tabulate evaluation variable with the variable concerning the school type. Differences are small, but statistically significant (.003). Why the special teachers do not consider that evaluation influences much their everyday work although documentation, for instance individualized study plans, is such an important factual aspect of their work?

The most ultimate tool for keeping some accountable for her job is a risk of being sued. This is to certain extent felt among the nurses: ‘very much’ (13.8%) – ‘rather much’ (27.3%) – ‘a
little’ (47.4%) – ‘not at all’ (11%) – ‘not relevant’ (0.5%). The same risk of being sued influences overall rather less the Finnish teachers’ everyday work: ‘very much’ (4.8%) – ‘rather much’ (16.5%) – ‘a little’ (45.5%) – ‘not at all’ (30.2%) – ‘not relevant’ (3%). There are though significant (.000) differences between the four age categories. The trend is obvious, the younger you are the more you think that the risk of being sued influences your everyday work. This certainly relates to the fact that the younger professionals are less experienced and confident about their skills. In other words, they are more afraid of making mistakes. Nurses’ greater tendency to perceive the risk of being sued can be understood by the legal means that are more available for the customers of a health care than that of education.

Documentation is one aspect that could be used as a means for holding professionals accountable for their conduct. Documentation is also a primary means for marking down and making available of information that is needed in professional work. Therefore, for instance in the health care settings symptoms, diagnostics and treatments of patients are carefully documented so that the professionals know the history and the present state of the patient. This is very important when professionals co-operate, communicate and exchange information with each other. Yet, the same documents could use at least indirectly as evidence for malpractice for instance, or as indicators of how accurately the guidelines and recommendation are followed. In itself evaluation is also a type of documentation, but in education, all sorts of plans, such as individualized curriculum or the plan for the academic year, are documents that are also required by the law and regulations.

For the survey statement concerning the influence of documentation, teachers report that documentation influences only to some extent their everyday work: ‘very much’ (4.3%) – ‘rather much’ (22.7%) – ‘a little’ (53.3%) – ‘not at all’ (17.8%). However, both categories of special teachers tend to say that documentation influences much on their work. Nurses’ work seems to involve much more documentation: ‘very much’ (32.1%) – ‘rather much’ (45.5%) – ‘a little’ (19.7%) – ‘not at all’ (2.3%). There are not any significant differences between the age groups in both professions. It is quite clear that special teachers’ work and nurses’ work contain similar demands and expectations regarding the use of documentation. The requirement of documentation is confirmed in the observations carried out in the health care clinics where information concerning the patients is carefully recorded. Similarly, legislation requires that every time a pupil is transferred or taken into special education some documentation is needed such as a psychological or medical examination and a personal study plan in addition to some formal meetings between teachers and parents.

We also asked whether the demand of written documentation is greater nowadays. Most nurses ‘agree strongly’ (75.4%) that the demand of written documentation is greater nowadays than before. 16.2% ‘agree somewhat’ and only 4.9% and 2.3% ‘disagree’ somewhat or ‘strongly’ respectively. There is a significant (.027) difference between the age groups so that the youngest group does not agree so intensively than the other age groups. This result parallel the objective change in the amount and accuracy of documentation required in nursing practice.

Most of the teachers agree that the documentation is greater nowadays: ‘agree somewhat’ (29.9%) and ‘agree strongly’ (44.6%). There is a significant difference between the oldest and the youngest age groups. The old ones tend choose more often than others the option ‘agree strongly’, whereas the young ones tend choose more often the option ‘don’t know/cannot decide’. Again special teachers tend to choose more often ‘agree strongly’. When examined relative to the school type, it is revealed that increased documentation is especially experienced at the lower level of comprehensive school than at the general secondary school. We may conclude that documentation is experienced of becoming more intensive than before.
and it is particularly nurses’ work that is more prone to documentation, but in addition, particularly special education teachers experience the increasing influence of documentation as well.

We also asked to what extent documentation is directly demanded in respondent’s job. The statement was the following: *Considerations and decisions I do in my job need to be well documented*. We obtained the following results for the nurses and teachers respectively: ‘not at all true’ (1.2% vs. 13%) – ‘a little true’ (13.4% vs. 48.4%) – ‘rather true’ (35.6% vs. 29.2%) – ‘very true’ (49.9% vs. 9.4%). This shows quite clearly that nurses’ work requires much more documentation than teachers’ work. Between the age categories there are no significant differences.

The item mentioned above could be regarded also an indication of the professional relation to knowledge. We see much less documentation in teachers’ work, which could be interpreted also as in indirect indication teachers’ mode of professional knowledge is more practical and implicit than nurses’ work which is more prone to medical science and technology. This, for one, relates to the real conditions of teachers work: there is neither need nor time to document, but to accomplish the daily urgencies of which the documentation is not the most important thing. In addition, teachers are not necessarily inclined to document and plan their work in writing. Teaching is considered more art than science. Although teachers have to prepare written lesson plans during their training it often occurs (according to statements that I have read from various sources) that in actual work the ‘plan’ is in teacher’s head. Indeed, teachers joke about so called ‘doorframe plan’, the lesson plan pops up in their head when they enter into the class. In nurses’ work this sort of thinking and attitude is not possible.

5.4 System Narrative and Life world Narratives: What does restructuring mean?

Periodisation

The history of the Finnish welfare state has three phases, which are the *Preparatory phase of the welfare state* (ca Second World War – 1960s), the *Golden age of the welfare state* (ca 1970s-1980s), and the *Restructuring of the welfare state* (ca 1990s-). This periodisation is based on the major changes in the administrative and policy ideology and practice which are manifested in the enactment of particularly important legislation concerning educational and healthcare services. These periods are also important if we want to make distinctions between various *generations* of teachers and nurses. First, different age groups have received their professional training in distinctive educational systems. Particularly, nurses professional education and class-teachers’ education is organized nowadays at the tertiary level, at the polytechnics and at the university.

The restructuring of education and health care is organized around the ideas of new public management that tries to tackle with the issues of costs, efficiency and effectiveness of welfare services. In addition, there has been an emphasis on the customer and the quality and equal access to services. Decision-making and responsibility has been de-centralized and deregulation has meant actually re-regulation so that goals are given by the state and then the service providers, municipalities, schools and health care organizations, are asked to evaluate their performance and results in terms of those goals. However, quasi-markets and real competition is not much used in the Finnish context. Indeed, new public management doctrines, that have Anglo-Saxon origins, are not followed slavishly, but are adapted to the Finnish reality. Historically, there has been a strong local autonomy of municipalities in Finland and a strong government power in relation to the parliament. In addition, trade unions and professional organisations have been influential, thus we may call Finland as a corporatist...
market economy. These factors have made it easier to change the centralized administrative structures with overt supervision and inspection to de-centralized administrative structures that rely on the self-governance and sense of responsibility of the service providers and practitioners.

When we look at restructuring from the secondary sources discussed in work-packages 1 and 2, we see that the timing of restructuring seems to be rather similar in the case of the Finnish nurses and teachers. Both professions have been under the similar influences of broad socio-economic conditions and the overall strategy of public administration. The period before the 1970s was a preparatory phase for the building of the welfare state. The era between the 1970 and the 1990 could be described as the golden age of the Finnish welfare state. New legislation was introduced while more resources were allocated to welfare services and the direct control of the central state administration was strengthened although the old tradition of local self-government in Finland meant that municipalities were responsible for organising and providing the services. The period from 1990 onwards stands for decentralisation of state administration, increasing local decision-making and responsibility, the management by goals and results and the evaluation of effectiveness of the processes and outcomes of services. All this occurred within the context of severe economic recession in the turn of the 1990. Despite the gradual recovery from the recession, the financing of the welfare services has been unstable in many municipalities, particularly in the poorer regions in the north and east of Finland, causing uncertainty in education and health care.

It is not straightforward to make estimates about the significance of restructuring for organising professional autonomy, working conditions, knowledge and accountability in various periods. But we can assess indirectly has there been any change in these issues. Obviously new tasks and demands have been imposed on teachers’ and nurses’ work during the past thirty years or so, whereas some of the old requirements have been abolished. Nonetheless, it appears as if these changes have not erased the core aspects of the workday settings of nurses’ and teachers’ professional practice. To put it simply, the organisation of the everyday work and the relations between various agents in the setting of a class-room and a sickroom are to certain respect the same today as they were about 40 years ago. Without doubt, there have been changes in nursing and teaching technology, procedures and general infrastructure, not to mention the empowerment of the clientele in terms of an increased self-determination and legal protection. However, the new demands, requirements and tasks, such as meetings, evaluation, documentation and training, are mostly done outside immediate the scene of work, which are the classroom and the sickroom. These requirements pertain to restructuring of administrative technology. We have to bear in mind too that the changes in work technology, such as those pertaining to caring and teaching methods are independent of administrative technologies, although these two may be combined with each other. Then for instance, particular methods could be represented as guidelines and their faithful application could be evaluated as an indication of effective delivery of the service.

What are the implications of these the demands for organising professional work and for professional knowledge and expertise? We can try to answer the question by looking at the both professional discourse and the practice. Clearly, demands for documentation and evaluation have increased and this means that professions have spent more time on those things than before. Indeed, ‘extra paper-work’ and ‘unnecessary meetings’ are often complained particularly in teachers’ discourse. These new tasks are considered as something extra that takes time from the functions that are considered to be more crucial for the profession, which are teaching and educating the pupils, or curing and caring the patients. But actually, particularly in the case of teachers these new tasks do not take much of teachers’
working time, which mostly occurs in the class-room. This is not to deny that such paperwork, meetings and strategic planning has increased during the past two decades.

However, the demands of documentation and evaluation do not touch directly teachers’ work procedures. One gets the impression that evaluation of teachers’ work is more like a formal administrative requirement that is fulfilled without any real contribution to work. For instance, Meyer and Rowan (1977) have argued that organizations that operate in rich institutional environments with plenty of normative and cognitive rules and requirements issued by the state, the professions and the public, are very likely to adopt the requirements of the institutional environment only formally. That means that formal structures are de-coupled from the real day-to-day operations of these organizations. By displaying only formally the institutional requirements such organizations achieve social legitimacy, but still maintain some independence in their real activities. Yet, efficiency requirements are introduced more indirectly through tight school budgets which mean for instance minimization of professional continuous education, old computer technology and textbooks, reduction of extra-curriculum activities and hiring of substitute teachers.

Restructuring influences more directly the professional work of nurses as the administrative structures of health care and the division of labour between health care professionals have been re-organized quite heavily during the past few years. Health care sector seems to be more prone to cost awareness and the calculation of productivity in terms of input and output than the educational sector. In addition, health care is more standardized in its procedures, such as patient visits, medical operations and symptom descriptions, which are also explicitly documented. Thus it seems to be more difficult to de-couple some of the requirements introduced by restructuring measures.

Restructuring measures, such as documentation and evaluation have not undermined the professional autonomy of these two groups. Quite contrary both professions have obtained more autonomy as the direct control has been lessened and their participation in decision-making has been increased. Professional autonomy has been increased but at the same time professional groups are evaluated for being accountable for their conduct. This is clearly the case in Finland for both professions. Yet, accountability through evaluation and documentation seems to be more significant in health care than in education. This is partly due to the fact that the procedures and outcomes are not so ambiguous in health care than in education. In addition, there is not such long tradition of systematic use of explicit criteria in education than in health care, but the educational assessments are based more on personal judgements than objective criteria. Teaching has been considered more as an art rather than a science. Yet, there are similar tendencies to emphasize caring as the core of nursing profession and an interpretation of the skill for caring as something that is personal and innate quality contrast to bio-medical skills and knowledge as tricks that anyone can learn.

The other side of the relatively strong autonomy of the nurses and teachers is the rather loose control exercised by the management and the immediate superiors at work. Indeed, both teachers and nurses tend to perceive that they have enough opportunity to take part in decisions that pertain to their work. At the same time they acknowledge that there are things that are given to them, such as the national curriculum. Particularly our qualitative data indicates that the social atmosphere in both the school and the health care centre that we examined is good and that the supervisors have achieved legitimacy in the eyes of the workers.

Working conditions seem to in good order materially, but there is an experience of lack of time and staff. This means that the teachers are rather exhausted from the haste at work, and that the nurses feel that they do not have time to care patients. The latter is considered as a
core of nursing identity and if this cannot be fulfilled nurses seem not to be totally satisfied at work. Thus there is a strong professional ethics to care patients. Similar kind of professional ethics to help the children and provide them good and safe learning environment is strong among the teaching profession. I would particularly emphasize a strong ethos of equality towards the pupils that was visible in our qualitative data.

One issue that is most often complained in our qualitative data is the level of salary in nursing and teaching. Teachers and nurses consider that their salary is unjust relative to the length of their education and the demands of their work. Among the teachers this concerns particularly the class-teachers and the subject teachers working at the primary schools. Table 1 below (p. 29) reports salaries for two teaching and nursing categories in the municipalities in 2003. The figures are provided by the Commission for Local Authority Employers. From the figures we can clearly see that class-teachers’ salary and particularly nurses’ salary are relatively rather low.

5.4.1.1 Generation

How could be discern generations in our data and particularly in relation to restructuring? I have argued in a short conceptual statement at the beginning of the chapter 4 that in the field of education (health care) teachers’ (nurses’) dispositions embody relatively permanent ways to realise teacher-hood (nurse-hood) in relation to the changing institutional requirements and other work life issues. To some extent teachers’ (nurses’) dispositions are common because the agents have been socialized into the common reality of work, but they are also diverse because individual dispositions are formed in different historical and social conditions and through differentiated experiences. These past social conditions can be measured approximate by some indicators, such as age and educational level and type of training. Moreover, the indicator of age relates the teachers and nurses to varying institutional conditions of the welfare state, education (health care) and education of professionals. The categories of age can be regarded as proxies of cohorts that indicate the participants’ formative experiences in the previous phases of institutional and socio-economic conditions. Yet, we have to remember that age groups refer also to the different phases of career trajectory. So, we should not consider age groups only as in relation to the past, but also as in their current phase and somewhat predictable future. Hence, there is a big difference between the one who has just started her career and expects to work for the next forty years and the one who is about to retire after a forty-year career in the near future.

Then, as regards the formation of habitus the different generations have gone through different social conditionings, such as the length, status and requirements of formal professional education has changed. As for their present professional position, different generations are in different career phases, so that the young are starting their careers whereas the old ones have longer professional experiences and some of them are about to retire. With the type of data we have, it is hard to distinguish between these two types of influences of age.

Cohorts and generations can be used as means to understand and analyze social change by locating individuals within the historical, social and cultural conditions (Mannheim 1952). A group of people can be regarded as a generation to the extent that they share the same objective location within the historical time and the related social and economic factors (generational location, cohort). Individuals are not necessarily aware of these social necessities, yet generational location renders individuals certain patterns of perception, though and action. Within the same society cohorts can fall apart into many sub-groups depending for instance on the class fractions. Thus, the same cohort can produce several and even antagonistic generational units (experiential generations) with their own distinctive ways of
being, acting and thinking. Finally, generational units can become actualized or mobilized generations. This means that some individuals participate in the common destiny of the social units by organizing and mobilizing social and intellectual movements. For my purposes it is futile to distinguish between cohorts and generational units. Thus, the age group refers here to the formative experiences of individuals belonging to the same chronological and socio-historical location.

Instead of focusing on the potential differences in the experiences of cohorts that would lead to generational units with distinct ways of being, acting and thinking, an analyst could rather concentrate on the shared core experiences of entire cohorts. There are some major events and structural stages and changes that leave their mark into entire cohorts (see e.g. Antikainen and Kauppila 2005). These could be war, deep economic depression, or in our case, the major structural changes in the education of professional groups and the services provided by the state and municipalities. Shared experiences can produce dispositions that are, regardless of some differences, also similar to an extent.

The varying generational locations can be analyzed with respect to varying socio-historical contextual factors which are presumed to significant. We could for instance take the periods of the administrative structures and policies of the welfare state, sequential periods of economic prosperity and recession, broad socio-economic and cultural changes, such as transition from a traditional rural society with waning agricultural work into a modern urban society with an increasingly important service sector in addition to industrial work, and demographic changes, such as baby-boomers and related migration from north and east to south and abroad. Thus, when we analyse individual life stories and experiences we examine them in relation to various socio-historical factors which help us to understand the formation and functioning of teachers’ and nurses’ dispositions. With the concept of generation we may distinguish the things which are similar and different between various age groups. Perhaps the most important aspect for us is the fact that the welfare state itself, and particularly the sectors of health care and education, has changed during the past few decades offering different periods for formative experiences for different age groups of professionals. For instance, Kauppila et al. (2005) distinguish three different generations of Finnish teachers based on teachers’ age, educational background and meanings attached to teacher-hood. But we have to be careful when we assess the significance of contextual factors in individual’s life, because contextual variables may operate differently depending on how proximate they are to individuals, that is, actors are not homogenous in terms of their exposure, sensitivity and vulnerability to contextual factors.

In the figure 1 below I have sketched so called Lexis diagram\(^{13}\), which presents simultaneously the age-groups or cohorts in relation to the pertinent structural changes. I assume that these cohorts share also core experiences due to similar structural conditions. We should be able to read and infer these experiences from our life story interviews. Lexis diagram shows at what age the four age-groups encountered particular structural influences. In the rows of the diagram there are age categories. One could also roughly insert the names of age-related normative roles to the rows, that is, pupil (from 7 to 19 year of age), teacher/nurse student (from 19 to 24 years of age), teacher/nurse (from 25 to 65 years of age) and retired (at the age of 65). Of course the individual cases do not necessarily follow exactly the normative life course pattern, but the age-related normative roles are sort of ideal.

\(^{13}\) The Lexis diagram was originally presented by Wilhelm Lexis in 1875. Matilda White Riley and her colleagues publish the idea again in their own model in 1972. (Riley, Matilda White & Johnson, Marilyn & Forner, Anne (1972) Aging and Society. Vol. 3, A Sociology of Stratification. New York: Russel Sage.)
categories that help us to grasp the main issues. In addition, as normative roles, they are reference points for people to make sense of reality. In addition to these normative age roles you could, based on secondary statistical information, depict, some other life course events and transitions, such as marriage, having children and buying a house, and so on. To summarise the main point: Lexis diagram indicates the social conditions of formation of teacher-hood and nurse-hood in different age-groups, and shows the stage and the future of the career.

In the bottom columns of the diagram there are the years and below these are the pertinent structural changes. The structural changes that are inserted into this diagram refer to administrative and policy changes of the welfare state and educational and health care systems, the general economic conditions and major changes in the education of both professions. Certainly there can be other structural features that could have been included in the diagram, such as cultural modernisation, great migration from the rural areas to the urban south and abroad and so on.

When forming the age groups and putting them into the diagram certain compromises had to be made in order to obtain suitable categories for statistical analysis. Therefore, the age groups cannot indicate the structural and societal changes without some ambiguities. For instance, in the case of teachers the oldest age group (-1950) consists of teachers who were born during or just after the Second World War. Most, but not all, of its members belong to so called baby-boomers. This cohort was educated to teachers and they started to work as teachers in the parallel school system before the comprehensive and teacher education reforms of the 1970s and 1980s. Knowles (1992, 129-131) argues that the teacher’s professional self-identity is greatly influenced by the experiences with the teachers he had as a pupil at school. This influence implies that also those teachers were influenced by the current institutional arrangements where they worked and they passed those influences to their pupils. Thus, we may assume that even the institutional context of education at the when teachers of this study were pupils at school has some, though difficult to measure, influence on the formation of teacher-hood.

The members of the next age group (1951-60) were pupils in the old parallel school system, but they started teacher education and a teaching career in a new comprehensive system that, however, carried certainly on some inertia of the old system. Thus, although all teacher education was incorporated into the faculties of education at the universities, the difference between class teachers and subject teachers was still analogous with the difference between elementary and grammar school teachers. Subject teachers are even today admitted to the subject departments and they become specialists in their subject(s) with less pedagogical and practical training than the class teachers. By contrast the latter are educated at the teacher training departments at the faculties of education and become overall educators with emphasis on pedagogy and practice. So their, education and expertise in any particular subject is rather thin. This could actually create an external relation to substantive knowledge. Indeed, our qualitative data suggest that class-teachers have rather external and un-committed relation to substantive knowledge of core subjects and text-books. Teachers regard text-books as irreplaceable teaching resources and one of the key determinants the way in which they teach (Webb et al. 2004b, 93). For instance, our male informant argued that:

You can always get knowledge, so if there’s something you don’t know about, say the Environmental Studies or some other subject, you can always find information in the books.  
(Male teacher, born in 1967, 11 years of work experience)

Our informant seems to conceive substantial knowledge of core subjects as merely external information, packed material that can be easily acquired if needed. This implies that
knowledge can be easily separated from the knower and does not require much theoretical thinking. Thus, the knower does not need to establish strong internal relation and commitment to knowledge (Beck and Young 2005; Bernstein 1996).

Despite the comprehensive school reform class teachers are still working only in the lower level schools at the classes from 1 to 6, and subject teachers are working almost solely in upper level comprehensive schools and in general secondary schools. The vocational educational system is very much separated from the academic stream though nowadays pupils may to obtain a dual degree from the general and vocational secondary schools. Yet very few youngsters take that option. Moreover, there tend to be a fine line between the teachers that teach academic and practical subjects. We could argue that the general secondary schools continued to carry on some of the academic and social traditions of the old grammar schools. In terms of administrative governance, the teachers of this age group were accustomed to work under a centralised educational administration that regulated the schools, municipalities and teachers with detailed orders and strict supervision backed by unexpected inspector visits at schools.

Most of the teachers belonging to the age group 1961-70 were pupils in the comprehensive school system. In addition, almost all of them started their teacher education and some of them their working life before the reforms of educational institutions were introduced in the early 1990s. However, another striking feature characterising this cohort is the economic recession of the early 1990s which hit especially those who were starting their teaching career during that decade. Indeed, the survey suggests that this age group has had the most precarious working careers. When compared to the nurses we get similar results. The general trend among the nurses is that the younger ones have more likely been at least once unemployed. But among those who have been unemployed for more than twice in their careers we find proportionally more often the members of the age group of 1961-70. Still, the younger you are more probably you work as a temporary nurse. Thus, there seems to be two types of insecurity in teachers and nurses working career. First, the young professionals work often in temporary positions. Second, some cohorts may have unsecured career and relatively more unemployment due to macro-economic conditions. Certainly, when these two sources of precariousness intertwine the situation is the worst possible.

Finally, the youngest age group (1971-) started their teacher education at the beginning of the economic recession. At the same time the new administrative measures that emphasized decentralisation, school management and control by goals were introduced. This age group experienced the recession in the form of university budget cuts that forced to ‘rationalise’ teacher education, for instance by reducing available courses and alternative specialisations. However, as this age group entered into the labour market the national economy was steadily making recovery from the recession, the municipal economies were in much better shape and thus it was much easier to find. However, the depressing discourse brought by the recession and the permanent problems to finance welfare services prevail in many municipalities.
When we try to use the Lexis diagram to describe the profession of nurses, we have to bear in mind that the nurses’ training has been only relatively recently lengthened and upgraded into polytechnics education. Thus, the oldest age group got education at nursing schools and started to work already before the enactment of public health law. Before the establishment of the polytechnics, the education of nurses was arranged at the institutions of health care slightly more than ten years. Based on the structural changes in nursing education and health care services we would assume to find some differences particularly between the oldest age group and the youngest age group. However, it is rather difficult to discern between the effects of a cohort and a career stage.

5.4.1.2 Profession

It was actually rather difficult to analyze and describe the periods and generations without also referring to professions and comparing them. Therefore, here I would like to concentrate on issues not touched in the previous chapters so much. These are (1) the overall professional position within the society, (2) the professional position within the professional fields, (3) the internal differentiation of teaching and nursing the professions, and (4) the real conditions of professional work in teaching and nursing.

The overall professional position within the Finnish society could be discussed with respect to several issues. One indication of the relative social position of the professions of teachers and nurses is the official classification. Such official and institutionalised definition is the Classification of Occupations of Statistics Finland\(^\text{14}\). In Classification of Occupations of 1997

nurses were classified as Professionals. In Classification of 2001 their status had dropped one level lower to the category of Technicians and Associate Professionals. Teachers continue to be classified as Professionals. Another indication of social position is the power of the professions to resist external threats and demand social benefits. One strategy to assess this type of professional power could be an estimation of the degree of unionization and bargaining power of the professional union. When we compare the professional unions of teachers and nurses in Finland we can see that almost all teachers are members of their union whereas the degree of unionization among the nurses is not as high. Moreover, the teachers union has a very strong social position and bargaining power. Nurses are not so much unionized and the union is not that strong. Yet, both unions have been unsuccessful for obtaining major rise in salary.

A third aspect of the professional position within the society is the level of salary that social trust and prestige. Salaries for some occupation categories in the municipalities in 2003 provided by Commission for Local Authority Employers (Kommunala Arbetsmarknadsverket) are shown in the table 1 below. In the columns of the table there are first the occupational title, then the number of workers, the percentage of women, the official minimum salary, and the real average salary.

Table 5.1: Salaries for some occupation titles in municipalities in 2003 (€)

<table>
<thead>
<tr>
<th>Occupational title</th>
<th>Number</th>
<th>% Women</th>
<th>Minimum salary (€)</th>
<th>Average salary (€)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Lecture in High School</td>
<td>101</td>
<td>59.4</td>
<td>2,605</td>
<td>3,471</td>
</tr>
<tr>
<td>Lector in High School</td>
<td>1,350</td>
<td>68.7</td>
<td>2,466</td>
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<td>7,133</td>
<td>71.3</td>
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<td>2,612</td>
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<td>553</td>
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<td>3,970</td>
<td>99.5</td>
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<tr>
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<td>1,637</td>
<td>99.6</td>
<td>1,456</td>
<td>1,829</td>
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</table>

The table clearly shows that in terms of the salary nurses are at the bottom of the occupational categories presented in the table, except for hospital attendants. Moreover, when we look at the proportion of women working in these different categories and the level salaries we can observe almost a linear trend. In general, the more men in a given category the higher salary the category gets. This trend is particularly true concerning the average salary. We should also note that the overall salary level for the doctors is higher than for the teachers. As mentioned above, in our case studies the relatively low level of salary of is a constant issue of complain among the nurses and the teachers. They regard they work in the current context so responsible, demanding and exhausting that they do not consider the current salary as fair. Both unions have long talked publicly about the possibility to raise the salary. Particularly the nurses have demanded higher salary due to new tasks and responsibilities imposed on them because of the re-organization of health care work and the division of labour between the
doctors and the nurses. Indeed, there is an unorganized social movement that strives for rise in salary for nurses, and the issue was very much in public before and after the latest parliamentary election in Finland in March 2007. According to a recent poll - carried out by the Union of Health and Social Care Professionals - showed a wide public support for the demands for raising salary levels for the nurses. Indeed, in the image of the general public about both professions is very positive. The work and professional quality of both the nurses and the teachers are appreciated and consequently they enjoy high level of social trust among the Finns.

The salary table above indicated already two other factors, the professional position of nurses and teachers within the fields of health care and education, and the internal differentiation of these professions. First, I examine the professional position of nurses in relation to other professional and occupational groups within the field of health care. The salary level of the nurses is located between the doctors and the hospital attendants, indicating also that the nurses occupy a social position between the doctors and the nurses within the field of health care and consequently within health care organizations. This intermediate position is related to the level and length of education as well. So that, the degree of hospital attendant could be obtained by very quickly, the nursing degree takes a little less than four years, whereas doctors’ basic education lasts six years. Moreover, the trinity described above is visible also in the division of labour between the attendant, the nurse and the doctor. Being between the attendants and the doctors, the nurses have to balance between caring and curing. In order to distinguish from the attendants the nurses have to emphasize the scientific rather than practical aspects of care and/or bio-medical aspects of their work. But, in order to distinguish from the doctors, the nurses have to underline that they are there to take care of the patients, even protecting these against to the domination of the doctors and bio-medical machinery.

The two-pillar management structures, with the doctors and the nurses having their own pillar, emerged at hospitals in the late 1980s. This presumably strengthened the position of the nursing profession generally in society, and particularly in relation to the medical doctors. Just about the same time nursing science was introduced at the university, especially for those who wanted to take the managerial roles in nursing. The division of labour between nurses and medical doctors, and the broadening of the nursing functions have been much discussed in Finland in the early years of the 21st century. Nurses have been given new tasks on the grounds of more flexible and effective caring in the context of shortage of medical doctors and increasing demand for services, particularly due to ageing population. At present nurses have also been given their own consultancies where they treat, guide and follow-up patients’ with some common national deceases such as arterial hypertension. This type of nursing consultation was also a target of the Finnish qualitative case studies. In addition, so called doctor-nurse work-teams have been established. Finally, the Ministry is considering allowing nurses a right to prescribe certain pharmaceuticals. All these changes have obviously strengthened nurses’ professional position, but they are still below the doctors in terms of salary, autonomy, educational level and social prestige. However, nurses are clearly above the nurse attendants and assistants who do the manual work of cleaning, feeding and washing.

I understand ‘professions’ as a process-like configuration that is modified by the changing power relations between state, municipalities, citizens, firms, civic organizations and professional bodies (Rantalaiho 2004). There is a constant re-organization of the division of labour and power between different professions, which involves professional knowledge and identity. For example, the institutional re-definitions of doctors’ and nurses’ tasks, such as the nurses’ potential right to prescribe certain pharmaceuticals in the future, are not just administrative rationalizations. They also re-define and re-value professional knowledge and
identity. From the doctors’ point of view nurses are probably given only ‘simple’ or ‘inferior’
tasks. However, these ‘inferior’ tasks may actually strengthen nurses’ self-perceptions and
their professional position within the society, but this does not necessarily undermine the
relative social distance between doctors and nurses. Nurses also tend to shift dirty, bodily,
ordinary, banal, mundane and routine tasks to the periphery of or outside their professional
core tasks, knowledge and identity. The washing and feeding of patients is given to the
nurses’ attendants and other service staff. These divisions and processes do not exist only at
the official institutional level, but are also negotiated at everyday work settings between
various fractions of health care staff. For instance, although the nurses had their own
consultancies, they also acted as doctor’s assistance in some minor operations. Our qualitative
material suggests that the nurses do not perceive there being any severe frictions between
these three categories of health care occupations. The co-operation between various groups
was smooth.

The nursing profession is also itself internally differentiated into various fractions. Therefore,
as we analyze nurses’ perceptions and experiences of institutional reforms, work and life, we
have to acknowledge that their point of view is taken from a particular position within society
and the field of health care (Bourdieu 1988; 2005). For instance, at the general level, there is a
division between practicing, managing and knowledge producing nursing professionals, who
may have divergent perspectives and interests (Freidson 1984). In addition, most career paths
and positions for nurses are institutionalized, such as the distinctions between medical
specializations and the division of labour between hospitals, health clinics and teaching
institutes. The comparisons between there fractions was not the goal of this report, but such
an analysis could yield interesting results.

Teachers’ position in society was discussed already in the chapter three that deals with the
restructuring in Finland. Teachers enjoy good reputation and trust among the Finnish public.
Teachers tend to situate themselves into the middle upper class. Yet, particularly the salary
level of the class teachers in not very high.

When exploring the differences in the associations between views and positions of teachers
we have to decide first the criteria of differences and measures of associations. The easiest
point of departure is to examine the differences between the positions is to use the
conventional administrative categories of schools, because they form shared ground for
understanding and experiencing the reality of education. Moreover, they refer to the factual
levels of schools and differences in the division of labour. In addition, research material is
usually readily available for those categories. In this paper I focus on three types of schools:
the lower level comprehensive schools (classes 1-6), the upper level comprehensive schools
(classes 7-9) and the general upper secondary schools, leaving aside the vocational schools.
The comprehensive schools belong to the compulsory education and hence they are the level
of education. General upper secondary schools, or high schools, are an alternative to
secondary vocational schools. Yet, we have to bear in mind that these conventional categories
disguise some other properties that are important if we want to understand the relative
positions of these schools within in the field of education and how these locations may relate
to teachers’ varying responses to changing institutional parameters (Houtsonen 2006). Similar
analysis could be carried out relative to the field of nursing.

The composition of the secondary differences, such as the type of teachers and their
education, gender and age, type of pupils and their age, type teaching and learning, and so on,
can be used to make further distinctions between the school types. In addition, these
properties can be regarded as indirect indications of resources and rights that help us to
understand the varying responses to institutional changes. In addition, some secondary
properties, above all the age composition of school types, help us to understand how the social inertia of schools, formed in the previous periods of educational reform and socio-economic conditions, is related to the response to the current institutional reforms. To conclude, the categorical labels of school types can be seen as functions that condense important secondary properties that put the school into particular positions within the educational field and thereby in relation to education institutions as well (Houtsonen 2006).

An analysis of the survey data shows that the teachers in high schools are almost solely subject teachers besides there being relatively large proportions of men, representatives of the older age groups, Master’s degrees, pupils from wealthy families and a quite secure workplace. All these facts indicate that high schools situate on a good position in the distribution of power in the field of education. Hence, we may assume that they are also relatively insulated from the institutional pressures. On the contrast, lower level comprehensive school teachers are mostly class teachers, but there are also many special teachers, special class teachers and headmasters in those schools. In addition, lower level teachers tend to be more often women, who work in temporary posts, belong to the youngest or the second oldest age groups and have relatively often seminary degree or Bachelor’s degree. Furthermore, their pupils come above the average from poor families. Hence, these schools and teacher are presumable not in such a good position against the institutional pressures as the high school teachers are. Finally, the teachers of the upper level comprehensive schools tend to occupy the middle position between the lower level and high school teachers.

5.5 Concluding Comments and Recommendations

When reading the results described in the previous chapters we must acknowledge that teachers and nurses have a different professional basis to relate to some of the new administrative measures. For instance, documentation in the form of casebooks and registers has been an integral part of health care and medical professions since very early on. In addition, in medicine people are generally much more concerned about the rights of a client (patient) regards to possible treatment injuries than in education. It is hard to imagine a situation where the parents claim rights for ‘educational treatment injury’. Indeed, the effective and rationalised documentation has been continuous concern for nursing and care. The latest rationalisation of documentation is “a national electronic patient record” which will be introduced in the end of 2007.

Based on our research I dare to make the following recommendation concerning both professions:

5.5.1 Support for the Young Teachers and Nurses

It is obvious that the basic academic training is necessary but not sufficient condition to work confident manner in nursing and teaching. Young professionals need lots of support and guidance from the more experienced colleagues. In the nursing profession this is relatively easily achieved in the settings where nurses work together or closely, but at school where teachers work alone in their class-room the situation can be dramatically different.

I recommend that the nursing and teaching settings could plan and execute mentoring programs for the inexperienced teachers and nurses. These could be rather informal and easy to realize, so they should be tailored for each particular teacher, school and municipality. Related to the need for support for the young professionals, it would be crucial that the further professional training continues after this initial period. Our data suggests that among the nurses the further professional training is better organized and the participation rates are

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higher than among the teachers. Further training does not only improve the skills and knowledge, but they could also motivate and commit the professionals to their. Finally, mentoring programs for young professional could have negative consequences as well. It could be that these programs undermine the new attitudes and skills obtained in the latest education and impel the newcomers partly to obtain some unproductive and worn-out professional traditions and procedures. This could also complicate and hinder the application of new governance measures.

5.5.2 Autonomy and Control

Professional autonomy and control are two sides of the same coin. To be sure professional work requires both a degree of autonomy and a room for professional judgement. However, professional work has a public function, and particularly in the Scandinavian welfare system it is mostly financed by tax-payers money. Therefore, the public control of professions is also crucial. There are basically two generic types of professional control, certification and inspection. Certification is about who does the work and inspection is about how well the work is done. Certification contains the entrance examination and professional socialization through education. It is back up strong professional association and professional ethics. This sort of autonomy presumably increases the attraction of the profession, particularly in the era of diminishing cohort and increasing competition for high quality work-force. By contrast if control is exercised as a direct inspection that will presumably erode the trust relations between the professionals and the management. Furthermore, this could create an atmosphere of fear.

Yet some sort of control is desirable and necessary in order to hold the professionals accountable for their conduct and in order to avoid moral hazards. In Finland, the control and management of teachers and nurses have emphasized more indirect control, through certification and relatively strong professional autonomy than direct inspection. I would urge to continue with this model of control as in the comparative perspective it produces better results in terms of quality of the work force and working morale. This requires, however that the professional training continues to be of high quality and involves strong socialization into profession. In addition, the further professional training should be compulsory, and possibilities for taking a study leave should be provided.

5.5.3 Accountability, Evaluation and Documentation

An important object of professional control is to keep professionals accountable for their conduct, so that they performance is up to the legal, ethical and intellectual standards of the professional work. Accountability could be arranged by inspection of how the work is done. Restructuring of welfare services changed the idea of professional control as we have witnessed a change from direct and external inspection to indirect and often internal evaluation of professional conduct. Thus, the authorities impose the goals for the service providers and give them more autonomy in deciding how to reach those goals. Hence, we understand the importance of documentation and evaluation in teaching and nursing has become much more significant.

There are some crucial issues in this kind of control. First, the rational for indirect evaluation and increasing demands for documentation should be clearly communicated and justified for the professionals. They should be clearly explained, particularly in relation to the old style of inspection and control. I wish to emphasize in this context, that contrary to many writers I do not consider evaluation and documentation as instruments of neo-liberalism, because such means could be used in various systems organized around divergent ideologies. Second,
documentation and evaluation should be based on facts. The procedures and the use of the results should objective, truthful, systematic, neutral and fair.

5.5.4 Professional Knowledge

Our results suggest that subject teachers are quite strongly committed to their subjects and from that attachment they have derived a relatively strong professional identity. Instead nurses and class teachers tend to have looser identities that are formed around rather permeable areas of caring and didactics (pedagogy). The latter knowledge area of class teachers could be described in their own terms as helping children and keeping order in the classroom. Class teachers tend to downplay the importance of substantive knowledge of core subjects the same way as the nurses downplay the significance of bio-medical knowledge and technical skills in their work. In reality, both subject knowledge and bio-medical knowledge are inherent aspects of class teachers’ and nurses’ professional conduct. In addition, there is a tendency in both professions to perceive caring and helping something that is inborn quality of professional’s personality. Certainly, there is personality involved in all work, but the point is that it is hardly possible to base professional knowledge principally on inborn personal qualities. First, these professional groups should argue for sort of ‘professional personality’ that is at least to a degree possible to be described objectively, and teach and learn systematically. Second, caring patients and helping pupils should be balanced by a strong commitment to knowledge of bio-medicine and core subjects as well. Nurses’ and class teachers’ external and uncommitted relation to these areas of knowledge could reduce the quality of health care and education. Third, seen professional work strongly as an application of real personality could have a negative contribution to work-life balance.

5.5.5 Professional Position

So far nurses and teachers have enjoyed public appreciation and trust in Finland. There is nothing on the horizon that would change this situation. However, we must acknowledge the fact that nurses and teachers are the agents that bring the patients and pupils in contact with the welfare state and the services it provides. Then the public respect and trust is very much dependent on the quality and quantity of the welfare services that are received by the citizens. If there is a lack of quality or quantity of services, particularly if these shortcomings influence the everyday work and encounter between the professionals and citizens, then we may expect that the public appreciation of these professions will decrease.

Finally, the level of salary is an important issue that should be solved particularly in the case of nurses and class teachers. Some of the subject teachers, particularly, senior lecturers and those who work in general secondary education, are in a better position. Certainly, material rewards are not the only source of motivation and job satisfaction. But there are clear signs that because of the relatively low salary level motivation, commitment and satisfaction are becoming weaker.

5.6 References


6 Greece:

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University of Athens

6.1 Introduction: aims and methodology

This report is based on the research that has been conducted in Greece as part of the PROFKNOW project which focuses on professional knowledge under restructuring in seven European contexts: England, Finland, Greece, Ireland, Portugal, Spain and Sweden (Linblad 2004).

The aim of this report is to understand the notion of restructuring of statehood in the context of Greece and its implications in work life of teachers and nurses. Teaching and nursing have been chosen as two professions in the public services sector that play a key role in the relationship between the state and the citizen and in that sense are representative of the transformations that are taking place in the European welfare systems. The main focus of interest is to analyse the changes that are taking place within the last three decades in the social positions of the professions and their implications in professional knowledge.

According to the technical annex this report should contribute to the following aims:

- To present comparisons of professional work and life in Greece within and between the professions of teaching and nursing.
- To achieve a more developed view of professional knowledge in the fields of teaching and nursing as a basis for the development of organisational, professional and educational strategies by the professions as well as administrators and policy makers.
- To describe, analyse and evaluate current restructuring in education and health from the point of view of teachers and nurses and their experiences from their interaction with clients.
- To present a conceptual framework for analyses of professional knowledge in restructuring organisations.

This report attempts to integrate in a concise form the findings of the research that has been done in two different levels:

- system narratives (policies and reforms analysed in WP1 and WP2)
- work life narratives (based on data collected from in depth interviews with teachers and nurses and ethnographic observations, analysed in WP4 and WP5).

The first section of the report focuses on the notion of restructuring and attempts to conceptualise it with regard to the Greek context of welfare provision with particular reference to education and health.

The second section of the report analyses restructuring in terms of the policies followed during the last three decades (system narratives) and juxtaposes these structural changes to the work life narratives of teachers and nurses.
Finally the report mentions the dissemination activities of the PROFKNOW project that have been promoted by the Greek team up to the report date.

6.2 National case presentation: restructuring in the greek context

6.2.1 The notion of restructuring as a world movement

In this report we understand restructuring as a global force which permeates global consciousness and social practices. Restructuring of statehood is performed through new modes of political legitimacy which are largely dependent upon knowledge transfer. Professional knowledge is a vital presupposition for knowledge transfer and contributes to the hybrid nature of restructuring. We argue that in the case of Greece restructuring is performed through the mediation of political and professional elites that are in a position to transfer and translate global trends into meaningful and operational policy measures at the local level by drawing upon or adapting to specific contextual configurations. Mediation and translation are essential in the technologies of restructuring in the sense that although restructuring of statehood may follow similar patterns across different polities forming a sort of a ‘world movement’, it is genuinely hybrid in its nature by interacting with embedded elements of each particular social context (Foss Lindblad, et al. 2007). It is questionable however whether the dramatic transformation of social relations is owed to globally disseminated policies or to contextually developed social strategies.

State intervention in the field of social policy has been a crucial component in the construction of welfare rights and in shaping of what has been defined as democratic welfare capitalism in the post war era (Dean 2002). Political legitimacy has been largely dependent on the gradual expansion of the public sphere and the redistributive element of the welfare state economy. However, the mode of political legitimacy varies significantly among the different types of welfare states, while the main distinctive feature of this variation lies on the specific configurations of the relationship between the public versus the private, the collective versus the individual, and the communal versus personal networking that dominate in each particular national context.

During the last decades different types of welfare states, either in Europe or in North America, are in a process of transition that has been understood as restructuring because it redefines the nature of the welfare institutions and the mode of appropriation of social goods (Esping-Andersen 1996; Jessop 2000). The implications of restructuring in key welfare state institutions, such as education and health care are overwhelming and transform dramatically the relationship between state institutions and civil society and the social positions of the professionals in a variety of countries, even in cases of ideal-types of welfare states, such as Sweden or Finland (Beach 2005). Policies of restructuring such as increasing commercialisation of social services and privatisation, a ‘workfarist’ mode of labour reproduction and a wider shift to a neo-liberal discourse, are apparently disseminated globally forming a ‘world movement’ whose dynamics lies in a wide range of technologies that allow for stabilisation as well as harmonisation of social practices. In these restructured polities state steering is accomplished through modes of governance that transcend traditional processes of political legitimacy and develop strikingly stabilised outcomes. It is in these modes of governance and processes of legitimacy that we will now turn to.

It has been widely argued that globalisation has led to convergent social practices and to a standardisation of institutions, policies and beliefs across the globe. Perhaps the most vital aspect of globalisation is the gradual globalisation of consciousness (Albrow and King 1990). Immanuel Wallerstein, following Marx, has focussed on the emergence of a ‘one world society’ based on the power of the capitalist world-economy that operates as an interstate
system (Wallerstein 1990a; Wallerstein 1990b). The state’s territoriality and jurisdiction on
the exclusive control of the means of violence, not least its capacity to control the ideological
apparatuses that shape public consciousness, has been intrinsically eroded. This position is
elaborated even further by neoinstitutionalism which argues that many properties of the
contemporary ‘nation-state’ derive from world-wide cultural and associational processes that
are surprisingly consensual (Meyer, et al. 1997). State policies and other rationalised domains
of social life follow patterns of structural isomorphism which are legitimated on the basis of
worldwide models. These models have become particularly powerful due to the
intensification of global interconnectedness in the contemporary era. The effective
dissemination of world models is mainly owed to the statelessness of world society.
Dissemination however presupposes agency and actorhood which mediates between the
global and the local. Responsible and authoritative actorhood still rests with the states but,
according to neoinstitutionalism, the likely outcomes of the interplay between the various
world models and local traditions would be rather limited. This is due to the fact that
legitimated actorhood such as professional societies is institutionally standardised and
organised to perform similar functions across the world converging into what Meyer has
called ‘world culture’.
Re restructuring as a world movement is performed through apparently similar patterns and
policy formulations across different countries: devolution, consumerism, new public
management principles, audit society etc. In this respect restructuring could be perceived as a
sort of travelling policy and in fact a process of policy transfer among different countries. The
process of policy transfer implies that legitimated actorhood at the national level is knowledge
embedded. One version of legitimated actorhood that performs policy transfer could be the
coercive action of supranational organisations that are in a position to impose policies, such as
the International Monetary Fund, the World Trade Organisation, the World Bank, etc. Even in
cases where policy transfer meets with strong local or international resistance (i.e. the anti-
globalisation movement), it derives legitimacy on the basis of high expertise exclusive
knowledge and global authority with overwhelming implications, especially for the less
economically developed countries. Policies of restructuring in this case intensify even further
the asymmetric relationships in the international division of labour. Another version of
legitimated actorhood in the restructuring movement is that which is performed through
sophisticated technologies of knowledge transfer. In this case national institutions learn from
global trends and transform their internal structures in response to these trends. Up to this
point our analysis is in agreement with neoinstitutionalism. It is on the question ‘how do
institutions learn’ and ‘in what ways the technologies of knowledge transfer operate’ that our
differences start.

Restructuring of welfare state institutions such as education and health care is becoming a
global force the power of which lies in the fact that it derives legitimacy on the basis of
expertise and professional knowledge. Professions in this case become the agents of
restructuring – as they are restructured themselves at the same time - and provide for the
legitimated actorhood which introduces ideas and change. This, however, is not a linear
process. Professions are also hierarchical structures and it is the professional elites which act
as the par excellence agents of reflexivity and innovation. The agency that facilitates global
knowledge transfer acquires as one of its main properties what Brian Turner defines as the
‘cosmopolitan virtue’ of global cultural awareness and distance from nostalgic identities and
tradition (Turner 2000). The role of professional elites in policy transfer is critical because
they are key agents in grasping meanings and constructing social realities. Globalisation,
perceived as time-space compression intensified by rapid capital accumulation and new
technologies, especially informatics (Harvey 1989), facilitates their social position and
empowers even further these elites. Professional elites participate in an intellectual world which is genuinely borderless and transnational, communicative and dialogic, scepticist and reflective, spaceless and virtual. To the extent that they share a sort of post-national civil identity they are in a position to codify global knowledge and re-contextualise it according to national specificities, social constraints and significations. In fact the technology of knowledge transfer, essential to restructuring, is policy translation, accomplished by the professional elites. These organic intellectuals are certainly part of a complicated procedure for producing social meanings and achieving legitimacy at the level of national institutions, such as education systems.

Restructuring as a world movement is not taking place uninterruptedly or without resistance. Restructuring diminishes redistributive policies, enhances asymmetric social relationships and reallocates resources for the benefit of market forces. The technologies of restructuring (such as accreditation, assessments, evaluation and auditing) are globally diffused policies, but they are locally reinterpreted and appropriated. World movements account for global ‘ideoscapes’ that govern communication between elites (Appadurai 1990) and for similarities in political formulations (such as policy borrowing), but not for the actual formation of education policy in each particular national context (Steiner-Khamsi 2006). In fact the exact meaning, implications and outcomes of these policies can vary substantially across countries, which means that restructuring can be viewed as convergent global discourses with divergent national configurations. The striking potential for dissemination and stabilisation of the restructuring movement lies in the complexities of the policy translation process. Translation presupposes participation in at least two different languages, discourses and contexts. Policy translation is not a process to be understood in mere linguistic terms. Professional elites make the global political culture of restructuring available to their national context and professional community through the de-codification of global policy with regard to embedded elements of their societies. Policy translation makes policies of restructuring meaningful and relevant to the local context. This is a communicative and in several cases conflicting process that involves negotiation, social struggle, and structural adjustment. It is quite possible that in this process professional elites are not alone. Convergent interests, not only on the part of internationally powerful organisations, such as transnational corporations, global media, Microsoft, etc., but on the part of highly competitive middle class social strata as well, may be supporting social actors in the restructuring movement. The field of education policy restructuring brings some evidence supporting this case. As a result of these processes restructuring is performed through eclectic policy transfer and it is intrinsically hybrid in its nature. In several cases embedded and articulated social interests in a particular national context are negotiated achieving new terrains and opportunities to satisfy their goals within the restructured knowledgeable polities.

6.2.2 Restructuring welfare in Greece

During the last three decades Greek society is undergoing a process of dramatic socio-economic change. On one hand the traditionally extended agricultural sector is facing a serious decline, a fact that has led to further urbanisation trends. On the other hand de-industrialisation processes have further diminished the industrial sector that has never represented a large part of Greek economy. De-industrialisation, however, especially in the fields of mining and textile industry, have led to high unemployment rates and social frustration in certain regions of the country (Getimis and Economou 1992). The new areas of intense capital accumulation are those of banking and services, shipping, information and communication technologies in particular, a process that has led to a considerable redistribution of income in favour of new emerging elites, especially during the 1990s and
Moreover, massive waves of economic immigrants (mostly coming from the Far East and Easter European Countries) provided for a cheap labour force occupied mainly in construction and auxiliary services. This ‘grey labour’ increased the already substantial informal sector of the Greek economy, which co-exists with a particularly extended public sector. During the 1990s the main proclaimed aim of the economic policy was the European convergence and monetary union, a discourse followed later by the politically disputed goal towards the efficient organisation of the Athens Olympic Games. While the main consequence of the decline of agriculture, de-industrialisation and urbanisation has been the widening of the Greek lower middle class, the post-1990s period represents a process towards the consolidation of key economic interests and networks of economic activity that dominate in the sphere of public policy. At the same time social inequalities are growing mainly affecting social strata that face the risk of poverty, such as the elderly who are depended on a poor system of social insurance.

Greece used to be the relatively poorer country after Portugal among the 15 EU member states with a GDP per capita of 19,600 in US Dollars in 2003 (OECD 2005, Society at a Glance). Today its relative economic position in the EU changes due to the European enlargement with the 10 new member states, many of which have a relatively weaker economy than the EU average level of economic development.

Internal inequalities related to relative poverty and income inequality are much more severe in Greece than the OECD or EU average. Situation for women is presented more unfavourable in the Greek labour market. Women’s participation in employment is much lower, while mothers with young children are less likely to work in Greece in comparison with the other OECD and EU countries. This is a fact which partly relates to the traditional social attitude regarding the division of labour between men and women, which, however, gradually becomes less influential in Greece, and partly to the lack of family policy and supportive social institutions for working parents. Moreover, fertility rate is the lowest in the EU, with the exception of some of the new member states such as Poland or the Czech Republic, and it is steadily decreasing. On the other hand, public expenses related to social policies are higher than the OECD average. A large percentage of these expenses though correspond to pensions and not to productive investment on social policies such as education or health infrastructure. The deficit of publicly funded social policy is depicted, for example, in the extremely high rate of private expenditure for health services in the country.

Some other social indicators, however, related to life expectancy, social isolation and suicide rates place Greece in a favourable position in comparison with the OECD and EU average. This is a phenomenon related less to social policy, but rather to the Mediterranean culture of food and life, as well as to the persistence of traditional modes of social solidarity based on individual and family networks.

The relatively higher rate of social trust in Greece in comparison with other European countries is observed also in the results of the European Social Survey, where the Greek respondents are more likely to express trust to others. Social conservatism, however, is presented particularly high in Greece. More religious and homophobic, more in favour of restriction of immigration (82.5%), 78.4% of them considering the immigrants as been responsible for the reduction of wages, the Greeks, more than any other Europeans, blame the immigrants for the raise of unemployment and crime. At the same time they are the most sceptical among the Europeans towards ethno-cultural and religious diversity and less prepared to support legislation for tolerance and equal treatment of the immigrants in the labour market. The family, work and religion are presented as the highest respected social
values, while at the same time their interest in politics is particularly low, which is a relatively new phenomenon for Greek society. ([http://www.ekke.gr/ess/ess_results.doc](http://www.ekke.gr/ess/ess_results.doc)).


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<td>Unemployment rate %</td>
<td>6,9</td>
<td>8,9</td>
</tr>
<tr>
<td>Employment rate for mothers with a child aged under 6</td>
<td>59,2</td>
<td>49,5</td>
</tr>
<tr>
<td>Out-of-work benefits</td>
<td>40</td>
<td>26</td>
</tr>
<tr>
<td>Relative poverty rate</td>
<td>10,2</td>
<td>13,5</td>
</tr>
<tr>
<td>Income inequality</td>
<td>30,8</td>
<td>34,5</td>
</tr>
<tr>
<td>Child poverty</td>
<td>12,1</td>
<td>12,4</td>
</tr>
<tr>
<td>Public social expenditure as GDP % (total)</td>
<td>20,9</td>
<td>24,3</td>
</tr>
<tr>
<td>Public social expenditure as GDP % (pensions)</td>
<td>8,0</td>
<td>13,4</td>
</tr>
<tr>
<td>Life expectancy (men)</td>
<td>74,7</td>
<td>75,4</td>
</tr>
<tr>
<td>Life expectancy (women)</td>
<td>80,6</td>
<td>80,7</td>
</tr>
<tr>
<td>Public Health Care expenditure as GDP %</td>
<td>6,0</td>
<td>5,0</td>
</tr>
<tr>
<td>Private Health Care expenditure as GDP %</td>
<td>2,4</td>
<td>4,5</td>
</tr>
<tr>
<td>Social isolation (rarely spend time with friends)</td>
<td>6,7</td>
<td>3,7</td>
</tr>
<tr>
<td>Suicides (per 100,000 persons, all ages)</td>
<td>13,9</td>
<td>3,6</td>
</tr>
</tbody>
</table>


The persistence of religion in the public sphere is an eminent characteristic of Greek society. The Christian Orthodox Church is the officially established state Church and the clergy is perceived as being public servants funded by the state (Foundethakis 2000). Secularisation, in terms of separation between the church and the state has never been a public issue, in spite of some marginal criticism on the part of some intellectuals and politicians. Attempts at de-establishing religion in some cases of public life, such as the introduction of civil marriage at an optional basis (in the early 1980s) or the abolishment of the reference to religious identity in the identity cards (in the 1990s) have met with strong opposition on the part of the Church. In both cases the state insisted in implementing the respected regulations, but in both cases the Church has managed to achieve social consensus and support in its anti-republican positions. In Greek public schools Religion is a compulsory subject of a clearly denominational character, referring exclusively to the established religion (Zambeta 2003). The public appeal of religion remains impressively high and is related to the specific construction of the modern Greek national identity which is perceived as intrinsically connected to Orthodoxy (Manitakis 2000). While in other parts of Europe secularisation has been a process of state intervention in the space historically dominated by the Churches, in Greece the state gave birth to the national Church as part of the nation building process. This is genuine feature of Greek socio-political context which represents a peculiar prevalence of tradition and romanticism over the ideas of modern Greek Enlightenment, a case that can be traced in the Greek historical trajectory since the late eighteenth century (Dimaras 1982; Dimaras 1983).

The welfare state deficit is evident in the low level of public funding in key sectors of social policy, such as education and health. Greece has the lowest percentage of public expenditure in education in the EU (see table no. 2). At the same time private expenditure on education is
particularly high. Despite the fact that education is considered to be a public good and it is offered free of charge, while private schools represent only 4.46% of the overall school units (see table no. 3) the private cost of education services in Greece is exceptionally high and it is steadily rising. This is directly related to the existence of a large informal sector of educational services which has to do with private tuition offered either at an individual basis, at home, or in special institutions called ‘Phrontistiria’. The cost of this sector, which is actually a ‘grey educational market’, is not easy to be estimated and it is not part of the official statistics. The same is the case for the additional cost covered by the family for educational services such as foreign languages, music, dance, etc. as well as extra support material for the school.

Table 6.2: Total Public Expenditure on Education as percentage of GDP (1995-2001)

<table>
<thead>
<tr>
<th>Country</th>
<th>1995</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROFKNOW Countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>6.8</td>
<td>6.2</td>
</tr>
<tr>
<td>Greece</td>
<td>3.1</td>
<td>3.9</td>
</tr>
<tr>
<td>Ireland</td>
<td>5.1</td>
<td>4.3</td>
</tr>
<tr>
<td>Portugal</td>
<td>5.4</td>
<td>5.9</td>
</tr>
<tr>
<td>Spain</td>
<td>4.7</td>
<td>4.4</td>
</tr>
<tr>
<td>Sweden</td>
<td>7.2</td>
<td>7.3</td>
</tr>
<tr>
<td>UK</td>
<td>5.2</td>
<td>4.7</td>
</tr>
<tr>
<td>Other OECD countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>5.2</td>
<td>5.0</td>
</tr>
<tr>
<td>Japan</td>
<td>3.5</td>
<td>3.6</td>
</tr>
<tr>
<td>Turkey</td>
<td>2.4</td>
<td>3.7</td>
</tr>
<tr>
<td>USA</td>
<td>M</td>
<td>5.6</td>
</tr>
</tbody>
</table>

Source: OECD, Education at a Glance, table B4.1

The OECD data on the relative proportion of public and private expenditure on educational institutions for all levels of education claim that the household expenditure on education in Greece is only 5.8% (OECD, Education at a Glance, table B.3.1). This percentage critically underestimates the actual private cost of education in the country. As it has been pointed out, international statistics construct certain representations of education systems which are used in politics and in several cases legitimate restructuring (Lindblad 2001). In the case of the Greek education system international indicators need decoding and contextualisation, while in many cases present a false image or even silence social reality.

Table 6.3: Private Schools by level of education as percentage in the total number of schools (1997-1998)

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Public</th>
<th>Private</th>
<th>Private %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursery Schools</td>
<td>5,594</td>
<td>122</td>
<td>2.17</td>
</tr>
<tr>
<td>Primary</td>
<td>6,172</td>
<td>390</td>
<td>6.32</td>
</tr>
<tr>
<td>Lower Secondary</td>
<td>1,755</td>
<td>91</td>
<td>4.93</td>
</tr>
<tr>
<td>Upper Secondary</td>
<td>1,096</td>
<td>79</td>
<td>6.72</td>
</tr>
<tr>
<td>Total</td>
<td>14,617</td>
<td>682</td>
<td>4.46</td>
</tr>
</tbody>
</table>

Source: Unpublished data from the National Statistical Service of Greece selected from (Stamelos 2002), tables B.3.1.2.1, B.3.1.3.1, B.3.1.4.1, B.3.1.5.1.
Another source of severe economic burden placed on the family is the cost of tertiary education. Many students, who study in Greek universities, find themselves at another city where they are obliged to pay for accommodation and subsistence, since the limited student hall facilities are insufficient to satisfy the demand. On the other hand a disproportional high number of young people emigrate in other countries in order to ensure a university placement (see table 6.4). The numerus clausus, as well as the system of examinations which regulates access to higher education in the country is a source of constant anxiety and stress for Greek adolescents, which leads to the explosion of the private tuition enterprise and, in the case of failure, to student emigration.

Table 6.4: Student Emigration (2002). Number of Foreign Students in Tertiary Education by Country of Origin

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROFKNOW Countries</strong></td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>9,853</td>
</tr>
<tr>
<td>Greece</td>
<td>50,015</td>
</tr>
<tr>
<td>Ireland</td>
<td>15,176</td>
</tr>
<tr>
<td>Portugal</td>
<td>11,245</td>
</tr>
<tr>
<td>Spain</td>
<td>26,564</td>
</tr>
<tr>
<td>Sweden</td>
<td>15,143</td>
</tr>
<tr>
<td>UK</td>
<td>27,525</td>
</tr>
<tr>
<td><strong>Other OECD countries</strong></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>5,299</td>
</tr>
<tr>
<td>Japan</td>
<td>62,222</td>
</tr>
<tr>
<td>Turkey</td>
<td>47,340</td>
</tr>
<tr>
<td><strong>USA</strong></td>
<td>36,136</td>
</tr>
</tbody>
</table>

Source: OECD, Education at a Glance, table C3.7

In the case of Health Services the welfare state deficit is a matter of constant social and political debate in Greece. According to the OECD data, health expenditure in Greece is steadily increasing. While in 1980 health expenditure corresponded to 6.6% of GDP, in the year 2002 it was 9.5% of GDP, much higher than the OECD countries average (8.4%). However, almost half of the overall health expenditure is private. At the same time there is wide discontent regarding the sufficiency and quality of health care provision in the country. Although it is argued that it is extremely difficult to estimate the accurate data on health expenditure in Greece, due to the difference and inconsistencies between the OECD data and the National Accounts (Soulis 2002)—a fact which applies in any field of social policy including education—it is evident that the private cost of health care is extremely high and on the increase since the 1980s (Souliotis 2002) (see table No. 6.5).

The inadequacies of the health care system are mainly related to the low quality of primary health care, especially in the geographically remote areas, the incapacity of high-technology diagnostic equipment maintenance in public institutions, the lack of institutions such as the family doctor and the low quality in care and hosting facilities in public hospitals. On the other hand the explosion in doctors’ and dentists’ supply, in some cases is accused for developing a false over-demand for health services. However, the steady development of the private sector in health care provision in the diagnostic, prevention and curative level is the outcome of the failure of the public health system to meet the demand and the expectations of the citizens. Most of the analysts working in the area of health policy and economics, though, argue that rationalisation in the distribution of available resources, rather than the increase in
public spending as such should be the answer to the malfunction of the public health system (Kyriopoulos and Souliotis 2002).

Table 6.5: Public Expenditure on Health as % on total expenditure on Health

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Finland</td>
<td>79,0</td>
<td>80,9</td>
<td>75,1</td>
<td>75,7</td>
</tr>
<tr>
<td>Greece</td>
<td>55,6</td>
<td>53,7</td>
<td>53,9</td>
<td>52,9</td>
</tr>
<tr>
<td>Ireland</td>
<td>81,6</td>
<td>71,9</td>
<td>73,3</td>
<td>75,2</td>
</tr>
<tr>
<td>Portugal</td>
<td>64,3</td>
<td>65,5</td>
<td>69,5</td>
<td>70,5</td>
</tr>
<tr>
<td>Spain</td>
<td>79,9</td>
<td>78,7</td>
<td>71,5</td>
<td>71,4</td>
</tr>
<tr>
<td>Sweden</td>
<td>92,5</td>
<td>89,9</td>
<td>84,9</td>
<td>85,3</td>
</tr>
<tr>
<td>UK</td>
<td>89,4</td>
<td>83,6</td>
<td>80,9</td>
<td>83,4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other OECD countries</th>
<th>1980</th>
<th>1990</th>
<th>2000</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>63,0</td>
<td>62,5</td>
<td>68,7</td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>71,3</td>
<td>77,6</td>
<td>81,3</td>
<td></td>
</tr>
<tr>
<td>Turkey</td>
<td>27,3</td>
<td>61,0</td>
<td>62,9</td>
<td></td>
</tr>
<tr>
<td>USA</td>
<td>41,5</td>
<td>39,6</td>
<td>44,4</td>
<td>44,9</td>
</tr>
</tbody>
</table>

Source: OECD, Health Data 2004, E3

The study of the welfare state and social policy in Greece is a relatively new field which has emerged during the 1980s (Stassinopoulou 1996). Understanding the nature of the Greek welfare system and the social constraints which shape its mode of development remains an open task for social inquiry. The Greek type of welfare state has followed a scheme of subsidiarity assuming that a large part of social services and support, such as childcare, care for elderly people etc. is provided by the family and traditional social networks. The process of the welfare state development in Greece is not similar to the cases of central or northern European welfare states, for reasons related to the specific socio-historical context (the civil war ended with winners and losers, a state legitimacy based only on the former, namely the political right, and a deep rift within the Greek society that prevented consensual social processes) and the forms of political legitimacy that prevailed in the post-war period. According to Tsoukalas the expanded public sector in Greece (around 40% of the wage labour were public sector employees in the 1950s and around 30% in the early 1960s) has acted as a form of socio-political integration of large parts of population and has genuinely shaped class structure (Tsoukalas 1986). In this sense the state as an employer has substituted for social policy. Although the principle of social welfare based on public provision is propagated at the level of political discourse, policy practice and implementation show that a substantial part of social services, especially in education and health care, is covered through private funding. This situation is in a process of intensification during the last decade and leads to the welfare state restructuring and to a dramatic increase of social inequality in the country.

6.3 Structural changes

6.3.1 System narratives: the construction of the Greek welfare state in education and health

The Greek education system has been considered as being systematized, geographically expanded and democratized relatively early in comparison to many of its European counterparts (Tsoukalas 1982). Indeed the provision of public and free of charge compulsory education for all has been introduced in 1834, much earlier than in other more industrialized
states or more democratized regimes in terms of civic and political rights. The early expansion of education institutions, however, does not entail the actual implementation of compulsory education or the dissemination of literacy in rural and deprived areas. Drop out rates and functional illiteracy, particularly in geographically remote areas, among the poor and among women, remained high till the WWII, the sixties and even the seventies.

The turbulent political life of the country, involving civil war (1946-1949) and a dictatorship (1967-1974), is reflected in education policy and to what has been defined as “the reform that never took place” (Dimaras 1987-1988). A continuous conflict with regard to educational objectives among conservatives, modernizers and left-wing intellectuals has actually prevented any attempt at democratization and modernization of Greek education for many decades during the best part of twentieth century (Frangoudaki 2001). The first education reform, aiming at the expansion of educational institutions and democratization of education was that of 1976, initiated by a right-wing government (New Democracy) (Eliou 1978; Kazamias 1978; Kontogiannopoulou - Polydorides 1978). The process of democratization and expansion of educational institutions has been continued during the eighties, by the social-democratic party (PASOK) (Zambeta 1994; Zambeta 2004).

Four main periods are identified in the main policies followed in Greek education since the WWII.

In the 1945-1967 post-war period education policy reflects the civil war political climate where education institutions and teachers are scrutinised.

The 1959 attempt at educational reform represents a vision of modernisation, westernisation and industrialisation of the country, influenced by the human capital theory (Kazamias 1983). It is a reform initiated by a rightist government, which mainly attempts to control and silence the left opposition. The cold war climate dominates in all fields of public policy. The certificate of political conviction was a prerequisite for employment in public sector, including teaching. While political scrutiny of the education subjects was put into practice, the modernising aspects of the reform were to be postponed and cancelled.

During this period the major attempt at education reform is the 1964 reform episode initiated by the liberal democratic government of George Papandreou. The key figure of this reform was Evangelos Papanoutsos, a liberal intellectual who has made the overall reform plan. Issues of democratisation and equality of opportunities as well as the teaching of ancient Greek literature through translation in Modern Greek were part of the reform agenda which was not implemented because of the fall of the democratic government in 1965.

The 1967-1974 period of the dictatorship reflects the lack of political legitimacy at any level of social life, as well as the intensification of political control in education.

The 1974-1989 period is the most fruitful in terms of the development of the education welfare state and the democratisation and modernisation of the education system and professional teaching. Europeanisation starts being a variable of education policy. The 1976 education reform initiated by a right wing liberal government practically implements the long standing demand for the resolution of the language question and the expansion of the educational system. Later, in the 1980s, the socialist party abolished the 16-plus examinations and the inspectorate which represented an authoritarian institution scrutinising the teaching profession. At the same time initial teacher education was upgraded at university level. This policy was exceptionally well received and supported by the teachers’ unions. The 1566/1985 reform low reorganised the system of general education and initiated the concept of democratic accountability and ‘social participation’ in education planning through specific
institutions. These institutions, however, had a marginal role and in the course of time became less active.

In the period of the 1990s onwards education policy reflects the restructuring of the educational welfare state and the effect of globalisation and Europeanisation processes. The entrepreneurial culture tends to dominate in education based on concepts of performativity, competitiveness, efficiency and market oriented education outcomes.

Table 6.6: Student Population by Gender 1960/61 – 1989/90

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Girls</td>
<td>Total</td>
<td>Girls</td>
</tr>
<tr>
<td>Kindergadens</td>
<td>40,247</td>
<td>-</td>
<td>87,067</td>
<td>42,239</td>
</tr>
<tr>
<td>Primary</td>
<td>895,887</td>
<td>428,130</td>
<td>919,964</td>
<td>439,315</td>
</tr>
<tr>
<td>Secondary</td>
<td>273,390</td>
<td>114,731</td>
<td>554,709</td>
<td>231,400</td>
</tr>
<tr>
<td>Non-university</td>
<td>-</td>
<td>-</td>
<td>13,507</td>
<td>4,594</td>
</tr>
<tr>
<td>Tertiary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universities</td>
<td>28,302</td>
<td>7,202</td>
<td>72,269</td>
<td>22,382</td>
</tr>
<tr>
<td>Total</td>
<td>1,237,826</td>
<td>550,063</td>
<td>1,647,556</td>
<td>739,930</td>
</tr>
</tbody>
</table>

Source: (Varnava - Skoura, et al. 1993)

Tables 6 and 7 show the gradual but steady expansion of the Greek educational system since the 1960s. In 1979 only 41.44% of the student cohort managed to acquire the Lyceum (upper secondary) certificate. In 1995 the Lyceum graduates corresponded to 81.15% of the student cohort, a fact reflecting the social impact of the educational reforms that took place in the late seventies and the eighties in Greece (Zambeta 2004). The 1997 educational reform, which initiated an intensive system of student assessment during the Lyceum and establishes a double educational network in upper secondary education, is dramatically threatening the democratisation achievement of the previous period.

Table 6.7: Student Population by Gender 1999/2000

<table>
<thead>
<tr>
<th></th>
<th>1999/2000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Kindergadens</td>
<td>145,472</td>
</tr>
<tr>
<td>Primary</td>
<td>643,475</td>
</tr>
<tr>
<td>Lower Secondary</td>
<td>368,560</td>
</tr>
<tr>
<td>Upper Secondary</td>
<td>251,236</td>
</tr>
<tr>
<td>General</td>
<td>123,834</td>
</tr>
<tr>
<td>Vocational (TEE)</td>
<td></td>
</tr>
<tr>
<td>Total Secondary</td>
<td>743,630</td>
</tr>
</tbody>
</table>

Source: selected figures from (Stamelos 2002)

At end of the civil war the public health system in Greece was in a deep crisis. According to the findings of a special committee consisting of American Public Health Services officials, appointed to estimate the situation and propose an action plan (as part of the American Aid to Greece), the quality of health services was extremely poor, basic infrastructure was unavailable, the distribution of hospitals, medical and nurse personnel was particularly uneven, while the level of the medical training was considered as inadequate. All the qualified nurses were working in Athens while in the rest of the country nursing care was only provided
by practical nurses. Many medical specialisations, such as microbiologists, were in scarcity in the periphery (Economou 1996). The re-organisation of the public health system was attempted through the 2592/1953 law which has been considered as particularly progressive and modernising at its time. The basic concept of this law was the development of health services through a decentralised system of administration and financing and the offer of certain incentives to the doctors to work in the periphery. The 1953 law, however, was never implemented as originally planned because it was actually in conflict with the genuinely centralised character of the Greek state and public administration system (Souliotis 2000).

In the post-war period and during the 1960s, the golden period of the welfare state expansion in the northern and central Europe, the Greek system of public health care provision presents a very slow mode of development that fails to meet the citizens’ expectations. After the restoration of parliamentary democracy in 1974 there has been a rapid increase of public health expenditure (from 2.6% of GDP in 1975 to 3.8% in 1980) which nevertheless remained much lower than the OECD average (5% and 5.5% respectively). Private health care expenditure remained relatively stable during that period, although 58% of the overall number of available beds were in private hospitals in 1981 (Souliotis 2000 p. 179). Nevertheless, despite the attempt at developing the public health sector, the uneven distribution of health care facilities maintained regional discrepancies and inequalities in health provision.

The reform law 1397/1983 ‘On the Establishment of the National Health System’ has been considered as the most radical attempt to plan health care in Greece (Kyriopoulos 1993; Souliotis 2000). Based on the principles that health is not a profitable enterprise but a public good that should be equally available to every citizen and that responsibility for health care provision rests with the state, the 1983 reform reorganised the whole system of health care. It introduced the concept of health policy planning through institutions of ‘social participation’, which was the ideological motto of the socialist government in the early 1980s. These political ends have not been accomplished though. The most important change triggered by the 1983 health reform was the development of the till then poor system of primary health care through the establishment of the ‘Health Centres’ at the regional and local level. Additional to that it initiated the institution of the ‘full time exclusively hospital doctor’, which in practice did not allow the doctors employed in the National Health System to work privately. The latter, although it was a popular policy, it became a source of constant tensions in health care institutions and in the medical community. On the other hand it is argued that the 1983 low created a doctor-centred health reform which ignored other contributors in the quality of health services, since it largely dealt with the regulation of doctors’ working relations. Medical doctors were not just the most powerful group within health care institutions, but a highly statutory and politically influential group in the Greek society. Moreover the silences of the reform on the nursing personnel give the impression that the reform ignores nursing. However, the developments on the quality of initial nursing training that follow could be seen as a political continuum of this reform. Certain attempts were made for the restriction of the private health sector in hospital care. This policy, however, mainly affected small private hospital units of relatively low budget. In the same period big and competitive private hospital units emerged which concentrated human and financial resources and offered luxury hotel services. At the same time the private sector developed an expansionist strategy by investing in the field of diagnostic health services. Very soon the best part of the private health expenditure, which is steadily increasing since the 1980s (see tables No. 5 and No. 10) was allocated to diagnostic health services (Souliotis 2000). The low level of citizens’ satisfaction from health care provision along with the immense problems related to managerial and financial incapacities have led to the subversion of the National Health System.
In 1992 a neo-liberal reform introduced by the political right constitutes a fundamental restructuring of the National Health System. The 2071/1992 low ‘On the Modernisation and Organisation of the National Health System’ echoes the principles of public choice theory and understands health services as a market place of collective consumption. Freedom of choice between public or private health care is the basic concept of the reform. At the same time the National Health System doctors can opt for a part-time contract and thus work privately as well. The Health Centres became independent from the hospital administration and were subjected to the prefectures. This however was a short-lived legislation because of the fall of the government.

In 1994 the 2194/1994 low ‘On the Restoration of the National Health System’ abolished the part-time doctors’ option and the Health Centres were again linked to the hospital system. Other regulations of this low had a limited implementation, such as the institution of the ‘family doctor’.

In the years to follow various legislation schemes (the 2519/1997 low and the 2889/2001 low) have found also limited implementation. The 2001 low in particular introduced a different logic to the health system through decentralisation and the adoption of the principles of new public management in health administration. Hospitals were to be governed by managers according to criteria of cost-effectiveness and efficiency. Rationalisation in the allocation of the scarce resources was proclaimed but the actual implementation of it remains a pending issue. Although the exact outcomes of this policy have not been assessed yet the failure of the system to meet the demand for quality health care and to satisfy the citizens is expressed in the constant repetition in the respected legal framework of the need for modernisation and upgrading of the health care services. Similarly to the case of education, health policy in the 1990s and early 2000s was professing the goal of modernisation of health services but in practice it was generating a restructuring of the National Health System.

**Table 6.8: Public Health**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Units</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>595</td>
<td>362</td>
<td>341</td>
<td>339</td>
<td>337</td>
</tr>
<tr>
<td>Private</td>
<td>239</td>
<td>144</td>
<td>144</td>
<td>144</td>
<td>145</td>
</tr>
<tr>
<td>Per 100.000 inhabitants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds</td>
<td>356</td>
<td>218</td>
<td>197</td>
<td>195</td>
<td>192</td>
</tr>
<tr>
<td>Hospital Doctors</td>
<td>576,8</td>
<td>496,7</td>
<td>499,2</td>
<td>487,8</td>
<td>489,0</td>
</tr>
<tr>
<td>Nursing Personnel</td>
<td>142,8</td>
<td>179,9</td>
<td>212,3</td>
<td>215,4</td>
<td>223,0</td>
</tr>
</tbody>
</table>

Source: National Statistical Service of Greece (2003), Greece in Figures, p. 7


Inequalities in access to health services are intensified due to the steady increase of the privatisation of health services coupled with the fiscal crisis of the social insurance system. It is estimated that around 2.4% of Greek households are at risk of bankruptcy because of ‘catastrophic health expenditure’ (Souliotis 2004) p. 560). This is particularly the case for elderly people with low income (see table no. 9). Since 1984 the number of hospital units has decreased as a result of, firstly, the National Health System policy for concentration of services in central public hospital units at the regional level (supported by a network of Health Centres for primary health care) and, secondly, the closing of small private hospitals and the concentration of private capital in large hospital units. The number of beds is also decreasing,
but this is a more general trend in the OECD countries related also to the parallel growth of the primary health sector and the shift of health care to the diagnostic and prevention services. On the other hand there is a steady increase in the basic health care personnel, which nevertheless in the case of doctors presents an over-supply, while in the case of nursing presents a shortage (see table 6.8).

Table. 6.9: Private Health Expenditure as % of total Private Expenditures

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All households</td>
<td>3.71</td>
<td>4.84</td>
<td>5.14</td>
<td>5.67</td>
<td>6.82</td>
</tr>
<tr>
<td>Single member household aged over 65</td>
<td>-</td>
<td>8.65</td>
<td>10.19</td>
<td>11.06</td>
<td>14.13</td>
</tr>
</tbody>
</table>

Source: National Statistical Service of Greece, Research on Family Budgets, as cited in (Tsaoussi and Douros 2002)

According to a bitter common saying in Greece, ‘the welfare of the numbers does not indicate the welfare of the people’.

6.3.2 The Comparative Grid for Greece

Table 6.10: System narratives and Worklife narratives – a Greece Overview.

<table>
<thead>
<tr>
<th>System narratives</th>
<th>What does restructuring mean?</th>
<th>How is restructuring working?</th>
<th>Professional strategies</th>
<th>Professional configurations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welfare state</td>
<td>1974-1990 Democatisation and egalitarianism Welfare state expansion</td>
<td>1974-1990 Expansion of the public sphere Institutions of social participation</td>
<td>1974-1990 The democratic and well educated teacher/ the caring and professional nurse, supporting the National Health System</td>
<td>1974-1990 Upgrading the professional status through university education and salary improvement</td>
</tr>
<tr>
<td>Building and Restructuring: Main Shifts</td>
<td>A conservative welfare state following traditional patterns of legitimacy (family and other traditional social networks, clientelism)</td>
<td>1990-today Intensification of social inequalities in the access to education and health Individualism and competitiveness</td>
<td>1990-today Europeanisation/ Modernisation Discourse of: privatisation marketisation public choice competitiveness efficiency Cuts in public expenses Evaluation and assessment policies</td>
<td>1990-today The competitive entrepreneurial self, performativity Resisting scrutiny and evaluation</td>
</tr>
<tr>
<td>Work life narratives/ GENERATIONS</td>
<td>What does restructuring mean?</td>
<td>How is restructuring working?</td>
<td>Professional strategies</td>
<td>Professional configurations</td>
</tr>
<tr>
<td>Senior</td>
<td>New hierarchies within the profession, new professional elites Proletarianisation with regard to new knowledge</td>
<td>Incapacity to catch up with social change Either inertia or frustration</td>
<td>Use of experience and collegial learning as a compensation for the lack of up-to-date knowledge</td>
<td>Less qualified than their younger colleagues ICT illiteracy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Teachers: The highly qualified and accountable professional against the old type professionalism The flexible and reflective learner Nurses: i.Diversification ii. Framing the territoriality of the profession</td>
<td></td>
</tr>
<tr>
<td>Generational Gap</td>
<td>Middle aged</td>
<td>Younger</td>
<td>Work life narratives / PROFESSIONS</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td>---------</td>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td>Depression and intensification of working conditions. Economic deprivation Tensions in work-life balance especially for women. Lack of control over time at work. Following recipes and directives. Practical knowledge vs prepositional learning: How to do things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More diversified (and higher) socio-economic background of young professionals Surviving in a competitive environment Instability, Uncertainty Accumulation of formal qualifications Competitive professional Intensification of working conditions, especially for nurses Frustration for the decreasing social status and respect in the case of teachers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work life narratives / PROFESSIONS</td>
<td>What does restructuring mean?</td>
<td>How is restructuring working?</td>
<td>Professional strategies</td>
<td></td>
</tr>
<tr>
<td>Teachers</td>
<td>School knowledge increasingly becomes obsolete Agents of change: i. the parents ii. a new professional elite alienated from the active professionals introduces new knowledge through the new textbooks. Teachers feel unable to teach them. European notion of “portfolio” and the Lisbon Agreement is adopted as a policy to reconceptualise the desired teacher image of the democratic teacher to the image of effective and competitive teacher. Prepositional knowledge acquired at universities is understood as insufficient knowledge at work Knowledge at work is understood as practical knowledge Teaching is taken over by other professionals (extra-curricular activities sponsored by parents are taught by other professionals), ‘medicalisation’ of teaching especially in the field of learning difficulties and special needs education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global governance and knowledge transfer</td>
<td>Rapid change: Globalisation Diversification of student population, Multiculturalism, New knowledge Competitiveness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>Increasing diversification and specialisation New hierarchies within the profession especially between nurses with different level of qualifications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring within an environment of scarce resources</td>
<td>1974-1990 Medically dominated 1990–today Trends towards autonomy from Doctors Intensification of working conditions Personnel shortages Competitive working conditions affect attitudes towards family strategy Young mothers do not take long maternity leave neither stop working as they used to in the past Defeminisation as professionalisation strategy Men’s entry in the nursing profession has not altered the gender composition of the nursing hierarchy at the moment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 6.3.3 What does restructuring mean in Greece?

#### 6.3.3.1 System narratives

The policies of restructuring that have been promoted in Greece since the 1990s are operating on a canvas of a welfare state deficit the main characteristics of which are related to the scarce resources allocated to the public services and to the compensational role of the family and other traditional social networks. Policies of restructuring, such as increasing competitiveness
and marketisation, are interacting with traditional embedded elements of Greek polity, mainly individualism and lack of a public system of social solidarity. The traditional role of the state as an employer continues being critical in the mode of social reproduction but less legitimated than in the past. Privatization narratives of neoliberal restructuring are understood as success stories aiming at modernization and effectiveness of public services verified by the powerful discourse of international organizations and European Monetary Union (EMU) thresholds. However these trends have been in tandem with a traditional sociopolitical culture which has always celebrated the family, the person, the church and the nation, rather than the social commitment to democratic citizenship and collective goods. In that sense, restructuring within a system of low public welfare may have less visible institutional outcomes, but more dramatic social implications.

(a) Tendency towards a greater degree of privatisation of health and education services:

The private cost of education and health services is steadily and dramatically increasing. In the field of education there is a clear tendency away from free education for all towards the privatisation of education as evidenced by the use of additional private educational institutions (“phrontistiria”) required to supplement students’ training in many fields, the increase in the number of private schools and the need for students to buy different types of educational material. On the other hand, the social status of private education is on the increase while the student emigration in the field of higher education is dramatically high. The National Health System in Greece is in a constant crisis due to scarce resources. The primary public health sector is very ill equipped and unable to satisfy the demand. As a consequence the private sector covers this area, a fact that imposes a serious economic burden to the family budget. Hospital care is provided from both the public and the private sector, whilst the quality of doctors and infrastructure in the public sector, in certain cases, are considered as more reliable than that of the private one. Nevertheless the lack of resources is evident in hospital care as well. Nursing shortages is one of the most critical problems in public health care. “Exclusive” private nurses need to be hired to attend seriously ill hospitalized persons. Privatization tendencies are also evident in the need to consult private physicians and to undertake needed diagnostic tests in private laboratories due to extremely long waiting lists in the public sector.

Scarcie resources allocated to public services became evident during the lengthy (6 weeks) teacher strike in the autumn of 2006 that paralyzed the educational system in Athens and many other large cities. These unusually long teacher strikes remained ineffective since the Government was not willing to make even some financial concessions to the teachers’ demands and in this way, teachers remain poorly paid and the educational system without adequate resources to satisfy technological and other material needs. In the case of the significant nursing shortages, however, there seems to exist relatively greater willingness for the Government to provide additional resources for the hiring of more nurses.

(b) Intensification of social inequalities in the access to education and health.

Several factors are responsible for the intensification of social inequalities in the access to education above the compulsory level, the most important ones being: private tuition as a result of insufficient preparation of students within the public schools and the extremely competitive educational environment, especially for the highly ambitious middle class. On the other hand, the institutionalization of a clear division between general and technical education at the upper secondary level during the 1990s has intensified social inequalities and hierarchies within education.
On the other hand access to high level health services is also based on income and social networking. Not only the luxurious private hospitals are inaccessible by low income families, but also the highly esteemed doctors, usually university professors as well, are not easily reachable by the poor, even though these doctors work in public hospitals also. Access to the ‘big names’ of highly specialized doctors presupposes knowing who these doctors are and getting an appointment. Poverty is an impediment to good health.

(c) Restricted professional autonomy.

State control over schooling and school knowledge is mainly achieved through the centrally decided national curriculum and the single textbook per subject and grade published by the Pedagogical Institute, an institution subjected to the control of the Ministry of Education and Religions. Professional knowledge is thus radically restricted and regulated by an external agency consisting of a body of professional elite. In the case of nurses, the medical profession regulates the extent of autonomy. However, some nurses may enjoy relatively more autonomy depending on the degree of their specialisation but also on their own willingness to assume greater responsibility. Furthermore, the passing of a new legislation in 2004 provides nursing with a professional body aiming to control the profession by giving the right to nurses with tertiary education to create an Association of Greek Nurses with the public power to regulate the professional rules governing the exercise of the nursing profession. The profession hopes that, when the new Law (3252/2004) will be fully applied, professional autonomy will be achieved and it will be easier for a nurse to become self-employed because by this legislation nursing tasks will be better clarified and differentiated from medical interventions. Because, however, the new professional rights are granted only to nurses with tertiary education, the legislation grants them higher professional and social position by underlining the distinction between nurses with tertiary education and all other types of nursing personnel with lesser education. The application of this Law, however, only now starts and therefore it is rather very early to speak about how effectively it will be enforced and what its effects will be on professional nurses’ lives.

6.3.3.2 Work Life narratives

A considerable implication of restructuring policies refers to the self-esteem and sense of social status on behalf of teachers and nurses. During the 1980s both professions experienced a sense of upgrading that has been materialised through the upgrading of their initial education to the university level and through a considerable increase in their income. These were policies that had been perceived as contributing to the democratisation and modernisation of the educational and health systems. During the 1990s however these policies have been practically deregulated by the lack of supportive measures that would enable integration within the respected services. Former non-university educated teachers and nurses have never received proper university education, a fact that creates internal tensions and hierarchies within the professions. In the case of teachers, educational upgrading led to the compulsory 6-18 months university coursework attendance on the part of teachers without university education. These educational “equation” efforts underlined existing differences among teachers and because they were undertaken in addition to regular teaching duties created overwork, resentment and dissatisfaction on the part of the “equated” teachers. On the other hand the general increase of the educational level, especially among the middle class social strata, creates uncertainty and calls professional knowledge and expertise into question. On the other hand the economic position of teachers and nurses is getting worse due to the lack of investment to public education and health. Greek teachers and nurses are worse paid than any other of their European counterparts. This fact affects all generations of teachers and nurses, but it is particularly felt by single parent families with young children.
Significant generational differences emerge with regard to attitudes towards knowledge and expertise in the context of restructuring education and health services. The importance of new technologies to which the rich and the younger have easier access is narrated by older professionals as a feeling of being unable to cope with this revolutionary change in the field of knowing. New professional elites emerge who have studied in European and American universities and are in a position to translate and transfer global knowledge at the national level. The new textbooks are an illuminating example of knowledge transfer that is enacted by a small professional elite, alienated from the profession. Within a system where the textbooks are the organising principle of teaching, teachers declare that they are unable to understand what to do with these textbooks and how to teach by using them.

Modernisation, competitiveness and increasing privatisation of the public services are narrated by teachers and nurses as need for a client oriented professional. Intensification of working conditions is understood as the outcome of the lack of resources and personnel shortages. Many middle aged professionals report that they have to do a second job in order to manage their family expenses. More diversified and more demanding clients develop a new working environment of consumerist control and uncertainty.

6.3.4 How is restructuring working?

6.3.4.1 System Narratives

Policies of restructuring since the 1990s emphasise on the need of modernisation and Europeanisation of the Greek state. Modernisation and Europeanisation have been highly legitimated political aims since they have been understood as contributing to socially transparent modes of governance and to economic and political stabilisation in a country with a turbulent historical past. The integration of the Greek economy to the EMU has been the main tool of restructuring policies in the field of social services. The thresholds set by the EU with regard to EMU resulted in the restrictions in public spending, a fact that had direct impact on the income of public sector employees, such as teachers and nurses. On the other hand the discourse of modernisation and promotion of effectiveness and efficiency has been materialised in policies manifesting control of quality assurance in the public services. An intense system of teachers’ and students’ evaluation and assessment of performance has been promoted by the 1997 reform law on Education (Kazamias and Zambeta 2000), with dramatic implications in the increase of competitiveness and social inequalities, especially in the upper secondary education. The discourse of modernisation and effectiveness has identified the teachers and all the public sector employees as the main agents responsible for the malfunctions of the public domain. Thus, restructuring the professions has been one of the means of restructuring in the social services.

In the case of teaching the introduction of a new system of teachers’ recruitment through state controlled examinations constitutes an important attack on teachers’ professionalism, since professional knowledge acquired through university education is no longer a sufficient prerequisite for admission as a civil servant in the profession. At the same time, the new system intensifies job uncertainty since it consolidates the fact that many qualified teachers will never actually enter the profession, at least in the public sector. The above institutional changes constitute a deep restructuring in professional teaching. Values of competitiveness, efficiency and market-oriented knowledge tend to dominate and construct the competitive entrepreneurial self as the ideal type of teacher and student in the Greek context. The same does not hold true for the nursing profession. On the other hand the increased emphasis on individuality rather than on collective values can be identified in teaching materials introduced in 2006. In the new teaching textbooks and other teaching material social
inequalities are presented as given, natural and not as attributed to power relations in social contexts. In addition, voluntarism is exclusively promoted rather than collective social action.

Significant restructuring in the public domain of both education and health is also taking place through government’s policies aiming to decrease public expenditures for permanent civil servants. Such decreases in public expenditure are realized through short-term contractual employment, e.g. 8-month employment contracts for nurses or short-term and limited hourly employment of teachers. Young nurses opt for such short-term contracts (despite job availability in private hospitals) when they cannot find a permanent job in a public hospital because they want the “soft” treatment of civil servants. Nevertheless when their contract is over, they may not be able to get another one for some months and such arrangements tend to overall decrease the nursing professional status.

6.3.4.2 Work life narratives

Restructuring in the case of teaching and nursing is experienced as intensification of the working conditions and uncertainty of the working environment. Additionally to that they report uncertainty regarding their work’s aims and methods of acting. While a small professional elite, in the case of teaching, constructs the new textbooks, teaching methods and modes of professional acting, the profession feels unable to follow the new standards.

Teachers’ work life narratives indicate that for the older generation of teachers, pupils’ performance level and their own conscience constituted the standards for their services, while for the younger generation of teachers, parents are perceived as the final judges of teaching. Younger teachers see their everyday work as a constant struggle to convince parents of their scientific competence. The increasing influence of neo-liberal ideology has contributed to the development of a wider climate that accepts consumerism as a mode of educational accountability and has changed the image of parents as the receiving end of educational services. All this does not hold true for nurses, although they also express their concern for satisfying their clients.

The teachers report a growing tendency to create negative representations of teachers’ behaviours and roles by a number of social agents, especially by the mass media. Parents and the society as a whole are getting a partial view on what happens in education through the mass media that tend to report sensational stories in the news without substantive ‘follow-up’ that can sufficiently inform the public. The public devaluation of teachers through the mass media has led to loss of social status and prestige and has facilitated the increasing influence of parental intervention. As a consequence, there is a special type of “parentocracy”, not in the sense of greater parent participation in the school community, but in the sense of greater control over teachers’ work. Parents represent the ‘panopticum’. No similar processes have been reported for the nursing profession. Other reported sources of teachers’ lesser professional status are the improved educational and financial level of the population and teachers’ lack of specialisation that does not guarantee them social recognition regarding their role in the intellectual and moral upbringing of the children. Within this context, “parentocracy” can flourish.

6.3.5 Professional Strategies

6.3.5.1 System narratives

The constant emphasis of educational and health policies on quality, performance and competitiveness force both teachers and nurses to accumulate certificates as credentials of
knowledge, despite the fact that they are considered by the professionals themselves as ineffective in improving performance.

On the other hand, teachers in particular have developed a systematic strategy towards resisting any implementation of evaluation and assessment of performance policies. The strong memories of the old type Inspectors who were acting as the remote state control over the profession, exercising ideological and political pressure, are still active. After the abolition of the old Inspectorate in 1982, no government has managed to implement any legislation regarding teachers’ evaluation of performance. This lack of assessment is considered as an impediment for the improvement of performance in the public domain in general.

6.3.5.2 Work life narratives

Teaching and nursing are not reported as a first choice professional career. When both teachers and nurses do not receive the necessary grades for admission to the university department of their first choice, they ‘adjust’ by entering the teaching or nursing university departments and by embracing and even excelling in these professions.

In a context of uncertainty the accumulation of formal qualifications represents a strategy for constructing a competitive professional profile on the part of teachers and nurses. Further education is perceived (by teachers and nurses) as a strategy towards securing their position in the profession, rather than a means of acquiring substantial professional knowledge. Further education has been purposefully connected to the political discourse of lifelong learning, quality of performance and effectiveness. In addition, the European notion of “portfolio” enters the Greek educational reality. Nurses, on the other hand, feel that more training is important and complain that they are not able to follow as much training as they would like because of the shortage of nurses in service. However, they feel that there is no real motive since in the civil servant model, years of service and seniority are the most important factors and further training or competence in job performance do not count.

Generational differences in the professional strategies towards restructuring are expressed as differentiated attitudes towards intensification of working conditions. Senior teachers and nurses tend to ignore the pressures and they use experience and collegial learning as the main way to cope with new demands at work and compensation for the lack of up-to-date knowledge. Working conditions are experienced as more intense and pressurising on the part of the middle aged teachers. Hierarchies among this age group are more peculiar since their formal qualifications vary substantially (some of them having two years initial education, some others four years plus additional university ‘equation’ training). Younger teachers and nurses tend to come from a richer socio-economic background and they all have university qualifications. They experience restructuring not as part of historical consciousness regarding the transitions the profession is undergoing, but as a frustrating client oriented working environment. Personnel shortages add to this feeling.

Substantial generational differences refer to the confidence in syndicalism as an effective professional strategy. In both the teaching and the nursing profession, the older generation is aware of the contribution of collective action in proposing and defending professional strategies. However, the younger generation of nurses and teachers are not interested in syndicalism and do not become active members, partly because the image of syndicalism has faded as part of the more general mistrust in politics.

Gender issues also emerge as generational differences. Significant changes in the status of women, that have taken place in Greece during the last 20 years, include an increasing number of women working even when they have small children, at least partly due to the small number of children born especially to professional women (who are more often than
other women childless or have only one child) and the realization that the incomes of both spouses are needed, if the couple wishes to enjoy a somewhat satisfactory level of living. Because of these factors, there are important generational behavioural differences with regard to employment of mothers with children under six and particularly in the case of highly educated and university educated women. Thus, contrary to women nurses of the older generation who stopped working while their children were under six years old, women in the younger generations view their career as a lifelong goal as it is shown by their delaying marriage and motherhood and by not interrupting their work. While this pattern holds true for university-trained nurses, it does not seem to hold true to the same extent for middle aged women teachers who understood the profession as a good family strategy (due to the long vocations) and they have been able to maintain a good work-life balance between teaching and family life obligations.

6.3.6 Professional Configurations

6.3.6.1 System narratives

The emergence of the new professional as against the old type one is evident in the following trends:

Recruitment in the profession in the public domain is regulated by the state through public examinations which are highly competitive. The old system of a waiting list for teacher’s entry to the profession has been abolished and since then there is no guarantee of acquiring employment in public education.

Professional knowledge continues being regulated by the centrally decided and appointed curricula. However, the teachers’ manual that have been promoted since the 1980s are offering specified guidelines and recipes for implementing the curricula, something that dramatically undermines professional autonomy. Interestingly, these detailed guidelines are welcomed by the teachers as the easiest answer to the ‘what to do on Monday morning’ question.

The competitive new professional is expected to be a flexible and reflective learner who nevertheless implements fully the agreed national curriculum guidelines.

On the other hand, as part of the modernisation discourse the new role of the teacher is fundamentally defined in terms of his teaching students to “learn how to learn” while at school and before entering further or higher education. This discourse, however, is in sharp contrast with the policy of prescribed, and in that sense inflexible, stabilised and unchangeable, curricula and textbooks. The concept of “learning how to learn” is compatible and a requirement for the implementation of the life-long learning concept. This redefinition of the teacher role changes the type of expertise teachers need that is, away from expertise in a particular subject of the curriculum and from the skill in teaching it to expertise in the use of digital technology and learning techniques. While, a similar process could be envisaged in nursing since patients with chronic diseases have to be taught how to actively participate in their care, at least in Greece there is no formalization of a redefinition of the nursing role.

6.3.6.2 Work life narratives

The most important source of knowledge acknowledged by teachers is experience. Experience is perceived as a sharing commodity. Teachers value most the ‘practical’ rather than the theoretical knowledge. In this sense, their concept of knowledge at work is more of that of an apprenticeship than of a profession. ‘Practical knowledge’ is what the teachers perceive as important and useful knowledge in order to do their work and is transmitted through
performance: through ‘showing’, through actual performance. Moreover, practical knowledge focuses on the everyday school practice and not on theoretical analysis, interpretations and explanations. Because of the value placed on “practical” knowledge, communication among colleagues and collegiality are vital aspects of teachers’ work. Interview and observation data point out, however, that while some teachers report that they have received significant help by their colleagues who were more experienced, such genuine collegiality is not always the case. In the case of nurses, while they value informal knowledge and experience that can facilitate the everyday performance of duties, they value equally or more formal knowledge. Moreover, nurses tend to avoid the dichotomy between caring and curing by presenting caring as part of curing since they provide psychological support to patients and help interpret doctors’ treatment to them.

In the case of nursing ‘defeminisation’ is perceived as a professionalisation strategy. Men’s recent entry in the profession is seen as a very positive change helping to improve the professional status of nursing by ‘defeminizing’ it and by increasingly transforming it from a ‘women’s’ nurturing profession into a more ‘scientific’ profession for both men and women. Men’s entry brought about a change in the name of nurses that has played an important role more than just a symbolic one in improving the image of the profession. Male nurses could not be called “adelfes” (sisters). Now the older term ‘nosokomos’ is only used to refer to the hospital orderlies (‘travmatiōforis’) who carry patients, wash them and perform other physical tasks. At present the new term ‘nosileftis’ [that we have translated as ‘nurse’ due to a lack of a better term] is used for both men and women with a university (or TEI training), while those with only a two-year training are called ‘assistant nosileftes’. The Greek word ‘nosileftis’ has a connotation of treatment (from the verb nosilevo that means to ‘treat’) hence a connotation of greater professional knowledge and prestige.

In the case of teachers the great majority of positions at higher levels of the hierarchy are almost entirely occupied by men primarily due to women’s reluctance to even become candidates, most probably because they do not want to assume additional responsibility. In the case of the nursing profession, the recent entry has not up to now affected the gender composition of professional leadership, probably only because men’s entry is recent.

The new hierarchies developed within the professions are not only related to the relatively higher level of initial education that the younger generations receive, but also to the relatively higher socio-economic background of the young professionals. In the older generations of nurses, that is in the 60’s and 70’s, nursing education took place within the context of large public hospitals and while getting training, nursing students could offer their services to the hospital and get food and board in exchange. For this reason, young women who became nurses came from families with very limited socio-economic means who wanted to get an inexpensive education that guaranteed them employment. Now the new generations of nurses come from a more diversified socio-economic origins including higher socio-economic strata and girls and boys from low-income families tend to attend the two-year nursing programs sponsored by hospitals that train assistant nurses. Similarly, in the younger generations of teachers the socio-economic background has broadened to include middle class social strata instead of the usual low socio-economic background of teachers in the older generations.

The use of digital technology marks a generational gap in both teaching and nursing. Nursing supervisors in their late 40’s or in the 50’s do not know how to use computers (despite having been trained) and resist having to use them because they do not like or trust computers and feel more comfortable following the “best practice” of recording all information manually. Despite the younger generation of nurses knowing how to use and willing to use computers, mainly because of supervisors’ negative attitudes toward computerization, have to record all
information manually and by spending a lot of time in administrative work exacerbates the existing shortage of nurses.

Dissatisfaction and frustration from the working conditions and the social recognition of the professional’s role is narrated by both teachers and nurses. In the case of nurses, they particularly express their dissatisfaction and frustration with the fact that the nursing and other auxiliary personnel shortages oblige them to often perform all kinds of unskilled tasks, even housekeeping tasks. They also have to often perform tasks that should be performed by assistant nurses and to relegate duties to assistant nurses for which they are not appropriately trained. These trends tend to impact negatively on nurses’ psychological outlook. The dissatisfaction felt by the inability of more prestigious occupations to transfer less important, routine or dirty tasks to less prestigious occupations that obliges members of the more prestigious occupations to perform these tasks is clearly expressed by the women nurses.

6.4 **Concluding Comments including Implications and Suggestions**

Both professions are been impacted by the increasing tendency to decrease public expenditures and the tendency toward a greater degree of privatization of health and education services. Welfare state restructuring, restrictions in public spending and the neoliberal ideology with regard to public services are gradually affecting the social organisation of schools as institutions and subsequently teachers’ workloads and performance. The recent lengthy teachers’ strikes showed that there is less willingness to provide additional resources to public education than to health (at least regarding the hiring of additional nurses) that may be resulting to the intensification of social inequalities in education beyond the compulsory level.

The role of the private sector and especially the role of parents in financing various school activities is a new situation that dramatically changes the social relations within the public schools and the position of the teachers. Also globalisation and the expansion of the middle classes seem to affect significantly the social position of teachers. Within an increasingly competitive environment, teachers no longer represent powerful social strata. It is also significant that teachers think that their professional knowledge covers many areas (the teacher ‘knows a little about everything’) and lacks scientific grounding. Within this context, middle class and relatively higher educated parents in particular are the most competitive social agents in education who develop closure strategies and challenge the professional expertise of teachers. Finally, teachers are NOT the principal agents of innovation in education. In several cases new knowledge and pressure for adaptation to the global trends comes from other agencies and most notably from parents or from a small professional elite that has access in decision making institutions (such as the Ministry of Education or the Pedagogical Institute).

6.4.1 **Policy implications**

Welfare state policies have contributed to the construction of democratic citizenship and to the European political culture as we used to know it. Frustrated, overworked, low-paid and with low self-esteem professionals in education and health can no longer sustain this political culture. This is a fact to be estimated by policy makers at the European and national level, as well as by all the socially active agents at the local level.

Modernisation and raise of standards in education and health can only be supported by highly qualified professionals who are satisfied from their job and their working conditions. This Keynesian condition continues being relevant in recent global times. As the restructuring
discourse can only be understood by educators who have easy access to sociology of education and educational policy texts, one of the contributions of PROFKNOW could be to provide them with the analytical tools to decode the ‘restructuring’ discourse. A relevant recommendation to University Pedagogical Departments would be the inclusion of a substantial corpus of Sociology of Education and Educational Policy courses in their curricula. As more nursing positions are becoming available in public hospitals, it can be expected that more men will enter the profession. Men’s increasing entry will be strategically important because it will help the profession completely escape the marginal position usually accorded to “women’s” occupations and it is expected that this process of “defeminization” will be completed when male nurses will constitute at least one-fourth of professional nurses with tertiary education. At this point, however, a considerable number of men are expected to assume supervisory and management positions and to alter the gender composition of nursing leadership. Research in the U.S. has shown that men in women-dominated occupations benefit from the “glass elevator” phenomenon because men assist each other to rise to high management positions. It remains to be seen how this changes in leadership positions will affect men-women relations and the nursing profession.

In addition to the planned hiring of additional numbers of nurses, another recommendation that can help considerably alleviate nursing shortages is the extension of computer training to all nurses and the implementation of obligatory and universal computerization of information regarding patients’ treatment. While the resistance to the use of computers may continue on the part of middle-aged nurses, this resistance might be overcome if the training of these nurses becomes connected with appropriate work-related benefits.

Another recommendation that would increase nurses’ interest for scientific knowledge and effective nursing treatment would be the institutionalization of obligatory evaluations of nurses’ performance on the basis of specific criteria. These criteria among others would include the use of appropriate scientific knowledge in the performance of their duties (treatment of patients or technical duties); the equal treatment of patients regardless of their personal characteristics (age, gender, disability, ethnic origin, race, religion, or sexual orientation); the extent of cooperation with other health personnel; eagerness to learn new scientific knowledge; and the effective use of digital technology. A similar recommendation for an objective evaluation would be also relevant for teachers including criteria such as the use of appropriate scientific knowledge in teaching; the equal treatment of patients regardless of personal characteristics; and eagerness to learn new scientific knowledge. Of course, significant resistances would be expected and the success of these evaluations would depend on the extent to which the promotion system within the Greek civil service could be reformed so as to make the transition from a counter productive mode to a more meritocratic and universalistic mode.

At any case, social dialogue and consensual procedures based on respect of the social actors involved are the basic prerequisite for any reform policy in teaching and nursing.

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7 Ireland

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7.1 Introduction

The purpose of Workpackage 6 is to integrate findings from work carried out in previous workpackages within and across the professions of teaching and nursing. The objectives of WP6 according to the technical annex are:

- To present comparisons of professional work and life in different European contexts within and between the professions of teaching and nursing.
- To achieve a more developed view of professional knowledge in the fields of teaching and nursing as a basis for the development of organisational, professional and educational strategies by the professions as well as administrators and policy makers.
- To describe, analyse and evaluate current restructuring in education and health in different parts of Europe from the point of view of teachers and nurses and their experiences from their interaction with clients.
- To present a conceptual framework for analyses of professional knowledge in restructuring organisations.

This report aims to describe, analyse and compare educational and healthcare restructuring and the professional lives and knowledge of three generations of teachers and nurses in Ireland. This report is based on previous workpackages (WPs) consisting of a literature review (WP1), a national case study including statistics (WP2), a national survey (WP3) and life histories and mini ethnographies with teachers (WP4) and nurses (WP5). The conceptual framework to be used is a combination of a policy discourse/systems narrative and a worklife narrative. The policy discourse/system narrative discusses reforms at a national level. The work life narrative examines reforms at a grassroots level using data collected from interviews, ethnographic observations and a national survey. This approach enables us to explore how various policies are refracted at different levels within the system.

First we present the Irish national context including the major changes in Education and Health from the 1970’s onwards. This narrative is divided into three periods and provides a useful background for the later comparison of teachers’ and nurses’ work life experiences. This is followed by an analysis of structural changes with special reference to restructuring. We compare professions, generations and policy discourse/system and work life narratives. The various themes that emerge from the data, such as accountability, role expansion and professional knowledge and skills, are discussed here also. The report ends with comments on the implications of the research project at the national level. A list of publications and exploitation to date is also included.
7.2 The National Case Presentation

It is difficult to define periods and their precise duration in the Irish context because they are more mosaic than discrete, mutually exclusive categories. Similarly, it is problematic to define possibilities for professional action and professional narratives at particular points in historical time. However, we have attempted to divide the years between 1970 and 2007 into three periods with certain prevalent characteristics namely: the demise of apprenticeship; ‘partnership’ as a new approach to policy making; and floodgates of reform. These characteristics are considered important in relation to the study of the professional lives of teachers and nurses.

7.2.1 1970- 1986- The Demise of Apprenticeship and Increasing Secularisation

In the early days of the Irish State the government was largely inactive in the field of social policy. The church, the voluntary sector and the family were in the main and in some cases the only suppliers of social services. For instance, until the end of the 1960’s secondary education was left almost entirely to religious orders. It was not until the publication of Investment in Education (OECD, 1966) that the significance of education for economic expansion energised some politicians and civil servants. Thus, universal (free) secondary education was introduced in 1967. The majority of fee-paying Catholic secondary schools opted into what was euphemistically described as the ‘free scheme’, thus such schools became eligible for maximum state support.

While universal free secondary education has been in existence since the 60’s the same cannot be said of healthcare. Although, citizens were and continue to be entitled to a range of health services, that are free of charge or subsidised by the Irish Government, those who earn below a certain limit are entitled to more free services than others, via a ‘medical card’. Those without a medical card are not entitled to free GP services and may have to pay in-patient and out-patient hospital charges.

The Catholic Church has traditionally been very involved in Education and Health Care. This is evidenced by the fact that most primary schools in Ireland are owned by the Catholic Church. Similarly, the major teaching hospitals are owned by religious orders. Prior to 1975, the local clergyman, typically the Parish Priest, was the manager of the local national (primary) school. Since that time primary schools have Boards of Management (BoMs) with parent, teacher and community representation, and it is no longer axiomatic that the chairperson of the board be clerical, while in many rural schools this continues to be the case.

The abolition of the Primary Certificate in 1967 was a significant reform in Irish education. It was abolished in order to facilitate the introduction of the 1971 Curriculum (Government of Ireland (GoI) 1971). The Primary Certificate was a State exam at the end of first level education and was indicative of the fact that the vast majority who attended primary school did not progress to second level. In many respects it was the Leaving Certificate Examination of its time. The 1971 curriculum has been characterised repeatedly as a ‘radical’ departure from the past- a move away from centralised prescribed curricula that were teacher driven to a professional pedagogy characterised by local school autonomy. In effect, a rhetoric of child-centredness was adopted and very quickly embraced by teachers.

In the early 70’s teacher education consisted of a two year Diploma programme that was based on apprenticeship. In 1974, primary teaching moved to an all graduate profession with the introduction of the new three year Bachelor of Education programme. The introduction of a degree for primary teachers has enabled primary teachers to negotiate a Common Basic Pay Scale (shared with second level teachers).
Nurse training at this time was carried out in schools of Nursing attached to hospitals where
the idea of vocation was central. The trainees learned the skills of nursing from their
experienced colleagues while taking part in the work of the wards. The need to provide
service meant that there were two intakes of students for training per annum. The programme
was described as an ‘apprenticeship’ model of training (An Bord Altranais (ABA) 1994)
which produced nurses with highly developed practical skills.

Although nursing would take much longer than teaching to progress to an all graduate
profession there were changes in terms of the theory-practice balance and curriculum content.
In 1980 the three year general nurse training certificate programme consisted of 28 weeks of
theory. The remainder of the time was spent in clinical areas. This structure stemmed from the
E.U directives 77/452/EEC and 77/453/EEC which were implemented in 1979. The directives
also meant that the specified areas of obstetrics, paediatrics, geriatrics, community care and
psychiatric nursing were added to the clinical experience required in the general training
programme. This had implications for hospital budgets as students had to be seconded away
from the service area. In most seconded clinical areas the student nurse was in addition to the
staffing compliment and was treated as a learner/observer and this was a break from the more
traditional apprenticeship model. Subsequently, EEC Directive, 89/595 of the E.U meant that
an extra twelve weeks theoretical instruction was to be included bringing the total to 40 weeks
of theory or one third of the programme and clinical instruction to one half of the minimum
4,600 hours required.

By 1975 accumulating demands for the reform of the nursing profession in Ireland and the
anticipated impact of European Union policies gave rise to the establishment by the Minister
for Health of a widely representative working party to take a critical look at the education,
training and grading structure of general nurses. The Working Party reported in 1980 and
became one of the key documents of the period in the formulation of policy. Its
recommendations included a revised hospital grading structure and more management grades
in nursing; matrons should become directors of nursing with greater emphasis on management
of services. It recommended that the nursing board (An Bord Altranais) establish a fitness to
practice committee to advise admonish or censure nurses and as a last resort, remove a nurse
from the register. The Report also recommended the ending of the traditional practice under
which nurses remained registered for their lifetime and its replacement by a live register
requiring annual registration. In this respect the nursing profession is more advanced than the
Teaching profession. It is only since 2006 that teachers are required to register with the
Teaching Council.

A long consultative process followed the publication of the 1980 report. Eventually in 1984,
the Nurses Bill (1984) was brought before the Dail (Parliament). It proposed implementing
many of the recommendations in the report. The Bill was subsequently enacted without
significant change as the Nurses Act, 1985. In accordance with the Nurses Act 1985, the
Board introduced a live register in 1987. The Fitness to Practice committee was established
toward the end of 1986 as provided for in the Act of 1985. The purpose of the committee was
to investigate complaints against nurses including the possibility of enquiry into fitness to
practice of individual nurses if deemed appropriate.

Also among the Working Party recommendations was the creation of a central applications
bureau where all applications for entry to nurse training schools would be processed. This
recommendation was widely but not universally welcomed. Some of the training hospitals
saw it as an attack on their traditional independence of choice and a threat to their own long
established cultural and ethical values. Hence, it was not until the early 90’s that a centralised
application system was put in place.
There were also calls for a centralised application system for pre-service primary teacher education. Thus, in 1984, the Central Applications Office (CAO) which processes virtually all other student applications for third level education, took over the application system for all pre-service primary teacher education. Interviews continued to be held (before the release of the Leaving Certificate Examination results) for the following two years. However, the process of interviewing every applicant who had included teaching on their CAO form (as one of their ten preferences) proved to be a logistical nightmare. Thus the interviews were discontinued in 1987.

7.2.2 1987-1997- Envisioning the Future- Partnership a New Approach

Conroy (1999) analyses the lack of progress in social policy in the 1960’s and 1970’s. She identifies the European Community, social reformers and worker’s representatives as the social actors who were instrumental in addressing social policy on a mass scale. According to Conroy (1999) largely as a result of the influence of these major social actors, coupled with the recession of the 1980’s giving rise to the acceptance of the notion that the state could not respond to meet the needs of massive poverty, emigration and employment, a new model of centralised collective bargaining was adopted at the end of the 1980’s. The first national agreement between the social partners (i.e the government, the trade unions and the employers) is generally regarded as a watershed in Irish social policy, as it marked the beginning of partnership as the basis of a new approach. A number of national agreements followed which included a much wider range of community interests. Thus, the process of constructing a comprehensive set of social policies began. The Programme for Economic and Social Progress (PESP) (1990-1993) (GoI, 1991) contained proposals for a fundamental structural reform including an assault on long term unemployment and a restructuring of social services in particular social welfare, the health services, education and housing.

As proposed by PESP (GoI, 1991) there followed a Government Green Paper (consultative document) on all aspects of Education in 1992 (GoI, 1992). A widespread process of consultation followed and this culminated in a National Education Convention in 1993, where all of the major partners were participants. A report emanating from this forum became the basis of a Government White Paper in 1995 (Coolahan, 1994 and GoI, 1995). The White Paper (GoI, 1995) made a number of recommendations including: the retention of a concurrent model of teacher education for the initial training of primary teachers; and the introduction of an induction programme to coincide with the teachers’ probationary year for first and second level teachers. The same paper (GoI, 1995) proposed that pre-service courses should not be narrowly confined to the immediate requirements of the system but should include the personal education and development needs of students. The paper also identified the need to strengthen and prioritise the education of student teachers in the creative and performing arts and in the scientific aspects of the social and environmental programme. Since this time Junior and Senior cycle programmes at post-primary level have been significantly altered in terms of content, pedagogy and modes of assessment.

As almost all teacher education programmes are accredited within the University system, and there are no agencies or organizations with a brief to oversee the content of these programmes, education faculties in Universities and Colleges in Ireland enjoy significant autonomy in comparison with other systems. However, the report that provided the final impetus for the establishment of a Teaching Council recommended a series of committees within the Council structure, including one with responsibility for policy on initial teacher education (GoI, 1998). It is likely, therefore, that this new (self-regulating) body will be much more specific in its requirements regarding the content of teacher education programmes.
PESP (GoI, 1991) also included proposals to develop primary health care and community based services so that patients can be dealt with at the level appropriate to their need. Correspondingly, a reorientation of health service policy came into being in 1994 with the publication of *Shaping a Healthier Future* (Department of Health, 1994). This document brought a strong commitment to the concepts of primary health care and health promotion. It followed two earlier documents advocating a similar approach (Department of Health, 1986; Health Education Bureau, 1987) and was in response to the World Health Organisation Strategy of Health for All. Thus, An Bord Altranais (1994) recommended that primary health care should become an essential feature of nursing curricula and that future programmes should provide nurses with knowledge and expertise in community nursing.

As the twentieth century moved into its last decade the demands of therapy grew, the acceptance of a holistic view of the individual’s ailments, scientific and technological advances, the shift from institutional to community care, all required new knowledge and skills. It was generally accepted that nurses needed increased flexibility and the ability to work more autonomously. Greater inter-disciplinary cooperation in the delivery of health care was also anticipated. Thus, in 1994 a pilot registration/diploma course was introduced at University College Galway following an arrangement with the Western Health Board. This led to the establishment of a centralised applications system involving the Western Health Board and the Department of Health. By 1998 similar training arrangements had been implemented for all schools of nursing and a revised centralised system, the Nursing Applications Centre was introduced with the participation of the Department of Health, the Local Appointments Commission and Price Waterhouse, the management consultants.

Developments in Irish society during the late 80’s and early 90’s impacted on the content of both education and nurse education programmes. For instance, there were a number of key developments and events during the 1980’s and 1990’s that led to the launch of initiatives such as the ‘Stay Safe’ programme. According to Mayock, Kitching & Morgan (2007) revelations about child abuse were influential in highlighting the need to address major gaps in the provision of health education to children of all ages. Confirmed cases of child sexual abuse rose dramatically between 1980 and 1988 (McKeown & Gilligan 1988) and this combined with strong expressions of concern on the part of health board personnel led to the development of an educational programme called ‘Stay Safe’ which was formally introduced into primary schools nation-wide in 1991. The aim of the Stay Safe programme is to teach children personal safety skills particularly in relation to feeling afraid being bullied and dealing with strangers and inappropriate touches. By the end of 1994 the programme was operating in about half of the primary schools in the country.

In 1995 the report of the Expert Advisory Group on Relationships and Sexuality Education (Department of Education , 1995) made a clear case for the introduction of Relationships and Sexuality Education (RSE). This document emphasised the radically changed context of sexuality in Ireland. Other arguments for the introduction of RSE included the earlier physical maturation of children and the increasing evidence of early sexual activity among the young. The advent and spread of HIV and AIDS was also thought to be of significance. The RSE programme subsequently commenced in post-primary schools in 1997.

As a consequence of widespread curricular reform in education there has been increased in-service provision. In the early 90’s the Department of Education and Science (DES) established an In-Career Development Unit to plan and co-ordinate in-service provision. The extent of provision and the number of providers has exploded in the intervening decade but largely in an ad hoc manner driven by waves of reform initiatives rather than anything resembling coherence (see Sugrue et al. 2001).
Similarly, the importance of continuous professional development was emphasised in nursing. The E.U Advisory Committee on Training in Nursing highlighted the need for continuing education. During the 1990's Ireland took measures to address this issue. Acknowledging the role of continuing education for nurses in advancing practice and preventing obsolescence (ABA, 1994) a report was undertaken to examine the situation and recommend proposals for the future (ABA, 1997).

There has been increased choice for consumers of education. During the 90’s as the country grew increasingly prosperous, secular and consumerist, there was a significant growth in the number of multi-denominational schools and these compete for pupils with local national (denominational) schools. While there are currently approximately fifty such schools there are plans by its umbrella organization (Educate Together) to increase this number significantly. The growth of this sector in particular in recent years has been greatly facilitated by a Government decision to fund entirely the establishment of such schools. There has also been a corresponding growth in gaelsecoleanna (Irish medium schools) at both primary and post-primary level. While some of these schools are located in disadvantaged communities, the accepted view is that in general they cater for those with cultural capital. Similarly, large urban centres have witnessed the growth of what have become known as ‘grind schools’ that do not receive any state funding. They market themselves on their capacity to maximise ‘points’ and thereby facilitate entry to the most sought after faculties in universities. Many students who attend non-fee paying schools also attend these ‘grind schools’ in the evening, at weekends and during holiday periods for tuition in individual subjects. This has become a major pursuit for those with the resources to purchase these services. These developments contribute considerably to the development of a mindset that education is a product that can be modified, bought and sold.

The climate of choice and privatisation in health care will be discussed in the next period.

Other significant events during this period include the elevation of two national institutes of Higher Education to University status and the establishment of the National Council for Curriculum and Assessment (NCCA). The NCCA has subsequently been reconstituted as a statutory body. The brief of the statutory Council is to advise the Minister for Education and Science on matters relating to: the curriculum for early childhood education, primary and post-primary schools and the assessment procedures employed in schools and examinations on subjects which are part of the curriculum. The NCCA also has a research remit.

7.2.3 1997-2007- Opening the Floodgates of Reform

The pace and extent of reforms in Education and Health has accelerated particularly in the last decade.

In 1999 an entire revised primary curriculum was launched (GoI, 1999). The revised curriculum was devised partly in response to changing needs in: science and technology, social personal and health education, and citizenship. Thus, initial teacher education programmes had to prepare students to teach the new subjects of Drama, Social Personal and Health Education (SPHE) and Science as well as original subjects according to new pedagogical emphases.

The Education Act (1998) has been highly influential on many developments in Irish Education in recent years. Similarly, the comprehensive report of the Commission on Nursing (GoI, 1998a) has led to significant changes in the nursing profession. It is relevant to note that the Commission on Nursing was established following a national strike by nurses in pursuit of better terms/conditions and the strengthening of career and educational pathways.
Issues addressed by the Education Act (1998) include: accountability and transparency, admission policies, and combating educational disadvantage. According to the Education Act (1998) each Board of management must prepare a school plan including the objectives of the school relating to equality of access, participation in school and provision for students with special educational needs. The notion of transparency with regard to admission procedures is highlighted. Each school must publish its policy concerning admission to and participation in the school. The Act also provided for the establishment of the statutory Educational Disadvantage Committee to advise the Minister on policies and strategies to combat educational disadvantage.

Inclusivity and equality of access are key principles permeating the Education Act (1998). Accordingly, the Minister has to ensure that there is made available to each person, including those with a disability or other special educational needs, an appropriate level and quality of education and appropriate support services. Since the Education Act (1998) there have been further developments to support pupils with special educational needs. The Education for Persons with Special Educational Needs (ESPEN) Act (2004) makes detailed provision for the education of children with educational disabilities. Important provisions of the Act include: the establishment of a National Council for Special Education; and the requirement of a child with an assessed educational disability to have a detailed goals-driven individual education plan, which is to be regularly reviewed. According to the ESPEN Act (2004) parents have a central role in all important decisions concerning the education of their children. However, with economic development over the past decade there has been a rapid influx of immigrants in Ireland. Consequently, they now constitute 10% of the population and school enrolment policies which are permitted to discriminate on religious grounds have become contentious as non-catholic immigrant children are perceived to be at a disadvantage. Very recently the issue has received unprecedented media attention and some comment that the Educational and Equality legislation now need to be amended to reflect a much more multi-cultural and pluralist Ireland.

Both nurse education and teacher education were the subject of debate during this period.

Following the recommendation of the Commission on Nursing (GoI, 1998a) pre-registration nursing education is now based on a four year degree programme, incorporating one year of employment, with structured clinical placement in the health service. This development was considered necessary to equip nurses with the appropriate knowledge and skills to cope with increasing demands such as those associated with scientific and technological advances, patients’ expectations, the shift from institutional to community care, and inter-disciplinary cooperation. The degree programme commenced in 2002 and nurse education is now fully integrated within the third level sector.

At the beginning of the 21st century, two separate ministerial committees were created to review provision in initial teacher education. The consultation process led to the publication of Advisory Group on Post Primary Teacher Education (GoI, 2002) and Preparing Teachers for the 21st Century, Report of the Working Group on Primary Pre-Service Teacher Education (GoI, 2002a). The primary report (GoI, 2002a) required each of the teacher education colleges to respond to its recommendations within a year of its publication. However, whatever impetus this report may have had is lost by now. Consequently, pressure for reform of this sector is more likely to come from the newly established Teaching Council, rather than from the teacher education community. The Teaching Council was established in 2006 and its objectives include: reviewing and accrediting programmes of teacher education; promoting the continuing education and training and professional development of teachers; establishing
and maintaining a register of teachers; establishing procedures in relation to the induction of teachers and procedures and criteria for probation of teachers (GoI 2002a).

At the beginning of the twenty first century, the emphasis on lifelong learning became increasingly apparent in both the nursing and teaching professions.

The issue of continuous professional development for teachers was addressed in the Education Act (1998). According to the Act, schools must identify and provide for staff development needs, including the needs of staff involved in the management of the school. Moreover, since the launch of the revised curriculum (GoI, 1999) there is general recognition that lifelong learning will have to become the norm, when policy states that initial teacher education cannot be regarded as the final preparation for a life-time of teaching (GoI, 2002a). Thus, the Revised Curriculum (GoI, 1999) has been accompanied by comprehensive in service provision and a pilot induction programme for newly qualified teachers began in 2004.

Similarly, there have been efforts to support the professional development of nurses who qualified prior to the introduction of the BSc degree programme. Nursing and Midwifery Planning and Development Units have been established in order to provide education and training. Moreover A National Council for the Professional Development of Nursing and Midwifery (the National Council) was established in November 1999, following the Commission’s recommendation. The purpose of the National Council is to give guidance and direction in relation to the development of specialist nursing and midwifery posts and post-registration educational programmes offered to nurses and midwives. Since its establishment there is now a proliferation of specialist posts and accompanying post-registration education programmes.

A clinical career pathway has been introduced for nurses. Following the recommendation of the Commission on Nursing (GoI, 1998a) nurses no longer need to become managers in order to be promoted. There are now clinical specialist and advanced practitioner roles. A similar career path is not evident in teaching. However, many teachers have been seconded to work with new bodies and agencies such as the National Council for Special Education, the Regional Curriculum Support Service and School Development Planning. There are also new positions as resource teachers, learning support teachers, Education Welfare Officers (EWOs), language support teachers and Home School Community Liaison (HSCL) teachers.

In addition to greater career opportunities, nurses have also extended their practice. Following the introduction of the Scope of Nursing and Midwifery Practice Framework (ABA, 2000) nurses no longer require certification of their ability to fulfil an extended role. The scope of practice framework is a decision-making framework developed in order to assist nurses in defining the parameters of their role. Moreover an implementation group has been established by the Minister for Health to oversee the roll-out of nurse prescribing on a national basis in Autumn 2007.

Teachers and nurses have received salary increases over the last decade. In July 2002 the Benchmarking Body’s Report (GoI, 2002b) recommended an increase in salary of 13% for all teachers, with further increases for senior personnel in schools. In the context of the new social partnership agreement, “Sustaining Progress”, the government agreed to implement this recommendation, over a time period, subject to a number of “modernisation” conditions by teachers. Such conditions include operating more flexible and parent friendly practices for parent/teacher meetings, staff meetings and school holidays. For instance, schools are required to standardise Christmas, Easter and mid-term breaks. This sought to put an end to
the variation in the closure times of schools which caused problems for families where children were attending different schools.

Similarly, under the national agreement, *Sustaining Progress Social Partnership Agreement 2003-2005* (GoI, 2003) nurses have received substantial pay increases (over 13%) in addition to the benchmarking increases of between 8% and 16%. In return for these pay increases, nurses (and the other parties to the agreement) committed to co-operation with flexibility and modernisation. The key modernisation achievements include: maintenance of industrial peace and the initiation of a major skills mix initiative (the establishment of the grade of Health Care Assistant) on a service-wide basis.

However, more recently (May 2007) nurses took strike action in pursuit of a 35 hour working week and better pay. Currently, nurses work a standard 39 hour week while all other health professional staff work a 35 hour week. Furthermore, according to a pre-budget submission from the Irish Nurses Organisation (INO) nurse/midwifery pay rates are at a lower level than all other graduate health professionals. The work to rule action continued for a few weeks and it was agreed that reduction of the working week of nurses and midwives would begin on a phased basis. In addition, payment was sanctioned for the 5% cost of living increases (3% plus 2%) which are due to nurses and midwives (and all other workers in the health service) under the “Towards 2016” social partnership agreement (GoI, 2006).

Staff shortages have been a problem in Education and Health during the late 90’s and early 21st century.

The shortage of qualified staff has been evident in both the primary and secondary sectors, until the school year (2004-5). The failure of supply to meet demand was due in part to an increase in population, a combination of net immigration, new immigrants, and a decline of emigration to negligible proportions. It is also possible that teaching became less attractive in a recent climate of economic success where there were many more lucrative opportunities for young graduates.

In order to address teacher shortages, the number of places within the Higher Diploma in Education graduate programme was considerably extended. Moreover, in 2003, a private provider, Hibernia College, accredited a Diploma programme through the Further Education Accrediting body, and had the programme recognised by the Department of Education and Science (DES). This development is frequently presented by the DES as a necessity due to the inability of existing providers to meet demands. Irish students also pursue teaching qualifications in England, Scotland and Wales with every intention of returning to Ireland on completion. A further measure to combat shortages includes the commencement of an integrated four-year degree programme in Science and Education to address the difficulty of recruiting and retaining mathematics and science graduates in the secondary sector.

The shortage of nursing staff may be attributable to a number of structural changes in the Irish health system and the nursing profession. Firstly, the format of nurse education changed. Pre-registration nurse education is now fully integrated within the third level sector, thus students are no longer part of the workforce. Furthermore, while previously there were two intakes of students per annum, the degree programme has just one intake of students per year. Hence, the reduced intake and the absence of student nurses on wards created a demand for more qualified nurses.

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15 as accessed at http://www.ino.ie/DesktopModules/articles/Documents/PreBudget%20Submission%20for%202007.pdf
Although the Department of Health recruited more nurses following the introduction of the degree programme there were difficulties filling vacancies. There were a number of factors that contributed to this problem. For instance, a substantial proportion of nurses continue to seek career and travel opportunities abroad. A submission from the Irish Nurses Organisation (INO, 2006) reports that almost 12,000 Irish trained nurses have left this country since 1998; this represents an average of over 1,500 per year which equals the number of nurses educated in Ireland each year.

Turnover also has an impact on staffing levels. According to the National Study of Turnover in Nursing and Midwifery (Department of Health and Children (DoHC) 2002) the rate of turnover in nursing and midwifery is a significant problem across services in the Irish health care system. Results of the turnover study show that the two major reasons for leaving a current position were reported to be to pursue other employment in nursing (35%), and to travel abroad (21%). Workload has also been cited as a reason for leaving the profession. The Dublin Academic Teaching Hospitals’ report (DATH, 2000, as cited in DoHC, 2005) on nurse recruitment and retention ranked workload fourth out of nineteen categories for most important factors that lead nurses to consider leaving an organisation.

Consequently, a number of recruitment and retention initiatives have been implemented by the Department of Health and Children including: operating more flexible working arrangements for nurses and midwives enabling them to work on a permanent part-time basis; and the funding of part-time nursing degrees and specialist nursing courses. Moreover, many nurses have been recruited from overseas. According to a study by Buchan and Sochalski (2004) in the year 2001 about two-thirds of new entrants to the Irish nursing register were from other European Union and international sources.

In the education context recent recruitment initiatives are specifically targeted at males. In the 1970s, approximately 30% of teachers were male. This fell to 25% in the 1980s, and has further declined to approximately 18% in 2005 (see DES, 2006). The Department of Education and Science (DES) is encouraging parents, teachers and guidance counsellors to encourage young people, especially young men, thinking of their career options to give strong consideration to primary teaching. The Men As Teachers and Educators Campaign was launched in January, 2006 on foot of a specific recommendation in the Report of the Primary Education Committee, Males into Primary Teaching (DES, 2006).

While nursing was traditionally a female dominated profession it seems that more men are now entering the profession. According to the most recent statistics approximately 6% (7,393) of registered nurses are male.

Research has become increasingly important in nursing. This is evidenced by developments such as the provision of a dedicated budget for nursing and midwifery research, and the launch of a research strategy for nursing and midwifery in 2003. In addition, research modules are now included in the BSc nursing degree programme.

While increasingly, in a knowledge economy, there is a much greater emphasis on research and innovation in the Education (Higher Education) sector, and there has been a massive injection of funding in this regard during the past seven years or so (see OECD, 2004), research capacity generally remains underdeveloped. This is a major challenge also in Education Departments in Colleges of Education as well as in Universities. Nevertheless new

16 Report of the Working Group to examine the development of appropriate systems to determine nursing and midwifery staffing levels (DoHC, 2005)
17 See http://www.nursingboard.ie/en/statistics_article.aspx?article=d863df67-a4af-4b34-a211-b00a38cb95ab
bodies such as the National Council for Curriculum and Assessment and the National Council for Special Educational Needs all have a research brief.

While there has been huge investment in both education and health care, it is frequently reported that many health services are under funded. For instance, the Irish Nurses Organisation documents on a daily basis the number of patients on trolleys in Accident and Emergency departments around the country. There are a number of possible reasons for the lack of funding for resources in health care. Such factors include: the method of allocating funds annually, changing demographics; expensive technological advances; and a lack of accountability in the health system for service planning, budgeting and expenditure control. The impending demands of the European Working Time Directive will also further strain resources. Thus, private health care has become more popular. For example, an American company, Beacon, is currently building a major facility in collaboration with John Hopkins University Baltimore and with plans for another 6 around the country. Similarly, due to an ageing population and a more mobile population as well as radical reduction in family size, there is a proliferation of private nursing homes. This general climate then is rapidly creating or extending a two-tier health service- private and profitable for clients with private health insurance and an over-stretched public system for clients who for the most part cannot afford to pay. However, for the next few years there has been a government fund to enable public patients to ‘buy’ such services as hip replacements in private hospitals in an effort to reduce waiting lists in the public system and to dampen adverse publicity. The latest proposed initiative is to build private hospitals on public hospital grounds with the aim of freeing up approximately 1,000 beds in public hospitals for public patients. However there are concerns that this will weaken the public system.

7.3 Analyses of Structural Changes with Special Reference to Restructuring

This section juxtaposes the policy discourse/system narrative of restructuring in health care with the work life narrative of the nurses. Similarly, the policy discourse/system narrative of restructuring in education is compared with the work life narrative of the teachers. The system and work life analysis is explored under various themes (consumerism, role expansion and professional knowledge and skills) and in relation to the comparative grid presented in the chapter 1. Comparisons are also made between the professions and between generations.

7.3.1 Theme 1: Consumerism, Quality, Documentation and Accountability in Nursing

7.3.1.1 Policy Discourse as System Narrative

What does restructuring mean?

Over the last 20 years there is increasing evidence of the marketisation of the health service. Patients as consumers of health care have been addressed by medical (Johnson, 1987) and nursing researchers (Cowman, 1989; McCarthy, 1992) in the Irish literature. Moreover, the publication of a Customer Charter confirms patients’ status as “consumers”. The charter (which is based on the 12 principles of quality customer service) specifies the rights of consumers (and internal customers) of health care. More recently, the ProfKnow survey data provides further evidence of more demanding patients. 83% of nurses indicated that their professional expertise is questioned more often by patients nowadays.

How is restructuring working?

As a consequence of the perception of patients as consumers of health care, there has been a developing focus on quality of service. Indeed, this is one of the key principles underpinning the Department of Health policy (DoHc1994; 1997; 2001). Similarly, Irish nurses responded to the issue of quality with the publication of ‘Standards for Nursing Practice’ (INO, 1986). The focus on quality is also prevalent in nursing literature. Nurses have written about quality (Savage, 1996), explored methods of measuring quality (Carway, 1994), and planned and implemented quality assurance schemes in general nursing (Buckley and Savage, 1995 as cited in Condell, 1998), psychiatric nursing (Gallagher, 1991; Gilheaney and Farrelly, 1993 as cited in Condell, 1998) and mental handicap nursing (Redmond, 1993). Irish nurses have also been involved in the clinical audit of palliative care (Hayes, 1993) and have examined quality assurance principles for infection control (Creamer and Smyth, 1993).

The rise in consumerism has been accompanied by increased litigation. The ProfKnow survey results illustrate the litigious climate in which Irish nurses work. 51.5% of survey respondents cited the risk of being sued as an influential factor on their everyday work.

*Professional strategies*

Related to these developments (consumerism, quality assurance and litigation) is a mounting emphasis on documentation and accountability. Elaborate paperwork is now included in nurses’ responsibilities and duties. For example, nurses in certain settings are required to engage in quality assurance schemes such as integrated care pathways. These are structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem and describe the expected progress of the patient. By facilitating the evaluation of outcome, these plans can be used as a quality improvement tool. In addition, initiatives such as Accreditation and Hygiene audits oblige nurses (and other staff) to spend considerable time documenting evidence that standards are being met. According to ProfKnow survey findings, 91% of respondents strongly agree that the demand for written documentation is greater nowadays and 80% of nurses state that the demand for documenting work very much/rather much influences their daily practice. Similarly, 89.8% agree that the considerations and decisions they make at work need to be well documented. Presumably, the purpose of documentation is to raise standards, ensure accountability and at the same time lessen the risk of litigation.

*Professional configurations*

As a result of these developments it is possible that a greater proportion of nurses’ time is spent on administrative tasks (e.g. documenting and auditing) rather than direct patient care. It is difficult to say if the activity of documenting enhances or detracts from trust relations with patients. Perhaps the activity reinforces nurses’ sense of responsibility and accountability to their patients. Equally it is possible that the nurses are motivated to protect themselves from allegations of neglect or inappropriate treatment. The increase in paper work and quality assurance related activity may impact on the professional identity of nurses in the sense that they feel less people oriented and more task-oriented. Expertise in auditing seems to be learned on the job. Perhaps skills and knowledge in the area of documenting are learned during pre-service education and maintained on the job (possibly with the support of preceptors).

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19 Accreditation is a quality initiative that involves evaluating the service and seeing what improvements can be made.
7.3.1.2 Work Life Narrative

When we juxtapose the system narrative with that of the actors (nurses) we find that each nurse emphasised the importance of documentation. Moreover, the nurses were observed to keep records and plans of their actions.

How is restructuring working?

Documentation was described as serving a number of purposes. The most experienced nurse, (Aideen who worked as a divisional nurse manager), felt that the process of documentation helped to raise standards. In this instance her narrative resonates with that of the system. She referred specifically to the Hygiene Audit. Following a recent controversy about the standard of hygiene in hospitals, nurses (and other staff) attended team meetings to discuss evidence for standards and to develop quality improvement plans. They were then required to document evidence that standards were being met. Subsequently, the results of the second hygiene audit indicated that the standard of hygiene had improved dramatically.

However, Aideen lamented the lack of resources to attend to the time consuming process of documenting and developing quality improvement plans. Nursing and other staff did not get protected time in order to perform these tasks. Such responsibilities were in addition to their clinical caseload.

Similarly, Ellen, (the nurse with eleven years experience), described how services need to be audited and how nurses need time to document. She indicated a preference for administrative support for her, at times, overwhelming workload.

Aideen also described how documentation makes nurses (and others) accountable for their actions. She suggests that documentation allows clients to feel more confident.

...these systems should be in place and people should feel one hundred percent confident and there should be a tracking mechanism if anything ever did happen. Aideen

According to Aideen, there is a notable increase in documentation since the beginning of her career (eighteen years ago). Where previously a patient was dusted off and offered a cup of tea if they fell out of bed, there are now hospital policies and procedures for dealing with such incidents. This is evidence of the change in society’s attitude towards litigation.

Documentation must be filled out, insurance people informed, risk management informed, families informed. It’s all what should be happening but it’s a time-consuming lengthy process. Aideen

Nora, (the newly qualified nurse), remarked how patients’ records can be used as legal evidence. Thus, she referred to the importance of practicing within her scope and ensuring that writing is in black ink. Apparently, there is a policy that patients’ records are in black ink for photocopying purposes.

In summary, the three generations of nurses find documentation time consuming yet important. The most experienced nurse manager emphasises how it serves to raise standards (improve quality) and make nurses accountable. The clinical nurse specialist and the newly qualified nurse points out how documentation can be used as legal evidence and presumably be a protection against allegations of neglect or inappropriate care.

Generation differences

The generations differed slightly in terms of the emphasis they voiced with regard to the various functions of documentation. Such differences may be related to their differing positions and responsibilities rather than their age and experience.
The survey data supports the idea that nurses of all ages, experience and contexts were quite homogenous in their responses concerning documentation. For instance, 80.1% of nurses indicated that the demand of documenting work very much/rather much influenced their daily work and 89.8% felt that the considerations and decisions they make in their job need to be well documented.

**Professional strategies**

The requirement to document makes the nurses’ work more demanding. As a consequence the nurse manager and clinical nurse specialist in particular find it difficult to complete their duties within contracted hours. Aideen the divisional nurse manager frequently works longer than her contracted hours in order to complete her tasks. While Ellen (the clinical nurse specialist) found that for the first few years of her job she was bringing work home, experience has taught her to manage her time more effectively.

**Professional configuration**

The data suggest that the role of the nurse has been restructured to include new tasks, responsibilities, skills and knowledge. For instance, they all develop (or contribute to) service plans, accurately document their practice, audit their service, and produce (or contribute to) quality improvement plans. Their position in relation to the patients has changed in the sense that they have possibly less time available to engage in direct patient care. There might also be a more defensive relationship with patients and relatives in a climate of increasing litigation. However, side by side with this accelerating phenomenon, in the Irish context too there has been significant ‘professionalisation’ of nursing as a graduate profession, a general move into the university milieu and away from the apprenticeship model, while postgraduate opportunities, and new ‘managerial’ positions and promotional opportunities have emerged.

7.3.2 **Theme 1: Consumerism, Quality, Documentation, and Accountability in Teaching.**

7.3.2.1 **Policy Discourse as System Narrative**

What does restructuring mean, how is it working?

The focus on quality is also evident in Education. According to recent legislation (The Education Act, 1998) schools have a responsibility to ensure the quality of teaching in their establishments. The Education Act (1998) also outlines the responsibility of the school to establish and maintain systems whereby the efficiency and the effectiveness of its operations can be assessed including the quality and effectiveness of teaching in the school and the attainment levels and academic standards of students. Implicit in this responsibility is the requirement to document (and demonstrate accountability) for the operations of the individual school.

Another development that points to the growing emphasis on quality in Education is the establishment of the National Council for Curriculum and Assessment as a statutory body in 2001. According to the mission statement:

the NCCA will play a key role in shaping a world-class education system that meets the needs of all learners, supports their participation in communities and in society, and contributes to the development of the knowledge society in Ireland. As accessed at [http://www.ncca.ie/index.asp?locID=66&docID=-1](http://www.ncca.ie/index.asp?locID=66&docID=-1)
The NCCA is committed to improving the quality of education through continuous review of curriculum and assessment provision. To this end an entire revised primary Curriculum was launched in 1999 (GoI, 1999).

The issue of improving the quality of education for those with special educational needs has also been addressed. The National Council for Special Education was formally established in 2005 under the Education for Persons with Special Educational Needs Act, 2004. It was set up to improve the delivery of education services to persons with special educational needs arising from disabilities with particular emphasis on children.

Legislation has targeted those who are at risk of leaving school early. According to The Education Welfare Act (2000) principals, teachers, parents, and the educational welfare officer are obliged (following a consultation process) to prepare and submit to the Board of Management a statement of the strategies and measures it proposes to adopt for the purposes of fostering an appreciation of learning among students attending that school and encouraging regular attendance at school on the part of such students. Thus, the need to provide a quality learning environment is inscribed in law.

The Teaching Council (established as a statutory body in 2006) has responsibility for quality control/ quality assurance in relation to teaching and learning, as well as pre-service and in-service courses. One of the functions of the council is to maintain and improve standards of teaching, knowledge, skill and competence.

**Professional strategies**

In order to facilitate the provision of a quality education, a number of strategies have been implemented. Many of these strategies include increasing demands for documentation and demonstrating accountability.

The introduction of the Revised Curriculum (GoI, 1999) has been accompanied by comprehensive in service provision. This includes School Development Planning (SDP) and the Primary Curriculum Support Programme (PCSP). The aim of the School Development Planning Initiative (SDPI) is to stimulate and strengthen a culture of collaborative development planning in schools, with a view to promoting school improvement and effectiveness. The mission of the SDPI suggests that planning and associated documentation is a necessary prerequisite to raising standards.

There is a new quality assurance scheme in the form of Whole School Evaluation. This was introduced in recent years and there is an emphasis on school development planning through internal school review and self-evaluation, with the support of external evaluation carried out by the inspectorate. Schools (rather than external evaluators) are encouraged to take responsibility for quality assurance and decisions about change. In order to facilitate self-evaluation the Inspectorate published *Looking at Our School: An Aid to Self-Evaluation in Primary Schools* (DES, 2003). According to this publication, planning and preparation (and the necessary documentation entailed) pervades every area of the self-evaluation process. By identifying and documenting their practice together with areas for further development, teachers are increasingly accountable for their actions. Moreover, the decision by the Minister for Education and Science to publish the Whole School Evaluation (WSE) reports may increase demands for external accountability. In addition, in September of 2007, testing of 7 and 11 year olds in all Irish primary schools was introduced.

The documentation requirement is inscribed in The Education for People with Special Educational Needs Act (EPSEN, 2004). It states that schools must provide an individual education plan for pupils with special educational needs. Similarly, according to the *Learning Support Guidelines* (DES, 2000) schools are obliged to maintain records (in respect of each
pupil who is in receipt of supplementary teaching) for planning and recording pupil achievement and progress. Individual Profile and Learning Programmes and Weekly Planning and Progress Records are recommended. The same guidelines (DES, 2000) state that the purpose of such monitoring is to ensure that class teaching and supplementary teaching continue to be responsive to the pupil’s needs at all times. This is another indication that documentation is thought to help to raise (teacher and pupil) standards.

As is the case in Health, the focus on quality of service in Education has been accompanied by increased litigation. The Child Protection Guidelines and Procedures (DES, 2001) may be considered one response to the increasingly litigious climate in which teachers work. The guidelines aim to give direction and guidance to all school management authorities and school personnel in protecting children and dealing with allegations/suspicions of child abuse. One means of dealing with suspicions is through the keeping of detailed records of observations and concerns.

Increased litigation has also prompted some schools to prohibit children from running in the school yard. Very recently, in response to a report on increasing obesity among children in Ireland, the Taoiseach (PM) commented that such practice is ridiculous, ignoring the fact that it is health and safety legislation that has forced some schools to take this course of action! This is what Sachs’ describes as ‘defensive teaching’ (Sachs, 2008).

Professional configuration

The policy discourse emphasises how teachers are accountable to pupils and parents. A more collaborative relationship with teaching colleagues is also advocated. Thus, the identity of the teaching profession as individualistic and autonomous is being challenged. The discourse suggests that expertise can be produced and maintained through in-service provision and initiatives such as School Development Planning. While the emphasis on quality may indicate that cognitive challenge is a teaching priority, the developments in educational welfare suggest that care is still paramount in the responsibilities of teachers. However, the ‘trade-offs’ between cognitive challenge and care is likely to vary considerably depending on the context of an individual school, with potential as a consequence to create middle-class, leafy suburb schools of largely cognitive challenge and ‘disadvantaged’ schools largely concerned with care, thus the demand to challenge and care may well be increasing what the Americans call ‘the achievement gap’ but restructuring elsewhere has had this impact also (see Thomson, 2002).

7.3.2.2 Work Life Narrative

When we juxtapose the system narrative with that of the (teachers) we find that while the system sees documentation as a means by which actors (teachers) can be made accountable and standards raised, the teachers see documentation somewhat differently.

How is restructuring working?

When asked about documentation, the teachers referred to pupil records such as school reports and the results of standardised tests. Such documents were seen as useful for monitoring pupil progress. Sarah (a teacher with 6 years experience) mentioned how a new teacher can blame herself and feel guilty for a child’s lack of progress. However, if the previous teacher has documented concerns s/he can demonstrate that the child’s problem is not new. Similarly, Teresa (a teacher with 30+ years experience) remarked that documentation can be used to support a child’s application for additional learning support within the school. Before a child can be assessed by an educational psychologist, the teachers must provide evidence that they have tried a number of strategies which have proved
unsuccessful in managing the child’s difficulties. Thus, documentation can be used to reduce the likelihood of teachers being blamed for a child’s difficulties and to support applications for additional resources. However, it is possible also that such test results and records could be used to assess the extent to which a teacher had provided ‘added value’, despite the learner’s difficulties. What is significant is that the teachers in the study, in general saw such records in a positive light.

The teachers did not complain about documentation requirements. The cúntas míostúil (the monthly progress record) was mentioned as the primary means of recording the teachers’ work. While each teacher acknowledged that they are obliged to have evidence of short and long term planning and preparation (such as yearly and fortnightly schemes) they stressed that such evidence is rarely sought from those in authority within the school. According to Conor (the newly qualified teacher) such planning and preparation documentation is only inspected during a teacher’s probationary year or during a Whole School Evaluation (which take place approximately every five to seven years). This suggests that while demands for more planning and recording have increased in many instances, implementation is left to individual teachers.

The survey findings support the notion that there is a growing awareness among teachers of the need to provide written documentation of their work. 96% of teachers concurred with the notion that the demand for written documentation is greater nowadays. However, only 57% of teachers felt that documentation demands very much/rather much influence their everyday work. The aforementioned findings demonstrate that there is some discrepancy between teachers’ perceptions of accountability and the actual measures that they take to demonstrate accountability. Perhaps this is evidence that, despite more legislation, and more demands that suggest ‘performativity’ and paperwork, the ‘legendary autonomy’ (OECD, 1991) of Irish teachers appears to continue to have some authority and silently resists more bureaucratic requirements. 90% of teachers claimed that someone in authority checks on their work less than once a week or never.

**Professional strategies**

However, there is recognition among the teachers of the need to plan and prepare. In order to facilitate such planning, there are class level meetings once a month where teachers meet to discuss various issues. Sarah finds the class level meetings beneficial for discussing teaching methodologies, time frames and ideas. In addition, during staff meetings teachers engage in School Development Planning and subsequently share the workload. Conor mentioned how he is a member of two review groups developing and reviewing the school plan for Irish and reviewing homework policy.

Teresa has taken the initiative to develop a new system of documenting teachers’ work. She uses a form to seek information from class teachers with regard to their teaching schemes for the following two weeks. She uses the information to better prepare pupils (who are withdrawn for learning support) to participate in their mainstream class. In this sense, documentation is used to help raise pupils’ achievement and standards. However this potentially useful system of collaboration is not practiced throughout the school. Hence, Teresa’s professional expertise in terms of planning and her knowledge gained through cooperation is not systematically exploited or shared in the school.

The Child Protection Guidelines (DES, 2001) have impacted on the work of the teachers in certain respects. One consequence is that they are aware of the importance of recording incidents that support a teacher’s hunch that a child is being neglected. For instance, Conor the newly qualified teacher notes times when a child has no lunch or comes to school without a coat. Such information is helpful if a social worker makes an inquiry. However, while this
may be evidence of ‘care’ in school, and concern for the welfare of individual children, it may also be understood as increased ‘surveillance’, whereby those in the lens of accountability, turn the camera on those ‘others’ who share their workplace. Accountability, and its various ‘technologies’ are not entirely value-neutral, and in the blink of an eye, the mere click of the camera’s shutter, is sufficient to turn benign record-keeping into surveillance that is inimical to trust and positive relationships.

**Generation differences**

Differences between the generations are difficult to discern due to the homogenising influence of the school context. There are similar expectations with regard to quality, documentation and accountability irrespective of the age and experience of the teachers. Teresa’s initiative in planning a framework for documenting teachers’ schemes may be related to her position as a learning support teacher rather than her age and experience. The progress of pupils with special educational needs tend to be more rigorously monitored for a number of reasons (as previously mentioned).

**Professional configuration**

The finding that just over half of surveyed teachers felt that documentation demands very much/rather much influence their everyday work supports the idea that there is some disjuncture between the policy discourse and the work life narrative of the teachers. The interview data indicates that one motivation for documentation is to gain access to resources rather than facilitate quality assurance and demonstrate accountability. In this sense the teachers may be considered contested professionals. School Development Planning and sustained professional support through the Primary Curriculum Support Programme (PCSP) during the past six years, seems somewhat effective in encouraging collaboration and developing expertise. However, knowledge gained through collaboration is not systematically disseminated throughout the school, thus CPD continues to be more serendipitous than systematic and contributing to capacity building, while continuing to leave room for professional autonomy, and judgement.

7.3.2.3 Comparing the Professions of Teaching and Nursing

Interview, observation and survey data suggest that the system requirement to document has a greater impact on the daily practice of nurses. There are several reasons why this may be the case. Firstly, nurses on duty change with every shift, thus continuity of care has to be planned for and transferred to colleagues, something that is predominantly not the case in teaching. Furthermore, the number and diversity of patients is more subject to change than the number and diversity of pupils in a class. These factors mean that nurses cannot rely on their memory (or the memory of their colleagues) to plan appropriately a patient’s care. They must accurately document the patients’ needs and treatment so as to allow for high quality and continuous care. Secondly, the consequences of a nurse failing to document, for example, a patient’s fluids may have arguably graver consequences than a teacher failing to document pupils’ learning objectives for the following two weeks. Similarly, failing to document that hygiene standards are being met could lead to infections.

The professions are analogous in the sense that they are possibly more rigorous in their documentation and monitoring of clients with serious needs. If records show that the treatment programme has not been effective, new strategies are discussed and developed with a team. In this way the standard of care and education is raised. However, it appears that in education, teachers as ‘street level bureaucrats’ continue to enjoy relative autonomy in
comparison with their nursing counterparts, perhaps facilitated by less hierarchical workplace organisation.

7.3.3 Theme 2: Role expansion and Decision Making in Nursing.

7.3.3.1 Policy Discourse as System Narrative

What does restructuring mean, how is it working?

While the marketisation of health care has led to a focus on quality of service, this movement has also contributed to the repositioning of nurses’ professional boundaries. Historically role extension for the nurse has occurred with the offloading of medical tasks to nurses (transferring appropriate medical duties to nurses is more cost-effective than employing more doctors). According to a discussion document, it was thought that transferring appropriate medical duties to nursing and other staff could help solve medical manpower issues (Department of Health, 1993). An example of such role extension is the issue of intravenous drug administration (O’Sullivan, 1984 as cited in Condell, 1998; Department of Health, 1996), with the inclusion of educational preparation for nurses for this role since 1984 (ABA, 1983).

Scope of practice for nurses and midwives in Ireland is determined by legislation, EU directives, international developments, social policy, national and local guidelines, education and individual levels of competence. Changes in nursing and midwifery practice (in Ireland) historically have been driven by a process of certification of extended roles. The emphasis has been on the mechanical addition of tasks to the nurse’s or the midwife’s role and the provision of certification of his/her ability to fulfil that role. This approach has been based on the notion that any task that goes beyond what is learned in pre-registration training requires official sanction by certification.

Professional strategies

An Bord Altranais (2000) recognised that the healthcare services and the work trends of nurses and midwives are undergoing continuous change. According to ABA (2000) these changes are driven by the demand for a consumer-responsive service that is cost-effective and responsive to the changing demographic and epidemiological profile of the Irish population. In order to respond to these changes in a dynamic way The Scope of Nursing and Midwifery Practice Framework (ABA 2000) was developed. It is a decision-making framework to assist nurses and midwives in making decisions about the scope of their clinical practice. This framework (ABA, 2000) provides principles, which should be used to review, outline and expand the parameters of practice for nurses and midwives. According to ABA (2000) the framework aims to support and promote best practice for all nurses and midwives which will ensure the protection of the public and the timely delivery of quality healthcare in Ireland.

An Bord Altranais (2000) considers that expansion of roles should be guided by informed professional discretion and certain fundamental principles, rather than by mechanical extension based on certification. ABA (2000) also asserts that expansion encompasses
becoming more competent, reflective practitioners, developing expertise and skills to meet patients’/clients’ needs in a holistic manner.\textsuperscript{20}

One may argue that the introduction of the scope of practice framework is an indication of the impact of market forces. It may be considered a cost effective way of facilitating role expansion. Presumably if nurses do not require formal education or certification of their ability to perform certain skills or tasks then they are learning such skills on the job. Moreover, transferring appropriate medical duties to nurses is cheaper than employing more doctors. However, the framework could also be seen as a means of promoting good practice and ensuring the timely delivery of quality health care.

The Scope of Nursing and Midwifery Practice Framework (ABA, 2000) is intended to help nurses make decisions that could potentially expand the parameters of their practice (without the need for certification). However, nurses are currently prohibited from prescribing medicine. Current Irish medicinal products legislation gives prescriptive authority only to doctors and dentists and not to nurses and midwives.\textsuperscript{21} A review and subsequent enactment of all relevant primary and secondary legislation is required to extend the authority to prescribe medicinal products to nurses and midwives.

A report by the National Council of Nursing and Midwifery (NCNM, 2005) presents a number of reasons for expanding nurses’ role to include prescribing responsibilities. Quality patient care and timely treatment were considered among the main outcomes of introducing nurse prescribing. Correspondingly, the same report (NCNM, 2005) recommends that prescriptive authority should be extended to nurses and midwives, subject to regulations under the relevant legislation by the Minister (for Health and Children) and regulation by An Bord Altranais. The report proposes that nurses should be enabled to devise and implement medication protocols. In addition, the report emphasises the importance of educating and training nurses in the use of such protocols. Subsequently, an implementation group has been established by the Minister to oversee the roll-out of nurse prescribing on a national basis in Autumn 2007.

Although nurses have expanded their role and responsibilities in recent years there are certain tasks which they are no longer required to perform. When nursing moved to an all graduate profession in 2002 the students were no longer on the ward because they were in college. Hence, they were replaced with health care assistants and more cleaners were employed. Consequently, tasks (such as making beds and cleaning) that were once the responsibility of nurses have now been transferred to health care assistants and cleaners.

\textit{Professional configuration}

In tandem with the repositioning of nurses’ role, nurses are seen as more responsible and accountable for both their professional practice and their professional development. According to ABA (2000) accepting responsibility and being accountable for one’s practice is an attribute of a competent professional nurse. The importance of taking responsibility for professional development is also highlighted and recently increased funding is available to support such development.

\textsuperscript{20} Expansion may refer to a change in the overall scope of practice of the professions to include areas of practice that have not hitherto been within the remit of nurses and midwives. It may also refer to a change in the scope of practice of an individual nurse or midwife to include areas of practice that have not been within his/her scope of practice, but are within the overall scope of practice of the nursing or midwifery professions.

\textsuperscript{21} This authority is contained in the \textit{Medicinal Products (Prescription and Control of Supply) Regulations 2003}. 
The nurse or midwife must take appropriate measures to gain competence .... Competence is developmental. The maintenance of competence and ensuring its continuing development is achieved by engaging in continuing professional development. (ABA, 2000, p. 7)

Practicing according to routine and ritual is discouraged. Competence is not static. One may learn a specific skill, but the knowledge underpinning that skill may change over time... (ABA, 2000, p. 7)

There is also an emphasis on adopting a problem solving approach to care utilising critical thinking (ABA, 2000).

Developments such as the introduction of Health Care Assistants have implications for the amount of time that nurses are engaged in direct patient care.

7.3.3.2 Work Life Narrative

What does restructuring mean, how is it working?

Each clinical nurse mentioned the scope of practice framework and how it informed their decision making. They appear to use the framework to lessen the risk of litigation and help define (rather than simply expand) their role. Indeed, Ellen mentioned that she constantly asks herself ‘is this my role?’ Aideen the nurse manager questioned whether nurses should be photocopying scans for doctors. She wondered if that was an appropriate use of a nurse’s valuable skills, expertise and time. Nora commented that she was wary of practicing beyond her scope for fear of being sued. Aideen stated that people quote the scope of practice like the Bible.

While the system talks of role expansion being organic, dynamic and responsive to client and service needs, it seems that this may not always be the case. For instance, Aideen feels that in the past nurses would have muddled through if they were unfamiliar with a patient.

> they would have rung the doctor or checked with another nurse to see ... what else they were meant to be looking out for.        Aideen

Now she feels they are more cautious and wary of being sued.

The scope of practice framework doesn’t appear to have enhanced Ellen’s autonomy to expand the parameters of her practice. While she is interested in extending her role, there needs to be a change in protocol and policies to allow her to titrate medication and refer patients to have scans or other investigations where appropriate. Ellen finds it frustrating that she cannot write prescriptions but insists that she is unwilling to take on prescribing responsibilities until there is further structured education, changes in law, discussion on liabilities and remuneration for role expansion. She believes that historically nurses have taken on too many responsibilities from junior doctors and that writing prescriptions is another one that is waiting. Nora echoes Ellen’s thoughts, saying she is also unwilling to take on prescribing rights without appropriate remuneration.

Aideen feels quite empowered in terms of the decisions that she can make which are mainly about nursing, nursing personnel and nursing issues. She makes decisions about care of the patient in consultation with the ward sisters.

Both senior nurses insist that they cannot make any decisions about the distribution of funds. Ellen insists that as a nurse she is not involved in decision making about whether or not additional resources are needed. Ellen’s comments are echoed by ProfKnow survey respondents. 80% of those surveyed indicated that they do not participate in general policy decisions about the distribution of funds within the overall budget of the place in which they
work. Similarly, 80% stated that they are not involved in decisions to increase or decrease the total number of people employed in the place where they work.

Professional strategies

The nurses who were interviewed seem to have extended their professional role and responsibilities through continuous professional development, promotion and specialisation. For instance, Ellen gained a number of postgraduate qualifications and is in the process of completing a Masters on a particular disease. Her experience and additional qualifications made her eligible to apply for a position as a clinical nurse specialist. Hence, her new responsibilities have come about through progressing to a more specialised and responsible position. She is involved in education. Audit of current nursing practice and evaluation of improvements in the quality of patient/client care are also essential requirements of her role. Similarly, Aideen gained a number of postgraduate qualifications that enabled her to take on new positions and responsibilities. She currently works as a divisional nurse manager.

Generation differences

The observed differences between the interviewed nurses’ roles and decision making capacities may be attributable to their differing positions and responsibilities rather than simply their age and experience. However, it is likely that more experienced nurses get promoted to new roles.

Professional configuration

The evidence presented here suggests that nurses are restructured professionals in the sense that they have expanded their roles and responsibilities. Similarly, they have been relieved of responsibilities such as cleaning and are more accountable for their practice. However, rather than simply facilitate the expansion of their role, the Scope of Practice Framework has enabled nurses to (re-)define their role. There is an area of contestation in relation to expanding their role to include prescribing medication. The nurses stipulate a number of changes that need to be introduced prior to taking on such responsibility. Data from interview and observation indicate that nurses primarily develop their roles through post-graduate education, promotion and specialisation. It appears therefore that, within the nursing profession, there has been a tradition of ‘training’ whenever new practices have been introduced, thus resonating with Elmore’s notion of the ‘principle of reciprocity’, whereby mandates for change are typically accompanied by appropriate capacity building measures (Elmore, 2004).

7.3.4 Theme 2: Role Expansion and Decision Making in Teaching

7.3.4.1 Policy Discourse as System Narrative

How is restructuring working, what does it mean?

In the Education sector, role expansion seems to have come about as a consequence of the Inclusion agenda. The Education Act (1998) provides that all children have the right of access to and participation in the education system according to their potential and ability. Thus, all pupils, including those with special needs, have a statutory right to have their educational needs met by the State. Similarly, the purpose of the Education for Persons with Special Educational Needs Act (2004) is to make detailed provision through which the education of children who have special educational needs because of disabilities can be guaranteed as a right enforceable in law. Such legislation means that teachers’ role has expanded to include educating a more diverse student population. Teachers need to be familiar with assessment
and diagnostic procedures for the identification of special needs. Similarly, they need to know how to provide for a wide range of special needs.

Demographic changes have also contributed to new responsibilities for teachers. The rapid and recent influx of immigrants means that teachers are required to teach in a more culturally sensitive manner. Moreover, they need to cater for pupils with varying levels of proficiency in English. Consideration also has to be given to children with special needs who are learning through a second language. Ireland owes its enlarged immigrant population to increased movement from other E.U countries\(^\text{22}\) as well as increases in asylum seekers and those issued work permits. According to the National Council for Curriculum and Assessment (NCCA, 2005) during the economic boom years of the late 1990’s and early 2000’s, significant labour shortages developed which had a negative impact on economic growth. The number of workers from EU countries was not sufficient to meet the economy’s labour needs. As a result work permits were issued to Non-EU citizens to fill specified jobs. In 2004, 34,054 work permits were issued to Non-EU citizens. This shows a substantial increase from 2000 when only 18,000 such permits were issued (see NCCA, 2005). Another group of recent immigrants to Ireland comprises those who are seeking asylum. Between the years 1991-2004, the number of people seeking asylum rose from 31 to 4,766 (NCCA, 2005). As a consequence of increased immigration 11.3% of the population is classified as “non-Irish” nationals (see www.cso.ie)

Following the introduction of the Revised Curriculum (GoI, 1999) primary teachers are now required to teach two additional curriculum areas namely Social Personal and Health Education, Drama, and an expanded Science curriculum. Thus, teachers need new skills and expertise to teach these subjects. The introduction of Social and Personal and Health Education is an indication of the teachers expanded role. They are now required to educate children about topics (such as personal hygiene) that were formerly the responsibility of parents and family.

**Professional strategies**

There have been several initiatives designed to support teachers in their expanded role and to facilitate the inclusion of pupils with special educational needs. Most of the initiatives respect teachers’ autonomy to make teaching related decisions.

There has been large scale recruitment of teachers at primary level to fill the new learning support and resource teacher positions. In addition, *The Learning Support Guidelines* were published (DES, 2000). The primary purpose of these guidelines is to provide practical guidance to teachers, parents and other interested persons on the provision of effective learning support to pupils with low achievement/learning difficulties.

The National Educational Psychological Service (NEPS) has expanded. NEPS’ mission is to support the personal, social and educational development of all children through the application of psychological theory and practice in education, having particular regard for children with special educational needs. As accessed at [http://www.education.ie/home/home.jsp?maincat=33437&pcategory=33437&ecategory=33437&sectionpage=27692&language=EN&link=&page=1](http://www.education.ie/home/home.jsp?maincat=33437&pcategory=33437&ecategory=33437&sectionpage=27692&language=EN&link=&page=1)

The National Council for Special Education was established in 2003 to improve the delivery of education services to persons with special educational needs arising from disabilities with particular emphasis on children. The Council allocates additional teaching and other resources available to support the needs of such children. It took over this function from the Department

\(^\text{22}\) particularly from the new EU accession countries
of Education and Science in January 2005 and Special Educational Needs Organisers (SENOs) were appointed to deal with applications for additional teaching and Special Needs Assistant support for children with special educational needs from all schools. SENOs rely on evidence from psychologists, teachers and other relevant professionals when making decisions about pupils’ eligibility for resources. There are also strict criteria (issued by the DES) that determine the amount and nature of support given to a pupil with a low incidence disability (such as emotional disturbance or Autism). Thus, teachers are not ultimately responsible for such decisions. However, since the introduction of the general allocation model, teachers can decide the amount of support given to pupils with high incidence disabilities (such as Dyslexia and ADHD).

The In-Career Development Unit of the Department of Education and Science established the Special Education Support Service (SESS) in September 2003. The aim of the service is to enhance the quality of teaching and learning with particular reference to the education of children with special needs. Schools and / or individual teachers can make decisions about their own professional development needs in relation to special education and apply to SESS for support. Support sought may be financial, professional and / or advisory in nature.

In order to facilitate the integration and inclusion of pupils from ethnic minorities a number of language support teachers have been recruited. The publication of ‘Intercultural Education in the Primary School – Guidelines for Schools’ (NCCA, 2005) may be considered another response to the issue of cultural and ethnic diversity. The aim of these guidelines is to contribute to the development of Ireland as an intercultural society based on a shared sense that language, culture and ethnic diversity is valuable. It is hoped that the guidelines will support teachers, both individually and as teams in developing a more inclusive classroom environment. They aim to support whole school planning and policy development within schools and to contribute to developing a school culture that is respectful and sensitive to the needs of children. However, no professional development has been provided to date. Additionally, there is an essentialist quality to the notion of ‘intercultural’ education being promoted, and the concept is poorly articulated; rather its meaning is taken-for-granted. In a context where there is increasing evidence of segregation around schooling, particularly enrolment policy, the emergence of a two-tiered education system and ‘white flight’, much more work is necessary, particularly in the absence of any national policy regarding multiculturalism, racism and anti-racism (see McGorman & Sugrue, 2007).

The introduction of the Revised Curriculum (GoI, 1999) was accompanied by a comprehensive programme of in-service. A variety of means of support were (and continue to be) provided for teachers to develop their knowledge and skills so as to enable them to teach new curricular areas and new curricular emphases. One aspect of the Primary Curriculum Support Programme is the provision of ‘cuiditheoiri’ (helpers) to support and advise teachers on aspects of the curriculum including curriculum content, teaching methodologies and school and classroom planning for curriculum. Again, teachers make decisions about the areas in which they require support.

**Professional configuration**

As a consequence of the developments in Education the system is more complex. The policy discourse seems to envisage greater collaboration among teachers in order to meet inclusion requirements and fulfil responsibilities associated with their expanded role. For instance, teachers need to co-operate and collaborate with language support teachers, learning support teachers, SNAs, SENOs, psychologists and ‘cuiditheoiri’. Collaboration can in turn facilitate teachers’ work becoming more transparent and open to public scrutiny. The expansion of teachers’ role and the development of expertise in facilitating inclusion seem to be supported
by curriculum documents, internal evaluations and reviews and in-service provision. In addition, teachers’ autonomy to make teaching related decisions seems to be respected.

7.3.4.2 Work Life Narrative

How is restructuring working, what does it mean?

The impact of immigration and the inclusion of pupils with special educational needs were apparent in the teachers’ comments and practice. They referred to difficulties associated with their expanded role.

Sarah described how she has to deal with pupils who have been traumatised in their home country, pupils who have no English, and pupils who are being bullied because of a body odour problem related to their diet. She elaborates how these issues have necessitated an adjustment in her teaching approach. She needs to know the background of the children before she can teach in a more culturally sensitive manner.

According to Sarah, teaching a diverse group of children requires greater planning and preparation. She mentioned how she differentiates lessons according to the needs of the children. She takes into account the various cultures and makes sure that the Muslim/Jehova children do not engage in any activities contrary to their beliefs. For example, a Jehova child could not do anything to do with celebration.

Sarah talked of the difficulty of attending to the needs of all the children in the class particularly the needs of low ability pupils and those with poor proficiency in English. Indeed the lack of time to attend adequately to pupils’ needs was cited as a source of frustration. This finding is supported by survey data. 94% of teachers agreed that lack of time was a serious obstacle to the realisation of their ideas.

Conor experiences conflict with regard to supporting international pupils struggling in the class. While he would like to give them all the attention they deserve he is conscious of neglecting the needs of the rest of the children. Conor sees the value of language support for the pupils and for the teachers but expresses frustration with the lack of resources to support adequately the progress of pupils from ethnic minorities. A similar sentiment is expressed by ProfKnow survey participants. 80% cited lack of economic resources as a serious obstacle to the realisation of their ideas.

Sarah commented how it is very rare that you would get a class without a child with special educational needs. She indicated that she would have appreciated more input (during her pre-service education) with regard to supporting international pupils and pupils with special needs. Teresa and Conor also indicated learning needs in these and other areas. This finding is partly supported by survey data where 33% of teachers claim that their schooling and formal training was not sufficient for their work.

Teresa did not refer to difficulties associated with inclusion presumably because as a learning support teacher she takes small groups of pupils with similar needs.

The less experienced teachers remarked how there can be no end to the work in teaching. Conor said

\[23\] A child who is learning English as an additional language is only entitled to a maximum of two years language support but this has now been relaxed as part of the most recent partnership agreement, Towards 2016 (GoI, 2006).
it can dominate completely it can just take over your entire life you can spend every waking moment doing something in reference to school..

Similarly, Sarah commented

I find it difficult to feel that I have done my job because I feel that there is always something I can be doing, no matter how much I have done. I always feel that there are a hundred and one more things that I could do.

With regard to decision making, all the teachers felt that they (rather than supervisors) control their practice within the classroom. The teachers stated that they make decisions about what, how and when to teach. They acknowledged that there are guidelines (in the form of the Revised Curriculum, (GoI, 1999) or Learning Support Guidelines, (DES, 2000)) but they are not restrictive or limiting. The teachers’ comments concur with the ProfKnow survey findings where 96% of Irish teachers (primary and post-primary) said that their own conception of how work should be done very much/rather much influenced their everyday work as a teacher. Nevertheless, it is generally accepted that there is much more prescription in relation to the ‘revised’ curriculum (GoI, 1999) when compared with its predecessor.

While the teachers expressed a sense of autonomy in terms of teaching related decisions, they lacked authority to make decisions about access to resources. It is pertinent to note that a considerable proportion of surveyed teachers in the ProfKnow study also had little or no input into decisions about staffing (93%) or the distribution of funds in their school (81%).

**Professional strategies**

The teachers have responded to new requirements in a number of ways. The class level meetings provide a forum where teachers can learn from each other. Formal measures such as protected time (within school hours) and class supervision make such meetings possible. In addition, the staff notice board is frequently used to share resources for teaching and learning. It should be noted however, that ‘protected time’ can only happen in very large schools, and, in any case, it is doubtful that it is actually permitted within current rules and legislation. Consequently, what is evident here is that schools have sufficient confidence and ‘autonomy’ to create local arrangements to facilitate more collaboration, but during school hours, thus protecting their own time, but reducing instruction time.

Similarly, the school development planning days (as part of the DES in-service programme) are used to share knowledge and expertise in various areas. The school recently held a planning day about responding to a much more culturally diverse school population.

Teresa has developed a system to facilitate close collaboration with the teachers of her pupils with special needs. In addition, new commercially produced textbooks have accompanied the introduction of the Revised Curriculum. Teresa notes that there are very good teacher manuals with the textbooks. Perhaps such resources have assisted the teachers’ ability to cope with the new demands associated with their role as special needs and multicultural educators.

Conor and Teresa have adopted another professional strategy to deal with the pace and extent of reforms. They have taken the initiative to continue their professional development through pursuit of postgraduate education. However, this education is at their financial expense and Conor notes that the DES does not provide meaningful incentives for such education.

**Generation differences**

With regard to restructuring the teachers have responded similarly to changes such as catering to the needs of immigrant pupils and pupils with special educational needs. The mainstream teachers differentiate more and they experience frustration and guilt when trying to attend to a
wide variety of needs within school hours (presumably Teresa doesn’t experience this conflict because she teaches pupils in small groups who have similar learning needs).

There did appear to be a difference between the generations in terms of maintaining the work life balance. Conor and Sarah talked about making conscious efforts to stop work because it can just dominate. Whereas Teresa simply said she found the balance ok. Perhaps Teresa’s experience has taught her greater efficiency or perhaps there are fewer demands on her in her position as learning support teacher. For instance, she does not teach subjects such as Science or Art which often necessitate time consuming preparation of resources. Additionally, there is some evidence within the system that more experienced teachers have availed of new and emergent teaching positions to move out of ‘front line’ classroom teaching, thus protecting themselves to some extent against demands for change, while this leaves the least experienced teachers in schools, particularly those in disadvantaged areas, to deal with the changed and changing circumstances in regular classrooms. Longer term, such strategies may be inimical to the interests of learners, while being an understandable response to the rigours and demands of restructuring.

**Professional configuration**

There are aspects of the teachers’ role that have been restructured. For instance, the teachers’ engagement in collaborative exercises during School Development Planning days is evidence of a shift away from teaching as an individualistic profession. These planning days indicate that workplace learning is now a necessity rather than an option. While the policy discourse outlines strategies to support the expansion of teachers’ role and the development of expertise in facilitating inclusion, the teachers’ comments indicate that these strategies are inadequate. The younger teachers in particular lament the lack of training and resources for catering for pupils with special educational needs and pupils from ethnic minorities.

### 7.3.4.3 Comparing the Professions of Teaching and Nursing

The repositioning of professional roles is evident in both Education and Health. The expansion of nurses’ role is purported to facilitate the timely delivery of quality health care. In the Education context, role expansion is necessary in order to facilitate the inclusion of a diverse population of pupils with a wide variety of needs.

While the introduction of the Scope of Nursing and Midwifery Practice Framework (ABA, 2000) has enabled nurses to define better their roles and responsibilities, a similar framework does not exist in Education. The nurses have pursued further education in order to develop their skills and knowledge. They also learn from their more experienced colleagues. In this way they are better placed to take on new responsibilities.

In order to cope with new demands, the teachers collaborate. They attend class level meetings where they share expertise and knowledge, and co-operate regularly in order to meet new requirements. For Teresa (and the newly qualified teachers) the induction/mentoring programme has also facilitated a great deal of co-operation.

Lack of support for implementing changes associated with new responsibilities is a source of concern for both teachers and nurses. In particular, one teacher lamented the lack of pre-service provision for learning how to support pupils with special educational needs. Another teacher was frustrated by the limited support for pupils learning English as an additional language. The nurses complain that no additional resources are allocated to allow them attend to audit or research responsibilities.

Although, nurses are making more clinical decisions than their predecessors, they are still constrained in decisions about funding and staffing. The nurses’ lack of decision making
capacity with regard to resources (financial and human) is a source of frustration. Although nurses give their input sometimes there are no resources available. Similarly, while teachers feel autonomous in terms of their ability to make decisions about what, when and how to teach, they have little or no input into funding and staffing decisions. Such decisions are made centrally (by the DES) and it is a source of frustration for the teachers who are overwhelmed by demands to teach pupils with wide and varied needs.

7.3.5 Theme 3: Professional Knowledge and Skills in Nursing.

7.3.5.1 Policy Discourse as System Narrative

What does restructuring mean, how is it working?

Many developments in health care have had implications for the professional knowledge and skills of nurses. Increasing specialisation, the acceptance of a holistic view of the individual’s ailments, the shift from institutional to community care, scientific and technological advances, emphasis on evidence-based practice, as well as repositioning of the nursing profession within a restructured and continuing restructuring of the health service, all require new knowledge and skills.

A holistic patient-centred approach to care is advocated in the literature (see DoHC, 2002; NCNM, 2004). Indeed it is one of the principles underpinning the Health Strategy (DoHC, 2001). According to ABA (2005) nurses must demonstrate competency in holistic approaches to care (and the integration of knowledge) so as to be eligible for entry to the register held by An Bord Altranais. Thus, nurses need the skills and knowledge to conduct systematic holistic assessments of client needs based on nursing theory and evidence-based practice. They also need the knowledge and skills to plan care in consultation with the client taking into consideration the therapeutic regimes of all members of the health care team. It should be noted also that the dominant language of these restructuring policy documents is new public management, where, for example, patients and the public are ‘clients’. Consequently, it is reasonable to suggest that by altering the discourse in pretty fundamental respects, the nature of relationships and, over time, the nature of care provided is also altered, while those within ‘the system’ may, as yet, be unaware of the manner in which their world view is being reframed.

The Report of the Nursing Education Forum (GoI, 2000) outlines the roles and responsibilities of nurses. Such responsibilities include promoting and maintaining health. Thus, nurses need the skills and knowledge to provide and manage direct practical nursing whether health promotional, preventive, curative, rehabilitative or supportive, to individuals, families or groups.

The importance of evidence-based practice (knowledge informing practice) is espoused in numerous policy documents. One of the key aims for the National Health Strategy (DoHC, 2001) is to ensure the delivery of high quality services that are based on evidence-supported best practice. Similarly, ABA (2005) state that nurses need to demonstrate a knowledge base and a level of competence in clinical practice skills essential for safe practice, which are grounded in recent evidence-based nursing research, where available. Potentially, however, such carefully crafted scripts, constrain professional autonomy and the exercise of professional judgment to a point where job satisfaction and morale may be diminished rather than enhanced.

Nurses are expected not only to practice according to evidence but to contribute to the knowledge base. In their report, the Commission on Nursing (GoI, 1998a) attached particular importance to the development of nursing and midwifery research at every level; within each
individual organisation (hospital or community), at health board level and within the Department of Health and Children. The Commission asserted that research should form an integral part of all aspects of nursing and midwifery if nursing and midwifery practice is to be evidence based.

More specialized knowledge is also demanded of nurses. As part of the reform of nursing due to external and internal influences there has been a significant increase in specialisation. The absence of a clinical career pathway in nursing and midwifery was seen as increasingly limiting the development of the profession. Consequently, the report of the Commission on Nursing (GoI, 1998a) recommended the development of a three-step clinical career pathway by the creation of clinical nurse or midwife specialist (CNS) posts and advanced nurse or midwife practitioner (ANP) posts. Those with CNS or ANP status are characterised by extensive relevant experience, appropriate post-registration educational qualifications and an extended scope of practice.

According to ABA (2005) nurses need the skills of critical analysis, problem-solving, decision-making, reflective skills and abilities essential to the art and science of nursing. Presumably such skills are necessary to practice in a complex and changing healthcare environment in a holistic, evidence based, preventative and health promotional manner.

**Professional strategies**

In order to support the development of nurses’ professional knowledge and skills several strategies have been implemented.

Following the recommendation of The Commission on Nursing (GoI, 1998a) pre-registration nursing education is now based on a four year degree programme, incorporating one year of employment, with structured clinical placement in the health service. This initiative commenced in 2002 and nurse education is now fully integrated within the third level sector. The new Bachelor in Science (Nursing) degree is a four-year full-time course that involves the study of theoretical and practice-based subjects. The concepts and principles of health, humanism, adult education and lifelong learning are evident in the programme aims. There is also an emphasis on planning, evaluating and reviewing care. In addition there is a focus on continuous professional development.

There have also been efforts to support the professional development of nurses who qualified prior to the introduction of the BSc degree programme. Nursing and Midwifery Planning and Development Units have been established in order to provide education and training. The units are also involved in research projects.

A National Council for the Professional Development of Nursing and Midwifery (the National Council) was established in November 1999, following the Commission’s recommendation. The purpose of the National Council is to give guidance and direction in relation to the development of specialist nursing and midwifery posts and post-registration educational programmes offered to nurses and midwives. Since its establishment there is now a proliferation of specialist posts and accompanying post-registration education programmes. In order to gain the necessary qualifications to practice as a specialist nurse, postgraduate diploma courses are available in areas such as gerontology, coronary care, intensive care, peri-operative care, paediatric nursing, and accident and emergency nursing (to name but a few) in 3rd level institutions in the Republic of Ireland.

A number of measures have also been introduced to facilitate nursing research. The Minister for Health and Children provided a dedicated budget to the Health Research Board for nursing and midwifery research. In addition, in 2002, a Research Development Officer was jointly appointed by the National Council and the Health Research Board. The Research Strategy for
Nursing and Midwifery was launched by the Minister for Health and Children (DoHC, 2003) and the BSc Nursing degree programme now includes research modules.

Efforts have been made to support nurses (and other professionals) to engage in evidence based practice. The Interim Health Information and Quality Authority (HIQA) have been established under primary legislation to advance this aim. For healthcare workers, the HIQA’s role\(^\text{24}\) is to ensure that: they apply best knowledge, they deliver best care, best value for money is obtained, and they are supported in achieving these objectives.

**Professional configuration**

As a result of these developments, nursing emerges as a more complex profession where nurses need to work in a holistic manner in order to promote as well as maintain health. Sophisticated levels of knowledge and skill are required so as to practice safely and effectively and according to the evidence base. In addition, more specialised knowledge (gained through post-graduate education) is necessary in order to work as a clinical nurse specialist. Furthermore, there is an expectation that nurses of certain grades actively participate in research and contribute to the knowledge base.

7.3.5.2 Work Life Narrative

*How is restructuring working, what does it mean?*

The system advocates a holistic approach to care and it seems that the nurses have embraced such an approach. Ellen refers to the importance of looking at the whole picture when considering how to manage a patient’s condition. She takes into account the personal circumstances and family dynamics of each individual case. Similarly, Nora cites a situation where knowledge derived from individualised, holistic, patient-centred assessment should inform the delivery of care.

Each nurse emphasised the importance of having sound clinical knowledge in order to practice safely and effectively. This finding is somewhat supported by survey data. 86% of ProfKnow survey respondents stated that it was quite true/very true that their work requires them to constantly learn new things. According to the nurses (who were interviewed and observed) knowledge of the area of specialty was considered essential. For instance, Ellen commented that specially focused knowledge about a particular condition is necessary to advise patients regarding its management. Similarly, Nora was observed to require highly specialised knowledge about post-operative care for certain conditions. Despite the fact that Aideen is no longer involved in direct patient care, she claimed that she still needs clinical knowledge to do her job effectively. For example, from her nursing experience she is aware of the kinds of conditions the patients have and the resources that are necessary to care for them. Such knowledge is particularly relevant when developing a staffing plan based on patient census, case complexity and staff experience. Furthermore, knowledge of the area of specialty helps her to plan professional development provision.

The nurses expressed similar perceptions with regard to the merits of evidence based practice. However, while Nora showed an awareness of the need to keep up to date with evidence, she felt that time pressures and staff shortages impinged on time available to read the various folders of information on the ward. Similarly, Ellen talked about finding the time to read

\(^{24}\) As accessed at http://www.hiqa.ie/about-us/default.asp
about current research and policies. Her comments suggest that her commitment to continuous professional development makes demands on her time management skills. Information from the survey suggests that a considerable proportion of nurses infrequently consult scientific/nursing journals. 76% stated that they use these sources of information only once a month or less. Perhaps time pressures and staff shortages (as described by Nora) impinge on time available to read up on the evidence base. This evidence suggests that, while there has been considerable expansion of responsibilities in the nursing role, while shedding others, the working day has not been restructured to take cognisance of the necessity to update regularly one’s knowledge base. Consequently, workplace learning has to be augmented, in so far as personal circumstances allow, by ‘borrowing’ personal time, and this means that some categories of workers, and at different career stages, can ‘negotiate’ these compromises more easily that others.

Time pressure seems to be a barrier to evidence based practice. According to Nora, nurses sometimes operate according to routine and ritual because they have so much to do and they are pressed for time. For example, she commented that they often give the drugs and then do the observations but perhaps it should be the other way round because patients in her area of specialty can change their status within a matter of minutes. Nora’s claim that nurses tend to practice according to routine and ritual suggests that some nursing practices may have been initially informed by an evidence base but soon become part of the routine.

While the system asserts that research should form an integral part of all aspects of nursing, only 3% of survey respondents listed research as one of their main duties. Moreover, the view that research is important was not shared by all interviewees. According to Nora, the basic nursing care is the core of nursing and that should always be the case.

> Everything else can change around it the policies and the research and everything but you have to be able to provide the basic nursing care and if you can do that then you are a good nurse. Nora

Ellen highlighted a number of obstacles to conducting research. She mentioned that nursing management feel it’s up to her to make protected time to do research. However, she doesn’t consider that practical with her caseload. Moreover, despite the recent emphasis on developing nursing research, it appears that it is difficult to procure funding from Nursing for this purpose. According to Ellen, nurses must apply through nursing management to avail of finances which are minimal.

The hospital provides in-service programmes to foster nurses’ professional development. Indeed the survey suggests that most health service employers provide some form of professional development. According to the survey data 78% of nurses indicated that they had participated in a course/conference organised by their employer during the previous year. According to Aideen, (in the case study hospital) professional development programmes are informed by nurses’ identified needs. Although, Ellen thinks that continuous professional development is very beneficial, she regrets that the system doesn’t allow employees to take full advantage of in-service programmes. Clinical caseload takes priority. Their evidence suggests that while the rhetoric of restructuring ‘talks up’ the importance of CPD and research, current workplace realities are such that, in many instances, these remain aspirational within existing workplace arrangements, and it may also be the case that existing CPD provision actually perpetuates hierarchical relationships and a dependency among the nursing profession rather than promote professional autonomy. The nursing profession therefore, intentionally or otherwise, may have bought into a Faustian bargain of becoming a graduate profession with increased professional responsibility—more for less—while being repositioned within a re-configured hierarchical medical model.
The introduction of specialisms and a clinical career pathway following the recommendation of the Commission on Nursing (GoI, 1998a) has had an obvious impact on Ellen’s work and professional knowledge and skills. According to Ellen, the Commission on Nursing has had a major and positive impact on her career as a nurse. It allowed her to pursue a clinical career pathway (as a clinical nurse specialist) rather than necessitate a move to management. In order to create a clinical nurse specialist position, Ellen had to develop specialised knowledge about a particular disease, its symptoms and management.

Evidence of reflective and critical thinking (as recommended in policy documents) was apparent in the nurses’ practice. Nora is involved in writing a policy about a particular assessment procedure used on the ward. In order to do this effectively, she requires the skills of analysis, critical thinking, problem-solving and reflective practice. Ellen uses similar skills when auditing her service. She collates evidence of patients’ care needs and reflects on the outcomes of audit. Her knowledge of patients’ care needs informs her practice in the sense that she counsels and empowers patients with information so they can look after themselves. Thus, her reflective and critical stance contributes to her responsibility to promote patients’ health.

**Professional strategies**

The nurses have employed a number of strategies to cope with new developments and demands on their professional knowledge and skills.

Colleagues are cited as an important source of learning. Ellen stated that she has learned an awful lot from her nurse colleagues throughout her nursing career. She learned different skills from different people. Nora referred to learning from her preceptor and her senior colleagues who would explain about the various illnesses and their treatment. In addition, Ellen remarked that she has learned from peer support (from consultants, psychiatrists and psychologists working in the specialty and registrars, medical fellows, the wide multidisciplinary team). She cited the method of ‘see one, do one, teach one’ as her preferred method of learning/skill acquisition. However, she acknowledges the role of formal education also. She believes her knowledge has expanded from the academic training and assignments and research she has carried out. Aideen summarised her sources of learning as follows: courses, colleagues (doctors and other professionals) and experience.

ProfKnow survey data confirms the importance of colleagues in terms of supporting learning. Colleagues were cited more frequently than journals, newspapers and the Internet. 53% of respondents said that, at least once a week, they consulted colleagues to gain knowledge. However, over-reliance on knowledge and expertise of colleagues, while useful, may actually contribute to the routinisation of practice that privileges procedural knowing over more principled understanding, while simultaneously privileging practice over more sophisticated blends of knowledge for and of practice.

Since clinical caseload takes priority during regular working hours, the nurses sometimes have less time to read up on the evidence base or attend continuous professional development events. Thus, availing of formal learning opportunities (Diploma and Masters courses) seems to be a strategy used by nurses to read up on and reflect on the evidence base (and expand their professional knowledge) related to their area of specialty. The nurses have also availed of funding to support their education. Aideen and Ellen have gained numerous qualifications since their pre-registration education and, at the time of study, Nora was about to begin a higher diploma in the area of specialty. The evidence suggests that nurses value formal learning opportunities to enhance their skills and knowledge. However, given that Ellen has had to go to the UK in order to pursue studies in her area of specialty, there is scope for developing the range of postgraduate courses available in Ireland.
According to the ProfKnow survey 39% of nurses have additional education at university level that is relevant for their work. The most frequent length of study was more than one year. As previously mentioned a majority of surveyed nurses also indicated that they participated in courses or conferences organised by their employer during the previous year. 64% attended courses between 3-9 days of duration. A further 14% participated in courses for more than 10 days in total. These findings highlight nurses’ commitment to lifelong learning.

Apparently, it is difficult to procure funding for nursing research. Thus, Ellen finds alternative means by which she can fulfill her responsibility to be research active. She collaborates with her medical colleagues and avails of medical funds.

Funding of individuals to further their professional careers and extend and deepen their own knowledge-base, may do little to enhance organizational capacity, even at ward level. Consequently, without restructuring current workplace learning and practice, thus creating spaces and opportunities for substantive learning within the working day, building and sustaining capacity will continue to be aspirational rather than actual, with significant consequences for the quality of service and the collective rather than individual knowledge base.

**Generation differences**

Nurses of each generation showed considerable initiative and dynamism in terms of expanding their professional knowledge and skills through further education. There did not appear to be any difference between the generations in terms of their commitment to continuous professional development. The similarity may be understood when one considers the manner in which the nurses were recruited for the study. A nurse manager sought their participation. Hence, it is possible that the manager was more disposed to approach committed and motivated nurses. Equally, the specialty might attract nurses who are academically oriented. However, when we examine the survey data, a difference between the generations emerges in terms of their participation in additional education at university level. The middle and youngest generation were significantly more likely to have pursued further education than their older counterparts.

There were differences among the generations of interviewees in terms of the degree to which they participated in research. However, the survey findings don’t reveal a similar pattern. The majority of nurses indicated that research is not included in their main duties. It is likely that the apparent differences between the generations of interviewees are due to their positions, tasks, and responsibilities rather than their age. For instance, Ellen’s job description specifies that she must keep up to date with relevant current research to ensure evidence-based practice and research utilisation. Similarly, she must contribute to nursing research which is relevant to her particular area of practice. It is unsurprising therefore that Ellen appeared more involved in research activity than the other two nurses.

**Professional configuration**

The work life narrative of the nurses appears integrated with the policy discourse as system narrative in certain respects. For instance, they all talk about working in a holistic manner and the importance of specialist knowledge and practising according to the evidence base. In addition, the survey findings suggest that nurses feel the need constantly to learn new things. Thus, nurses may be considered restructured professionals to a degree. However, there is an area of contestation in the sense that nurses lament the lack of time and support to enable

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25 The oldest nurses are 49 years of age or more, the middle generation consist of nurses between 35 and 48 years, and the youngest nurses are at most 34 years old.
26 97% of survey respondents did not list research as one of their main duties.
them to read up on the evidence base. Another area of contestation relates to research. Apparently there are insufficient resources available to allow nurses to participate in research. Perhaps lack of resources partly explains why only 3% of surveyed nurses listed research as one of their main duties.

7.3.6 Theme 3: Professional Knowledge and Skills in Teaching

7.3.6.1 Policy Discourse as System Narrative

What does restructuring mean, how is it working? The Report of the Working Group on Primary Pre-service Teacher Education (GoI, 2002a) lists major domains of knowledge and skills, to which teachers should be exposed, and in which they should achieve a level of competence, though they acknowledge that they are not in a position to define that level.

The following categories were defined:

- Subject-matter knowledge
- General pedagogical knowledge and skills
- Skills in teaching particular curriculum areas
- Knowledge of learners and learning
- Knowledge of educational contexts
- Communication skills
- Moral sensitivity, values, and attitudes appropriate to a caring profession
- Ability to analyze and reflect on practice

As previously mentioned there have been a number of policies, initiatives and demographic changes that have impacted on the professional role of teachers. Such developments also have implications for the professional knowledge and skills required to teach effectively.

The introduction of the revised primary curriculum (GoI, 1999) necessitated the development of teachers’ professional knowledge and skills. Drama and Social Personal and Health Education (SPHE) are new additional subjects in the primary curriculum. Thus, teachers need new subject matter knowledge and pedagogical skills to teach these subjects effectively. As compared to the 1971 curriculum, the revised curriculum differs in terms of pedagogical emphases. A communicative approach in Irish is recommended and there is a renewed emphasis on oral language in English and on the Arts, and greater attention to estimation skills and real life problem solving in mathematics. Hence, teachers need to develop their capacity to teach in such a manner. Also of significance is the recommended use of Information and Communication Technologies (ICT). Approaches to pupil assessment have also had to reflect the basic principles of learning in the revised curriculum. Consequently, teachers need to be up to date with technology and assessment procedures.

Recent legislation (Education for Persons with Special Educational Needs Act, 2004) has necessitated the expansion of teachers’ knowledge base in the area of special needs. Following the integration of pupils with special educational needs into mainstream schools, teachers need to be familiar with assessment and diagnostic procedures for the identification of special needs. Similarly, they need to know how to provide for a wide range of special needs within a diverse classroom.
It is likely that the increasing multiculturalism and rapidly changing demographic of Irish society has challenged the mindsets and pedagogical routines of teachers. They need knowledge and skills to teach pupils who are learning English as an additional language. Moreover, they need to know how to teach children with special needs who are learning through an additional language. Consideration must also be given to the issue of creating an inclusive classroom and a school culture that is respectful and sensitive to the ethnicities and cultures of all children. Consequently, teachers need knowledge of a more diverse group of learners with similarly diverse learning needs. This is a particular challenge in an education system that is almost exclusively denominational, and where concerns about enrolment and segregated schooling have already emerged. Consequently, the complexity of the teachers role has been increased significantly while systemic and practice related challenges have emerged (McGorman & Sugrue, 2007).

**Professional strategies**

In order to support the professional development needs of teachers a number of strategies have been implemented. Many of these strategies were previously mentioned in the section discussing teachers’ role expansion.

Since the launch of the revised curriculum (GoI, 1999) there is general recognition that lifelong learning will have to become the norm. Each primary teacher is currently in receipt of six professional development days per annum, typically organized on the following basis- 4 days out of school and two days working collaboratively with colleagues in school or, in clusters in the case of small rural schools. Except for more recent provision, there has been almost no attempt to create a differentiated programme with the majority of courses being of short duration without subsequent follow-up or support at the level of the school (Sugrue et al., 2001) However, professional support for the implementation of the revised primary curriculum is beginning to provide support of a more sustained, differentiated and targeted kind. Towards this end, a Cuiditheóir (Support) person is made available to a number of schools through their nearest Education Centre, while anecdotal evidence suggests that this has had uneven impact, very dependent on the skill, interpersonal and otherwise, as well as expertise of the individuals concerned. More recently, this support is now being reduced as the roll out of the Revised Curriculum is being regarded as ‘complete’.

The report on primary pre-service education (GoI, 2002a) recommended extending the length of the BEd programme to four years. It was felt that extra time was necessary to prepare teachers for their role. However, whatever impetus this report may have had is lost by now. Consequently, pressure for reform of this sector is more likely to come from the newly established Teaching Council, rather than from the teacher education community.

The report on reform of initial teacher education in the secondary sector (GoI, 2002) places heavy emphasis on reflective practice and portfolio development as well the allied notion of the teacher as researcher. In this regard, the secondary sector report seems to be imbued more with international discourses on teacher education reform than its primary counterpart. However, while this report was prepared for publication it was neither launched nor distributed.

After several false starts, a pilot induction project began in the primary and secondary sector in 2003. The National Pilot Project on Teacher Induction seeks to develop an effective, systematic and rigorous approach to the induction of Newly Qualified Teachers (NQTs) with due regard to the range of their professional needs, the varied school/class contextual realities as they exist at primary level and at second level, and the needs at system level.
Special Education provision has expanded beyond recognition during the past 5-10 years, as a policy of inclusion has been pursued in the mainstream, as there is an increasing demand for more teachers with expertise in learning support, as well as a growing demand by mainstream teachers for more knowledge and skill in this area. As a way of illustrating this phenomenal expansion, the Special Education Department at St. Patrick’s College currently has a staff of twenty while less than ten years ago this number was three. This department was the only special needs provider in the system, while this too has altered dramatically in recent years. Following the recommendation of the report on Primary Pre-service Teacher Education (GoI, 2002), all colleges of education now include modules on special education in their undergraduate programmes. Additional initiatives include the publication of The Learning Support Guidelines (DES, 2000) and the establishment of the Special Education Support Service (SESS).

Teachers have also needed to expand their professional knowledge and skills in order to include effectively pupils from diverse cultural backgrounds. The Intercultural Guidelines (NCCA, 2005) aim to support whole school planning and policy development within schools and to contribute to developing a school culture that is respectful and sensitive to the needs of children. However no professional development has been provided to date.

**Professional configuration**

As a consequence of recent developments, teaching is configured as a more complex and demanding profession. In particular, knowledge of diverse learners, subject matter and catering for a wide range of learning needs is required. One may argue that a more reflective, critical stance is necessary to achieve competency in these regards. The primary means of developing knowledge and skills is through in-service provision following the introduction of the Revised Curriculum (1999), while an increasing number of teachers are availing of traditional and online provision of masters programmes as a means of furthering their professional learning.

7.3.6.2 Work Life Narrative

**What does restructuring mean, how is it working?**

Observation and interview data suggest that teachers’ professional knowledge includes: subject matter knowledge; pedagogical knowledge and skills; skills in teaching particular curricular areas; and knowledge about learners and learning. Thus, many aspects of their work life narrative and practice resonate with the policy discourse about teachers’ professional knowledge and skills.

Both Conor and Sarah were educated about the Revised curriculum during their pre-service education. While Conor acknowledges that teachers need to keep up to date with new suggestion or ways of doing things, he considers that he has a strong knowledge base to tackle any of the subjects in the curriculum. Knowledge of the constructs of music is identified as one area requiring improvement. He seems to have particular expertise in the area of Information Technology as evidenced by the class project on World War One.

Conor (and Sarah’s) use of Gaeilge conforms to the communicative, task-based approach to language learning advocated by the Revised Curriculum. Sarah’s observed use of questioning in the Mathematics lesson follows the Curriculum recommendation that a strong emphasis be placed on developing the ability to question, to analyse, to investigate, to think critically, to solve problems, and to interact effectively with others. Conor’s reference to planning why he is going to teach particular lessons resonates with the curriculum emphasis on planning a
programme that is appropriate to the individual school’s circumstances and to the needs, aptitudes and interests of the children.

Teresa’s comments to differentiation suggest that she assesses the needs of the learners prior to planning learning objectives. This practice concurs with the curriculum philosophy where assessment is described as an integral part of teaching and learning. Similarly it is clear that she takes into account the pupils’ affective and social development (as recommended by the Revised Curriculum) when she plans opportunities for the pupils to enjoy successful learning experiences.

The principle of guided activity and discovery learning and engaging the child with the immediate environment (another principle of the curriculum) is demonstrated by Conor’s approach to science experiments.

The teachers described their experiences of (and thoughts about) pre-service education. With hindsight Sarah asserts that she would have liked more input into teaching pupils with special educational needs in college but at the time it didn’t seem that relevant. However, it is now very rare to get a class without a child with special educational needs. Similarly she would have liked more preparation on dealing with different cultures. Teresa feels that the relevance of what she learned in college became apparent later on. She echoes Conor’s thoughts about the material not making sense at the time. According to Teresa there is a lot that you can’t learn in college because it is on the job learning and one of her tasks as a mentor is to bridge the gap between the theory of college and the practice of teaching. She emphasises that learning is a lifelong process for teachers.

While Sarah feels that her pre-service education did not adequately prepare her for certain aspects of her role as a teacher, this view does not seem to be shared by teachers surveyed. 61% of teachers indicated that their schooling and formal training was just right for their current job. However, this finding is later contradicted when 53% of teachers cite lack of professional training as a serious obstacle to the realisation of their ideas. Furthermore, 87% of the survey respondents felt that it was quite true/very true that their work requires that they constantly learn new things.

What Sarah’s experience (and the experience of the majority of survey respondents) illustrates is the necessity for workplace learning and support as well as opportunity for ongoing learning. Thus, many teachers look to their colleagues to develop their knowledge and skills. 62% of teachers reported consulting colleagues at least once a week to get knowledge. However, the structure of the school day is often inimical to the reshaping of the environment as a learning community (Wenger, 1998). In several studies in the Irish context, time has emerged as a major constraint to a more collaborative culture in schools as well as the structure of the school day and inflexibility in staffing schedules, while evidence was presented above of ‘protected time’ as a below the radar means by one school to circumvent such limitations.

Professional strategies

The teachers use several strategies to develop their professional knowledge and skills. Such strategies are similar to those they use to respond to new requirements and the expansion of their role.

As previously mentioned, the class level meetings are a forum where teachers learn from each other. Formal measures such as protected time (within school hours) and class supervision make such meetings possible. In addition, the staff notice board is frequently used to share resources for teaching and learning.
Similarly, the school development planning days (as part of the DES in-service programme) are used to share knowledge and expertise in various areas. The school recently held a planning day about responding to the needs of multi cultural pupils.

New commercially produced textbooks have accompanied the introduction of the Revised Curriculum. Teresa notes that there are very good teacher manuals with the textbooks. Perhaps such resources have assisted development of the teachers’ knowledge base and pedagogical skills in relation to teaching new subjects and emphases in the revised curriculum (GoI, 1999).

Teresa has taken responsibility for her professional development and attended courses and gained qualifications. Part of her motivation was that she needed more knowledge and skills in the area of teaching children with special educational needs. She felt that she was sinking rather than swimming. What her story illustrates is that the ongoing development of professional knowledge extends beyond the workplace.

Similarly, Conor has taken the initiative to continue his professional development through pursuit of postgraduate education. However, this education is at his financial expense and he notes that the DES does not provide meaningful incentives for such education. Perhaps the lack of incentives makes many teachers reluctant to pursue postgraduate education. 66% of those surveyed indicated that they did not participate in additional education at university level.

In addition, Teresa’s participation in the mentoring programme has possibly enhanced her understanding of how to facilitate workplace learning.

Each teacher refers to learning from experience. Sarah talked about acquiring knowledge from experience, reflection and consulting with colleagues. Similarly, when Teresa was teaching senior infants (5/6 year olds) she learned that getting the pupils to put their books away and line up was a lesson in itself. Furthermore, she commented that she has learned from experience teaching children with special needs; you can never assume they know anything. This informs her teaching in so far as she constantly reinforces material and explicitly teaches skills that their mainstream peers may take for granted. Interestingly, one reference Conor makes to learning from experience is when he says he learned to stop work when he needed because for the first few months of teaching it can just take over and dominate so much time.

What is not apparent from this evidence is the extent to which such workplace learning is adapting and refining previous thinking and strategies rather than anything more fundamental. In a time of rapid change exclusive reliance on this kind of learning only is probably inadequate.

**Professional configuration**

The evidence presented here suggests that the teachers’ narratives about their professional knowledge and professional development is integrated with the system narrative. Their comments and practice echo policy discourse about child centred constructivist approaches, assessment for learning, the importance of collaboration and lifelong learning. The harmony between system and work narratives may be understood when one considers the manner in which the interviewees were recruited. The principal sought their participation. Hence, it is possible that he was more disposed to approach committed, motivated and compliant teachers. However, a majority of survey respondents also acknowledge the need constantly to learn new things. In addition, there is evidence that many teachers are child centred in their approach. 43% indicated that the opinions of their pupils very much/rather much influence
their everyday work. Thus, in many respects, teachers may be considered restructured professionals.

**Generation differences**

The teachers’ qualifications differed in the sense that Teresa graduated with a diploma after two years and Sarah and Conor gained a Bachelor in Education after three years of study. One might assume a difference between the generations in the knowledge they bring from their pre-service education but in practice teachers share a common working context and do not speak of a wide generational divide. There are a number of factors which may have reduced possible generational differences in knowledge and approach. They include: participation in In-service initiatives for the Revised Curriculum; the induction/ mentoring programme; and the collaborative networks within the school. Learning from the apprenticeship of observation (Lortie, 1975) may also reduce generational differences in approach.

Among those interviewed, both the most and least experienced teachers share the view that further education can be used as a tool to diversify their job and enhance their employment prospects. The survey data did not reveal any significant differences between the generations in terms of additional education at university level.

**7.3.6.3 Comparing the Professions of Teaching and Nursing**

There are a number of similarities between the professions in terms of initiatives to support the development of their professional knowledge and skills. Both nurses and teachers are educated to degree level and there has been a proliferation of postgraduate education programmes in recent years.

The recognition of the importance of lifelong learning is apparent in both professions. However, nurses referred to struggling to find the time to read up on the evidence base. Both groups have taken the initiative to pursue further qualifications. These qualifications serve many purposes. They equip them with knowledge and skills to fulfil effectively their new responsibilities. At the same time the additional qualifications (and sometimes specialist knowledge) enhance their employment prospects and marketability.

Workplace learning is quite commonplace for both teachers and nurses. Although the nurses experience difficulties finding the time to attend continuous professional development events. They refer to the need to prioritise their clinical caseload. On the other hand, the teachers have protected time to attend in-service provision for the revised curriculum. Similarly they are entitled to a number of days for school development and planning, although this is now being minimised. The case study school has developed an additional measure to facilitate workplace learning and planning. They have class level meetings once a month.

Continuous professional development differs for teachers and nurses in the sense that nurses can select courses that are relevant to their needs and interests. On the other hand, in service provision for the revised curriculum is not differentiated according to the knowledge and experience of teachers.

In the absence of formal learning opportunities, nurses and teachers emphasise the importance of learning from their colleagues.

Reflecting on and criticising practice is apparent in both teaching and nursing. By participating in audits, nurses have the opportunity to identify service needs and associated areas for improvement. Similarly, by participating in school development planning days, teachers take responsibility for quality assurance and decisions about change.
Nursing and Midwifery Planning and Development units were established to support professional development through education and training. In Education the Regional Curriculum Support Service and Special Education Support Service offer a similar service.

The National Council for the Professional Development of Nursing and Midwifery (The National Council) recognises the importance of continuing education for nurses and midwives in the provision of quality care and has responsibility for overseeing postgraduate education programmes for these professionals. The establishment of the Teaching Council in 2004 as a self-regulatory body for the profession represents considerable progress. It is likely to have important effects on the professional development and induction needs of teachers.

The pilot induction programme is an initiative to support newly qualified teachers. In nursing, there are preceptors available to support newly qualified nurses. However, it is sometimes difficult to organise the timetable so that the experienced and newly qualified nurse are working together.

Research is more prominent in the work of nurses than teachers. Indeed it is included in the job descriptions of nurse specialists that they must contribute to the knowledge base. In addition, research modules have been added to the BSc Nursing degree programme. While the teachers referred to keeping up to date with current knowledge, they did not mention disseminating their own knowledge. Nor was there any reference to funds available to support research projects at school level. Furthermore, the BEd programme does not include a research module. However, the Teaching Council is planning to award research bursaries to teachers.

While increasingly, in a knowledge economy, there is a much greater emphasis on research and innovation in the University sector, and there has been a massive injection of funding in this regard during the past seven years or so (see OECD, 2004), research capacity generally remains underdeveloped. Although the SSHRC funds research in Education and Humanities, relatively little so far has been secured by Education. Traditionally, academic staff was hired to teach in Education faculties, while research was perceived as something that was done idiosyncratically and at ‘one’s leisure’. Nevertheless the new bodies such as the NCCA, National Council for Special Education etc all have research briefs. This will contribute to the knowledge-base. The challenge will be to provide appropriate Continuous Professional Development to increase, renew and sustain capacity in schools while building research capacity is an ongoing challenge.

7.4 Concluding Recommendations

The conclusions and recommendations to be drawn from our research will be discussed under the following headings: accountability and documentation; professional role; and professional knowledge.

7.4.1 Accountability and Documentation

The demands for documentation have increased the workload of both teachers and nurses. While the nurses consider it worthwhile they would appreciate some training to assist their capacity to attend to tasks such as auditing. They also expressed a preference for administrative support and protected time to attend to documentation responsibilities. In the teaching context, the structure of the school day may be an impediment to meeting accountability requirements. Many of the demands for programme planning and record keeping require close collaboration with teaching colleagues and other professionals. However, there are limited opportunities where such collaboration can take place. Thus, we recommend that protected time be allocated to teachers and nurses in order to collaborate and
meet accountability requirements. Additionally, while the demand for more planning, more record-keeping has, by now, become an established staple of policy documents, what is much less certain is how much time, effort and energy should be devoted to this, before it begins to erode actual engagement with learners and patients? If there is evidence internationally that the rays of a new dawn of post-standardisation are being perceived on the policy horizon, then there is need also to restore some discretion about the range and type of paper work that is most suited to a quality service. Consequently, in addition to advocating protected time, there is need also for additional research into the maximum use of such time, and its impact on quality service.

7.4.2 Professional Role

Both nurses and teachers have expanded their role to include new tasks and responsibilities. Lack of support for implementing changes associated with new responsibilities is a source of concern for both teachers and nurses. Sustained, targeted and differentiated education and training should be made available to ensure that changes associated with their new roles are implemented.

7.4.3 Professional Knowledge

The findings in relation to professional knowledge indicate that both teachers and nurses have identified gaps in their knowledge and are committed to continuous professional development. Apparently, the difficulty lies in finding the time and resources to further learning. In addition the way workplace learning is organised (particularly in schools) is increasingly problematic and will require more attention in the future. While there have been several reforms in the Education sector the structure of the school day has remained virtually unchanged. Although the teacher participants in the study report having protected time to hold class level meetings, this is only a possibility in larger schools where there is sufficient staff to cover classes. Similarly, nurses must prioritise their clinical caseload and thus have less opportunity to attend professional development courses or read up on the evidence base. We recommend that workplace learning be discussed, amended and debated in the light of government commitments to continuous professional development. It should be worked out both at a local and national level within a clearly articulated framework. Such deliberations will need to pay attention to workplace conditions for learning, to create a more appropriate balance between on- and off-site learning, and the impact this will have on a reconfigured workplace. In the absence of a more thorough restructured working day, current reform efforts are more likely to lead to performativity, with negative consequences for morale and quality of service, attrition etc., rather than improved quality of provision.

7.5 References


The Education Act 1998

The Nurses Act 1985


8 Portugal

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Since the mid-eighties, internationally, the various professional groups working under the direct dependence of the state and in touch with the general public have experienced strong changes in their work, which have had significant implications for the way these professionals fulfil their tasks, relate to customers and users, deal with their professional knowledge and with the demands of their functions, the way they fit in the professional context where they work and the way they individually and collectively shape their own professional identity. The political process underlying these changes has frequently been named *restructuring* and it will be dealt with in this report. Our analysis will focus on two specific professional groups, primary school teachers and nurses, as these are two of the largest professional groups among civil servants and are also among those that best represent the commitment of the State to welfare and social improvement policies characteristic of a welfare state.

In general terms, *restructuring* can be conceived as a global transnational movement based on a neo-liberal approach, whose core concepts are decentralization, deregulation, privatisation and marketisation (Beach, 2005). At a more restricted level, the concept can also be understood in relation to the political changes that have taken place in the welfare state itself (Goodson & Norrie, 2005, p. 8). Restructuring has been implemented by changing the offer of public services through the introduction of a market model springing from the private business world, which explicitly aims at rendering it economically more effective through the introduction of competition mechanisms. It results in the predominance of discourse and practices that highlight (Beach, 2005, p. 9):

- cuts in public spending;
- rises in the level of external surveillance exerted over the professions;
- changes in government methods through the introduction of private enterprise management models;
- introduction of a new accountability-oriented political agenda;
- changes in public service labour processes;
- public service offer based on criteria related to costs and profits, rather than on professionals’ advice on best practices.

Most of these changes were caused by the adoption by the State, since the beginning of the 90’s, of a new approach to public policies now known as New Public Management, which originated in two different but complementary movements: managerialism and the new institutional economy (Rhodes, 1996). The first movement introduced private enterprise management methods into public organisations: management functions attributed exclusively to professionals; definition of explicit performance indicators; adoption of ways of measuring that performance, supported on the analysis of outcomes; control of costs and an effort to increase proximity between service providers and their users. As to the second movement, it was characterized by the introduction of new types of initiatives in the offer of public services. Through fierce criticism of bureaucratic traditional systems, it proposed the
promotion of more competition by outsourcing, the establishment of market-like processes, as well free choice by users, as stepping stones of public services.

These changes have taken diverse dimensions, expressions and emphases in different European countries and, in each of them, among the various professions. In Portugal, in education, restructuring is apparent since the mid eighties, but particularly since the nineties, especially through decentralization initiatives and important changes in made in the structure and in the functioning of the welfare state, even though these tendencies have been accompanied by parallel patterns of re-centralisation and reinforcement of state control. More recently, these patterns have been particularly visible in the restructuring of teachers’ careers, in the ruling and regulation of teaching practice and in the (still incipient) development of policies for the external evaluation of schools and for the assessment of teachers’ performance. There is little evidence of privatisation and of marketised practices in the Portuguese educational system, apart from nursery schooling and higher education, where the private, co-operative and social solidarity sectors are predominant and where typical measures of the New Public Management have been introduced (particularly in higher education).

In health, evidence of restructuring is particularly visible in the legal frames adopted by public health care entities and in the implications of these frames for their internal organisation, namely for the labour bonds they establish. Until the end of 2002, the majority of hospitals functioned as public institutions, ruled by the Ministry of Health, and they enjoyed administrative, financial and patrimonial autonomy. The staff was approved by the Health and by the Finance Ministries and staff regulations were those applied to all civil servants (Simões, 2004). The first experiments with a different model took place in the nineties, and can be illustrated by the establishment of some public-private partnerships or by the management of public hospitals by private entities. However, the major legal changes that played a crucial role in the introduction of changes in hospital management models date from 2002 (Law nº 27/2002). A nationwide global movement towards the businesslike management of health care units was then set into motion. The State aims at widening the gap between its roles as financer and caregiver. In this new context, there is also a growing interest by economic groups in the establishment of new private health care units that specialize in specific areas.

Although taking into consideration that the effects of globalisation in the various countries are inevitable, the analysis carried out in this report focuses on a national perspective of restructuring, especially identifying and making explicit the changes that have taken place in the country, cross-analysing the policies adopted by the state and their impact on the professions. The report includes six main parts: in the first one, we provide some general data on the present situation of the health and educational systems in Portugal, highlighting the characteristics and the situation of the professionals that work in both areas. In the second part, we develop a systemic and temporal analysis of both professions (primary school teachers and nurses) since the 60s, proposing a timeline which makes it possible to identify the crucial moments of their evolution and the key factors that identify the most meaningful restructuring events that have taken place in these professions. Then, supported on empirical data, we analyse restructuring as it has been and still is experienced by the players (primary school teachers and nurses), highlighting, in this context, not only their personal opinions and thoughts on the change processes that have taken place in their professions, but also the way generation issues might influence their way of representing and experiencing these changes. In the fourth part, we reflect on the strategies developed by both professions and the configurations they have taken along the way as a result of their internal dynamics and of the relationships they have maintained with the State. In the fifth part, we draw a comparative analysis of both professions, trying to outline and discuss common aspects and
meaningful differences between them. We conclude the report by synthesising the main conclusions and providing some recommendations for both politicians and professionals.

8.1 The Portuguese Context: General Data on Education and Health

Portugal has undergone the longest period of military control and political dictatorship in the history of twentieth-century Europe, which lasted from 1926 to 1974. This is why the policies that are characteristic of a welfare state were only initiated among us in the mid-seventies, when the North European states were already entering the first stages of regression in their systems, as a result of the 1973 oil crisis and the ensuing economic depression.

In Europe, mass education progressed at very different paces in different countries. In 1900, the Scandinavian countries, the German region and the Netherlands, for example, already had a literacy rate of 90%, whereas in Portugal, in 1960, the illiteracy rate was 40.3% (Carreira, 1996, p. 436). In the beginning of the 90’s, it was still 11%.

In its initial stage, the dictatorship of the Estado Novo (New State) dealt with this problem by introducing a minimum curriculum for primary teaching (“reading, writing, and counting”, under the legal obligation of inserting moral sentences in the textbooks), reducing compulsory education from 5 to 3 years (in 1929) and creating a new kind of teachers – the school regentes – with a minimum number of requisite qualifications. Teacher education became the responsibility of restructured institutions and the length of the courses was shortened. The new regime that came out of the 1926 military coup also prohibited co-education and, in 1936, it ruled that female teachers needed a ministerial permit in order to marry. At the same time, the usage and dissemination of primary school textbooks, clearly inspired in the Italian schoolbooks of the Mussolinian period, was promoted. These clearly emphasised Catholic and nationalist values (Carreira, 1996, p. 439).

In 1974, due to the Revolution of the 25th of April, the country went through an unstable political period, characterised by radical changes in many areas of social life, including the nationalization of private property, a process which was only reverted, slightly at first and later with stronger determination, in the period that lasted from the nineties to the present date. The beginning of privatisation of previously public property marked the launching of the restructuring process at a moment when the “revolutionary fervour” started fading away and private enterprises progressively reassumed some importance in national economic life. However, except from nursery school and higher education, the impact of the private sector in education has been very slight. For example, in the school year of 2003-2004, in the total number of teachers working all over the country, from nursery to secondary education, only 11.8% worked in the private sector. With respect to primary school teachers, that percentage was even lower: 7.7%.

The second half of the eighties was a crucial moment when new educational policies were launched, which had important systemic consequences at organisational, curricular and teaching professionals’ careers levels, and also when compulsory education was raised up to nine years.

Over the years, primary education has been losing weight among the other education levels, not only in terms of the number of students enrolled, but also due to the expansion of the other levels of schooling and to demographic tendencies which reduced the number of students entering school. In demographic terms, the relative weight of primary schooling, which was close to 86% of the total number of students in elementary and secondary education in 1975-1976, dropped to only 23% in 2005-2005 (GIASE, 2006a, p. 14).
Despite this negative evolution in the total number of students, and except for nursery education, where the number of teachers in the last two decades has more than doubled, official figures (GIASE, 2006a) indicate a positive (albeit slight) quantitative evolution of the teacher body, between 1997-1998 and 2004-2005, across all education levels. In primary schooling, during this time frame, this growth was 0.8% (from 34,239 to 36,181 teachers), despite a notorious decrease in the number of students.

In relations to teachers’ age levels (GIASE, 2006a, pp. 19-20, 27), in 2002-2003 17.4% of the primary school teachers were under 30 years of age, 22.3% had between 30 and 39, 37% were between 40 and 49 and 23.3% were at least 50 years old. This was the level of schooling that presented the older professionals, with an ageing rate of 82.7%, only overcome by the second level of compulsory education, with a rate of 92.1%, and very distant from the third and secondary levels (52.1%) and from nursery education (only 26.9%). Between 1997-1998 and 2002-2003 there was a slight decrease in the ages of primary school teachers, as the percentage of teachers over 50 years of age decreased from 45.8% to 37%, whereas that of teachers under 30 rose from 11.4% to 17.4%.

On the other hand, in 2002-2003, the rate of feminisation was 98.3% in nursery schooling, 91.7% in primary teaching, 72.2% in the second cycle of compulsory education (5th and 6th grades) and 71% in the third cycle (7th, 8th and 9th grades) of compulsory education and in secondary education (GIASE, 2006a, p. 37). In nursery and primary education, there has been a slight decrease in this rate (GIASE, 2006c, p. 27). Teachers’ qualifications are another relevant indicator. If we take into account levels such as a bachelor’s degree/others (three-year courses), a licentiate’s degree or equivalent (fours years) and a master’s degree or a PhD, we notice that in 2002-2003 the percentage of teachers with a bachelor’s degree amounted to nearly half of those in nursery and in primary education (45.2% and 43.3% respectively), whereas in the second cycle of compulsory education it corresponded to only 17.5%, and in the third cycle and in secondary education it was 11.1%. The percentage of teachers with a master’s or a PhD degree was merely residual in all levels (0.6% in primary education and 3.5% in the third cycle of compulsory education and in secondary education). In this respect, there has been an important development between 1998-1999 and 2002-2003, as the percentage of teachers with a bachelor’s degree in primary education dropped from 74.3% to 43.3% and the percentage of those with a licentiate’s degree more than doubled, rising from 25.4% to 56.2% (GIASE, 2006a: 43). This is a remarkable development, in only five years. However, the data show that this level of education is still far from having a highly qualified professional group.

More recently, the professional situation of primary school teachers has evolved towards more precarious work contracts, but generally it is still characterized by stability. The percentage of teachers under contract in this education level rose from 7.0% in 1999-2000 to 8% in 2000-2001, 8.7% in 2001-2002 and 9.8% in 2002-2003 (GIASE, 2006a, p. 74). Nevertheless, the situation is much more favourable than in the second and third cycles of compulsory education and in secondary education, where, in 2002-2003, the percentage of teachers under contract was around 20%.

To sum up, the global education indicators of the Portuguese population show a growing level of qualifications, although these are still very far from the average patterns of the European Union. The demographic tendencies indicate a trend towards a gradual reduction of the number of students who access the educational system. The teaching personnel in primary

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27 This is the ratio between the amount of teachers aged 50 or more and the amount of those under 25 years old, multiplied by 100.
education have tended to stabilize, in quantitative terms, despite the progressive and obvious reduction in the number of students who attend this educational level. This professional group is constituted mostly by women, it displays a slight tendency towards renewal in terms of age, it is characterized by strong professional stability, but low qualifications still predominate in it, despite a growing tendency to increase them.

With respect to health care in Portugal, in the mid-twentieth century, the Portuguese system was very fragmented. In the time span between 1945 and 1968, despite an increase in the number of labour-associated social insurance systems (the welfare system), the State only played an supplementary role and health care was regarded as an individual responsibility of the Portuguese citizens (Biscaia et al., 2003). As a matter of fact, in 1974, only 58% of the population enjoyed some sort of health insurance program (Simões, 2004).

At that time, the health sector was characterized by the co-existence of different institutions with very diverse origins and orientations: i) an extensive network of hospitals which belonged to the Misericórdias (centenarian social solidarity institutions), ii) the “Social-medical Services” (SMS) who provided medical care to the beneficiaries of the Federação das Caixas de Previdência (the Portuguese version of the health welfare system), iii) Public Health Services (aiming at health protection – vaccines, pre- and postnatal care, environmental sanitary care), iv) a few central state hospitals and v) private health care for the upper classes (OPPSS – Spring Report, 2001).

By the beginning of the 70’s, Portuguese socio-economic indicators were very unfavourable when compared to those of other Western European countries (for example, in 1974, infant mortality rate was 37.9% – compared to 5.0% in 2001 –, and public health care financial capacity was very limited – only 3.9% of the GDP (9% in 2000) (Simões, 2004).

After the Revolution of 1974, under the new Constitution, every citizen was ensured the right to health protection, through universal, general and free health care, through the establishment and the expansion of the National Healthcare System (SNS – Serviço Nacional de Saúde). In 1979, the establishment of this system made it possible to grant total coverage of the population in terms of access to health care. Later, new health policies changed the principle of free health care and the revision of the Constitution of the Republic in 1989 established that health care services are “preferably” free of charge and recognised that the right to health care is not limited to the National Health Service.

With respect to the nurses’ profile, close to the seventies, even though they had ensured some advantages, namely with respect to control over their education processes, they were still regarded as “the doctors’ servants”, they carried the stigma of their humble social origins, their work was associated with a deep-rooted idea of Christian charity and there was still a predominance of female nurses (Rebelo, 2002). One has to bear in mind that at the time the legislation explicitly favoured women over men for admission to nursing courses and also that, until 1963, female nurses were not allowed to get married.

Two professional groups shared nursing care: nurses and auxiliary staff. Nurses were in charge of conceiving and supervising nursing care. The auxiliary staff had to perform the more technical tasks. Nurses were required to attend a three-year training course, which they could be admitted to after having qualified with the then second level of high-school education (the 9th grade). The auxiliary staff attended an 18-month course, which they could enter provided they were qualified with the then first level of high schooling (the 6th grade). In quantitative terms, the two groups were very uneven: 3 000 nurses versus 15 000 auxiliaries (Nunes, 2003).
In the post-revolutionary period, the auxiliary staff category was extinguished and there was a rapid increase in the number of nursing professionals. In 1975, there were 18,593 professionals (including the auxiliary staff); in 1985, 20,695; in 1995, 29,685, and in 2005, 48,185 (DEPS: DGS/DSIA, Nurses’ Order, 2006).

With respect to gender, there is an obvious predominance of female nurses. Despite a slight trend towards a reduction of the trend, the rate of female nurses has remained stable in recent years (it was 81% in 2005).

In relation to age levels, in 2005, 29.4% of nurses were under 30 years of age, 29.7% were between 30 and 39, 21.4% were in the 40-49 group and the other 19.5% were over 50 years old. There has been an obvious tendency towards age renewal in the profession. In 2005, 70% of all nurses had less than 45 years of age and 44.8% of the total was under 35 (Nurses’ Order, 2006).

As to the professionals’ qualifications, since 1988, through the integration of Nursing Education in the Portuguese Higher Education System (Technical Higher Education), admittance to the profession required a bachelor’s degree in nursing. Ten years later, in 1998, the course was increased to four years and from then on it granted a licentiate’s degree.

The vast majority of professionals work in hospitals. According to the statistical data of the Nurses’ Order in 2005, among the total number of nurses whose type of contract was identified in the database (i.e., excluding retired nurses, recently graduated unemployed nurses and those who have not provided information on the type of labour link under which they worked), 17.5% worked in health centres, 71.6% in hospitals and the remaining ones worked as supervisors or in other types of institutions. Another crucial piece of evidence is that the National Health Service is the major employer of this professional group. Among the nurses who have provided information on their type of labour link and excluding those who are working in education and training, one can see that the State employs 92.6% of all professionals: the private sector employs only 6.5% and there is only residual autonomous labour (0.8%).

In short, the rapid growth of the group of nursing professionals in the Portuguese health system has been one of the most significant trends in the recent years of the profession’s evolution. This rapid, significant rise has been absorbed by the labour market due to a shortage of these professionals, by European standards.

8.2 Restructuring and the teaching and nursing professions: a systemic narrative

In the Portuguese context, from the sixties up to the present date, one can identify different pieces of evidence and manifestations that represent important trends and significant events that need to be taken into consideration when trying to understand the restructuring process and its relationships to the teaching and nursing professions. In Portugal, in these professions, restructuring occurred (and still occurs) in a group of areas and sub-areas, namely:

- **Changes in the organisational context of professionals’ work**
  - global organisational context (organisation of the national system);
  - local organisational context (administrative structures, management models, formal definition of roles and functions, professionals’ participation in management, etc.).

- **Rules, regulations and professional roles**
  - structure and organisation of the professional career;
- professional self-regulation.

- Changes in the professions’ training models
  - access to initial training;
  - curricular emphases in initial training;
  - models and control of initial and in-service training.

In the following pages, and for each profession, we specify the meaningful changes that have occurred, organising them chronologically. The periodisation is similar for both professions, but each of presents some specific patterns.

8.2.1 Teaching

8.2.1.1 1st period: “Modernisation” stage of the New State (1960-1973)

Between 1960 and 1973, the professional life of primary school teachers and their work contexts were shaped by political structures whose roots can be traced to a time that preceded this period. As Sarmento (1998) recalls, “the management model of primary schools dates back to 1910” (p. 40), the year when the “school council” (a formal professional body constituted by all teachers who had a permanent contract with their school), was created. This council had extensive pedagogical functions (such as the definition of how to implement the program of studies and the organisation of the school timetable) and it was chaired by the headmaster.

In 1933, the Estado Novo extinguished all school councils, prohibited all meetings in primary schools and transferred the responsibilities of the former school council to the headmaster alone (Legal Decree nº 22 369, March 30, 1933). Primary schools lost their collective professional bodies, a situation that lasted until 1974. Therefore, each school was run by a headmaster, who was a teacher appointed by the General Director according to a proposal that was put forward by the school district inspector.

In order to create a submissive group of teachers, the Estado Novo closed all Teacher Training Schools between 1936 and 1942 and completely restructured their curricula, shortening the course from three to two years (Carvalho, 1986). When these institutions reopened, in 1942, the mark of regular teaching that had prevailed in them since the transition from the 19th into the 20th century had been “deleted”. There was a regression towards a “merely technical and didactic view of teacher education” (Nóvoa, 1991b, p. 8). Referring to this official measure, Nóvoa (1991b) holds that the Estado Novo had two purposes in mind, both of which were successfully achieved:

- on the one hand, it aimed at putting an end to the fancies of teacher education supported on a sound intellectual basis and on scientific references, because, the preparation of teachers who would be able to fulfil “the practical and Christian ideal of teaching to read, write and count properly and to exert the moral virtues and a deep love for Portugal” (Legal Degree nº 27 279 de 1936) did not require a high academic level in primary teacher training;

- on the other hand, it aimed at diminishing teachers’ social status in order to interrupt the professional development process and to reintroduce a “missionary” conception of teaching practice (p.108).

Until 1974, the curriculum for primary school teacher training was, in its essence, similar to the one that was legislated in 1942. The main characteristic of the curriculum during this period was “the low standards of its contents, the frailty of the pedagogical education and the
sexist ideology that underlay it, materialised in one of its subjects - Feminine Education – which was attended exclusively by female students, during the first three semesters of the course” (Lopes et al., 2007, p. 34).

The selection and the education of teachers were issues of utmost concern for those responsible for the educational policies of the Estado Novo. Due to the ruling regime’s strong concerns with the maintenance of ideological control, it tried to implement a selection of applicants for teacher training schools which was based “on an inquiry into requisites not only of intellectual, but also of moral and civic nature, [which were regarded as crucial] for those who intend[ed] to educate the youth” (quoted in Barroso, 1991, p. 63).

After the Second World War, the educational policies of the dictatorship abandoned their focus exclusive on using the school system as a tool of political propaganda in the official values of the regime. Then, the government began to confer this system with a growing economic mission in which the notion of modernity gradually became the key idea conveyed in political discourses related to educational matters. This new official definition of the role of education led to changes in teacher education, namely, a rise in the requisites needed for application to a primary teacher training course. Additionally, basic compulsory education was extended from three to four years in 1956, even tough at first this only applied to boys (it was only in 1960 that the measure was extended to girls). In 1964, compulsory education was lengthened again to six years (both for boys and girls).

In 1968, after the death of Salazar, Marcello Caetano took power and launched a political period known as the “Marcellist Spring”. During this period, the regime’s economical and developmental conception of education was strengthened, although there were other even more extreme innovations in political practice and discourse, among which we highlight the public expression of the need for educational policies to contribute to the democratisation of the country. The internal contradictions of the regime and its urge to acquire social legitimacy made possible the introduction of important changes in educational policies (Stoer, 1983). In 1973, Minister of Education Veiga Simão proposed a reform which was approved and which introduced important changes, such as the establishment of nursery education as part of the educational system and the lengthening of compulsory education from 6 to 8 years (Carvalho, 1986).

In this period, in teacher education, technical expertise was strongly valued and strong emphasis was placed on didactic and pedagogical issues, which were regarded as vital technical knowledge for good professional practice. This was quite the opposite of the former proposals for a minimal curriculum that aimed at educating teacher candidates and their forthcoming students in the virtues of passivity and ideological compliance (Formosinho, 1987). Some measures were also taken to facilitate admission into teacher training institutions and to widen the number and range of organisations where this training could take place. However, during this last period of the regime, there were no significant changes in primary school education, which was the educational level on which the “reformist aims and practices” of Veiga Simão focused the least (Sarmento, 1994, p. 50).

8.2.1.2 2nd period: Post-revolutionary period (1974-1975)

The democratic revolution of April 25, 1974, led to the return of educational policies with a more explicit ideological dimension (Stoer & Cortesão, 1995, p. 198). The revolutionary atmosphere stimulated a strong politicisation of educational issues, according to which the school was regarded as a privileged place and a tool for democratisation, aiming at the establishment of a classless socialist society. The 1976 Constitution, which resulted from the revolutionary process, established, in the second paragraph of its article 74, that “teaching
must be changed so as to overcome any conservative function of economic, social and cultural inequality”. The period that lasted between April 1974 and November 1975 was dominated by social movements characterized by strong popular and military involvement, and by numerous self-government experiences in schools, led by groups of teachers and students that were organised spontaneously and were legitimised in huge assemblies that took place in schools’ premises (Lima, 1999).

After the 25th of April, the formal structure of schools underwent important transformations, from “a structure that promoted compliance into a structure that was aimed at participation”, even though this was restricted to school members (teachers, students and staff) (Teixeira, 1995, p. 82). In primary education, through the Legal Decree 68/74, published in November 16, it was ruled that schools with more than two teachers would be run by a school board. This governing body was granted responsibility in issues related to planning, the development of proposals, school organisation and decision-making (Teixeira, 1995, p. 140).

The April Revolution also caused direct and immediate changes with respect to the organisation of teacher education, which was seen as a means of intellectual expression of the new educational ideology (Stoer & Cortesão, 1995, p. 209; Lopes et al., 2007). In primary teacher training, the previous emphasis on didactic issues gave way to an equally or even more important set of new curricular dimensions, according to which, for example, the first three months of training were spent in “contact activities” between student-teachers and local communities, activities that were later analysed in seminars held by teacher educators. The dominant teacher education model proposed in this period was that of the teacher as social activist and promoter of the whole development of students and their communities.

During this period, although initially the general secondary school diploma or its equivalent was still accepted as the required qualification to be admitted into a teacher education school, in 1975, three-year nursery and primary education courses (thus, with an extra year) were established. In the curricula of the then-called Escolas do Magistério Primário (Primary Teacher Training Schools), areas such as Arts-Communication, Psycho-pedagogy, Professional Practice and Interdisciplinary Work were given a strong emphasis (Lopes, et al., 2007).

8.2.1.3 3rd period: “Normalisation” (1976-1985)

When the 1st Constitutional Government came to power, in 1976, it started a process that would become known as “normalisation” (Stoer, 1982). The purpose was to cease the extensive social unrest and the self-governing processes that had been growing in schools and to reinstate State control over education. In this process of normalisation, international organisations such as the IMF, the World Bank, the OECD, and the EEC played an important role in supporting the reinforcement of the State (Stoer, 1986).

The 1st Constitutional Government used its democratic legitimacy to impose compliance with general legislation on schools in order to reach stability and submit the local interests to the general well-being. In order to do so, a Law – Legal Decree nº 769-A/76 – was passed that regulated the management of preparatory (5th and 6th grades) and secondary schools until 1998. This law sought to regulate the exercise of power in schools, establishing a model that would become known as the “democratic management model”. This model displayed the following features (Barroso, 1961, p. 69):

- collegial representative group administration;
- participatory structures for teachers, students and general staff;
- principle of election for the different functions;
functional separation between administrative power (the direction board) and professional/pedagogic authority (pedagogic and subject group boards);

power to the teachers, as professionals, to guarantee the orientation and the pedagogic coordination of the school.

Commenting on this legislation, Barroso (1991) considers that, despite it being an advance over the previous situation, “it [still] was nothing more than a ‘democratic prosthesis’ in a bureaucratic administration” (p. 69).

Normalisation also resulted in restrictions over teacher recruitment and thus access to the teaching profession was no longer possible for those who weren’t formally qualified for it. Stoer (1986) describes other manifestations of this normalisation process:

The suitable places were teaching was allowed to take place were also determined and, as a result, many popular initiatives in various educational areas and new environments (particularly in the area of nursery education and in some cooperative education experiences) soon came to an end during the “normalisation” period. The new curricula were limited through the suppression of some subjects (sociology, introduction to politics) and of certain activities (those of the primary teachers’ education schools that aimed at putting students “in touch” with the children, particularly those of the local peasant populations); pedagogy was controlled through the selection of teachers (this was particularly effective in the area of teacher education, except for the inland schools where there were no teachers other than those of the revolutionary period). In many cases, assessment procedures were redefined, most often by retreating to traditional practices (p. 65-66)

In 1977, qualifications for admittance to teacher education courses were increased; they now require a secondary school diploma or equivalent qualifications. Lopes et al. (2007) comment on this evolution:

These changes indicate an intent to increase the value of primary teacher training, and this can be observed through an analysis of course contents, which were deepened and also integrated subject areas that had been excluded from the curricula up to that moment. We mean, namely, Human Development Psychology, Sociology, Linguistics, Infant Literature, Dialectical Theory of History (replaced by Introduction to Politics […]), Psycho-pedagogy, Arts Education, Movement and Drama, as well as a variety of optional and School Intervention subjects. (p. 36-37)

In the eighties, the regulating official discourse gradually put aside the constant references to the importance of education for the consolidation and development of a democratic society and began to include more explicit concerns for efficacy, quality and students’ preparation for “real life”. The “modernisation” discourse was added to the democratisation discourse that had been developed until then by government officials. This change affected the structure of school knowledge, the definition of those who were endowed with legitimacy to intervene and rule in education, and also the mechanisms that were regarded as suitable to plan and manage education (Correia, 1999). In this new framework, school knowledge came to be progressively regarded as an “economic asset” and school attendance became more and more articulated with aims related to vocational education, which led Stoer, Stoleroff and Correia (1990) to speak of a new “vocation-oriented” trend in Portuguese educational policies. In spite of this, although at the level of discourse some governments and lobbies started to use terms such as “freedom of choice” and “market” as synonyms of educational quality, privatisation and introduction of principles of free choice by consumers did not become a reality in the majority of educational areas, particularly in primary education, where these
changes were never experienced. One might even say that, while apparently the State became more flexible and promoted school and teacher autonomy, in fact, it gradually reinforced its power (Nóvoa, 1992).

The school curriculum and teacher education also became less based on a contextualized approach to professional and educational knowledge, and progressively became more detached from local contexts. However, generally speaking, and opposite to what occurred in other areas of educational policy, teacher education managed, at least to some extent, to free itself both from marketisation strategies and from the State’s suffocating control. As Stoer and Cortesão (1995) put it, teacher education approaches developed and adopted in the 70’s, which relied on project work and action-research methodologies, managed to survive the ongoing restructuring process, which suggests a degree of autonomy of the teacher education institutions from the central State.

8.2.1.4 4th period: Restructuring (from 1986 to the present day)

During this period, despite having undergone a restructuring process, the State never cast completely aside its welfare-state features, nor did it reduce its presence in the economic and social life of the country. Therefore, it is more accurate to talk of a heterogeneous state (Santos, 1993), resulting from the superimposition of diverse and opposite social regulation methods, whereby political initiatives strongly relying on the role of the state as social regulator co-existed with anti-state discourses and measures directed at enhancing private enterprise, the privatisation of the economy and the reinforcement of so-called “civil society”. From then on, one witnessed the launching of social and economic neo-liberal policies, especially during the second government of Cavaco Silva, a time when the second revision of the Constitution (1989) took place, which provided the legal framework for a policy of privatisations and “paved the way for the liberalisation of the economy and for the consolidation of other forms of market regulation” (Afonso, 1997, p. 134).

In education, a crucial milestone that inaugurated this period was the passing of the Educational System Act (Lei de Bases do Sistema Educativo – LBSE) in 1986. This law mirrored the contradictory and heterogeneous nature of the State. On the one hand, it introduced elements of deregulation and liberalisation; on the other hand, it also took new responsibilities that were typical of a welfare state, such as free compulsory education, the establishment of educational aid measures for students, social and health support measures as well as psychological, educational and professional orientation support measures (Afonso, 1997, p. 144).

Among many other relevant changes, the Educational System Act established a new definition of teachers’ social and professional mandate and introduced new organisation principles for the educational system and its schools, with important consequences for teachers’ career, their work contexts and their relationship with professional knowledge. The Act established the following organisational purposes for the organisation of the educational system, among others: to decentralise and diversify the educational structures and activities and to develop democratic discourses and practices through the adoption of participatory structures and processes.

Changes in the organisational context

From the beginning of the ninety-nineties, the official educational discourse began to incorporate an organisational perspective of education that made teachers and schools more accountable for students’ results (Correia, 1999). This semantic evolution was combined with tangible measures aimed at the decentralisation of the educational system and at promoting
the school autonomy, which was legislated with the passing of the School Autonomy Law, Legal Decree nº 43/89, in the end of the eighties.

However, these initiatives did not result in the introduction of pure market-like regulation in education, as the legislation on this issue had to reconcile a diverse and contradictory set of social interests, many of which did not favour deregulation nor the adoption of a market approach to educational issues. This resistance was particularly incorporated by teachers’ associations and unions, which, at the time, were powerful entities in the Portuguese educational area and exerted a strong influence in the definition of educational policies (Barroso, 1999).

Following the Educational System Act of 1986 and the School Autonomy Law, passed in 1989, Legal Decree nº 172/91, passed in May 10th, 1991, brought about deep changes in the formal structure of primary and secondary schools in Portugal. With respect to primary education, this decree replaced some of the legislation that was passed in 1975. This education level was (and still is) characterised by wide geographical dispersion and by very small schools. In an organisational diagnosis on this situation, supported on data from 1992, Formosinho (1998, p. 25) put forward a few meaningful figures, among which we highlight a rise in the percentage of schools with less than 10 students, which was 15.3% in 1991-1992; a growth in the percentage of schools with only one teacher (33% during the same period); an increase in the percentage of schools that had only one or two teachers (55.5%, in the same school year) and a decrease in the percentage of schools with more than four teachers (only 22.2%). These data suggested a clear gap between a school network the historically suited to a rural world and the evolution of an increasingly more urbanised Portuguese society suffering from demographic regression, particularly in the inner areas of the country (Formosinho, 1998, p. 25).

The passing of Legal Decree nº 172/91, in May 10th, 1991, aimed at radically changing the organisation of all educational institutions, except in higher education. This legislation established that the central body of school management would be a single person: an executive director. Another major change was the establishment of a school council and the fact that this new body was given not only management functions but also directive ones. Another equally meaningful innovation was the attribution to the school board of sole responsibility for electing or dismissing the executive director. Overall, the major change introduced was the separation between direction bodies (the school – or school area – board) and management bodies (two single-person ones: the executive director and, in school groups, the group coordinator and a collegial body, the administrative board). According to this legislation, the school board (or school group board) would be “a collegial body based on the participation of the various school stakeholders (teachers, students, general staff and parents) and of community representatives (city council and representatives of the local social, economic and cultural interests” (Teixeira, 1995, p. 51). The school board would play roles in five distinctive areas (Teixeira, 1995, p. 51): (1) choice of the management body; (2) establishment of principles and criteria for school management; (3) management control, through analysis and approval of reports; (4) conflict management; and (5) disciplinary action against students (namely, suspension punishments).

Teixeira (1995, pp. 56 and foll.) underlines the fact that the new school board structure that was foreseen fulfilled a new organisational strategy, aimed at the implementation of the democratic participation principle in school management, according to the orientations of the Educational System Act, which presented, as general principles for school administration, “the partaking of all interested parties in the administration of education” and the “institutionalised interaction between school and local community”. Besides, as the author
pertinently mentions, the prologue of Legal Decree nº 172/91 mentioned that the new model aimed at fulfilling the principles of a representative, democratic and community-integrated school. In Formosinho’s words (1999), it was all about transforming the school from a “local state service” into an “educational community”.

In this decree, Barroso (1991, pp. 76-77) identified two major “rupture areas” between the proposed model and the previous one: (1) “the attempt to institutionalise parents’, city representatives’, local cultural and economic parties’ participation in schools’ internal decision-making”, and (2) “the attempt to promote professional-like management”. The truth is that, in the first case, “participation was more symbolic than real and [was] conceived, in a merely formal and minimalist way, as a public relations imperative rather than as an effective process of transferring power to the community” (Barroso, 1991, p. 76); as to the second area, this was “one of the most meaningful elements to fulfil the paradigm of the proposed management model” (p. 77), which was based on the need to replace collegial management in order to obtain greater “effectiveness”, “stability” and responsibility. According to Barroso (1991, p. 78), such evolution would bring school management nearer to a rational organisational model, close to the mechanistic bureaucracy characteristic of the period prior to 1976.

However, this new management model, which was on trial in numerous schools, was never generalised to the whole educational system and new legislation passed in this domain, in 1998 (Legal Decree nº 115/A98, which is still in effect today), did not contemplate some of its most controversial aspects, namely, the replacement of “collegial management” by an “individual manager” and the banishment of the election system to choose the head of school. Nevertheless, the 1998 legislation brought about important innovations, such as the existence of a school board (now called School Assembly), which is the main political decision body of the school and includes an extensive, though not in majority, participation of other elements besides the teaching staff (parents, general staff, students, community representatives, etc.). Therefore, it was only by the end of the nineties that a new model of school organisation, administration and direction was generalised to the whole country. Also, it was only then (and especially after the middle of 2000) that a profound reorganisation of the primary schools network was set into motion, resulting in the integration of many primary schools into wider educational organisations (school groups, Basic Integrated Schools), in accordance with the 1998 legislation.

The new school administration and management model that was passed in 1998 – Legal Decree nº 115/98 – established that the autonomous management of schools is ensured through four main bodies: the School Assembly, the Executive Board (or the Executive Director), the Pedagogical Board and the Administrative Board. The School Assembly is the body in charge of defining the global orientation of the school. It is this body that ensures the participation of the school community by joining together the representatives of teachers, parents, students (in secondary education), general staff, local authorities and other community members. The number of teachers cannot outnumber 50% of the total of members, a percentage that is higher than the one currently adopted in most of the other countries of the European Union. On the other hand, parents must represent at least 10% of the total number of members. A teacher elected among the representatives of the teachers chairs the Assembly. This body ratifies, for example, the main school policy documents, namely, the School Educational Project and the Internal Regulation, and it establishes a framework for the management of the school budget.

Another important innovation brought about by this legislation was the introduction of the “autonomy contract”. According to article 47, a school’s autonomy is developed on the basis
of its initiative, through several stages, and is fulfilled through the granting by central administration of growing levels of competence and responsibility according to the institution’s proven capacity to take over these prerogatives. The transfer of power to the school is negotiated with the Ministry of Education and may also involve city authorities, leading to the establishment of an “autonomy contract”. Article 47 of this legislation allows for the attribution to the school of additional powers in areas such as: flexible management of the curriculum, independent management of a certain amount of hours (to be used, for example, in the teachers’ teaching hours, in the exercise of administrative roles or in the development of innovative projects), adoption of specific institutional rules regarding the organisation of timetables and classes, intervention in the selection of staff (but not teaching staff), management of the school budget (through a global attribution of resources, specifying the items and their correspondent amounts), the possibility of raising funds and managing its own resources, association with other schools and the establishment of partnerships with organisations and local services, among others.

Both the 1991 and the 1998 legislation reveal an explicit willingness of the state to install a social regulation of education within schools by imposing the participation of parents and community representatives in the bodies that rule these institutions. However, this rhetoric is not translated into real practice (Afonso, 1995, 2003), both because there is no tradition of social control of schools in the country and because pressure from teachers unions managed to reduce that participation to a minor and merely symbolic representation in the decision-making bodies of the school.

Besides, many years have gone by without any autonomy contract being negotiated and to this day only a few schools have established such contracts, and these have done so in areas where their powers are not substantially increased. While formally giving educational institutions more opportunities for self-regulation, the State creates constraints that limit the autonomic potentiality of its own legal measures. Quoting Lima (1999), the concept of autonomy is revealed as a “celebration of diversity in the peripheral execution of central decisions” (p. 59).

As a consequence of the 1998 legislation to which we have been referring, the organisational conditions in which many primary school teachers work have changed considerably. Since then, a compulsory policy of school grouping has been implemented with vertical and horizontal variants. With respect to vertical groupings, numerous organisations have been integrated into Basic Integrated Schools that enrol students from the 1st to the 9th grade. Under this new organisational format, integrated primary schools were designated as “nucleus” and started to function as components of wider organisations and no longer as single entities. They no longer have their own director, but rather a “nucleus coordinator”, who is directly accountable to the Executive Board (or the Executive Director) of the Basic Integrated School.

Changes in rules, regulations and professional roles

The Educational System Act established of a new mandate for teachers. This Act defined that the teacher should have a critical, self-directed attitude; he or she should become a researcher and an innovative professional, develop reflective practice and educate him- or herself on an ongoing basis. He or she should also develop professional practice not only within the walls of the classroom but also in the whole institution and in relationships with the school’s surrounding community.

The Educational System Act also accepted the existence of specialised functions in the educational system and in schools and established that in order to perform these functions, teachers should obtain specific qualifications in specialised education courses in areas such as
special education, school administration, socio-cultural administration, educational orientation, curriculum organisation and development, pedagogical supervision, teacher management and orientation, educational communication and information management.

Until 1990, the Primary Education Statute, established by Legal Decree nº 6137, in September 29th, 1919, was the main legal framework that regulated primary teachers’ professional lives. After 1990, the Statute of Nursery School, Elementary and Secondary Teachers’ Career prescribed the content of their professional contract (Legal Decree nº 139/A from April 28th). In this statute, besides the traditional teaching functions, the State highlighted the importance of the teacher’s role in managing students’ learning; in ensuring their “integral education and fulfilment, their cultural development and their integration in the community, an in ensuring the development of partnerships with other educational partners.” In short, quoting Teixeira (1995), “according to the State’s perspective, the teacher is (…) much more than someone who teaches; he or she is also more than one who merely relates to students. He or she is committed an important role in the ecology of the relationships with the community where the school is integrated.” (p. 91). It was even established that the evaluation of teachers’ performance should contemplate their community services. With respect to “other functions”, the statute established that teachers should take care of equipments and facilities, and that they should study, research and run services. The second aspect is particularly relevant, since it was the first time in Portugal that this was legally recognised as a function of teachers in these educational levels. However, research practices were not proposed as a duty, but rather as a possibility (Teixeira, 1995, p. 93).

The passing of the 1990 Teacher Career Statute represented a profound change in the legal framework of primary school teachers’ work as it established a single career, thus putting an end to the former distinctions in salary and career progression requisites among teachers of the various educational levels, which used to be strongly hierarchic with disadvantages for primary school teachers in terms of income (Alves-Pinto, 2006). In 1997, a change in the Educational System Act and in articles 56 and 57 of the Career Statute established that the new academic degrees obtained by teachers would allow them to move up the career ladder. As Alves-Pinto notes, “differentiation according to academic degree, not to teaching level, meant a total rupture with the symbolic distinction scale that had always existed between secondary and primary school teachers” (p.13).

As Alves-Pinto (2006) also puts it, teachers’ career became a single career for everyone, not only because all teachers were treated alike regardless of their teaching level, but also because it integrated a multitude of functions beyond mere teaching (p.13). With respect to this, the author comments:

Through the new academic degrees obtained, even if these would qualify them to fulfil new functions, practising teachers would not move into new careers. The diversity of functions in the single career matches a plural identity in which each teacher is freer to draw his or her own path and professional identity (Alves-Pinto, 2006, p. 14)

On the other hand, until the beginning of the 90’s, when legislation such as Teachers’ Career Statute and the Educational System Act which inspired it were passed, there hadn’t been any sort of teacher evaluation that might affect their professional path, even though the Educational System Act had established, in article 36, nº 2, that “career progression should be connected to the assessment of all of the activities developed, individually and in group, in the educational institution at the educational, teaching and community service level”. This was a global concept of teacher evaluation, which was not limited to classroom performance. During the negotiation of the Statute, teachers’ unions rejected the possibility that teacher evaluation might be based merely on bureaucratic observation procedures (such as
absenteeism or the filling in of forms or registrations), or on student outcomes, opting instead for an “intrinsic evaluation – related to the content of the educational task itself (pedagogical relationships, scientific rigour…)” – which was the one that became established in the Statute and was translated into the mere presentation of a individually produced written report of the activities developed by the teacher.

Despite the introduction of a teacher evaluation system in their Career Statute, in practice, there has never been any differentiation among them on the basis of an evaluation of the quality of their work. Until the end of 2006, the vast majority of teachers (almost 100%) were rated as “satisfactory”. Besides, the established system did not evaluate performance, but rather the content of the reports written by the teachers themselves. On the other hand, although this legislation established that teachers’ evaluation should be used to improve the quality of education and teaching and to identify the teachers’ professional development needs, in practice, there has never been any discussion of the reports nor of the evaluation results with the interested parties and neither has any sort of feedback been established. Beyond that, the relationship established in the law between career progression and the compulsory acquisition of a minimal number of credits through in-service training courses led to a “chase for credits”, in which the educational and professional development aims predicted for teacher evaluation gave way to an “autistic, minimalist and bureaucratic” perspective on that evaluation (Simões, 2000, p. 169).

In the beginning of 2007, the government passed new legislation (Legal Decree nº 15/2007, in January 19) that introduced profound changes in Teachers’ Career Statute. Unlike the 1990 legislation, the 2007 Career Statute stood out meaningfully for not having resulted from an agreement between the Ministry of Education and teachers’ unions; on the contrary, it was imposed on all of them despite their criticism and fierce resistance. The changes introduced by this legislation were vast and profound and a detailed description of all of them is beyond the goals of the present report, as this would take too much space. It is useful, however, to highlight some structural changes that have direct implications for the relationship between teachers and the State, in the context of restructuring as conceived in this report.

In the first place, the new Statute changed the required qualifications for entry into the profession, by adding to the existing ones a national examination of teachers’ knowledge and skills. Secondly, an internal hierarchy was introduced in the career: from a single career, it changed into a two-level career – teacher and main teacher (“professor titular”) – in which the former “plays all the roles of a teacher plus coordination and supervision of other teachers, school leadership and the leading of teacher in-service training centres” (Basilio & Nogal, 2007, p. 23). Access to the main teacher category is made through public open competition and discussion with a jury, in which the applicant’s curriculum and work is discussed and assessed. Thirdly, teacher evaluation now includes new dimensions, such as their performance, observed and evaluated by senior peers in the career hierarchy (the department or teacher board coordinator and the school executive direction) and monetary performance prizes are established. Lastly, this sort of evaluation takes places every two years and not only in the transition between career levels, as occurred previously.

These changes aim explicitly at introducing a wider internal distinction in the teaching profession, a more efficient performance evaluation, competition among teaching professionals for the better-paid career levels and the rewarding of merit, identified and measured through performance evaluation and through the good outcomes obtained by teachers. These policies are obviously inspired by central postulates that are characteristic of New Public Management ideology. It is, however, too soon to realise if these measures will
reach the aims of the legislator or whether, as with so many others before them, they will be absorbed and accommodated by teachers’ prevailing professional culture (Lima, 2006).

**Changes in teacher education models**

As a consequence of the Educational System Act, *initial teacher education* was integrated into polytechnic higher education institutions, with respect to nursery and primary school education, and into university education departments, with respect to the third cycle of compulsory education and secondary education. For primary school teachers, this structural change meant a clear rise in status, as their previous initial training was done in institutions that enjoyed less social prestige, such as the Primary Teacher Education Schools (Magistério Primário), which, since the 1970’s, granted post-secondary level qualifications (yet, not higher-education ones) (Campos, 2002, p. 22).

Access to initial teacher education was open to any student graduating from any secondary course, as there was no specific policy regarding this issue.

The transfer of all initial teacher education, including, more recently, specialised education, to higher education institutions was in tune with an international trend towards bringing teacher education under the responsibility of universities (Campos, 2002, p. 22). The Teacher Education Colleges (Escolas Superiores de Educação), which replaced the former “Escolas Normais”, were integrated into polytechnic higher education and were allowed to qualify students for teaching at the nursery and primary school levels. According to Campos (2002, p. 23), in 2001, initial primary teacher education courses were provided by 6 public universities, 13 public teacher education colleges and 11 private universities and teacher education colleges (including the then called “concordatórias” schools). As Alves-Pinto (2006) underlines, the change from the “Magistério” schools to higher education institutions was not only a transfer regarding the institutional level at which the diploma for entry into the profession is obtained: a concomitant change, which hit the “identity core” of primary school teachers, was the fact that, whereas the courses from the “Magistério Primário” schools focused on the first four years of schooling in a single-teacher system, the courses provided by the ESES and CIFOPs (the new higher education teacher training schools) included an education that focused both on these four years and also on the teaching of a specific subject in the 5th and 6th grades of compulsory education.

In 1997, an amendment to the Educational System Act established that nursery school, primary and secondary school teachers could only obtain their professional qualification provided they attended a higher education licentiate’s degree course (which lasted for 4 years with respect to nursery and primary school teachers, and 5 or 6 with respect to the others). This legislation completed the process of unification of teachers’ qualification levels (Campos, 2002, p. 24).

Campos (2002) mentions several advantages of the trend to bring teacher education under the responsibility of higher education institutions: the unification of education levels, with consequences for the end of the previous gaps in social and economic status within the teaching profession; the bringing of teacher education closer to the training of the more prestigious professions; a better scientific background in content knowledge and in educational and didactic, theoretical and practical education; and a “closer relationship between education for teaching and research on the teaching and learning contexts and processes” developed in the universities. The author reflects on the consequences of this trend for the emergence of a new teaching profession:

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28 Named after a political agreement signed between the totalitarian regime and the Catholic Church that became known as the “Concordata”. 
As the movement towards university-level teacher education progressed, there emerged a social awareness of the fact that the teacher professionalism that was needed was not the same as the one previously provided by primary teacher education schools and by the public administration of education. Thus, this movement cannot be restricted to providing the same sort of professional qualification in a different institution; rather, it is expected to ensure a different qualification, according to the new performance demands of the teaching profession. (p. 67)

However, higher education institutions have experienced some difficulties in building a new model for teacher professional education. Regarding primary school teachers’ education, many of these institutions tend to bring the curricular structures from the teaching area (content knowledge) closer to the previously existing ones in the education of teachers for other levels of schooling, thus opting for a technical model of teacher education, which highlights mainly “practical training in basic teaching skills, following the craft model and neglecting educational theory and content knowledge” (Campos, 2002, p. 74). Very often this technical model is joined to a traditional (subject-supported) academic model, through addition rather than mutual integration or creative fusion into a third model.

This critical balance complements the analysis of Formosinho (2001), who considers that “the movement towards university-level teacher education (regarded as a movement towards academic emphasis in education) does not lead to a pedagogy for autonomy and cooperation” (p. 37) and that, in many universities, the growing replacement of pedagogy by educational sciences has confined education to the intellectual component of teacher practice” (p. 38). Thus, according to this author, this process “tends to change initial teacher education into a theoretical process divorced from practitioners’ concerns” (p. 44).

From the mid-eighties onwards, the Portuguese central administration has also produced a lot of legislation aimed at institutionalising in-service teacher education (Estrela et al., 2005). The first significant moment in this domain was the approval of the Educational System Act, which, in article 35 (chapter IV), recognised the teachers’ right to in-service education that may guarantee the development and updating of their professional competences and contribute to their career progression.

In 1989, a Legal Framework for Teacher Education (Legal Decree nº 344/89, published in October 11th – Ordenamento Jurídico da Formação de Professores –was passed. In this law, professional training was regarded as a duty and not only as a right and, besides highlighting the importance of in-service education, the law also highlighted other forms of professional development such as those resulting from research, involvement in innovation processes, self-learning and involvement with the community. The right to offer in-service education was granted to a wide number of entities: initial teacher education institutions, central, regional or local administration bodies, teachers, scientific and professional organisations, teaching institutions connected through resource centres and other organisations. In 1990, the Teacher Career Statute highlighted in article 15 teachers’ right to in-service education and its role in career progression.

Until 1992, opportunities for teachers’ in-service education were scarce and, even though teachers’ associations and their unions were already providing it, the major entity responsible for teacher education was the central education administration, particularly when it introduced new methodologies or programs into the educational system, related to the reforms that it mandated. Higher education institutions were almost absent from this process. In 1992, a Teachers’ In-service Education Law (Legal Decree nº 249/92, published in November 9) was passed which ruled that Teacher Training Centres were allowed to take responsibility for this task. Numerous Teacher Training Centres organised by School and Teacher Associations emerged and took advantage of public support for in-service education through governmental funding programs such as FOCO and FORGEST. In 1996, legislation on these centres freed
them a little from the obligation to work as tools for the fulfilment of national teacher education priorities and granted them enough autonomy to provide more school-centred teacher education and to meet the needs of the community where the school is located (Estrela et al., 2005, pp. 111, 112). Another important qualitative change in this legislation was that it established that the Centres’ aim should be the meeting of the educational needs expressed by teachers and schools, which reveals the introduction of an institutional and not merely an individual logic in the conception of in-service training courses.

According to data provided by the Scientific and Pedagogical In-service Teacher Education Board, presented by Campos (2002, p. 24), in December 1999, in Portugal, there were 263 authorised In-service Teacher Training Centres, 85 of which were linked to higher education institutions, 201 to school associations, 57 to teacher associations and 20 to other entities. Data presented by the same author indicate that by then 8 026 out of the 11 475 courses with a valid permit were provided by School Association Centres, 1 453 by Teacher Association Centres, 1 274 by higher education centres and 722 by other entities (Campos, 2002, p. 29).

The teacher education system established in Portugal since the beginning of the 1990s results not only from the 1992 legal framework, but also from the “need to fulfil the resolutions of the teaching career statute regarding career progression, which depended on obtaining in-service education credits: it was necessary to (…) create a credit-granting device” (Campos, 2002, p. 81). Besides, European funds were made available for this domain” (idem, ibidem).

Taken together, all these factors joined originated a somewhat perverse development of the in-service education system:

On the one hand, the system is predominantly moved by the educational supply available and not by needs or demand and, on the other hand, demand is both highly conditioned by offer and not always related to the performance needs or problems that promote learners’ success. Furthermore, such needs and problems are not only the individuals’ responsibility but also the school organisation’s. There’s nothing in the in-service education system that structurally (and not only voluntarily) drives it to contribute to the improvement of students’ learning. Nevertheless, the system seems structurally suitable for spending European funds and for credit granting. (Campos, 2002, 81-82)

The evidence thus suggests that the in-service education system was not structured to promote the real transformation of the prevailing culture in the teaching profession.

8.2.2 The Nursing Profession

8.2.2.1 1st period: Development of autonomy and reinforcement of nursing education (1960-1973)

In the Portuguese society, besides the previously mentioned experience of living under a dictatorship, the 60’s were characterized by the existence of a colonial war, which led to the presence of Portuguese troops in various African countries. This background promoted nursing visibility in two ways: by highlighting nurses’ roles in providing medical care for the wounded (there was a corps of parachutist nurses) and by the emerging role of these professionals in the treatment and rehabilitation of these wounded persons.

However, the profession was still predominantly feminine, it enjoyed low social status and income, and its professionals originated from the lower social ranks (Nunes, 2003). These conditions made it difficult to recruit new professionals.

In this period, beyond the lack of professionals, three other crucial aspects must be highlighted: i) the reform of Nursing Education; ii) the restructuring of nursing careers
(1967), and iii) the struggle of nursing auxiliaries to be promoted to the category of nurses through education.

The sixties were characterised by a shift in nursing education, which was transferred from hospital instruction to the school system. At the same time, there was a redefinition of the role of chief nurse (enfermeiro-chefe), who used to supervise students in the wards and who, from then on, focused his or her practice on the operational management of health services (Nunes, 2003).

Due to its characteristics, the reform of nursing education in 1965 is one of the milestones worth mentioning:

- the Nursing General Course kept its length of three years and required a 9th grade diploma required qualification for access to it;
- education and nursing schools’ management bodies came under the control of nurses;
- the curriculum emphasis moved towards a nursing perspective rather than a medical-centred one that focused on pathological processes.

In parallel, the existing nursing auxiliaries’ courses were taught at the same nursing schools, lasted 18 months and only required a 6th grade entry qualification.

In 1963, nurses were granted permission to get married, which they had previously been forbidden to do.

The reform of the Health and Care Services, published in 1963, but regulated only in 1971, established that health care was not restricted to the hospital and healing area. Although they were still attached to medical action, nurses now found a new field of professional action in the domain of health centres where they managed to play leading roles in the areas of health, disease prevention and teaching (Rebelo, 2002; Nunes, 2003).

By the end of the 60’s (1967), the Nursing Careers Law was passed. Through this new legislation, nurses were divided into three careers, according to their area of practice: i) public health, ii) hospitals, and iii) education. To reach the upper career levels (auxiliary chief nurse, chief nurse, general nurse and superintendent), besides the Nursing General Course, access qualifications required an 11th grade diploma.

8.2.2.2 2nd period: Standardization (a single level for health care) and centralisation (a single career within the National Health System) (1974-1987)

From 1974 onwards, ideologically, there was a left wing turn in Portugal, censorship was abolished and an unstable and uncertain period began. The role of the state in public life was reinforced and the big companies were nationalised. Social balance was unstable and there was a rise in unemployment rates. During the revolutionary crisis, under the rising influence of the unions, there was a process of reinforcement of nursing professionals, who claimed and got better salaries and social recognition. During that revolutionary period, one of the decisions that marked Portuguese nursing was the extinction of courses for nursing auxiliaries. In 1934, the Course for Nursing Auxiliaries was extinguished and promotion courses were organised to allow this staff to qualify as nurses.

The country witnessed a rise in the number of students who proceeded with their education. Universities couldn’t accept all applicants. As a result, many looked for nursing courses.

The 1976 reform of nursing education reinforced the control of nursing education by nurses as teacher nurses now taught the course. In curricular terms, there was a reinforcement of social and human sciences in nursing teaching. It was by then that contents such as health promotion and nursing theories were introduced. Research concepts were also approached, albeit very
briefly. This would be a crucial curricular change in the two following decades. From 1976 onwards, nursing education, which was not yet a part of the Portuguese higher education, required an 11th grade diploma as qualification for entry.

In 1981, Post-Elementary Nursing Schools (Escolas Pós-Básicas de Enfermagem) were created and the current nursing specialities were legally established: mother health and obstetrics nursing, rehabilitation nursing, parish nursing, medical-surgical nursing, neonatal and paediatric nursing, mental health and psychiatric nursing.

In 1976, the passing of the Constitution of the Portuguese Republic established the right to health through universal, general and free care, which would constitute the core of political decisions in the area of health in the following years.

The Single Nursing Career Law of 1981 (Legal Decree nº 135/81) aggregated the three existing careers into a single one, regardless of location of practice. It predicted five levels: level I - nurse practitioner; level II – staff nurse; level III – nurse specialist and chief nurse; level IV – nurse educator; level V – nurse technician (consultancy). It was established that progression through the various levels would require an open public competition and that in order to become a nurse specialist one would have to qualify through specific education obtained at a Nursing School. This legislation defined for the first time the functional contents of the various career levels (although in general terms) and established that nurses could only be evaluated by their peers.

The NHS (National Health Service), created in 1979 and financed through the General State Budget, integrated various health care structures (hospitals and health care centres, among others) and absorbed the majority of nurses, who became civil servants. Both in primary health care units and in hospitals, a functional hierarchy of nursing was established ranging from the practice level in services to the strategic level of institutional management.

8.2.2.3 3rd period: Integration of nursing education into higher education and consolidation of its position (1988-1995)

This period of economic growth and of political stability was globally characterised by the country’s entry into the EEC (European Economic Community), in 1986.

For the nursing profession, the major change had to do with the integration and consolidation of its instruction into the Portuguese higher education system (at the polytechnic level), in 1998. This measure made it possible to expand nurses’ chances of academic education, together with other professions from the multi-professional area of health.

In 1988, initial nursing education was integrated into the national educational system (Legal Decree nº 480/88). Through this measure, responsibility over the training of nurses shifted from the Ministry of Health to the Ministry of Education. After this change, the 12th grade became the minimum educational requirement for entry into nursing education, there was recognition of the academic qualification of nurses in the educational system, nurses were given access to the different education levels and research in nursing was promoted (Rebelo, 2002). Instruction for specialities became a second instruction level (Higher Specialised Studies Course), which granted a licentiate’s degree. This integration into higher education brought about a major decentralisation in nursing instruction. Through integration into higher education, the schools acquired scientific and pedagogic autonomy. This feature has characterised Nursing Education until the present day. Although there is a minimum regulatory set of teaching hours and syllabus contents that need to be in place, each educational institution takes responsibility for its organisation. Thus, from then onwards, there
has been the emergence of diverse models of education, curricular organisation, and articulation with clinical practice locations, all depending on the options each school makes.

In 1991, the first master’s degree courses in nursing sciences began. These courses were and still are an academic qualification that contributed strongly to research in nursing. There is not, however, any direct relationship between this qualification and nurses’ career progression.

In the 1989 revision of the Constitution of the Portuguese Republic, room was made for a new perspective on health care financing and the National Health Service came to be regarded as “preferably free of charge”, “according to the economic background of the citizens”.

In 1990, the Health Act (Law nº 48/90) introduced the idea that health is a shared responsibility of the State, individuals and society. This law supported the development of the private and social health sector and proposed a growing participation of individuals and the community in the “definition of the health policy and in the control of service functioning” (Fronteira et al., 2006).

The nursing career was reformulated in 1991 (Legal Decree nº 237/91). Through the passing of this law, the functional content of each of the career levels was defined in more detail (nurse practitioner, staff nurse, nurse specialist, chief nurse and nurse educator). Three areas were defined for nurses’ practice: care, management and consultancy). Open public competition for career entry and progression was maintained, as well as the rule that competition juries must be comprised by nurses.

In 1993, the Statute of the National Health Service was published (Legal Decree nº 11/93). This Statute aimed at a more structured and closer management of the health service by its users. As Fronteira et al (2006) mention, Regional Health administrations were thus created [five altogether, established according to geographical areas of influence] with the purpose of decentralising responsibility for the health of the population, coordinating health care at all regional levels and matching, at this same level, the resources available to the existing needs” (p. 10). However, the management of human resources and hospital financing remained centralised under the Ministry of Health.

8.2.2.4 4th period: From regulation reinforcement and the emergence of self-regulation to an (un)certain changing system (from 1996 to the present day)

For the nursing profession, the latest period is characterised by the passing of the Regulation for the Professional Practice of Nursing (DL nº 161/96); by the beginning of self-regulation processes (establishment of the Nurses’ Association in 1998) and by a new change in the minimum educational requirement for professional nursing practice (a licentiate’s degree). These changes occurred in a period of national recession, budget cuts and decreasing economic growth, which, with ups and downs, brought into the area of health (as to other state-controlled areas) more sustained ways of reducing intervention and promoting decentralisation, connected to a growing orientation towards new business-like and contract-supported management models.

In turn, as recruitment of human resources for public institutions breaks with the previous open competition logic in favour of a logic of individual-work contracts, the issues of education and of the qualification level required for professional nursing practice are brought to the fore, due to the restructuring model proposed by the Bologna Process.

Changes in organisational context
In 2002, the new Hospital Management Law (Lei nº 27/2002) was passed, which made possible the existence of individual work contracts as well as collective ones, thus enlarging the labour regime that ruled nursing professionals in the NHS. Consequently, a major number of hospitals (about half of all hospitals in the country) changed its legal status, shifting into a business-like statute, similar to a publicly-funded anonymous societies (Sociedade Anónima de capitais públicos). By the end of 2005, these hospitals lost their anonymous society status and became public business-like entities (HEPE - Hospitais Entidades Públicas Empresariais) (Legal Decree nº 93/2005). This regression regarding the state’s initial intentions is justified in the legislation with the argument that there’s a need for “more intervention at the level of the Ministry’s strategic intervention and supervision exercised by the Health and Finance Ministries for the suitable functioning of the whole of the institutions of the National Health Service both at the level of execution and at the level of the economic profitability of investment decisions” (prologue to Legal Decree nº 233/2005).

The new organisation of hospitals highlights the need for the presence in the Administration Board of at least one clinical director (a doctor) and a director-nurse, who are responsible for ensuring the technical coordination of their respective areas of intervention.

In parallel to this process of business-like management of public health units, the current government put into motion other reforms which had an impact on professionals and users of the National Health Service. On the one hand, there is a movement towards restructuring primary health care supported on the establishment of family health units, in which professional groups get together and organise themselves so as to provide health services according to contracts agreed-upon with the state. On the other hand, there is a restructuring of the network of emergency and urgent care services, which is defined at the central level. This leads to the shutdown of many small units, in favour of more skilled, better equipped and more differentiated medical care provision. This process has been controversial due to opposition from local populations and city councils that experience the shutdown of their local permanent health care centres or fear that these will soon be closed.

**Changes in rules, regulations and professional roles**

In 1996, the passing of the Regulation for Nurses’ Professional Exercise (REPE - Regulamento para o Exercício Profissional dos Enfermeiros – DL nº 161/96), set the stage for the State to introduce a legal tool for ruling nursing practice independently of its contexts: public, private or individual practice. This legislation “contributed to the regulation of the profession, clarifying concepts, interventions and roles, as well as basic rules of nurses’ rights and duties” (Nunes, 2003, p. 340). This way, access to the profession, nurses’ practice and intervention, their rights, duties and incompatible roles were regulated. In the whole of multi-professional performance in health teams, the State recognised that “there is a functional complementarity between nurses’ and other health professionals’ performance which is characterised by a similar level of professional dignity and autonomy” (article 8).

In 1998, the Nurses’ Order was established and the State recognised nursing professionals’ right to self-regulation (Legal Decree nº 104/98). This professional association became responsible for promoting regulation and disciplinary measures of nursing practice, as well as to ensure the fulfilment of the profession’s deontological principles. The association became responsible for registering nurses, defining educational requirements for nursing practice and exercising disciplinary action among professionals.

**Changes in education models**

The legislation aiming at reorganising the network of nursing education schools (Legal Decree nº 353/99) promoted the integration of Nursing Higher Education Schools into larger
educational organisations (Polytechnics and Universities). The same legislation extinguished the bachelor’s degree in nursing and replaced it with a four-year licentiate’s degree. In curricular terms, the major difference was the introduction of research in nursing at the elementary level of nursing education and the reinforcement of subject matter contents in the area of health service management and professional development, which had previously been restricted to specialisation courses.

Concomitantly, educational institutions provided Supplementary Education Courses for in-service nurses. There was a massive return of nurses to school in order to attend a supplementary education year that granted them a licentiate’s degree. However, attending this course did not lead to any advantages in terms of career progression or income. The curricular design was not organised to promote the development of clinical skills; rather, it was supported on conception and planning-related contents such as research in nursing, management of health services, nursing ethics, conceptual frameworks in nursing, and intervention projects in work contexts.

At the time of writing of this report, the issue of adapting Portuguese nursing education to fit the Bologna Process had not yet been dealt with. The Nurses’ Order, which is responsible for defining the minimum requirements for professional nursing practice, has already claimed that, as stated by all other professional associations: “the first level of higher education (a licentiate’s degree) does not fulfil the minimum requirements for professional nursing practice and thus the second level of qualifications is required for applicants to be regarded as fit to enter the profession” (Nurses’ Order, 2006). Thus, the association claims that a master’s degree is the requisite qualification for entry into the profession. There is not yet consensus on this issue among all interested parties (educational institutions and the Ministry). If such a standpoint is accepted, access to the profession will require a five-year long master’s course.

8.3 Professionals’ experiences of restructuring: individual and generational dimensions

One if the aims of the PROFKNOW Project was to reach beyond a mere documental and policy analysis of the restructuring phenomenon, by attempting to collect empirical data on the way this process has been experienced by actors in the field. Specifically, the study aimed to understand three main issues:

- How have professionals experienced the changes that have occurred in public policies and in their profession over the years?
- In what way has their relationship with work and professional knowledge changed?
- In what way do these changes relate to their wider life circumstances?

To answer these questions, the methodological design of the study chose a life history method, supplemented by the ethnographic observation of professionals’ work in their workplaces. Three professionals were interviewed in each profession: one at the beginning of the career, one at the middle and the third one at the end. Two long interviews were done to each interviewee. These were then supplemented with two additional focus group interviews (one for each profession, with five interviewees each) of a thematic nature, in which the main and the emergent themes of the life history interviews with the three key participants in each profession were explored in greater detail. An ethnographic observation of key participants’ workplaces was implemented during three workdays per participant. On the whole, in the two professions, 14 interviews were conducted involving 18 professionals and 18 days of ethnographic observation.
In the life stories narrated by the participants and in the focus group interviews, we collected testimonies that illustrate the structural changes that have affected their professional lives. In the following brief presentation of results, we focus on participants’ experiences and we highlight the ones that they regarded as having been important in their work. We also highlight the experiences that are identifiable in their stories, even if not expressed as such, and the ones that we have observed in their workplaces.

Through the research questions presented above, we also had the aim of understanding how the experiences might vary according to the different career stages in which the professionals were; that is, in what way primary school teachers and nurses constructed and interpreted the restructuring processes that affected their work on the basis of their own temporal experiences of socialisation. In order to reach this goal, an approximate “generational profile” was drawn for each professional and for each profession. Although this profile cannot be generalised, it may work as a useful framework which may allow us to understand some of the key factors that may have been present in that construction and interpretation. When performing an analysis in order to build a generational profile, we took into account, as crucial factors, the type of initial education that each professional had and the aims of that training, the work contexts where their professional action occurred and the users with which they professionals have worked. The profiles were built by integrating the contributions of the literature (WP1), the policy analyses (WP2) and the analysis of participants’ testimonies and work practices and contexts (WP4 e WP5).

Below, we present, for each profession, the main results that we have achieved in the empirical study, as well as a draft of the generational profiles, which may be used as an interpretative framework that helps understand those results.

8.3.1 Participants’ experiences

Regarding the experiences reported by the teachers and nurses interviewed and observed during the project, we may systematise the aspects that may be directly or indirectly related to the restructuring process in six main themes: impact of organisational changes; challenges to participants’ conceptions of their role and, consequently, their professional identity; changes in relations with users; experiences of work supervision and evaluation; balance between personal and professional life, and changes in participants’ relationship with professional knowledge. In these different themes, we found evidence of formal restructuring, but also of accommodation and reinterpretation by the players, who often adjusted their perceptions and behaviours to the new contexts and dynamics that they faced.

Impact of organisational changes

In primary schools, from the organisational point of view, the most significant period of impact of the restructuring process was the one that started in 1998, a key year in which a new organisational, management and administration model was implemented in all Portuguese schools. This model had important consequences for primary schools, which were experienced mainly by those professionals who were in the “front line”, i.e., those who held management roles in their schools and had to deal directly with the changes. The main transformations were related to the integration of primary schools into horizontal or vertical “school groups” of institutions, in which each school had a “coordinator” who replaced the former director. The teachers felt somewhat disoriented and experienced a strong feeling of anxiety towards what they regarded as a lack of information from their superiors regarding this new stage. They complained particularly of the lack of training to fulfil their new roles, especially for dealing with the paperwork required by the new organisational model into which they were being integrated.
However, although at first these feelings of uncertainty and anxiety were intense, in the end, transition into a Basic Integrated School was not acknowledged by many of them as a fundamental change in their work. In fact, according to the reports that were collected, transfer into the new organisational model seems to have been experienced mostly as a surface phenomenon, rather than as a deep transformation:

I think that it was a turning point that really changed… teachers’ relationship to power [higher-rank administrators], so to speak, didn’t it? The fears, the anguish… “what is it going to be like?” Because in the [previous organisational model], we were a close family, we knew one another, we used to deal with everything there, internally. When we changed to the Basic Integrated School, at first, there were… fears, but, then, they naturally faded away, as they usually do. (…) and then, later, we’ve come to realise that it was the same thing, after all. The name [of the organisational model] changed, but that was… when they [the teachers] started to realise that it was sort of more of the same (…) well, then people started to settle down. (Focus group interview; teacher with 18 years of service).

With respect to nurses, we may say that the changes that caused the major impact were the ones introduced from 2002 onwards, through the statutory changes introduced in the majority of hospitals (which adopted a business-like type of management in the public sector). These changes, which put an end to the process of hiring nurses as civil servants, introduced target-driven management, and the contractualisation of services between health institutions and the State. With respect to nurses, the impact of the changes has to do with contract models and labour stability, rather than with professional performance itself. Therefore, the younger nurses are the ones who feel a stronger impact and instability in the ways of accessing the labour market, while the older ones retain their status as civil servants. One of the newly graduated nurses mentioned the recruitment models of the new hospitals and the impact that they cause on the younger professionals. In her view, in two years the situation has changed and now there are health units that resort to different strategies for having nurses at their service without offering them a permanent contract.

It’s three months, they have a period of holidays, generally, they work for three months more, they reach the end of that half-year term and then they are fired, two days later they are hired again only and exclusively in order to get another contract, because after three contracts, we are entitle to be hired on a permanent contract by the institution. That way, they are fired and there’s no such obligation and that doesn’t provide stability to anyone. (Life story interview, nurse with one year of service)

Apart from the issues related to the new recruitment and hiring forms that have a direct impact on the younger nurses, just as with teachers, nurses who are working in direct care-giving do not seem to be very interested in strategic management and they don’t seem to identify deep changes that these new organisational formats may have introduced. They express a strong withdrawal in terms of interest in strategic management. Maybe it doesn’t make sense to say that nurses lack interest for strategic management and for a global knowledge of institutional functioning regarding the country’s structural political orientations. In fact, there are nurses in the administration boards of health institutions and they have responsibilities in institutional strategic management. It makes sense, however, to say that the nurses who are directly involved in care-giving revealed a small interest in management, political or professional regulation issues, provided that these did not interfere directly with their specific work area (WP5, Portuguese case report, p. 33).

there is more instability, because the Board changes, they change the… they change the directors, they change the nurse directors… some instability, but the work… is… it’s exactly the same. (…) I think that those things sometimes cause… sort of… a certain instability, but the day-by-day work is exactly the same. (…) In my… here… honestly, I didn’t… I didn’t… I’m
used to performing my duties, I didn’t notice any difference, you see? (Life story interview, nurse with 35 years of service)

Conceptions of professional role and identity

Through teachers’ reports in the study, it is possible to understand that, compared to the period when several of them went through their initial teacher training, their professional role now encompasses much more issues than they had expected and is thus much wider than the role they were trained to perform, which originates dilemmas, internal tensions and reflections on the nature of their professional identity:

The profile of the twenty-first century teacher has nothing to do with the one from the twentieth century and even less with the one from the other century, because, nowadays, sometimes I ask myself: “What have I done at school today? I get home and talk to my husband (…) and I tell him: Well! Today, what have I done at school? A report because the father says… the mother says whatever”. I don’t have… well, it’s not that I don’t have anything to do with this, I’m in the middle of a war and I’m not… I’m not a character in that story, am I? Well, I’m more like… sort of a spectator, but, in fact, they request reports, they request this, they request that and I lose… a lot of time with issues that are not exactly curriculum or teaching issues. That’s it, there are so many extra-school requests, I mean, of school in the sense of a place were we go to learn the skills, other things that… I get to the conclusion: Well, I was a teacher today, today I was a bit of a teacher, I was a bit of a mother, a bit of a psychologist, I was also a nurse, because they get hurt and whatever… social assistant, because I got to school earlier and there was already a kid waiting for me with his backpack on, crying because he didn’t want to have problems at home and, then, how am I supposed to go into the classroom and teach anything? I can’t, can I? (…) I think that the teacher, when one educates teachers, now, one should explain this to people very carefully: “Watch out! You are going to do a lot more than the things that are established in your syllabus”. Besides, none of these is predicted in the syllabus. (Focus group interview, teacher with eighteen years of service)

Attention to students’ social and emotional well-being students takes an increasingly more important place in the work experiences of the teachers and the discipline control occupies an important part of the time they spent with the students, as noticed during the ethnographic observation periods of the project. This goes against the dominant belief among them that their main role is to teach the syllabus and that being a real teacher means having “their” own students, “their class”. This latter conception was quite obvious, during the observations, in the situations where the teachers had not been given a class, which made them feel as “lesser professionals”.

Likewise, nurses, particularly those who graduated twenty or thirty years ago, admit that they have witnessed a change in what they regard as their role and the way they feel prepared to act professionally. The major change they insist on highlighting has to do with the shift of emphasis from practical technical action to a more informed practice supported on personal knowledge.

We were very much into techniques, we did not value the patient as a person and I think that, nowadays the great change… (…) it seems that twenty years is a long time, but, all things considered, in order for such a big change of culture to happen in a profession, I think that it was a rapid evolution… to no longer regard the patient only as that little bit that we treated, rather than caring for him or her… let’s say, to care for the patient as a whole. I think that the nursing profession, and that was the big change, became much more person-oriented than biomedical. (Focus Group interview, nurse with 23 years of service)

Relationships with other groups of actors
In teachers’ reports and through observation of their work experiences, it was also possible to identify important changes in the way they relate to the various groups of actors with whom they are in touch with, namely, students, parents, the community and their own colleagues.

**Students.** The vast majority of the participants stated that they were experiencing important transformations in the public they have been dealing with at work. Besides the disciplinary problems experienced by the teachers in some institutions, the main professional difficulty reported in the interviews has to do with the challenge of having to teach mixed-ability classes. More than the cultural diversity of an ethnic or national nature, characteristic of many other schools, it was the diversity of learning levels within the same class and the integration of handicapped students into the regular classes that caused more concern. The adoption of an inclusive policy, which brought students with special needs into the regular classes, was, in fact, the transformation that the participants regarded as having the strongest (negative) impact on their work. The solution proposed by all of the participants for these difficulties that had to do with student heterogeneity was placing more support teachers in their schools and in the classrooms, although some also expressed the need for more training in mixed-ability teaching.

These difficulties are aggravated in communities where the students and their families live in extreme poverty. The following excerpt from an interview illustrates this well:

> [At a school located in a poor fishermen’s neighbourhood, by the end of the nineties]. It was a very difficult class, all of them had failed for several years, with many failure prevention plans, many needs... there were 16 students, sometimes there were as few as six at school. (…) They missed classes a lot. In the first week that I worked there, I used to get home (…) sit and fall into tears (…), I had to make a tremendous effort to pull myself together there [at school], because there was a lot of aggressiveness in the language, physical aggressiveness, the children constantly refused to performing any kind of task. (…) They would grab the table, turn it upside down and say: “school doesn’t put bread on our table!” and they would turn it upside down and they didn’t want to do it. (…) For some time, they stopped coming to school and we reported it and then, later, they would come back. While their fathers went to sea, they used to stay in the port, preparing the bait. I remember that, in the beginning of the year, (…) one day, we wandered through the neighbourhood, one of those days at the beginning of the year when there aren’t any students, yes, and I was deeply shocked. It would make me… as if I were, really, an alien, going through that place. So, those children, who were going to be our students, barefooted, some were wearing only dirty T-shirts, the babies with only with T-shirts on, loud music, garbage on the ground, lots of garbage which had been there for several days, lots of clothes hanging out to dry in the… those women looked so relaxed, as if all of that was normal and I… that first impression made me feel awful and I said: “well those are the children that are going to that school” and I could see that it would be a rough year… (Life story interview with teacher in the middle of the career).

**Parents and communities.** Several participants who had already worked in schools located in remote rural areas recalled with some nostalgia the docility of the students in those places, the cooperation of the families and their deference towards teachers, a behaviour that they regretted not having met in the schools situated in more urban areas. Therefore, the urbanisation of the country itself seems to have presented teachers with new difficulties regarding the way to perform their professional tasks.

With the parents of the many at-risk students with whom they work now, who live in circumstances of social exclusion, the teachers’ relationships are more challenging and their professional roles are enlarged to encompass areas previously out of their responsibility. A participant in the study described the relationship that she maintains with these parents as a “love/hate relationship”.

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Despite these transformations, the testimonies provided in the interviews and the ethnographic observations that were conducted reveal that the main regularity in the work of the participant teachers is still the existence of minimal contact with the families and the community and that such encounters, when they occur, tend to be unsystematic in nature and very short. They consist almost exclusively in end-of-term meetings where the grades are communicated to parents.

**Colleagues.** The reorganisation introduced in the educational system made primary school teachers enjoy new possibilities of interaction with colleagues, namely, with support teachers and with teachers hired to perform specific functions with some types of students in their school area. However, the empirical data reveal that co-ordination between regular teachers, who have responsibility for a class, and teachers with specific educational functions (for example, Physical Education teachers, support teachers or colleagues working with special needs children) was established on an essentially *ad hoc* basis. Regular teachers tried not to invade the “curricular space” of their colleagues and usually limited themselves to “handing over” the students during the period reserved for specific contact with those teachers. There were only a few conversations among them as to the nature of the work to be developed.

The integration of primary schools into Basic Integrated Schools also faced teachers with another new challenge in relational terms: to coordinate their work with colleagues from other levels of compulsory education. The testimonies collected suggest that there are different perceptions of status that, at least in the beginning, seem to have made this interaction between the institutions where the participants worked particularly difficult:

As to the interaction with colleagues, it was difficult, very difficult (…)…the primary school teacher, the female primary school teacher. I felt that in my skin when I went to work in a school with the second cycle of compulsory education (5th and 6th grades) … I… felt a bit like the child of a lesser God… First, I was up against a wall, I was… I was… I was marginalised. In order to become accepted and included, it had to be 99% of sweat; that is, I had to prove that we primary school teachers are also… I don’t mean to say better, because I am not going to get into rivalries…but that we can do a good job and I tried to show that to people. That’s what we lack a lot, it’s… we live a lot within our little houses, our little schools… 2, 3 or 4 colleagues and… much of the excellent work, of the excellent effort (…) is not noticeable (…)… That is what I felt, with respect to work conditions and the relationship with [the new] colleagues [from the other cycles] and it hurt me a lot. (Focus group interview, teacher with 19 years of experience)

With respect to the nurses, the study also identified important transformations in their ways of relating to various groups, no matter whether the users, other health professionals or their own peers.

**Users.** Two of the functions that nurses traditionally perform towards the users are the decoding of the context and of the languages used and the mediating function between the user and the health care system. Changes in professional performance caused by transformations that have occurred in the public are quite visible in these areas, as the following excerpt illustrates:

Now the patients are much better informed. (…)Now the patients say: “Nurse, I watched this surgery on the net. Is that what you are going to do to me? Is the type of anaesthesia the same?” (…) They make us feel a bit uneasy. One must always know what is going on. (…) Now I feel that patients are much better informed. We have to evolve very quickly. I don’t know if people are going to be able to keep up with it. I feel that everyday… (Focus group interview, nurse with 23 years of service)

The mediating and decoding function of nurses towards the users has been changed under the pressure of information technologies. The nurses that participated in the study reported that the use of new information and communication technologies forced them to make some
professional readjustments and to adopt self-education procedures. In the area of information supply, the relationship used to be asymmetrically supported on two poles: those who didn’t know and the ones who possessed and decoded information. This situation has changed rapidly. The integration of new information technologies led to a change in those roles. More than transmitting information to many clients, the nurses’ role is now to mediate between the huge amount of information available to them and its suitability for specific concrete situations (WP5, Portuguese case study report, p. 33).

Other health professionals. Regarding relationships with other health professionals, the relationship with the doctors is the most meaningful one. This type of relationship is not free from the history of relation between both professions and from a traditional logic of subordination of nurses’ work to the power of medical prescription, particularly in hospital work environments. This integration of the relational dimension between the two professional groups emerges in the context of a discussion of nurses’ autonomy of action. Regarding this matter, the legislation (Legal Decree nº 161/96) states explicitly that nurses enjoy an autonomous sphere of action and are entitled to the same dignity as all other health professions and the State allowed nurses to establish a professional association (the Nurses’ Order) with the aim ensuring self-regulation as a profession. On the other hand, the restrictions imposed by organisational contexts and types of work organisation do not favour the emergence and the visibility of this autonomous professional sphere. This tension has been identified repeatedly in numerous studies (Abreu, 2001; Guimarães, 2002) in which it is acknowledged that the strong conditioning of the medical model of work division and the organisational emphasis placed on the dimension of instrumental assistance in nurses’ work does not allow the emergence of competences in the domains of conceptualisation and of nursing intervention focused on a more psycho-social-oriented dimension of caring.

Colleagues. There is a culture of collaboration among nurses at work. Factors such as information sharing about the group of users assisted, the global definition of each one’s responsibilities through a daily work plan, professional integration in the different action areas and professional performance in an open space (permanently observing others and being observed), all of these factors promote a culture of collaboration. The daily distribution of activities/responsibilities does not inhibit cooperation. Cooperation results not only in attitudes of mutual support in instrumental and routine activities (as it is assumed that the responsibility for the decisions to act lies with the person officially in charge of a specific area), but also in the establishment of an informal “plan” for the monitoring and supervision of less experienced nurses (WP5, Portuguese case study report, p. 32). This latter aspect will be dealt with in more detail in the following section.

Supervision and evaluation of work

The evidence collected regarding teachers indicates that there is feeble work supervision and that the evaluation of the work developed has an essentially formal nature and does not have any impact on their professional trajectory. Participants’ relationships (both direct and indirect) with their hierarchical superiors were very rare: they interacted mainly with their nucleus coordinator and it was this person who ensured contact with the main leaders of the Basic Integrated School. The nucleus coordinator was not regarded as a superior by her colleagues nor by herself, but rather as a mere colleague who was temporarily chosen to ensure coordination tasks.

Even though teacher evaluation was established in the Teacher Career Statute, none of the participants regarded it as a meaningful dimension of their professional life. On the other hand, various participants reported experiences of encounters with school inspectors at different moments of their careers and they all shared negative perceptions of those
experiences. Most of the testimonies suggest that the inspectors’ actions were of an essentially bureaucratic nature, focusing on checking the fulfilment of regulated procedures. Only in this context can one understand, for example, the practice (noticed in the case study) of observing the classes of a teacher who was about to retire in a few days, due to having reached the age limit. Moreover, the participants regarded inspection as mere vigilance. For example, one of them complained about the absence of feedback by inspectors on the observations that they had done in his classroom:

It was only during this year that I had a very short visit from the pedagogical inspection, which came to the schools because of the… of the support to handicapped children and… but it was a very short visit, so much that I wanted to talk a little bit more and clarify some doubts that I had, but the gentlemen came in only with only two or three very specific questions and there was no opportunity for saying anything else, I think there was plenty to talk about.

(Focus group interview, teacher with 18 years of service)

With respect to nurses, work supervision and evaluation present quite different characteristics from those described above. The existing nursing career (Legal Decree 437/91) establishes that a formal evaluation must take place every three years in the job, on the basis of interviews with the nominated chief/evaluator, of the development of a professional intervention project and of a reflective report about the activities that have been developed. We did not found abundant evidence of a significant impact of this type of evaluation on nurses’ lives. But it seemed that it was among the newly graduated and newly hired nurses that the weight of formal evaluation had the strongest impact, as a way of ensuring the shift from a short-term contract into a place among the permanent staff. Supervision and performance evaluation is ensured by a hierarchical chain that exists in the different institutions (chief nurse, nurse supervisor and nurse director) whereby nurses are the ones responsible for the direct and operational monitoring of their peers in care-giving, namely in the recognition of each nurse’s individual competencies with respect to the type of activities that are distributed daily in the work plan. We also collected evidence of the existence of an informal evaluation mechanism promoted by continuous and mutual interaction, by professional practice being performed in open areas and being observable by other nurses, by other professionals and by users, and materialised through the dynamics established between two groups of nurses: the oldest ones (externally regarded as more competent) and the youngest (regarded as beginners in the profession).

The brief induction of nurses into clinical settings is compensated by informal mechanisms, which emerge from the cooperation and training attitudes of some of the more experienced peers. These attitudes of training and performance control by the “older colleagues” emerge spontaneously and play no role in the formal mechanisms of performance evaluation, but are accepted and regarded as natural within the profession and are often constructed as helping relationships (WP5, Portuguese case study report, p. 19).

It is only natural that in a medicine ward, as these people are very young in the profession, that they are not at ease to make some decisions, isn’t that so? Sometimes one searches inside the service and in our reality, as we all work as a team, don’t we? … So, there’s always a reference person or an older element who helps the younger ones to take some decisions. (Focus group interview, nurse with 23 years of service)

Balance between personal and professional life

Generally, the teachers’ reports suggest that restructuring in their workplaces has not originated significant disturbances in the balance they keep between their personal and professional lives. Most of them stated that they had enough time for themselves and their families and that they didn’t feel that their work was so stressful as to prevent them from enjoying their free time, from having hobbies or from being with their friends. There were
only a few cases in which the teachers reported, for example, having to stay in school much longer than the usual schedule, or taking a lot of work home for the evening.

However, the situation was more difficult when teachers had management functions and/or when they attended simultaneously courses aimed at improving their professional or academic qualifications. For the teachers with leadership roles (for example, the nucleus coordinators), the need to take work home was more frequent and taking part in numerous meetings reduced the time that would otherwise be available for their families. These difficulties were felt more acutely at times of complex organisational or political change in the workplace and women, especially those with children, were the ones that felt most affected:

Before the birth of my daughters, availability was obviously different; we dedicate ourselves 99% to… to the profession, when we are preparing the materials in the first years of service and all those tasks that have to be done, right at the beginning of the career. (…) After four years of service I gave birth to my oldest daughter and then things got different. Obviously, we begin to monitor the children’s growth and the domestic demands become different and we have to divide our time with family life as well. (…) we take a lot of work home not only as a teacher and now, I’m also talking as coordinator, we have many tasks that are performed at home (…). And that’s not all, there is one meeting after the other, these… these have been growing in number year after year in an almost inhumane manner. And, besides all of that, to make things even worse, in the last two years, I’ve also been attending the complementary education course (…). And along all these years, I’ve heard very often: “mother, you only care about school and university now; what about us?” Sometimes I feel guilty. In spite of… well, of having tried to juggle both, I have to admit that I don’t always manage to give them what they need, what the family needs. Maybe this balance is something that I haven’t achieved yet … there’s no balance. (Focus group interview, teacher with 16 years of service)

In the case of the nurses, there was also no significant evidence of a worsening of the balance between their personal and professional lives, as a consequence of the restructuring measures. An exception to this is the difficulty of juggling personal, professional life and Education at the Nursing Higher Education Schools by attending an intensive one-year long complementary training course. Most of the nurses who had graduated before 2002 attended these courses on a shared regime of work and study.

Yes, it was very hard work, and… I was busy, right? Because I had a strict timetable, I had to study in the morning and I worked in the afternoon till 11 p.m. and all, every single weekend working, it was a… difficult year, wasn’t it? During this time one has almost no personal life, there’s no time for it… (Life story interview, nurse with 12 years of service)

Professional knowledge

The data collected through the interviews and the ethnographic observations in the case study school suggest that, generally, the participant teachers conceived of their professional knowledge as a body of knowledge that is generally acquired outside the school through contact with “experts” and that may be applied later during their practice. This knowledge was regarded as a set of “bits” of information collected gradually through education processes. The idea that such knowledge is something that may be constructed by the teacher individually or in interaction with colleagues was seldom apparent. Although in some cases the participants understood that knowledge could be addressed and used in a more flexible manner (for example, by altering the sequence of the syllabus contents or organising the knowledge around themes that would be more meaningful for students), knowledge itself, its forms of production and its keepers – in short, its almost sacred character and its possession by experts (generally, higher education experts) was never addressed as an issue deserving discussion. There was, thus, an external relationship with professional knowledge whereby teachers regarded themselves as consumers rather than as producers.
It is true that some situations were identified in which the practitioners themselves socially constructed knowledge, collectively produced and developed in context (for example, in school-area projects, pedagogical animation initiatives and educational projects involving various schools), but these were reported as past experiences that seemed to be fading away from participants’ professional life.

All the teachers said that they felt some lack of knowledge which they would like to overcome, particularly, regarding information and communication technologies, teaching strategies to deal with mixed-ability classes, aspects related to the administrative dimension of the school and to work with children with special needs. In all of these areas, they considered that these difficulties might be overcome through more education.

Curriculum-wise, the 1990s and the beginning of the 21st century were a period of intense experimentation in Portugal, with constant changes in curriculum plans and even in the fundamental concepts underlying the curriculum structure, which implied the introduction of new concepts and terminology (school-area, school failure prevention plans, in-service and formative evaluation, alternative curricula, competencies, school and class curriculum projects, non-disciplinary curriculum areas, etc.).

The big curriculum changes that emerged during this period made teachers feel disoriented with respect to the adequate way of performing their work. The intense pace of these changes and their lack of clarity in the eyes of the teachers made these professionals impermeable to the reforms and sceptical with respect to their relevance, usefulness and opportunity. This led them to engage in passive resistance with regard to their introduction in the classroom. For example, a female participant commented the following on the 2001 curriculum reform, specifically with respect to the introduction of the concept of “competence” and its use as a structuring element of her way of teaching:

T: Listen, as I see it, that’s only… it is only words, really [laughter]. (…) The competencies, I think that’s what we used to define as “goals”… that, so, that’s when the student… we want them to follow a path and to reach a certain goal, or a certain competence and… to do so, they go… there are objectives that one gradually fulfils… (…)

I: Didn’t this reform introduce major changes in your way of working?

T: In my case, I don’t think so, because… what they have there… the cross-curricular areas and all of that, we already used to do that, even in the Magistério school. (Life story interview, teacher with 32 years of service)

In terms of teacher education, the nineties were characterised by an abundant in-service training offer, which teachers attended massively, among other reasons, because of its compulsory nature in terms of career progression, as established in the 1990 Teacher Career Statute. Although the participants in the project acknowledged and valued positively the availability and the quantity of this on-the-job training, they identified in it problems of conception and of effectiveness, highlighting that its concentration in brief, single periods during the school year (known as “training windows”) was inadequate. They also mentioned that these actions were used by teachers mainly as a “hunt for credits” rather than with truly educational and professional development purposes. In the eyes of most participants, easy access to in-service education has merely bureaucratic effects (career progression) and does not change their relationship with professional knowledge nor their way of building their identity as teachers. At this level, all of the teachers interviewed mentioned the need for in-service training sessions to promote a more practical knowledge suited to their contexts of practice and able to meet teachers’ true needs.
Still with respect to teacher education, in the beginning of 2000, the Government ruled the organisation of teacher Complementary Education Courses in order to allow those with a bachelor’s degree to qualify with a licentiate’s degree. This experience of a longer training process (which contrasts with short-term training courses) and in contact with higher education institutions had profound effects on the relationship of many of these teachers with professional knowledge in teaching. The testimonies that were collected show that many professionals regarded the shift of teacher education into higher education as an important opportunity for professional learning and renewal. This education was also regarded as an opportunity for the teachers to become aware of the need to learn more and of the areas where that was more necessary:

Only after entering complementary education, did I begin to understand that… really, that I was in need of… of a course like this. I needed to recycle, to update myself (…) I said: well, it’s time, I also need updating and I think that this is the best way, because through in-service training sessions we will never get there, because we often are unable to attend courses on the themes that we feel we need and… and… we always depend on … the availability of vacancies. (Focus group interview, teacher with 18 years of service)

In the participants’ relationship with professional knowledge, in the context of these courses, it was apparent that they appreciated, particularly, the possibility of “acquiring” knowledge applicable to their classroom:

With respect to pedagogical projects, we could come to the university on Mondays, Tuesdays and Wednesdays, “steal” everything we could learn here and put it into practice in the classroom, that a very positive thing. (Focus group interview, teacher with 19 years of service)

Some participants also highlighted that, in the complementary training course, they got in touch with the concept of teacher as researcher and they became more aware of their potential role as school change agents.

One thing that was new for me was the teacher researcher concept. I had never done research in my whole life. The theme that we chose [to work on in a subject in course] was a theme that had to do with my reality (…) we did a research paper on… on all the projects that steer the school, the educational project, the curriculum project, the internal regulations, all of that, and that was extremely productive, because one thing is to work in the school, [another is] to get to understand how it works, why things are the way they are and why we have these curricula and not other programmes and we begin to understand that, maybe we are the ones responsible for changing things. (Focus group interview, teacher with 19 years of service)

Some of the participants in the focus group interview with the teachers were attending or had recently attended a master’s course, which put them in intense contact with a university institution in order to deepen their education. In their course, they particularly valued the learning of new ways of analysing and developing educational projects, the contact with innovative educational practices and the conduction of a research project.

With respect to nurses, in the first place, the interviewees valued the importance of their work mainly in the relational area and in the area of meaningful contact with the users, to the detriment of a set of technical activities that used to take a significant part of their work schedule. The relational dimension and the type of relationship established with users were regarded as critical axes for distinguishing clearly between what is truly essential and what is secondary in nursing. The ability to develop a meaningful relationship is the sort of professional knowledge that is only regarded as valid when it has been developed through practice. Participants admitted that in the academic context these contents are taught and valued, but they also thought that only professional experience can support a deeper understanding of their true meaning. This sort of knowledge was regarded as professional and developed through professional practice. It is, however, a type of knowledge that nurses found
difficult to express clearly as they viewed it as something that is sensed (and shared among peers) rather than possible to theorise (WP5, Portuguese case study report, p. 32).

Another dimension observed through the focus group interview with the nurses was the repeated identification of their personal experiences as users of the health services as a source of knowledge that could be applied and transferred to their professional practice – precisely in the relational domain.

I… had a personal experience in which… in which I lost a son, I spent many years with him… hospitalised, ill, going through a difficult trajectory and that makes me… I experienced the other side a lot, not only the side of my profession, (…) when I was going through the process with him and accompanying him… I would check on the others, too, what I was getting out of that experience, better and worse to… those things that I used to hear that I could adapt to my professional life and I think that… I think that I learned a lot out… out of that experience and, very often, I think… I stop to think and I say: no, I’m not going to do that, because I wouldn’t like that… And I have important moments and painful ones that I’ve experienced throughout in my life that today make me do precisely the good things that they did to me. In a painful moment that I had, some people’s behaviours… colleagues’ support and all… now I do exactly the same, because I remember that time, they did this to me and I feel I must do the same, and I do, I’m not trying to imitate anyone, but I feel I should do it, because it made an impression on me… Life experience matters a lot to the profession and to me as a person. (Focus group interview, nurse with 23 years of service)

The relational dimension of knowledge use in an approach intended to be holistic in the dimensions of caring for someone in need of help to facilitate the different transitions in the processes of illness or development requires prepositional knowledge as a requisite, but it only seems to be meaningfully developed in clinical contexts. It is in this sense that one should analyse the nurses’ perception of the usefulness of their higher education complementary training to obtain a licentiate’s degree, which mobilised the majority of the nurses in the country. In these courses, more than a set of theoretical knowledge, nurses valued the development of reflection, research and professional development competencies, which in their view allow them to evaluate their performance and their professional intervention activities in a different manner.

When I went to obtain my complementary training, I think that it was the reflecting on our daily tasks. I didn’t learn much more than I already knew, it was the reflecting, the knowing… (…) I think that once in a while there should be licentiate’s degrees in nursing or complementary education to make us go back to school and rethink our profession again and I think that… (…) a licentiate’s degree in nursing or the return of many people to school, particularly the older staff, to do… to think about the profession. (Focus interview, nurse with 23 years of service)

In many respects, this complementary training shook those routines and gave us the courage to… because there was an obligation to presenting a project, to do this and present the results and, then, we really saw that we were able to do it and that filled us with pride and commitment and that is something that I believe we didn’t lose. At least, with respect to the health centre, we have been doing many things. Many of the projects that we developed then have been continued, even by other elements and… one works on a project basis. I mean, a new mentality has been created, in terms of… of work and… and I think that the attitude has changed… both at the level of nurses’ relationship with their peers, users, other health professionals, and also because a different knowledge is now demanded, because… the thing is, I think we’ve learned to value ourselves. (Focus group interview, nurse with 19 years of service)

However, from the legal point of view and contrary to what has occurred with teachers, attending a complementary training course did not have any effect in terms of nurses’ career progression. This was a matter of dissatisfaction among these professionals, who, as a result of a higher academic qualification and of a period of personal and professional investment in
formal education, did not receive any recognition in terms of income. It was precisely the comparison with teachers that followed a similar educational path that made their discontent more obvious.

It was also possible to note that the nurses were aware that, although complementary training was not mandatory and did not result in career progression or in a change of functions, a large number of professionals felt compelled to acquire this type of formal academic qualification out of fear that they might otherwise put their future development at risk.

8.3.2 Generational profiles

It is natural to expect that the way teachers and nurses experience restructuring and interpret it be strongly affected by their socialisation trajectories, which are marked by the social context in which they were born and brought up, by the qualification levels they acquired and by the education they attended to become certified practitioners.

Referring to teachers, Alves-Pinto (2006) highlights the importance of taking into account the type of socialisation experienced, in order to understand their positioning towards educational change:

Nowadays in the educational system there are teachers who have witnessed all the changes of the Portuguese School as well as the evolution of the expectations of Portuguese society towards schools and teachers in the last 35 years. This makes us go back to the last years of the Ministry of Veiga Simão and to the whole democratic period post April 25th. The teachers who are close to 35 years of service initiated their functions in 1969. Only as an example, directed at the younger people who may read this, I do not resist mentioning two facts: primary school teachers ceased to have to ask permission to get married in 1970 and co-education in primary and secondary schools was reintroduced in October 1st, 1973. (p. 8)

Alves-Pinto (2001, pp. 49-53) organised some central distinctive features of the social and educational context in which some teachers, who were in different stages of their career at the beginning of the 21st century, joined the profession:

As Alves-Pinto (2001) points out, these different socialisation experiences have decisively conditioned the way teachers have constructed their collective and individual professional activity.

According to the factors that may have conditioned the construction of a generational professional identity of the PROFKNOW participants, one can say that this project included teachers from three very distinct cohorts:

The “missionary” teacher. The participant belonging to the first cohort attended her teacher education course before the 25th of April. This education was obtained in a Magistério School, in a two-year course whose recruitment qualifications, according to the different periods, ranged between the present 5th and 7th grades. The teachers from this cohort were trained to teach a “minimum curriculum” (reading, writing and counting), with a strong ideological emphasis. They were trusted with the mission of educating for conformity and for social and professional stability. They were also taught that the teacher is not exactly a professional but rather a “missionary” at the service of a national system of values. Their prospects of employment when leaving the teacher education school were assured, although unstable, and their professional practice was frequently performed under very difficult work conditions.

The “empowering” teacher. The participant who belonged to the second cohort attended her teacher education course already in the years immediately after the 25th of April. This qualification was still acquired in the Magistério Schools, but by then training courses lasted for three years and required an 11th grade access qualification, after 1977, and a 12th grade
qualification, later on. In these institutions, teachers were prepared to offer an “enriched curriculum”, aiming at the whole development of the student as a person, with a strong expressive component (Visual and Performing Arts) and of social/community intervention. School was now regarded as centre of social development and education as an empowerment and upward social mobility tool. Teaching was thus regarded as educating for personal development and for the improvement of people’s social position. Employment prospects were still assured, although more unstable and frequently in even more difficult work conditions than he previous generation.

*Table 8.1: Socialisation experiences of primary school teachers with different years of service*

<table>
<thead>
<tr>
<th>Service years in 2000</th>
<th>Context</th>
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| 35 years             | • Initiated professional activity in the mid-60’s  
                      | • The country was ruled by Salazar and was going through Colonial War  
                      | • Compulsory education lasted 4 years  
                      | • Post-compulsory education was split between high schools and technical schools and an access examination was required to enter both  
                      | • Teachers were evaluated according to the percentages of their students’ approval: in order to obtain a positive grade they needed to get a 75% approval rate with 2nd, 3rd and 4th grade students and a 65% approval rate with 1st grade students.  
                      | • There was a strong control of teachers by inspectors  
                      | • Teachers needed superior authorization to organise meetings |
| 30 years             | • They entered the profession in 1970 (already in the “Primavera Marcelista”)  
                      | • Compulsory education lasted for 6 years, including the then called preparatory levels of secondary education (5th and 6th grades)  
                      | • Public discussion of the Veiga Simão reform was taking place  
                      | • Several teacher education strategies were launched  
                      | • There was still differentiation between high schools and technical schools from the 7th grade onwards  
                      | • Strong student rebellions occurred in the three Portuguese Universities (Coimbra, Lisbon and Oporto) |
| 25 years             | • They initiated their teaching career already after the 25th of April (in 1975), i.e., they experienced the revolution at the end of their Magistério Primário course  
                      | • They did not experience the professional control previously exercised over their colleagues  
                      | • Teachers’ unions were organised, which played a decisive role in the improvement of their work conditions  
                      | • The model of “democratic school management” was implemented  
                      | • They experienced the beginning of the third cycle of education, after 1975/76, although as students they had attended the previous system, which differentiated between high schools and technical schools |
| 20 years             | • They entered the profession in 1980  
                      | • They were probably admitted into the Magistério Primário schools in 1977  
                      | • As students they attended secondary education split between high schools and technical schools |
| 15 years             | • They initiated their teaching activity in 1985  
                      | • They will have been affected by the *numerus clausus* (maximum number of students accepted in a higher education course) for access to the courses they attended  
                      | • The group integrates the last teachers who qualified for primary school education with a Magistério Primário diploma (i.e. who did not have a higher education degree)  
                      | • As students they were attending the 5th and 6th grades when the 25th of April Revolution occurred |
| 10 years             | • They initiated their professional activity in 1990 when the negotiations that led to the Teacher Career Statute had already been concluded  
                      | • Almost all of them attended school after the 25th of April |
From technician to “reflective professional”. The participant that integrates the third cohort obtained a higher education qualification. In this cohort, education for professional practice was already acquired in Higher Education Schools or University departments, which regarded teachers as “technicians” or, later, as “reflective professionals”. Teacher education courses lasted for four years and required a 12th grade access qualification. The education provided in these courses deepened the technical dimension of professional development that had already been present in the previous cohort (a strong emphasis on methodology and curricular development subjects) and introduced or highlighted other components such as the ones related to educational technologies or to information and communication technologies, special needs, learning difficulties, as well as to the orientation towards more professional reflexivity, by favouring learning in the areas of educational research, educational administration, ethics and professional deontology. The teacher was now regarded as someone who is educated to deal with instability and uncertainty and to educate in and for diversity. The prospects of finding a job were getting more and more uncertain.

Likewise, in nursing, initial education seems to be the crucial factor for the development of a certain professional model and for the type of appreciation that the professional makes of his or her practices. The place where education is developed does not change: the institutions remain the same although they have been formally moved into Higher Education Schools integrated in Polytechnic Institutes or Universities. The teaching staff is the same – going through a transition from a nursing career into a higher education teacher career. It is the emphasis placed on education and the value placed on the distinct areas of nurses’ knowledge that promote a new attitude towards the work performed within multi-disciplinary teams.

Our study included nurses educated in different periods with distinct emphases: the General Nursing Course, the Bachelor’s Degree Nursing Course, and the Licentiate’s Degree Nursing Course.

The nurse as perfect technical practitioner. This cohort integrates nurses who took the Nursing General Course until 1988, in nursing schools. The course lasted for three years; it accepted students with a 9th grade and later with an 11th grade diploma. In curricular and conceptual terms, since the 1976 reform, there was a transformation: the introduction of nursing theories in teaching and the strengthening and increased attention given to the areas of disease prevention and health promotion and not only to teaching centred on pathological processes. Essentially, professional education was still oriented towards execution according to norms.

I have nothing to do with … a newly graduated nurse 19 years ago. All I wanted was to make a bandage and I would feel totally fulfilled whenever it was very well wrapped.

I remember that when I was newly graduated, that we were a bit dependent, so to say, from medical orientations (…) Ah! The doctor! There was an urge to deliver things and to… and… to show the work done. (Focus group interview, nurses graduated according to the model of the general nursing course).

During this period, in a context where there was a great lack of nurses, there weren’t any problems related to employment.

The nurse between acquired concepts and the logic of practice. This cohort includes professionals who got a bachelor’s degree in nursing. This type of education lasted until 1998 and took place during three years in Higher Education Nursing Schools. Courses lasted for three years and the required qualification to access them was a 12th grade diploma, just as
with any other Portuguese Higher Education course. Nurse education was based on a curriculum that promoted the integral consideration of the user rather than a restricted focus on his or her disease and which valued the dimensions of caretaker comfort and well-being. Health was now conceived as a multidimensional concept and it was no longer confined to the absence of disease.

In nurse education and professional practice, this was a period marked by a sense of transition: from an excessive emphasis on techniques to an emphasis on the relational component; from a traditional logic of subordination in work settings to the emergence and promotion of professional autonomy.

I... I think that I am exactly the transition. I, all along the course, I felt that emphasis on techniques, not that I despise it, obviously, right? (Focus group interview, nurse educated according to the model of the Bachelor’s Degree Nursing Course)

Employment prospects remained high, as there was still shortage of nurses in the country.

The nurse as reflective practitioner in contexts of uncertainty. In this cohort, nurses attended the Licentiate’s Degree Nursing Course (initial education after 1998). Courses were still taught at Nursing Higher Education Schools or at Health Higher Education Schools. By then, most of the schools were integrated into Polytechnic Institutes or Universities. Course duration is four years. The curricula are structured according to a perspective of intervention in nursing, supported on organising axes such as the Satisfaction of Human Needs, the structure of Nursing Diagnosis, or the language of the International Classification for Nursing Practice.

When I left the [training] school, I was already valuing other sorts of things; that is, I was not taught to value the techniques, I was taught to value the human dimension much more, the relational part of it, knowing how to be, knowing how to behave, rather than knowing how to do things. (Focus group interview, nurse graduated according to the Licentiate’s Degree Nursing Course)

In this cohort, the emphasis of nursing education is put on developing professionals with an operational and autonomous ability to intervene, supported on the ongoing development of competencies, resulting from reflection on practice according to a nursing professional perspective in a multi-professional context such as health care. This change in training emphasis is not accompanied by changes in nurses’ role in the institutions where they work, nor by how services regard their staff (WP5, Portuguese case study report, p.31). The work settings do not promote the development of these conceptualisation competences. These constraints in the contexts of work that are in opposition to the profiles of the new professionals (with a higher education degree, high grades in secondary school, educated according to a model that promotes professional autonomy) are one of the sources of tension worth following in nurses’ professional development.

In terms of recognition, in terms of type of work, in monetary terms, in terms of everything, there’s no recognition whatsoever. (…) I think that we are a bit marginalised. (Life story interview, nurse with one year of service).

Nowadays, nurses’ employment rate is still high, but job stability is decreasing as a result of a large increase in nursing education offer and the concomitant number of applicants. Also, in this new context, the State is losing power in labour relationships with the newly recruited nurses. It is still the largest employer, but public companies now mediate the labour bonds and business-like rules were put in place to regulate the recruitment of human resources.
8.4 **Professional strategies and frameworks**

In order to understand the strategies and the frameworks adopted by the professions, it is important to take into consideration the context where these develop and the specificity of its historical-social evolution. In the case of teaching, unlike other countries, and notwithstanding the restructuring legal measures that were taken since the mid-eighties, the degree of centralisation is still high in Portugal: despite the curriculum flexibility and alternative curricula policies that were introduced, there is a strong national curriculum; the recruitment of professionals is still done through national public competition and not by schools or local authorities and the State is the main employer; teachers’ career is defined and regulated by the State; the criteria for teacher evaluation are defined by the central administration and not by the profession and, even though school autonomy has been legislated for almost two decades, it is more formal than substantive (recently, Joaquim Azevedo, a prominent member of the National Education Board, named it a “legal fiction”). All these factors have consequences for the fragility of teachers’ professional autonomy and for their huge dependence on the State. This illustrates the idea put forward in WP1 (Goodson & Norrie, 2005) that the balance between decentralisation and centralisation is complex and that, notwithstanding the transfer of power to local organisations, the centre keeps, and, in some cases, even reinforces its power.

In the face of the above-mentioned factors, the strategies developed by the teaching profession have been mainly reactive: they express mostly a systematic rejection of the initiatives proposed by the central administration than a pro-active and anticipatory presentation of new forms of structuring and promoting the professional group. There is also a lack of collective global mobilisation: the degree of union influence and mobilisation is low and there are no other entities with enough significance to represent a strong public voice of the professional group. Collective action has been almost exclusively centred on the action of the union federations, with a special emphasis on issues of labour bonds and salaries. Only recently (since the end of the eighties) have the unions discussed a structure for the teaching career, but even then, they have done so, as stated above, in a primarily reactive manner, trying to keep things the way they were and resisting any attempts of change, rather than proposing structural changes that might improve the quality of professional practice and its outcomes. Besides, in public discourse and in unions’ mobilisation actions, the issues of initial and in-service education (with strong implications for teachers’ relationship with professional knowledge), of access to the profession and of teacher evaluation have occupied a relatively secondary place. The definition of the requisites and of the organisational principles of teacher education is done by the State and performed by higher education institutions, without any direct intervention from the profession. On the other hand, although the legislation has reinforced the possibility that in-service education can be controlled and managed by the profession (through Education Centres organised by school or teacher association), research developed so far has shown that such potential has not been used and that most of the education provided by these institutions still serves the political agendas of the central administration.

This global diagnosis is echoed in the words of Nóvoa (1991a), who referred to the process of turning teachers into public servants, a trend that was already visible in the 1980s:

> The eighties were not easy times for Portuguese teachers; the conditions associated with their burnout worsened. More than a profession that lacked prestige “in the eyes of others”, the teaching profession became very difficult to live from within. The absence of a collective project that would mobilise all teachers made it difficult for them to enjoy social recognition and led to a defensive stance that is more typical of *functionaries* than of reflective practitioners (pp. 65-66, italics in the source).
Paradoxically, this difficulty in achieving the autonomy of the professional group is parallel to policies that resulted in higher qualifications among teachers and a higher specialisation of their activity. If, in abstract, the movements towards the growing qualification of professionals can be seen both as a reaction to the growing complexity of their functions and, especially, as a strategy that groups use to improve the social status of their profession, through the purposeful establishment of a monopoly, of professional closure (Goodson & Norrie, 2005, p. 15), the truth is that, in the case of Portuguese teachers, that progressive qualification resulted from the voluntary initiative of the State rather than from any organised and strongly pressing strategy developed by the profession. Likewise, the increase in teachers’ specialisation, established in the Educational System Act since 1986 – a specialisation that which was initially acquired, mainly, through the taking on of local leadership and management functions which have progressively required specific training, although not yet in mandatory terms) was not exactly a demand made by teachers but rather something that was imposed by the state. More recently, in January 2007, the central administration also imposed upon the teaching profession a hierarchical internal differentiation (between teachers and main teachers), which, despite huge opposition and resistance by teacher unions, was turned into law in the new Career Statute. All of these phenomena are important indicators of the profession’s feeble power with relation to the State.

This situation is reinforced by the fact that the professional knowledge that teachers emphasise in their quest for higher academic qualifications, as mentioned above, relies mainly on a replicable and applicable conception of knowledge (Eraut, 1994) which compromises the feasibility of their empowerment and their emancipation strategies as a professional group. Indeed, as Roldão (2007) states, in times of a strong pressure from the administration and from economic power towards reinforcing teachers’ status as mere subordinate public employees, the issue of professional knowledge is crucially relevant and absolutely essential for the group’s distinction as a profession. However, as the author recognises, today, professional knowledge is precisely the teaching profession’s “weakest link”. One of the main reasons for this is teachers’ own adhesion to an “applicationist reading” of the relation between theory and practice, which is very visible in the testimonies gathered in the PROFKNOW study. This applicationist interpretation compromises the generation of new bodies of knowledge that would be specific of the professional group and which might nourish and transform its action. On the other hand, the preponderance of professional practice that is developed mostly in isolation from colleagues (Lima, 2002) also hampers the development of one feature that might be distinctive of teachers’ professional knowledge, which is also pointed out by Roldão (2007): communicability and circulation. In fact, as the author claims, today this is probably the area that separates teachers the most from owning full professional knowledge, since it strengthens the tacit components of that knowledge and hampers its explicit articulation, as well as critical dialogue with peers and, consequently, the necessary theorising and questioning that might help transform mere practice (and the practicist emphasis that is associated with it) into authentic professional action.

Concerning the nursing profession, the strategies employed have been essentially active and were integrated, since the 1979s, in two fundamental stepping stones: the reinforcement of nurses’ professional qualifications through the extension of initial education courses and the role of the professional unions as catalysts for professional regulation. These stepping stones were joined, in the end of the nineties, by the Nurses’ Order, and thus the self-regulation process was started and a new social partner emerged, which represented the whole class in issues related to national discussions of changes in health policies.

Academic education and qualification, and the requirement of a university degree in order to be allow to develop registered practice, were the main professional promotion tools that the
nursing profession used. The recognition of the academic degree strengthens the role of the University/Higher Education School with respect to the validation of professional knowledge. This academic recognition provided the formal context which allowed for a greater social recognition of the professional group in work contexts, in particular, and among the population, in general.

The issues that affect the professional group are beginning to gain clarification with respect to the action domains and areas of intervention of the different participant organisations. Thus, responsibility for initial education (and to a great extent, for research in nursing) is committed to nursing teachers working in Nursing or Health Higher Education Schools. Although recognised as nurses and registered by the Nurses’ Order, these teachers are, from a professional point of view, almost completely bonded to a teaching career, which is completely different from the career that is followed by nurses practicing in health care.

In turn, unions are focused on labour issues, on workers’ rights, on issues related to contract agreements, and on the career negotiation processes. The present career establishes different levels with different incomes among them. The Nurses’ Order is responsible for regulating the profession, for registering nurses, and for exercising jurisdiction over every professional, regardless of his or her area of intervention.

In analysing the issues of power and of the relative importance of different professional groups within Portuguese hospitals, Simões (2004) describes clearly the global effect obtained through the combination of these three sides:

The establishment of the Nurses’ Order and the licentiate’s degree in nursing represented, by the end of the nineties, in the last century, the end of a process of growing recognition of nurses which conveyed into the hospital field, and particularly into hospital services, younger, better cultivated professionals, with high secondary school grades, enjoying a different professional, social and economic status, integrated into a very clear and disciplined hospital hierarchy (nurse director [a member of the Administration Board], supervisor nurse, chief nurse), with a trade union militancy that promotes, with rare success, processes of professional claim. (p. 165)

The present context of the country is characterized by a set of measures that affects both the Higher Educational system (such as changes in course offer resulting from the Bologna Process) and the State’s relationship with health care institutions in the National Health System, as a result of the changes in statute which those institutions have gone through.

In the country, this balance of power in the profession, which is grounded on the above-mentioned three stepping-stones (the Order, the unions and the schools) faces challenges related to the areas of contact between each of the systems: the educational system and the professional one, where the Order and the Unions interfere simultaneously.

There are two essential aspects under discussion in nurses’ professional development strategy: (1) the second level of higher education (a master’s degree and a five-year long education period) as the initial qualification requirement for registered practice, and (2) the route of professional development, which requires compulsory specialisation in a clinical nursing area, after an initial period of general health care, eventually allowing for a diversity of specialisation paths not confined exclusively to the responsibility of Nursing Education Schools.

These are the two strategies outlined and proposed by the Nurses’ Order as a way of regulating both access to the profession and the moments in which re-certification of competencies is needed. In this sense, it is time to define the contact areas among the systems. Strategies with such a future impact imply commitments from the State (both due to the
changes predicted in education and to the changes in its role as employer). They also imply negotiations regarding the implications of specialisation paths and the definition of a system of labour contracting (the unions’ privileged area of intervention), as well as the role of schools/universities in professional development/ specialisation (up to the moment, these institutions have enjoyed exclusive responsibility for such educational processes).

This movement towards growing complexity in functions and, essentially, towards growing qualification, together with the absence of an auxiliary nursing group, leads to the emergence of new work groups in the area of health care, which invade or threaten the territory that used to be exclusively occupied by nurses. There are now new pressures from the market stemming from new outcome-oriented management frameworks, originating especially in private management institutions, which press towards the transfer of activities traditionally performed by nurses to other less qualified and, therefore, less costly labour groups.

8.5 Restructuring in comparative perspective

Until now, we have presented the results of empirical and document analyses that illustrate the way professions like elementary school teaching and nursing have evolved in Portugal since the 1960’s and how they have been affected by Welfare-State restructuring, as well as how professionals have experienced these changes. In the present section, we will make a comparative analysis between these professions, in order to detect similarities and differences between them. In Table 8:2, we summarise the transformations identified in both.

8.5.1 Similarities

At the organisational context level, we have identified global changes in both professions, based on the approval of fundamental laws and on essential principles of restructuring of public services. Such measures include, for example, the closing of many small units, giving way to structures with greater capacity and resources and greater service differentiation. In the case of teaching, those measures also affected professionals’ most immediate organisational contexts, such as internal bodies in their working units and ways of organising pedagogical work. These processes of restructuring have affected mainly the professionals that hold management positions: those who develop regular tasks, both in the classroom and in clinical contexts, are a lot more impermeable to their effects.

The organisational changes have given place to consumers’ greater intervention, though still tenuous, in the offer of public services. In education, there has been a growing involvement of clients in professionals’ work, due to the entry of the former in areas earlier reserved for the latter, namely, by beginning to have a seat in school boards, though still in minority. This development results in greater permeability of professionals’ areas of action, due to the entry of new actors in a space that was hitherto reserved to them. Although, until now, this tendency has been apparent mainly in education, in health care there is also the emergence of new occupational groups that threaten to invade the territory that used to be occupied exclusively by nurses. In the health, there is also some pressure from the market, resulting from new forms of management by objectives that are typical of private institutions, so that nurses’ tasks may be performed by, for example, ward assistants. In health, the greatest intervention of clients is materialised in: (1) the increase of consultation processes with respect to users’ levels of satisfaction with health services, a procedure that is considered to be key for the accreditation of health care institutions, and also (2) more specifically in the field of nursing, in the inclusion of client’s satisfaction as one of the quality standards set for professional nursing practice, established by the Nurse’s Order. In education, the new Teaching Career Statute of 2007 also foresees that the parents may act as evaluators of
teachers’ professional performance. However, in this case, that may only occur only when there is consent from the teacher under evaluation, which erases the measure’s potential symbolic meaning as an indicator of greater social control over the profession. Notwithstanding these evolutions, one might say that in both professions, in general, professional action is still relatively well-protected against significant external interventions by clients and that the changes that have been introduced have had more of a symbolic than an effective expression.

**Table 8.2: Evidence of restructuring in the teaching and nursing professions**

<table>
<thead>
<tr>
<th>Restructuring areas</th>
<th>Teaching</th>
<th>Nursing</th>
</tr>
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<tbody>
<tr>
<td><strong>Organisational context</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Local</td>
<td></td>
<td>X</td>
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<tr>
<td><strong>Regulation, control and professional role</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structuring and organisation of the professional career</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Professional self-regulation</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Training models</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conditions of access to initial training</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Curriculum emphasis/focus in initial training</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Control of initial training</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Control of in-service training</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Restructuring has had little effect in PROFKNOW participants’ sense of balance between professional and personal life, although, in this domain, professionals with leading/management roles are more frequently penalised than the others, particularly in the case of women with growing family responsibilities and who are simultaneously involved in processes of improvement of their academic and professional qualifications.

In terms of regulation, control and professional roles, the evidence collected illustrates redefinitions of the nature of work and of the tasks to be performed, with a clear extension of teachers and nurses’ professional roles. For example, in elementary teaching, the professional role has widened: besides teaching, now professionals have to consider the student’s whole development, taking into account his or her personal, interpersonal and social needs, thus being pressured to interact more frequently and openly with parents, the community and other professionals involved in education. As for nurses, the social role has also widened: today, more than the perfect skill of a technique, the standardised treatment of hospitalised clients or a work organisation based in the fulfilment of routines, nurses’ professional discourse is increasingly centred around a single word: “caring”, which, in the research participants’ view, means taking into consideration the client as a whole and not reducing one’s actions to treating sick people. The latter side is seen as a small parcel of nurses’ professional role.

With respect to the restructuring of professional careers, both professions have first experienced a process of unification of separate categories (elementary school teachers and the ones from other levels of teaching, on the one hand, and nurses or nursing assistants, on the other), which was later followed by progressive internal differentiation. In education, the
unification occurred later than in nursing: it only took place in 1990, through the approval of teachers’ single career. On the other hand, internal differentiation is a process late in the teaching profession: it was instituted, in embryonic form, at an early stage, through the definition of the possibility of specialised training that was set in the 1986 Portuguese Educational System Act. Later on, in the beginning of the 2007, there was the imposition on the teaching profession of an internal hierarchy comprised by two categories. Now, lead teachers (“professores titulares”) are responsible for the coordination and supervision of other teachers, and for managing schools or training centres. In both professions, the deep pattern is the same: what distinguishes them is the timeline in which the processes occur – first in nursing and, later, in teaching.

On the other hand, in both professions, professional practice seems to be developed essentially under tenuous, formalistic supervision and evaluation of work, except in the case of recently-hired nurses when they go through the process of applying for a permanent contract. Thus, professional practice occurs generally within a frame of wide individual autonomy, although we might say that, in the case of nurses, the more frequent integration of teams and the constraints exerted in the organisational context by the group of physicians limit this autonomy a little bit more, inhibiting, to a certain extent, the emergence of skills in the areas of conceptualisation and intervention in nursing, especially those related to the psychosocial dimension.

As to training models, in both professions, there has been a process of social valuing of the training that is needed for professional practice, which, in the case of teaching, has resulted mostly from the state’s initiative and not so much from the claims of the professional group itself. Over time, there has been an increasingly higher standard of requirements for entry in pre-service training and new curriculum emphases have been introduced that have changed the professional profile that is aimed for in these courses. Since the 1990’s, higher education institutions’ role in the validation of professional knowledge has become very important for primary teachers as well as for nurses. In both professions, contact with these institutions has lead to important transformations in terms of the professional knowledge that is recognised as legitimate by professionals. Nevertheless, the great importance attributed to higher education as a status awarding institution and as a legitimate source of fundamental professional knowledge coexists with a certain devaluing of the abstract knowledge that is emphasised in training institutions and of its applicability and utility for professional practice.

8.5.2 Distinctive aspects

At the organisational context level, the introduction of measures based on the main tenets of New Public Management, although very recent (it dates from the beginning of the XXI century), is much more apparent in the health sector (expressed mainly in the establishment of individual contracts and of performance evaluation in the beginning of the nursing career) than in primary teaching. At the time of writing of this report, while most teachers admitted at public schools were still public servers, the same could not be said of all nurses admitted to public healthcare institutions.

The specificity of teaching is expressed by development of measures of restructuring typical of the retreat of the Welfare State, in parallel and often in contradiction with initiatives that deepen this state’s intervention. The transformations that had a greater impact on the participant teachers’ experiences were not related to the deregulation component of restructuring (decentralisation, reorganisation of units, introduction of performance evaluation procedures, etc.), but rather with areas of greater state intervention which constituted a counter-current to neo-liberal restructuring (for example, changes aimed at making the curriculum more flexible and more significant for students, and inclusion policies designed
for students with special educational needs). In other words, the changes that the participants perceived as most significant in their work were the ones that have affected the content of that work (the programs of studies, the curriculum), and the type of users with whom they interact. These latter changes are not so much the result of restructuring processes but rather of state social policies in the field of education. Thus, what the participants highlighted the most were features characteristic of a Welfare State that still proceeds with and even reinforces its action in certain domains (as was visible in the end of the 1990’s and in the beginning of 2000). The processes of formal and organisational restructuring were widely irrelevant for them; it was the changes that most directly affected their work in the classroom that proved to be crucial for the way they evaluated the quality of their professional experiences. In nursing, the deepening of the social state’s intervention was not so noticeable. On the contrary, what we observed was a retreat of that state (for example, the recently legislated rise in moderating taxes in hospitalisations).

In terms of regulation, control and professional role, in nursing there is recognition by the State of the right to self-regulation, something that contrasts with teaching, where there have been constant efforts of framing and subordination of the profession to the power of the State. Thus, there is a profession of nursing that reflects about itself and that has a collective public voice, contrasting with a teaching profession that lacks a collective project and which is in a relationship of permanent subordination or resistance to the State.

The study also identified important differences between both professions in terms of the dominant form of professional practice. In nursing, there is a greater use of teamwork, usually of a multidisciplinary nature. Although sometimes this may also be visible in teaching, due to a growing opening of the school to the outside and to the multifunctional diversification of tasks given to teachers, isolated work still remains the rule in teaching and the articulation amongst professionals is slim. In order to understand this difference, many factors may be considered. For example, it is important to take into consideration the type of client with whom professionals work and the time these professionals spend with him or her: the nurse doesn’t have “his” client, since he or she doesn’t spend a long time with the used – he or she “receives” him or her from someone (frequently, in a public situation) and “passes” him or her to other professionals; in teaching, on the contrary, the teacher is “entitled to a class” and develops a feeling of ownership towards it, especially in primary teaching. At this level of schooling, the time spent in the contact with the client is much longer, which sets a less immediate need for contact with other professionals. To summarise, the public or private nature of professional practice may truly limit the choice of team or isolated work, as well as really influence the length of time spent with the client, which may result in different dynamics at this level. Nevertheless, it is important to find other factors that account for the weak adherence of primary teachers to the teamwork that is officially sponsored by advocates of restructuring measures.

In relation to training models, in nursing there has been a progressive control of pre-service training, which is ensured by nurses’ peers. In teaching, the responsibility for this training is held by a group of external experts, higher education teachers, who are not and have never been, with rare exceptions, primary teachers. In education, the State has recently allowed the profession a greater control over the choice of its in-service training, but this opportunity has seldom been used to deepen a form of teacher professionalism that is built collectively and more autonomously from central administration.

On the other hand, whilst in nursing the professionals’ relationship with their professional knowledge takes on reflective and holistic dimensions, in teaching the evidence collected shows that that this knowledge was regarded as given and dealt with by professionals as
something that is unproblematic – as a set of information that may be received through formal processes of training, conveyed by experts standing outside the profession, and directly applicable to professional practice. In nursing, we have identified a shift of the emphasis in professional knowledge, from a focus on practical and technical performance to an action that is more grounded in knowledge that is specifically produced by the profession and that is oriented towards the client as a whole person. In teaching, on the contrary, we have identified a conception of professional knowledge as a feeding device for instrumental action which is based in a technical logic (Habermas), with little evidence of knowledge as reflection-in-action (Schön, 1983), and even less of it as a product of situated learning grounded in social participation in a community of practitioners (Lave & Wenger, 1991), which confirms the conclusions arrived at in this respect by Goodson and Norrie (2005, p.19).

8.6 Conclusions, implications and recommendations

In this report, we have tried to understand the nature of Welfare State restructuring in Portugal and how it occurred in two fundamental areas of its intervention: education and health. In order to achieve this goal, we studied two occupational groups – primary school teachers and nurses – and attempted to understand which manifestations of restructuring could be identified in these professions and how they where experienced by professionals. We have drawn an interpretative framework and a periodisation that enables us to understand the most significant transformations that have occurred in both since the 1960. The data collected allows us to conclude that there is some evidence of restructuring with impact in the experiences of professionals in Portugal. However, the data also suggests that this restructuring is characterised by low intensity and mitigation, which differentiates the Portuguese case, in terms of degree of restructuring and of the meaning of this restructuring for professionals, from other European Union countries and other areas of the globe.

To understand restructuring in Portugal in the professions under analysis, it is therefore essential to take into consideration the historical-cultural context of the country and the late moment of construction and expansion of the Welfare State, comparatively with other countries. Indeed, in the policies under analysis in the present report as well as in the professional experiences that were documented, we have found a complex and sometimes contradictory mixture of restructuring manifestations typical of a declining Welfare State, in coexistence with evidence of reinforcement and even of strong voluntarism from a Welfare State that is still in expansion. Thus, it is not surprising that the professional experiences of primary school teachers and nurses are marked by the convergence of both movements, though each group experiences them in particular ways, which results in distinct professional configurations.

In the comparative analysis that we have undertaken, we found two professions with an increasing level of qualification and whose initial education that increasingly related to higher education. The two professions are taking on a wider professional role in an organizational network that has been restructured into larger units, where the consumers are enjoying greater power, although the latter is still relatively limited. Both professions have gone through an initial stage of unification, followed later by processes of greater internal differentiation. In both, the professionals who hold positions of management responsibility seem to experience the effects of restructuring most immediately, much more than the average practitioner, who remains relatively immune to its impact.

On the other hand, we have found a nursing profession that is more affected by restructuring measures that are typical of New Public Management, particularly in recent times, contrasting with a teaching profession where, while existing, some of these measures are less visible in
professionals’ immediate experience, and are accompanied by voluntary initiatives typical of a Welfare State; a nursing profession that, compared to teaching and notwithstanding its greater exposure to restructuring, holds greater control of its professionals’ training, acts mainly in uni- or multi-professional teams, relates with professional knowledge in a more reflective and holistic way, and enjoys greater self-regulatory power.

Obviously, these common elements and distinctions constitute a temporary interpretative framework that needs to be confirmed, developed, consolidated or eventually rejected with further research.

Taking into consideration the analysis and the reflections that have been developed until now, we concluded this report by presenting some strategic action recommendations to professionals and decision-makers.

To both professional groups, we recommend:

- Greater investment in the promotion of models and processes of pre-service education that favour the deepening and development of the specificity of the profession’s knowledge, with a richer articulation between conceptual formalisation and reflection focused on practical experience;

- The organisation of professional development initiatives based on systems of collaborative interaction among peers, grounded in collegial intra- and inter-institutional networks;

- The development of a more autonomous and dynamic relationship with higher education institutions, recognising the fundamental part they play in the valuing of professional knowledge, but, at the same time, stimulating greater attention on their part to real-life professional action settings and to the need for systematic reflection on them, grounded in analytical categories introduced by the professionals themselves and not merely on traditional interpretative schemes typical of the university academy;

- Greater investment in a collective pro-active public discourse and in practices of internal mobilisation that bring to the fore a discussion of the nature of functions of the profession and of its professional knowledge, as well as of its social mission and the ethical dimensions of its activity;

- The monitoring of the impact of structural changes, due to the effects that these may have on professional identity, motivation, professional/personal balance, but also on the development of professional knowledge, due to, among other factors, the introduction of new tasks/expectations in the development of professionals’ specific role.

In the case of primary school teachers, among other aspects, this monitoring should also focus on:

- The transformations in identity and in the relationship with professional knowledge stemming from greater interaction with other professional groups in larger, restructured organizations;

- The transformations in the internal dynamics of the profession and in its professional culture resulting from recent changes introduced in the Teacher Career Statute, especially those related to the creation of an internal hierarchy and to the intensification of performance evaluation schemes;
The degree of autonomy in training offer and in the use of the opportunities that were created in this domain as a result of the legislation on training centres directed by school and teacher associations.

As to nurses, this monitoring process would focus aspects such as:

- The effect of the rejuvenation of the professional group on healthcare organisations;
- The regulation of the market in terms of contract stability, due to the restructuring public institutions that now generally use private models of management;
- Professionals’ adherence to the changing processes that are defined by the profession’s regulating bodies, namely with respect to the process of professional development under discussion in the country.

Finally, to policy-makers, we recommend:

- The development of a discourse and of political practices of restructuring that take into account the need to preserve professionals’ sense of dignity, competence and social recognition, thus avoiding processes of public blaming, work overload and constant changes with ominous and demoralising effects on the professions, with predictable negative consequences for the quality of their work experiences and of the services they provide to the public;
- The recognition and/or reinforcement of the legal legitimacy of the professions’ autonomy of action and of the deepening of their construction of specific forms of knowledge that are not controlled by the State nor by any other entity external to these professions;
- The creation of conditions and incentives that enable these processes to emerge, unfold and consolidate;
- The external and accountability-oriented supervision of these professional groups, in order to ensure that, in their process of progressive autonomy and empowerment, they do not deviate from the goals of public service and common good that need to be fulfilled by any profession developing its activity within the realm of the State.

8.7 References


Públicas e Conhecimento Profissional: o Ensino e a Enfermagem em Reestruturação”, Ponta Delgada, May18-19.


9 Spain:
Isaac Marrero, Jörg Müller, Fernando Hernández, Juana Sancho, Amalia Creus, Max Muntadas, Verónica Larrain and Xavier Giro
University of Barcelona

9.1 Introduction.

Workpackage 6 aims at integrating findings from work carried out in previous workpackages within and across the professions. The focus is on comparison between nursing and teaching professions on the level of the national reports as well as across the participating countries for the D06 report. The central question we try to address in this final study for the ProfKnow project concerns the commonalities and differences that allow to gain a deeper and more developed view of professional knowledge and processes of restructuring. The results will serve as the basis for the development of organizational, professional and educational strategies by the professions as well as administrators and policy makers. In sum, the objectives of WP6 according to the Technical Annex consist in:

- To present comparisons of professional work and life in different European contexts within and between the professions of teaching and nursing.
- To achieve a more developed view of professional knowledge in the fields of teaching and nursing as a basis for the development of organisational, professional and educational strategies by the professions as well as administrators and policy makers.
- To describe, analyse and evaluate current restructuring in education and health in different parts of Europe from the point of view of teachers and nurses and their experiences from their interaction with clients.
- To present a conceptual framework for analyses of professional knowledge in restructuring organisations.

This national report is structured in two parts. First, we will present the Spanish national context, that is, the major changes from the 1960s onwards on the macro-economic and socio-demographic level. This will establish the backdrop on which the comparison of teachers and nursing professions and work live experiences will take place. The comparison itself is organized along the distinction between “system” vs. “work-live” narrative. The contrast between official discourse on restructuring and how teachers and nurses see their relation with “clients” affected will provide important guidelines for fleshing out the decisive dimensions of professional knowledge in transition.

9.2 The national case presentation

The Spanish Welfare State exhibits a series of salient features that distinguishes it from the continental and northern welfare models and places it into the vicinity of other south European states like Portugal or Greece. Its relative late development and its inauguration under the Franco regime stick out as the two most characteristic features. The rollout of social welfare caught precisely momentum when the existing Keynesian reference models of the continental and northern European counties entered in crises from the 70’s onwards. The Spanish system started to implement social policies that corresponded to a modern, industrial production and economy, but at the same time imported the neo-liberal rhetoric of social cutbacks (Rodríguez, 2003: 9; Adelantado and Góma, 2003: 72). The relative undeveloped of
the Spanish welfare state in comparison to other European countries remains a recurrent starting point for its critique (Navarro, 2004).

**Illustration 9.1:** GDP Growth Rate. Source: Eurostat

We will briefly comment upon the key aspects of Spanish Welfare State as we’ve conceptualized them during the research process: its weaknesses and decentralization. They should also be understood against a backdrop of steady economic growth. The Spanish economy has consistently grown above the EU-25 average for more than 20 years, but public social spending remains well below the European average (see illustration 9.1 and 9.2). Despite the economic expansion and growth of recent years, public spending has been frozen to the level of 1997 (second year in power of conservative Partido Popular), which means that an ever decreasing percentage of the produced richness is destined for public/social spending. The state protection against poverty and social exclusion is diminishing, the cleavage between affluent and impoverished widening.

**Illustration 9.2** Public Social Expenditure % of GDP. Source: OECD

This certain quantitative weakness in comparison with EU standards is paralleled by several qualitative ones. We should recall once more that the birth of the welfare state occurred under a dictatorial regime. Therefore, the welfare state was not strictly dependent upon the existence of democratic institutions, nor dependent upon certain levels of social spending, or the coherence to an archetypal welfare model. Rather, its dynamics are primarily understood as a consequence of the (late) process of capitalist modernization from the 1960s onwards –as a mode of social regulation buffering the insecurities of the market (Rodríguez, 2003: 76-77; Gutiérrez 2000).
It’s been also said that Spain confronts a structural problem which Ferrera (1996) terms the “southern syndrome”. The development of the welfare state has occurred “against a backdrop of social heterogeneity, territorial disparities and in the context of resource constraints and inadequately institutionalized state structures which have been based in many instances on clientelistic rather than rational-bureaucratic forms of administration” (Rhodes, 1997: 15)\(^{29}\).

The Spanish welfare has a weak and fragmented administrative structure operating over great territorial disparities between north and southern regions and faces historically grown clientelistic complicity which traverse the Spanish society and diminish its role in functioning as mediator of social disparities and exclusions.

![Illustration 9.3: Decentralization of Education Budget. Source: MEC 2004](image)

It also should be reminded that following the end of Franco’s regime, an important process of decentralization started to take place, meaning that responsibilities over many welfare services are distributed (Rico, 1997). More specifically, it means the redistribution of competences from the Central Government to Regional Governments (Comunidades Autónomas). To make things even more complex, this was a multi-paced process, with different regions gaining control over different services at different times. Already in the 80’s regions such as Catalonia and the Basque Country had started to manage education and health services.

When talking about the Spanish Welfare State, therefore, we should never think of a monolithic, unified structure. It is more like a complex network of bureaucratic structures unequally developed. As an example, the following illustrations clearly reflect the extent of decentralization and its history (Illustration 9.3) and the unequal expenditure among regions (Illustration 9.4), as seen in Education.

\(^{29}\) Similarly, the ESWIN report estates: “As a result, the current situation is one of great diversity, with different actions being taken by different administrative bodies having different structures. In many cases there are insufficient links between them and, together with the flexibility of the system itself, this has led to a situation in which it is difficult to identify and visualize the social services system” (The Spanish ESWIN Social Welfare Summary Fact Sheet, 2000)
9.3 Analyses of structural changes

9.3.1 System narrative

9.3.1.1 Restructuring: what does it mean and how is it working?

In a general sense, the discourse on restructuring in Spain might be characterized by not having developed any own strong, theoretical point of view. The relatively late rollout of the Spanish welfare system might be mirrored in a certain delay in its theoretical reflection leading to the adaptation of terminology developed in the continental and northern countries. Research has hardly conceptualized key concepts such as restructuring in relation to the specificity of the Spanish case. We will nonetheless try to assemble a system narrative that can be compared or juxtaposed to the work-life narrative later developed.

Talking about restructuring both in education and health requires us to talk briefly about structuring. As we have already said, the very late development of Welfare State in Spain has to be acknowledged when dealing with restructuring. Only doing this one can understand the specificity of the Spanish case, which is something like a compressed and anomalous history of the Welfare State in Europe. Public health and education institutions were firstly developed in democracy in the 90’s. Before that, as we know, there were timid build-ups by Franco’s regime. Up until 1967 in health and 1970 in education there wasn’t a comprehensive system for providing basic services to most citizens. So basically what we see during the nineties is the building of the kind of welfare institutions that most European countries developed after the Second World War. A decade later, the first clear symptoms of their dismantling were manifest. In what follows we will discuss this process for both health and education chronologically, so that the many parallels become apparent.

The main changes since the 60’s in the Spanish Education System are concentrated in four Acts linked to global educational reforms: the LGE (Ley General de Educación), which was passed in 1970 still under the Franco regime and established a basic education for all until 14 as a preparation for the labour market. With the LOGSE (Ley Orgánica de Ordenación General del Sistema Educativo), passed in 1990 under the socialist party government, the aim of education changed, putting the emphasis on a democratic and comprehensive education and the development of the students’ personality. Education was thought fundamental for accomplishing the transition from the dictatorship of the past towards a truly integrative and
democratic society. With the LOCE (Ley Orgánica de la Calidad de la Educación), passed in 2002 under the conservative party government, the aim of education again acquired a different flavour now insisting above all on a culture of individual effort, efficiency and quality. Education was oriented towards results, importing clearly a neo-liberal vocabulary. However, the dramatic changes with the 11-M bombing in Madrid and the change in government (from the conservative PP to the socialist PSOE party) prevented the implementation of the reform. The PSOE pursued a new reform LOE (Ley Orgánica de Educación) which was approved in April 2006. Although its contributions in content don’t face contemporary challenges, its scope surely is in that it readjusts the legislation that has been in place for the last 35 years. Its main aims try to cope with emerging educational demands, such as the school adaptation of emigrants and the reduction of drop outs figures. The Law readapts all previous reforms including the LOGSE (but with exception of the LODE) by unifying previous legislative frameworks into a single one.

With respect to health, we will distinguish three periods of reform, roughly coinciding with three decades: 80’s, 90’s and 2000’s. During the eighties the main concern was building a national health system, something that Franco’s dictatorship had not achieved. Therefore, just when the model was starting to be questioned (at least in northern Europe), it was being built in Spain. During the nineties, the situation changes radically. The system is rendered as unsustainable and liberal reforms are implemented. In some way, there is synchronization with general trends in the field: cost-control, private management, and flexibilization. Finally, the 2000’s meant the entry of two new principles of organization: quality and participation. The patient is now conceived as “the centre of the system” (MSC, 2003: viii). Quality, in turn, is the new axis of the system’s spirit.

The decade of 1960’s witnessed a rapid economic growth in Spain; the income per capita increased by 350 percent and the working population underwent a radical transformation in correspondence to the general industrialization of the country (migration to continental European countries and to South America, rural migration to the cities) (Rodríguez, 2004). However, the main obstacle for a steady development, as detected by the technocratic ministers of the Franco regime was the non-existence of a sufficiently skilled work force. The need to educate the working population in order not to completely loose contact with the continental European capitalist economies led to a quite polemical discussion and finally to the approval of the Ley General de Educación (LGE) in 1970. It followed the logic of introducing different measures of rudimentary welfare provision in order to regulate and push for economic growth and capitalist modernization on the one hand, balancing at the same time the social demands connected to a large work force and the insecurities of the market.

Whereas education was formerly a rather elitist realm where teachers had to attend a selected group of students, it turned into a massive undertaking which confronted teachers with a highly diverse student population. Through the Act, the State further acknowledged openly its primary role in planning and providing education, and in guaranteeing the equality of opportunities in basic and higher university education in combination with safeguarding its general quality. The Act also foresaw the continuation of an important share of private institutions in education.

Shortly before, in 1967, the Basic Social Security Act was sanctioned, the first attempt to provide ‘universal’ health care. It actually expanded coverage to self-employed professionals and qualified civil servants and it helped the creation of a network of somehow modern public owned hospitals. As a result, the percentage of population covered rose from 20% in 1942 to 53% in 1966 and 81% in 1978 (EOHCS, 2000: 10). According to the European Observatory on Health Care Systems, the “predominance of public provision within a social security
system… can be considered the main distinctive feature of the Spanish health care sector as it emerged from the Franco period. Consistent with this, the vast majority of primary health care provision is public, with general practitioners having the status of civil servants” (ibid.: 10).

It was not until 1982 that a comprehensive reform of Spanish health care system could start. The Socialist Party’s wide majority allowed for the first time to overcome the lack of support the reform had had before. The major challenge was the transition from a Social Security model to a National Health Service one, based on universal access, tax-based financing and predominant public provision. This was attained with the General Health Care Act of 1986 (14/1986 Act), which consolidated and integrated most of the partial reforms made since 1977, including the decentralization process (the transference of competences from the Central Government to the Regional Governments had already begun in 1981 with Catalonia). As it has been already argued, one of the most salient features of the Spanish Welfare State is its decentralization. And the Health Care System is no exception. The process on consolidation of a comprehensive system has been parallel to its decentralization, and sometimes even anticipated by it.

The main objective of the National Health Service is defined as “health promotion and illness prevention”. Towards this goal, two levels of attention are defined: primary health care and specialized attention. The primary care network should always be the first and main level of attention, and it is located in Health centres. Specialized attention is located at hospitals and deals with more complex treatments. Both are supposed to be engaged with all kinds of health promotion activities, according to the “social” view of health care (embedded with the community) that defines the document. Both levels are, too, part of the professional training circuits. This reform implies a process of power redistribution at two levels: within the organization, the work team takes power from doctors, and nurses and other lower positions better their position around it. Secondly, the transition from an assistance-oriented model to a primary care one implies once again the reduction of doctors’ biomedical discourse relevance. Health promotion will replace cure as the leading rationality. The main objective is not individual illness treatment anymore; it is the improvement of collective health. This explains the key importance of the new Primacy Health Care System in relation to the hospitals’ network, clearly orientated to illness eradication. The change from a curative system to a preventive one also means that health is no longer doctor’s business; it concerns a wide and heterogeneous array of professionals.

The end of the decade sees the implementation of the tax-based financing system (replacing the old contribution-based one) that allowed in 1989 to extent coverage for the first time to everyone regardless of their economic situation (Royal Decree 1088/1989). “Universality, equity and solidarity” can be therefore said to be the principles of 80s reform.

During this very same period huge changes in the education system started to occur. In 1985 the Organic Act on the Right to Education (Ley Orgánica del Derecho a la Educación, LODE) articulated the basic educational rights set forth in the 1978 Constitution. It granted all Spaniards the right to access to basic education; in addition it established a network of public and private schools to guarantee this right to education; and finally this act regulated the participation of the educational community in the control and management of schools financed with public funds. A process of intensive debate and experimentation towards educational reform had been initiated by the socialist party in 1983 and involved the active participation of schools and teachers. It followed a bottom-up strategy giving the educational community a decisive role in shaping the planned reform and thus strengthening the overall democratization processes of the country. From 1983 onwards each school term approximately 25 schools joined the effort and participated in the definition of educational
objectives and curriculum design (Marchesi & Martín, 1998: 436). This experimental phase also counted on strong movements of pedagogical reform which played a major role as opposition force during the 1970s of the Franco regime, the Movimientos de Renovación Pedagógica (MRPs).

In 1990 the Organic Act on the General Arrangement of the Educational System (Ley Orgánica de Ordenación General del Sistema Educativo, LOGSE) was approved by the parliament regulating the structure and organization of the Spanish education system at non-university levels. As such it replaces the 1970 General Act on Education. The LOGSE, among other things, extended compulsory education from 6 to the age of 16; changed the structure of the educational system (now consisting of 6 years of compulsory primary education, 4 years of obligatory secondary education, and a choice of either two years of bachelor or vocational training); and completely reformed the vocational training. The Act placed an emphasis on development a democratic education, culture, and society.

Many parallels, as we see, during the 80s reforms of health and education. In general, it was a period of huge changes and important attempts towards the democratization of the country. But problems soon arose. The impact of the reforms wasn’t as big as hoped at the everyday level. Many practices remain, many changes didn’t happen. At another level, Spain was trying to develop a strong and comprehensive Welfare State at the same time it was being severely questioned almost everywhere else. While neo-liberal politics were starting to set the new trend, Spain was going in another direction. But this discrepancy didn’t last much and early in the 90’s started the pressures for a more ‘flexible economy’. When in 1996 the Conservative Party won the general elections, the way for restructuring was almost paved.

To complete this general picture we add the fact that in 1990 the Government asked for a report of the Health System situation. Known as Informe Abril (April’s Report) and signed by the Commission of Analysis and Evaluation of National Health Care System (CAESNS, 1991), the report pleads for ‘synchronization’ with the general trend towards ‘new management formulas’. The reform of the system would rely on ‘excellence’, ‘costs-control’, ‘management strategies’ and ‘adjustment to users’ expectations (Irigoyen, 1996). The planned reform also opens the way for ‘collaboration’ with the private sector (out-sourcing) and introduces the idea of competition between services’ suppliers to raise quality, scope, and price of provisions. Its main features are therefore: flexibility, decentralization and internal competition. This pretty much suits with the situation of other European countries (see WP1), where the trend towards the split between functions of financing, buying and service provision was already popular. The Report’s proposal was nonetheless quite radical: among other things it suggested to make public health centres enter the Private Right Regime, like any other business, through the concept of ‘foundation’.

Opposition to the report was strong enough to pretty much paralyze any comprehensive changes. Nonetheless, the decentralization of the system allowed some room for it. The 1990 Catalan Health Care Act, for example, “opened the way for the introduction of new flexible forms of organization and management of health centres, explicitly including for the first time the possibility of contracting out the management of publicly-owned health centres to the private sector or to public providers opting out of the public system” (EOHCS, 2000: 114). This was just months after Thatcher’s National Health Service and Community Care Act 1990 in Britain, the document it was based upon. Its more important points regulated the separation between financing and buying from provision of health services and it insisted on the diversification of health provision institutions and a stronger competition between them. The Catalan region, governed by the conservative nationalist party (CIU), took a leading role in implementing the neo-liberal ideas planted in the Informe Abril and that the conservative
government from 1996 onwards rescued and revived on a national level. We will later see a particular example of this trend in our case study.

With the conservative party winning the general election in 1996 the spirit of the Informe Abril was promptly rescued. The 10/1996 Royal Decree established new forms of management for the INSALUD (the organism in charge of health care management in those communities without competences) and the 15/1997 Act of new forms of management of the national health system opened up the way for the same kind of changes in the whole of the system. Their logic is roughly the following: the growing exigency of efficiency and “social profitability” makes it indispensable to put out “more flexible organizative formulas”. That is, a separation of competences of financing and buying on one hand and management and provision on the other, and the direct participation of the private sector in the system’s management. The 15/1997 Act even talks about a certain “spirit” of reform, namely “flexibilization and autonomy in health care’s management”.

The 16/2003 Act of Cohesion and Quality of the National Health System is extremely important, since it is one of the more comprehensive reforms of the system carried since its foundation in 1986. It starts by acknowledging “deep changes” in society (cultural, technological, socioeconomical, ways of life and illness…) and therefore new challenges for the National Health System like orientation to results, empowerment of users, professional involvement, and integration of sanitary and socio-sanitary attention. Equity, quality and citizenship participation are seen as the keys for such a change. The first is related with the need for mechanisms which assure equal access in a decentralized scenario. The second is defined around innovation, effectiveness, and anticipation. Finally, the third is related to promoting users’ self-autonomy, knowledge, and experiences.

This rhetoric of quality is one to be highlighted. It has to be understood in relation to other policies by the conservative party, in particular the Organic Act on the Quality of Education (see below), and of course the ‘total quality management’ ideas that beginning in the late 90’s have come to dominate the business management strategies (Marazzi, 2002). Quality, in this sense, is linked to ‘lubricating’ the system, to eliminating everything that could hinder its performance. Quality means leaving all ballast behind, assuring a continuous flow of information and overcoming bureaucratic organization’s rigidity. Collaboration with the private sector is therefore advisable (e.g. out-sourcing).

The Act continues to recognize the division between primary health care as the main and first level of attention and specialized care as precisely a specific level. It also emphasizes the social dimension of their actions (promoting public health, organizing diffusion activities, etc.). However, there is no mention to the interdisciplinary character of their functioning. Moreover, there is no mention of the ‘primary health care team’, so important during the 80’s reform. The problem has been left out of general legislation and transferred to the regulation of health care professions. We could adventure to read this movement as a restitution of a clear hierarchy, with doctors on the top.

Similar kinds of forces are visible in the same period in education. First, with the change of the government from the socialist to the conservative party in 1996 educational expenditure was frozen. The politics of austerity executed by the Popular Party implied a steady decrease of public spending in education from 4.7% of the GDP in 1996 to 4.4% in 2004 situating Spain well below EU-15 average of 5.4% (MEC 2004b: 11; Navarro, 2004: 10; Bas Adam, 1997). At the same time Government support for private schools with public funding was increased – especially for those of catholic confession30. Second, as it was mentioned above,

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30 Public funding of private schools increased in 1997 by 1.6% whereas funding for public schools
the new government set forth its own educational reform, the Organic Act on the Quality of Education (*Ley Orgánica de la Calidad de la Educación*, LOCE) approved by the parliament in 2002. It made substantial changes to the LOGSE emphasizing individual responsibility and effort in the educational process, intensifying pupil’s assessment processes, and conceding more autonomy to educational establishments in financial and administrative terms.

In addition, the politics of the Popular Party aimed at the alignment of educational quality to customer (parent) satisfaction by, for example, giving schools more autonomy to select their students (Viñao Frago 2001; Torres 2003). The rhetoric is one of individual effort, efficiency and quality. Education is oriented towards results, importing a neo-liberal vocabulary. As for concrete actions, infant education (age 0-3) was removed from the official educational system and qualified as kindergarten. Being not considered anymore as forming part of the education system, the state reduces its responsibilities on this level and withdraws from its provision and regulation. Primary and Secondary Education kept their basic structure, but with important changes in curriculum. The Act also opened the possibility to establish ‘itineraries’ at Secondary school, so that students are classified according to their ‘capacities’ and attitudes to learn. As mentioned, the reform never came to be implemented. Rather, the PSOE in power since 2003 pursued its own, new educational reform, the above mentioned LOE. The new text - which has been approved in April 2006 – gravitates around “quality” and “equity” and is heavily aligned with official EU (and UNESCO) policies and the Lisbon agenda of converting the European Union into the most competitive knowledge society in the world. It addresses specifically this European convergence as an objective (Jiménez 2006). The LOE didn’t affect the structure and organization of the Spanish educational system and reflects the attempt to update legislation from 1990 and before to the new social realities of the 21st century. Given its fundamental status, it should be analysed in terms what it failed to address when setting the agenda for non-universitary education in Spain for the upcoming years (until 2010). Especially in relation to teachers, there is no clear directive on improving the selection process for teachers; no clear definition of the tasks and responsibilities of teachers in their daily work in the wider school community, including the relation to the school, colleagues, and families; no clear professional career which would be based on the professional work merits of teachers and not on examinations; a regulation of the evaluation of teacher which is transparent, public and contributes to improving the quality of education (Pozo Ortiz 2006)

9.3.1.2  Professional strategies and configurations

We will now discuss the evolution of professional strategies and configuration for the same period, maintaining the system narrative. Changes in the teaching profession have been parallel to the changes in the overall structure of the Spanish education system we just reviewed.

There are three different types of teachers depending on the educational level they teach: *maestros* for infant and primary education; *profesores* for secondary education and vocational education; and vocational training technical teachers. Although these three kinds of teachers have remained almost the same throughout all educational reforms undertaken since the LGE in 1970, their characterization in terms of initial training and age groups they attend has undergone substantial changes.

According to the structure installed by the LGE, *Profesores de EGB* (teachers of basic general education) taught all of compulsory education from age 6 to 14. *Profesores de BUP* (teachers

decreased at the same time by -2,0%  (Bas Adam 1998, p.82).
of Unified and Polyvalent Baccalaureate) were responsible for teaching the post-compulsory level, comprising pupils age 14 to 18. Technical teachers attended vocational training. The changes introduced with the LOGSE implied a major change for this organization of the teachers’ profession. Maestros were assigned to attend infant and primary education age 0-12 and, with a university degree, to compulsory Secondary education. Profesores had to attend both the compulsory secondary education (ESO) ranging 12 to 16 years of age and the post-compulsory (Baccalaureate and Vocational Training, age 16 to 18). Vocational Training Technical Teachers Corps carried out specific vocational training (age 16 – 20). However, the restructuration of the teachers’ public body is not just a matter of redistributing the different age groups. Linked to them are the different initial training requirements for Maestros and Profesores, which as we will see below has had a direct impact in professional careers.

The first important change introduced by the LGE (1970) for initial teacher training consisted in the integration of infant education and primary education teacher training into the University. From 1839 up to 1970 initial teachers’ education had been carried out in non-university training colleges (Escuela Normal de Maestros). The LGE then stipulated that Maestros should at least have a three year diploma (Diplomado). Initial teacher training for Secondary Education was already being provided at universities before the LGE.

Teaching in secondary education in the academic branch, that is, BUP and COU (University Orientation Course), required a four or five years degree (Licenciado) plus a short pedagogical course (CAP) of 100 hours which includes a period of teaching practice -50 hours-. This course has been criticized by several authors (Esteve 2000, Marcelo 1995, Pérez Gómez, 2004) because its lack of pedagogical training which would prepare teachers better for dealing with the diversity and complexity to be found in real class rooms. For vocational training a degree of Diplomado was enough.

After successful completion of the degree, teachers in addition are required to complete a civil service examination/competition held by the regional educational authorities. This test is broken down in two steps: a) an exam assess academic knowledge as well as command of teaching techniques and pedagogical skills; b) in a competitive process, the candidates previous teaching experiences and academic training will be taken into account. Teachers that have successfully completed the examination/competition can enter a public official teaching position. If not sufficient teaching positions are available, teachers will enter a waiting list. Access to public official teaching position can also be obtained through an interim contract. Selection criteria for part-time teachers are specified by each Autonomous Region. The aim is to fill vacant positions or to substitute public official teachers. Those part-time teachers are usually filled by candidates who took the competitive exam but have not obtained an official position and who are on the before mentioned waiting list of teachers. However, every person who has required qualification can apply for making a substitute teacher as long as s/he has the CAP without passing the ‘concurso-oposición’.

An important innovation of the LOGSE (1990) consisted in organizing the nation wide mobility of teachers. A periodic national call allows teachers to apply for a teaching-position in each of the Autonomous Regions independent of his/her origin.

The 1984 Act Measures for the Reform of the Public Function established teachers in the public sector as civil servants with a life-time position. The State is thus in charge of determining professional competences and politics. Private school teachers have been subject to their own labour regulations. The Government, after consulting with teachers’ unions and acting on a recommendation made by the Ministry of Education and the Ministry of Labour, laid down the by-laws for private sector teaching and auxiliary staff and established teachers’
minimum emoluments. Currently, general labour laws govern private school teachers’ conditions of employment (which make dismissals easier).

There have not been any substantial changes in teacher’s salaries over the past two decades. For all state employed teachers there is a basic salary which then gets increased according to years of experience, the professional category. The following table refers to the non-university staff in Catalonia.

Table 9.1: Non-university staff in Catalonia.

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Basic Salary</th>
<th>Complement, academic level of exercise</th>
<th>General component</th>
<th>Specific complements Total</th>
<th>Monthly</th>
<th>Per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catedrático</td>
<td>1,091,02</td>
<td>690,47</td>
<td>563,97</td>
<td>50,89</td>
<td>614,86</td>
<td>2,396,35</td>
</tr>
<tr>
<td>Secondary Teacher</td>
<td>1,091,02</td>
<td>576,47</td>
<td>563,97</td>
<td></td>
<td>563,97</td>
<td>2,231,46</td>
</tr>
<tr>
<td>Vocational Training Teacher</td>
<td>925,96</td>
<td>576,47</td>
<td>563,97</td>
<td></td>
<td>563,97</td>
<td>2,066,40</td>
</tr>
<tr>
<td>Primary Teacher</td>
<td>925,96</td>
<td>468,09</td>
<td>551,41</td>
<td></td>
<td>551,41</td>
<td>1,945,46</td>
</tr>
</tbody>
</table>

Source: Departament de Educació - http://www.gencat.net/educacio/profe/retir.htm

The last 30 years have been important in the definition of nurse and its professional competences. The General Council of Nursery (Consejo General de Enfermería) is the organism dedicated to the definition of the nursing profession and its representation. During the 70’s, it led the transition in the definition of nursery from the “art of healing” to “a profession with a university degree and recognized by the State” and managed to get the first statutes for the profession passed in 1978. These statutes were later modified in 1993 (Royal Decree 306/1993) and completely redone in 2001 (Royal Decree 1231/2001) and 2003 (Act 44/2003). The Council considers the latter developments to be a “historical milestone” since it includes explicitly a new regulation of the basic principles of the practice of the profession. The previous reforms had dealt with the representational and organizational issues, but not with the definition of the profession itself. The Council acknowledges the difficulties of the professionalization process. First of all, there have been problems to organize in a stable fashion and lack of social recognition. But even more importantly, it has been difficult to unite professionals around a common denomination. Midwife, medical assistant, technical sanitary assistant, minor surgeon or nurse, among others, have been overlapping categories and have created a “tremendous blurriness in the definition of the profession” (Consejo General de Enfermería, 2005), unable to build itself upon common grounds. Recent changes are much clearer if we shortly comment upon the previous situation.

In 1960 (Decree 2319/60) the professional competences of Technical Sanitary Assistants (equalled to nurses) were defined as to “apply medicaments, injections and curative treatments”; to “assist doctors in their interventions”; to “give assistance, in case of emergency, in the absence of any superior professional”; and to “assist childbirths when in absence of midwives”. By contrast, in 2001 (Royal Decree 1231/2001) the mission of nursery is to “give health attention to individuals, families and communities during all life cycle”. Their interventions should be based upon “scientific, humanistic and ethical principles”. Finally, in 2003, the long pending definition of health professions is accomplished (Act 44/2003), together with the new Statute for Health Professionals (Act 55/2003). These two documents represent a comprehensive reform, a complete new framework for professionals.
The General Council of Nursing conceives them as “the re-foundation of the nursing profession” (2005: 2) and the end of a legislation that had considered nursing to be “a profession always at the service of other and never at the service of society” (2005: 3). For them, it was not possible, rigorously speaking, to talk of ‘profession’, since there was “no definition, no autonomy, no responsibilities”. The subordinate character of nursery has been finally overcome, since the mission of nursery is “to give health care to individuals, families, and communities during all stages of life and development”. This allows to enunciate a new definition of nurse: “a professional legally entitled, responsible of her professional acts, with knowledge and aptitudes enough over her field and who bases her practice in scientific evidence” (ibid.). Now, always according to the Council, it is possible to talk about nurses’ own functions: assistance, research, teaching, and management. And finally, professional competences: “the aptitude of the professional to integrate and apply knowledge, skills and attitudes associated to her profession’s good practices in order to resolve problems in everyday practice” (ibid.: 7).

The last milestone in the recent constitution of nursery as a profession on a legal level has been the Basic Statute (Estatuto Marco). Passed also in 2003 (55/2003 Act), the Statute regulates the legal status of health workers, pending since the Constitution, which establishes for them a special kind of civil servants category, called “statuesque personnel” (personal estatutario). Health workers have historically had a specific regulation, related to the special characteristics of their labour and the National Health System, and the Act reaffirms its necessity. The Act importantly establishes that all health workers who accomplish the requisites (who have passed the civil service examination) are subject to the Basic Statue and classifies them according to their academic level: personnel with a university degree (licenciados and diplomados, with and without specialization) and personnel coming from vocational training (técnico superior and técnico).31 Once the selection process is passed, all personnel should be permanent. Temporal jobs (also within the statuesque category) are to be used by the health services in case of “need, urgency, or development of temporal or extraordinary programs”. In fact, temporality is linked to three situations: covering a vacant post; developing a temporal task; or substituting somebody. In any case, the total time of temporal jobs cannot be superior to 12 months in two years. Stability of employment is in fact the first right of statuesque personnel according to the Act. Promotion is also regulated: health workers can voluntarily improve their category (specialize) every 5 years. There are four levels, each having its own evaluation process. This is supposed to given an incentive to in-service training. The retirement age changed from 70 to 65 years. In terms of working conditions, the Basic Statute fixes a series of relevant conditions:

- The maximum of working hours per week (regular hours plus extra hours) must not exceed 48
- The regular working day must not be longer than 12 hours, with 12 hours of minimum rest time until the next working day
- Workers have the right of at least 24 uninterrupted hours of rest a week
- Workers have the right of at least 30 days of vacation a year

31 In the same way we saw for education, the legislation distinguishes between two professional levels: diplomados (holders of 3 year university degrees: nurses, physiotherapists, occupational therapists, chiropodists, among others) and licenciados (holders of 4 or more years university degrees: doctors, pharmacists, dentists, and veterinarians).
However, the Act establishes the possibility of exceptions, since ‘especial services’ might require different working conditions. With respect to payments, the Act has little to say. The question is left for specific legislation.

The process of negotiation of the Statute was long and difficult. There were several arenas of discussion. One of them was the competences: all nationalist parties considered that the legislation violated their competences. Another issue was mobility. The plan to introduce the possibility of compulsory mobility was resisted by health workers and finally changed: in its final shape, the Act conceives mobility as a right, not a duty, and it is rendered as voluntary. But again, some exceptions are allowed. The Act was finally passed with the abstention of the Socialist Party.

A quick look at the local situation observed during the research makes it possible to contrast all these intentions with an everyday reality. We should also recall that decentralization allows different regions to operationalize the reforms in different ways. In the hospital we studied, a leading institution in the privatization of health services, there is no staff with civil servant status as it is the case with most public health institutions. One reason for the creation of the IMAS in 1983 (the local ‘institute’ managing health) consisted precisely in eliminating the status of civil servants for health professionals that pertained directly to the municipality and having greater flexibility in the management of worker’s contracts. There are three types of contracts: temporary, interinaje, and permanent contracts. Temporary contracts cover usually very short periods of time - contracts for one day are not unusual. They can be substitutions in case of emergency, sick-leave, holidays, etc. There are also temporary contracts of a second type specifically for vacant positions. Meanwhile a given position is not officially published for being covered with a permanent contract, it is occupied by an interino/a who will have an interim contract that is more stable than a temporary one, but offers less security than a permanent one. They are not uncommon, since many nurses with permanent contracts take sick-leaves or ask for transfers to other shifts. Permanent contracts finally provide more stable work relations and economic security. They have no temporal limit. They offer a status similar of that of a civil servant and are only accessible after a public call and examination.

Adding to these three categories, there are also four different contracts regarding the number of hours (excluding substitutions, which are absolutely flexible). Therefore, there can be temporary, interim and permanent contracts of 14 (weekends), 21 (weekends plus Monday or Friday), 35 and 40 hours per week. Temporary contracts are slightly better paid by hour (because they are subject to fewer taxes). Average earnings are: 560 € for a 14 hours contract; 800 € for 21 hours; 1250 € for 35 hours, and 1500 € for 40€. The actual final amount is however difficult to estimate, since there are many bonus payments: working on a bank holidays, night shift, or risky position, among others. Permanent personnel are eligible for trienios, a special bonus for every three-year period worked.

Nurses receive 12 payments plus 2 extra ones in July and December. In addition, in the hospital we studied they have a third payment in April depending on their punctuality and attendance. After having worked for 25 years, nurses receive one extra month of vacations. With 30 years one gets an extra week of vacations or the pay check that corresponds to this week. There also exists a regulation which allows nurses from 60 years of age onwards to take partial retirement, which means that they can work less hours by earning the same. All these conditions are related to collective agreements, which are signed between each hospital (or group of hospitals managed by the same institution) and the different parts, with the approval of the union trades. It is precisely the decentralization of agreements that allows very
different working conditions within the Spanish Health Care System (and between public and private centres).

This process of professionalization cannot be understood without considering the academic transition from vocational training to universities, and the recent reconfiguration of specialization. With the General Law of education of 1970 (LGE) Schools of Nursery were transformed into University Schools or Centres of Professional Vocational Training, a first attempt at giving a university standard to nursing studies. The actual transformation of nursing studies into university studies in the period 1977-1983 meant that for the first time in Spain the curriculum of Health Studies was oriented towards Health Care in a comprehensive and public service-oriented perspective. One of the objectives of raising nursing studies to a university level was precisely to decouple nursing education from hospitals, and to give health care education a more holistic perspective including physical, psychical, biological, social and cultural necessities of the person and/or community, and finally to introduce models and theories of nursing and their development in educational contents that promote a change in ideologies and methodologies of nursing attention. In 1990 a new curriculum was introduced, allowing universities more flexibility in its final design. It is a three year university degree (diplomatura) with a 50% proportion between theory and practice.

During the last years very important debates and changes have occurred in the organization of nursing teaching. First of all, the Bologna Declaration on the European Space for Higher Education has reopened the debate on the duration and status of nursing studies. Currently a three year degree nurses’ associations are pressing for a four year degree (licenciatura) that would almost equal them to doctors, dentists or psychologist’s. The struggle for increasing professionalization is quite clear in this debate. The General Council of Nursing, the organism in charge of representing the nurse profession, pleads for the necessity of the implementation of such a degree to consolidate the nursing profession according to present times.

In 2005 the reform of Nursing Specializations (Royal Decree 450/2005, of April 22nd) was passed, radically reorganizing the scheme by setting up a system very similar to the doctor’s one. Once the nurse degree is obtained, a nation-wide exam has to be passed. The exam establishes a ranking that is used to access the different Training Units (Unidades Docentes) were each Specialization takes place. It is a full time training, in a regime of mentored training. During their residence in the unit, nurses are subject to evaluation. When the period finished and all evaluations passed, the diploma is awarded. The system is not compulsory and acknowledges the status of “generalist nurse” for those not specialized.

9.4 Work-live narrative

We will now proceed to change our point of view and study these issues from the actors’ perspective. In juxtaposing this work-live narrative to the system narrative we hope to get a much more complex understanding of the processes of change in Spanish Welfare State.

9.4.1.1 Restructuring

The recent history of the Spanish educational system just mentioned provided a quite concrete picture of restructuring from a system’s narrative. However, it failed to be identified as a meaningful player for the teachers themselves. A high degree of scepticism and cynicism was observed regarding the impact of policies in everyday practices. First and foremost the material tells that the three teachers perceive their profession and their work on a daily, personal basis rather then embedded in large socio-political contexts. Therefore, restructuring wasn’t thought of as a kind of local expression of global dynamics, so a very interesting gap remains between their conception of the system and the theoretical causes and explanations.
some theorists of the field may put forward. Even when drawing explicitly the attention to 
changes in the legislation from our side, this was not perceived as influencing day to day 
business, either because changes are too cosmetic or lacking the necessary time to become 
applied practice. The educational projects associated with the different political parties were 
met with a dismissive shrug, unable to affect their working conditions towards the better. 
What happens on the level of politics is perceived as having little or nothing to do with the 
real necessities in the school.

Sophia (5): I don’t care about a lot of political things, but on your daily life… That’s also 
why I believe a little less each day in political things. I mean, the little I know, they 
disappoint me so much that beyond my daily life, why should I care about politics?

However, as the following paragraphs will show, there have been quite direct links between 
educational changes and teachers’ professional careers.

In this sense, the case of Rosa (15) is interesting since her career was most directly affected 
by the restructuration carried out by the LOGSE. Rosa initiated her professional career just 
when the LOGSE had been approved in 1990. This meant that her initial training still 
followed the old educational system where she was meant to teach children between 11 and 
14 years of age. But because the LOGSE redistributed the age groups she had to decide to 
either professionally adapt to the higher age group (13-16 years of age) or to “downgrade” 
and teach in primary education. This meant that the curriculum specialties and age group of 
Rosa’s academic training did not exist in that form anymore when she started to work. Unable 
to fulfil the conditions for ascending into the status of secondary teachers, she opted for 
descending to the primary level until reaching finally infant education. The restructuration 
carried out by the LOGSE also coincided with very low birth rates and therefore a substantial 
reduction of the student population on the entry levels of schooling. The difficulty to pass 
entry requirements to teach on secondary level combined with a lack of students was 
responsible for the scarcity of work among primary teachers. For Rosa this meant an instable 
work situation. Although she passed the state entry exam to her profession which usually 
guarantees a secure job, half of her professional career, as it was the case of many other 
teachers, was marked by the instability of changing between schools and/or educational level.

From this initial restructuration as a political “fact” different interpretations in terms of effects 
on individual teachers lives emerged. Many teachers of her generation perceived 
this change 
in the educational system as affecting their professional identity Rosa quite on the contrary 
took it as a positive opportunity.

Rosa (15): And instead of doing the leap to the first years of the ESO, I kept going down 
and now, see, I’m in P3. I don’t know if some day I will end up with the babies in the 
nursery but… I don’t worry. I was a lot of years working in primary education, first and 
second grade, where you get all the reading and writing process. And I enjoyed it a lot 
and I found myself very comfortable working there. In the school I was working, in 
primary education they worked together with the kindergarten. To tell the truth, I was 
delighted with the dynamic, and the kids enjoyed it too, because the children haven’t lost 
their innocence.

The changes between different schools and the need to adapt to changing social contexts, 
school projects, and teams is claimed as essential part of her being or learning to become a 
professional. Since in some of the schools she also was in the school governing body this 
experience of changing contexts becomes a marker of her professional identity. It underlines 
the knowledge that currently informs her teaching practice such as working in team, what it 
means to commit yourself to others, or the low esteem she shows towards political reform. 
Especially the later deserves some further attention, since the main reason why she shows 
such a low opinion of political agendas is the different timings involved in really
implementing a legislative change. Informed by her work experience, the time necessary to take a new law into classroom practice is in no relation to the rapid modifications on the political level. Change in schools – be it in relation to legislation or other – happens very, very slow causing the disconnecting between official policies and actual school practice (Fullan, 1999). In her eyes, it is not that the actual laws don't function but rather that they are missing the necessary resources to be actually implemented, a fact which actually corresponds to the implementation of the LOGSE under the PP from 1996 onwards, as we already saw.

Although Maria (30) also lived the restructuring process of the LOGSE, her professional career rather revolves around a different set of questions. Since no formal qualification for infant education was required at the beginning of the 1970’s when she started to work at the age of 18, her professional career was marked from the start by seeking alternative sources of pedagogical formation. She continuously participated in private curses of progressive pedagogical movements that compensated her lack of official education. However, with the introduction of the LGE in 1970, initial teacher training for infant and primary education became integrated into the University. A three year degree was needed to teach. As a consequence, maestras like Maria who previously had been working without official certification had to catch up with the requirements as the LGE entered into full vigour or change their profession. She went to a teacher’s college, but the title she obtained was not really satisfactory for her. Because her three years degree (diploma) was not equivalent to a five years degree (licenciatura), as required for secondary school teachers, Maria, as many primary school teachers, experienced the diploma degree as lacking status. However, her official certification did not really change the continuity of her “private,” parallel investigations and permanent desire to learn.

What runs as a common thread through the different professional careers is a rather high instability during the first years of work life. The change between schools or one’s curriculum specialty, the impossibility to engage in a long term project, or instable contracts have been a reality for the interviewed teachers no matter when they started to work. Although the reasons that cause this dynamic are very different between the cases, what remains quite similar is the positive interpretation of this flexibility. Both Rosa and Maria come to the conclusion that they were enriching experiences constituting an essential part of their formative years. From this initial experiences and the knowledge it generated emerges also the high esteem of continuing education for teachers as an indispensable part of the professional career. However, it is worth emphasizing the generational differences. Whereas for Maria parallel professional development courses were the means to become a professional teacher (in the sense of professionalism), for Sophia, the youngest teacher, a post-graduate course opens up other professional options (switching from teaching to music therapy). Visiting further courses appears in one case as the consolidation of a professional practice whereas for Sophia it signifies the flexibility between professions. What counts for Sophia as the youngest teacher is not the profession (its corpus of knowledge) itself but a personal, ethical, project.

The recent restructuration of class hours in Catalan schools offers us another good example of the dynamics at play. During March 2006 the National Agreement on Education Alliance decided that one additional hour should be destined to develop basic skills (like reading, oral communication, math and arts). This additional hour is currently run by part-time teachers.

For those who wanted to enrol two more years at university, the licenciatura could be obtained. However, having a full university degree does not mean for primary school teachers a direct increase in their salary or a promotion, as the short career ladder of the Spanish educational system is not based on teachers qualifications but in performing coordinating or managerial positions. What they can do is to apply for a secondary school job which has more academic status, better salary and less teaching hours.
Most schools have opted to extend classes half an hour at noon, reducing the time of lunch break and extending the afternoon classes as well by half an hour. In the perspective of the Catalan government this measure would only affect the students but not the teachers. Since the additional hour is covered by new staff, the gained “free hour” for the previous teachers should be dedicated to work in the school. But as it emerged from the focus group discussion, this is not the case. On the one hand it has become more difficult to establish relations with students because less time is shared with them. On the other hand, teachers now have less time during their lunch break to come together and discuss issues related to their work. Therefore, the difficulties to work in a team are increasing. The teacher with 30 years of experience expressed it the following way:

It is a big step backwards in terms of finding spaces for us to get together, not so much for doing meetings of the teachers body, but for talking to each other and for making our things in a more settled way. I think we made a big backward movement. In the past during the lunch break everybody was in the school [...] and although there were meetings of the teachers body there was always room. But now, since you have to adapt to the new schedule which is one hour more for the kids, you stay three times at noon but there are two more days where there is no reason to stay. And then happens what always happens. There are people who dedicated always not just the hours officially required but the hours they think are necessary. But of course, once there is no official duty there are people who leave. The two days which it is not obligatory to stay in the school they go home. And although you may want to share [things in relation to the school] you don't find anybody.

The relation with the administration (particularly school inspectors) is another good example. Especially in recent times there is a constant flow of ever new administrative requirements to which especially Maria has to respond; she feels like an administrative staff having even to control and report the cleaning service and maintenance service, for example. Although Maria manages to deal with the school administration, it is consuming a lot of energy and often runs on the cost of her private or other school time. For example, although it is not her responsibility, she fills out the documentation for the students’ canteen subsidies. Normally, each family would have to fill out the required forms for their children. However, since many parents are illiterate, Maria together with the school board takes on the responsibility to fill out 165 forms, one for each student they have. Apart from these administrative requirements, the relation with the administration is rather a relation of “control” than of “help” and “support.” As Maria but also Sophia states, to get the necessities of the school and the requirements of the educational authorities under one hat is very difficult.

Sophia (5): “There are like things you have to show to the Departament d’Ensenyament, which are as they should be, and then you have the indoors reality, that is always different. There is a long distance between the one working with children and the one in an office, receiving things from… The step is very big. And I don’t know. We are here like… The principal has been trying to move one of our kids to special education for a year. It’s been two weeks since he left. It’s been like… letters, medical reports, psychologists, psychiatrists… It’s all like this, like super-slow.

Maria (30): “For example, what happened to us here? The inspector came last year –this might interest you because of what you are researching, about external help– the inspector comes… to ask for timetables, timetables, timetables. That day I must have been nervous and I don’t know what happened… he was in a big hurry: “so many hours of special education, so many hours of whatever, so many hours…” and then he asked me for several things also in a great hurry, and we were in the first term of the new management team, which was very, very complicated. The previous head had been there for many years, and all the administrative work was not very well organised and it was really difficult for us sorting it out. Well, I don’t know what happened to me on that day
but I burst into tears. [...] He then forgot all about everything he had come to ask for, I think at that moment he really responded and we arranged to meet another day only to talk about the things that were bothering us there.

For their part, teachers participating in the panel agreed that the bureaucratic requirements have increased after the implementation of the LOGSE. They have to confront an absurd and useless paper war which just consumes time. But because they see this need for documentation as an absurd and imposed requirement of the State in the name of the restructuration of the educational system, they convert it into an “empty” procedure by just photocopying the same document over and over again.

“There is a lot of absurd paper work, useless which takes up a lot of time [...] you just photocopy and that’s it. Who is going to look at all this? This is just impossible. Where does this go to? What is it good for?”

These examples have provided, to our understanding, a very interesting insight in the way restructuration is lived and conceived by teachers. We will now tackle nurses in a similar fashion, establishing some lines of comparison.

First of all, nurses didn’t think of restructuring in the same way we do—in relation to the reorganization of capitalism or the transition from the welfare state to the flexible state. However, it was lived and experienced through very concrete mechanisms such as contractual agreements. This will be our first example, which draws an important difference with teachers in terms of the impact of flexibilization of working conditions.

The average trajectory for nurses is to live on temporary contracts for about 5 years. That is, being available for work anytime, any day for a last-minute call. After this stage it’s possible to accede to an interinaje, which means a fixed schedule and certain stability—until the position is officially called for. Some nurses are able, after being interim, to get a permanent contract. There are few exemptions to this rule. It is extremely difficult to get a permanent position without having been an interim first; it is difficult to be an interim without having worked under a temporary contract first.

Temporary contracts then characterize above all the beginning of the working experience of nurses. The precarious conditions they impose become apparent when considering that contracts are made from one day to the next. Nurses often do not know if they will work the next day or not. This implies that they have to organize their live around those contracts, always pending to receive a call from the hospital.

Maite (5): “Because when you start they don’t give you a contract for a whole year, but give you a series of short contracts as a substitute. And so you probably go home one day, and you finish your contract and you say to yourself, ‘I wonder when…?’ And tomorrow morning they call you, ‘please come’ they say. The worst thing is the type of contracts. It’s horrific at the beginning, because there are one-day contracts, two-day contracts, three-day contracts, or contracts where they only call you for the weekends, but they call you on Friday. Or they call you to come immediately. You can’t have a life like that. On the other hand, what you want to do is work, but you don’t have a life because you are always hanging about wondering whether they are going to call you or not. Of course if you say you can’t and you say that you can’t a lot of times, then they stop calling you.”

33 We could relate them, first of all, to the flexible management of public health centres recently introduced at the local level. And these new strategies are inevitable linked to the liberalization, privatization, and flexibilization of the National Health System carried on during the last 15 years (pretty much in line with the WHO criteria)… and so forth. But they didn’t.
Those temporary contracts leave little room and stability when it comes to planning private life. In addition, the contract has its negative effects on professionalism. As already mentioned in the description of their professional careers, the nurses rotate very frequently between the different services, where the hospital needs them.

Maite (5): “So today you are in neurology and tomorrow in gynaecology and the next day in general surgery… Of course you are the Jack of all trades and master of none: in other words, you know a little bit about everything, but you don’t really know anything. You can’t work with much security…”

The temporary contracts are often tied to be a “shift runner,” where a nurse has to help out across all services of the hospital where someone is needed, changing even between several units in one day. Participants in the focus group pointed at the non-sense of the situation: shift runners are the most experienced and valued workers in other countries, whereas here it seems to be a kind of punishment or rite of passage. Quality of attention, they said, is highly compromised by putting inexperienced nurses in such a stressful and difficult position. A similar kind of highly dynamic situation was observed during our stay with Jenny, where the secretary and the assistant nurse continuously changed between attending patients in the waiting room, doing administrative work in the operating theatre, working with a medical team or helping Jenny. Without being able to establish more stable relations neither to patients nor to the work itself Maite felt physically and psychologically exhausted. She had no sense of belonging, she felt alienated from work and disoriented in relation to its goals.

“For of course, you get lumbered with all the hard jobs of all the departments, and you end up, well, apart from the physical exhaustion, psychologically you don’t know whether you are in Paediatric, if you have gone up there yet, if whoever told you whatever they told you, whether the surgeon… Of course, you reach a moment when… I was six months doing this and I asked to them take me out of there because I was going mad.”

These conditions were also commented by the participants in the focus group. The will to work, they said, was stronger than the concern about working conditions. Asked about the limits of the situation and dignity, they laughed. There seemed to be a reluctant or ironic acceptance of such a stage of precarity. Other opinions were registered, though. Although Flor has a permanent contract now, she passed in the beginning of her career through many different services doing substitutions. And although it is stressful to jump without preparation right at very special tasks (she had to work in the operation room from one day to the next), she also positively notes that it gives you a very broad knowledge base.

Flor (15): “I came into the hospital, if I remember rightly, in a department that was called semi-intensive. It was an intermediate stage between intensive care and the general hospital ward, and from there I went to the ward, I was moving around for a time on substitute contracts and the like and well, I did a full tour that was good for me personally because I got a lot of training from it: I didn’t have a set post, but I was replacing nurses who had holidays or the odd day off and so they needed someone. So I went around different departments and different shifts and this gives you quite a wide-ranging knowledge base. Which is quite typical of this hospital and I think a fairly accurate reflection of the health service in general”

Flor also gave the impression in the interview that the precarious contractual conditions have partially been assumed as normal for the profession reflecting just the standard labour situation outside nursing: “They don't have a permanent contract, that's true, but it's not necessarily worse than in other professional collective”.

Certainly, these conditions are not exclusive to nursery. When it comes to working conditions, flexibility, uncertainty and precarity are the general situation. The rate of temporary contracts in Spain is the highest of the UE (+90% if we group all kinds of them, and with a clear tendency to grow in the last 5 years.
Jenny (30) rejects this situation on the grounds that permanent contracts were the norm when she started to work. It is remarkable that in her account no temporary contracts or rotations between services figured. Here we find a very important generational dimension. The reality of nurses has changed quite a bit in the last 30 years; precarious work conditions are the norm now when starting to work as nurse. The last ‘chance’ to start working with a permanent contract finished in 92 with the Olympic Games. The hospital experienced a period of strong growth where many nurses entered with permanent contracts. As Maite states, after the Olympic Games the worst contractual conditions developed following a general trend to liberalize the labour market. Currently, with the increase of the 14/21 hours modality, more nurses can have access to a permanent contract—which nonetheless obliges them to look for second and third jobs to earn a living wage.

We have to note, however, that the work conditions as described in the IMAS are not generalizable even at the local level. They are specific for this employer. Compared to other public health service providers in Catalonia, the IMAS can be characterized as leading a tighter regime. In the brochure celebrating its 20th anniversary, an administrative employee recalls the bewilderment that the installation of an attendance recorder (clock) caused among the workers of the hospital when the IMAS took control (IMAS, 2003: 11). It makes clear that this type of control is far from being usual and accepted. According to Flor, who now coordinates different mental health centres which in part belong to other public entity (Institut Català de la Salut, ICS)35, whereas normally health professionals are contracted for 37.5 hours per week in the centres that pertain to the ICS, nurses only work 30 hours. In her opinion, the ICS which belongs directly to the local government allows this type of non-attendance resulting in a missing shift. Flor, coming from the IMAS which has a tighter regulation aims to remedy those nuisances as well as other “bad habits” that apparently have been converted into “acquired rights” in the institutes that belong to the ICS, such as coming late, leave early, taking half hour breaks. This was confirmed, and quite celebrated, by one of the participants of the focus group, who lived the transition. Now, she said, they are real workers, having to deal with discipline: no more shopping in working ours, arriving one hour late etc. She said that changes in management also meant that they had to justify every expense, so they took consciousness of how much their work costs. This, according to her, has resulted in a much more efficient management. However, the group couldn’t decide whether this resulted in a better service provision.

9.4.1.2 Professional strategies and configurations

In this section we will contrast the system’s narrative on the professional evolution of nursing and teaching with the participants’ account of the process. In doing so, knowledge emerges as a key factor in the discussion. Its relation with the definition and sense of the profession is extremely important.

From a structural point of view, a key element in the configuration of teaching as a profession has been its inclusion into the university system in 1970. Teachers, however, called into question the relation between the university and the profession since the university and formal training is unable to provide professional and social status to teachers. For all three teachers it is safe to say that initial education at the university did not establish their professional identity. Whereas teaching has seen a process of professionalization and integration into a

35 The Catalan Institute of Health is the biggest public health service provider on the level of Catalonia. It includes 8 hospitals and more than 32,000 professionals and the three strategic lines of health care, research, teaching.
structure of formal higher level education, the generation of a professional identity has remained outside this frame.

The most telling example in this sense may be the case of Maria who initially perceived a university degree as desirable but later on came to see it as making no big difference in terms of her professional knowledge. This has to be seen in relation to her biography were she started to work without any official qualification. The other, younger teachers for whom the formal initial qualification was a normal step to take in order to start working see it as rather contra-productive to their actual needs. Initial education seems not provide the base of the profession since it is too distanced from the real, practical necessities as described by teachers. What is most likely to become their professional marker are the skills and experiences generated during work which are not based on the knowledge acquired during the initial years of their education at the university.

This re-inscribes the fundamental distinction between explicit/formal and tacit/informal knowledge. And as a result, it maybe only consequent that at the core of the profession reigns a certain angelic (self-)image. A central idea for all three teachers was the social nature of their work – being engaged in a social project. This makes it in turn necessary to engage with the argument on vocationalism and altruism set out in WP2 (p.275). One should not forget that this observation may be due to the type of school in question: being situated in a marginalized neighborhood frames the school not within academic issues but rather within a wider project of social integration and cohesion. To be a primary school teacher in the current working conditions demands much more than being competent in the development of literacy skills. Today the first challenge of schools teachers is to know how to cope with the cultural diversity of pupils and their families. Cultural diversity means, for example, different ways of interpreting and transferring school knowledge. Or how understand and act in front of questions such as social expectations of learners, family values, and influence of religious beliefs. This diversity asks a professional strategy to situate the social, cultural and personal context of each learner. This could be a complex and difficult task when a teacher has to work isolated with a large number of pupils in an institution with a poor level of collegiality.

Although altruistic ideas play a role in each of the interviews, the question remains if it can provide the cement for the profession. Sophia for example clearly states that she doesn’t consider herself a teacher because she will not be able to do this very “hard” job for a long time. She sees no reason why to endure such “low quality work conditions” throughout her working career. Another crucial point mentioned in WP2 was that the altruistic ambition in the profession was constantly contradicted by the imposed working conditions and managerialism. The case of Maria shows how the requirements to be met by the educational administrators stand in contrast to the real necessities in the school. Vocationalism or altruism could in these cases be operating on the level of individual identity, formulated as a personal, biographic project, more than on the level of the profession. Surveying the system’s narrative one would think that professional cohesion and identity should become visible in the organizational infrastructure and the like: examples would include provision of certification, organization in trade unions, visible protest movements, etc. However, listening to the teachers one asks whether it is the most adequate form for capturing how they define their own profession.

The case with nurses is not entirely different. The clear dividing line in terms of knowledge runs between technical, task oriented knowledge on the one hand, and person-centred knowledge on the other. The literature usually draws the same distinction in terms of explicit vs. tacit knowledge, or curing vs. caring. All three nurses agree that instrumental, biomedical knowledge such as measuring blood pressure, handling injections, administrating medication,
reading and writing medical documentation, down to the more sophisticated skills constitute
the taken for granted medical base of nursing. It is well established in the scientific literature
(they call it “techniques: that which everybody can learn”). On the other side, however, the
real core of nursing does not reside in this biomedical knowledge but rather is constituted by
an implicit knowledge of personalized, holistic care, a capacity to relate with the patient. This
basic personal knowledge was defined in part as being unavailable to explicit forms of
representation and management. On the contrary, it usually was understood as a personal
attitude and pre-disposition, “something that one cannot learn”.

More specifically, this care-oriented tacit knowledge was described by Jenny as “practicing
empathy towards the patient.” Explicitly she made the point that a nurse treats patients as
individual persons being responsive especially towards their affective and psychological
needs. This requires a high flexibility since each patient is different. It is a skill that cannot be
learned:

“The personal relationship with the patient, the family and considering them is not in the
text books and they don’t study this, and it’s something that I don’t know whether it is
innate or it is education or… I don’t know what it is. But I do believe that it is basic, it is
fundamental. And I have always worked in this way: it is not something that through
experience I do more now. It is also true that psychiatry also taught me a lot about how to
deal with the patient.... in all its richness, this is brilliant isn’t it? With all their stress and their anxieties and suchlike. I think that nurses should spend
some time in psychiatry compulsorily in order to understand how people suffer. And this
is nothing to do with having a vocation. I believe that it is very basic… Communication,
placing yourself in the situation of another person. ”

Communicative skills are implied in a non-instrumental notion of care. From the ethnographic
material and the interviews it emerged that “caring” essentially means to respond to the
emotional needs patients have when undergoing very stressful situations such as being treated
in a hospital. It means to be responsive to their concerns and anxieties, to provide comfort by
keeping them informed on what’s happening and ease their stay in the hospital. This
preservation of a human touch in the face of a biomedical machinery represented by doctors
cannot be learned. Equally the youngest nurse described that besides all the technical
knowledge, there is the “heart”, the “personal attitude” at the centre of nursing which you
cannot learn.

Maite (5): “You learn the techniques. The time comes when you have to inject, place
tubes, make probes… all this is a technique which is like the person who knows how to
do any manual thing, since you learn how to do it. But then you have to have what is
really the heart, the genesis of nursing. And if you don’t have that inside you… There are
people who have it and people who don’t. That’s something you cannot learn.”

A very important contradiction therefore emerges between an official sense of
professionalism gained through the establishment of academic recognition, possibilities of
specialization, etc. (more often than not tied to a ‘scientific’ base of knowledge) and this
sense of a holistic, personal, caring ‘heart’ of the profession. Especially Maite and Jenny
coincide in their main motivation: to treat a patient holistically attending his/her emotional,
psychological, social needs as opposed to delivering a pure biomedical, instrumental, task
oriented service. Their ideal profession gravitates around a “human touch.” That’s what
distinguishes a true professional from a “nurse” just doing her job: “There are two types.
There is the good nurse who is concerned and there is the other type of nurse who is a
technician. Only doing the techniques is not nursing.” (Jenny).

The inherent difficulty in providing this type of care, its emotional and thus often pre-verbal
nature situates the core of their professional identity on the personal level. It is a personal
attitude towards others that distinguishes a “good” form a “bad” professional. Just applying instrumental, biomedical knowledge has no special merit in itself; anybody can do it. However, to care and to respond to patients needs independent of one's own emotional state requires a special, a strong character. As Maite puts it, “I always say that being a nurse is like being a nun. You have to have something inside you, because there are lots of times when you would chuck it in.”. Flor further develops the theme:

“In nursing I think there are a lot of people working because they like doing it. It's not simply a professional opportunity among others... Of course there are also people, who just do that, but the big majority are people who believe in the profession and they like it, and they are motivated to do things. Actually most of the people I get in contact with, new people that arrive here, I honestly have to say that they surprise me; because of their education, their motivation to continue in education and because they have an ability to sacrifice themselves which is unfortunately required in our profession.”

Jenny's position on the core of the profession is interesting because it is marked by a certain ambiguity. She stressed, as did her colleagues, that not everybody can become a nurse. It requires a special attitude, certain social and communicative skills to put yourself in the skin of the other, the patient. At the same time, however, she was much more explicit when it came to distinguish this notion of care from the traditional stereotypes of nursing. Caring as defined by her has nothing to do with the traditional feminine role associated with the nurse. It has nothing to do with the nurse as mother. Equally, it has nothing to do with vocation. For her things will start to get better once a nurse recognizes that this “caring” can be established as the defining, legitimate core of her profession, leaving behind the traditionally associated metaphors of “sacrifice”, “mother”, “vocation.” She links this professional notion of nurse also to continuing, self-directed desire for knowledge.

“As mentioned, Jenny's account is interesting because it leads us to a kind of ambiguity in relation to the nursing profession. On the one hand she states that nursing cannot be learned, that it is a trait of a person’s character, innate, pre-verbal, a skill not to be learned. But at the same time, she sees very clearly that nursing is in need of defining very precisely its professional boundaries to combat the subordinating stereotypes of the past. “Caring” would define the profession and provides the base from which the profession can claim its authority, its genuine contribution within the team of the other health professions. However, it seems that by maintaining this type of knowledge on a tacit, non-explicit level, by defining it as personal attitudes and situating it on the inter-personal level it is essentially antithetical to taking on a legitimizing function. The conflict arises when contrasting this self-image with the formal process of professionalization. The entrance of nursing in the university system and its recent ‘upgrade’ don’t quite seem to operate at the same level. The scientific side of the profession is exalted.

The focus group gave us more information about these issues. The confrontation between a quasi-vocational conception of nursing and a highly professionalized one was present. Three of them were extremely critical about the idea that there is a technical dimension (what you learn) and an emotional one (what you are). They convincingly argued that both dimensions are taught and learnt. One of them went even beyond, saying that she’s not a nurse, but works as a nurse. “If I were a nurse, I’d have to go around helping people”. For her nursing was a job with a schedule and a salary. Nothing else. This could also be an important generational
difference, her comment being made as a sort of manifesto for different, younger, professionals. It was interesting how the group questioned all the mythology surrounding the profession, the mother-nun referent was identified as an obstacle to the development of the profession in terms equivalent to other health professionals. They were very sceptical about the way the professional career is being re-design (they didn’t believe it was going to result in any kind of status increase) but they were even more critical with traditional ways of thinking about nursing.

Flor explained that nursing as profession has come a long way and that the discipline has its distinct corpus of knowledge that grants it a distinctive weight when compared to the neighbouring medical professions. However, without further detailing specifically this genuine nursing knowledge it was clear from the observations and the interviews that this knowledge not necessarily has succeeded in a greater professionalization of the discipline. Tacit knowledge is not acknowledged on the same grounds as biomedical, scientific knowledge. Two examples will allows us to develop these themes.

The first example concerns the “professional career”. Flor has been involved in the attempt to professionalize nursing. The she works in was the third hospital in Barcelona which adopted in 1998 the implementation of professional careers. The main idea was to find a common and official formula to reinforce the profession, provide incentives for continuing education and to devise a manner to recognize and value the individual effort of each nurse (but also doctors). Before entering into details it should be stressed that the “professional career” despite its label actually doesn’t pertain to the profession but to the health provider! Neither there exists a professional career on the national level, nor even on the local level, but each company (IMAS, ICS) has its own model. As a consequence, when a nurse changes between those health providers her professional career will be invalidated; it is non-transferable between employers. Each health provider negotiates its own model of the professional career with representatives of the employees (nurses and doctors alike), trade-union members, and members of professional organizations. The specific philosophy agreed upon in the case of the IMAS is summarized in the following list:

- Participation is voluntary
- Irreversible (other places it is reversible; a nurse can be downgraded).
- Economic benefit
- Not automatic
- Results from a continuous evaluation during the whole career
- It is considered an instrument for professional development
- A way for learning from experience.
- An instrument to increase motivation of professionals
- An instrument for establishing a tighter linkage between professional organization and the objectives of the company. An instrument to consolidate the organizational culture and to extend it to all professionals.
- An instrument to modify the routine at work and that prevent accomplishment of quality work

36 This may also be the reason why there exists no official documentation. Each health service has its own model of professional career. Flor provided us with the internal documents of the IMAS.
An instrument to reinforce the self-esteem of professionals.

It specifies four career levels and a nurse needs at least 23 years to reach level four, given she has a permanent contract. Each level is associated with a certain wage increase. To accede to a new level, a nurse undergoes a process of evaluation that corresponds to her specialty. Those aspects will be evaluated by a team comprising the head of human resources, the head of nursing, the head of the ward or department, work colleagues and trade-union representatives (as observers). A nurse will be evaluated horizontally (by her work colleagues), vertically (by her superiors) and by herself.

Jenny's reaction to the professional career was quite sceptical. As she states, the main player from her point of view, the patient, is left out of the picture.

“..."I am doing it but the fact is this idea of the professional career is a bit of a trick. You see, there is the curriculum part and the other part which is where you don’t really know what they are evaluating. The teamwork, you don’t know who is evaluating you, your knowledge and the projects with your colleagues that you don’t know how they are evaluated. There is a whole series of things that mean that... Let’s take the curriculum. You know how to count, so therefore you know if you have a curriculum or not. And the other aspect is something highly subjective. You don’t know who evaluates you, or how. No, I don’t believe in all this stuff about the professional career. Apart from the colleagues and the curriculum, I think the clients should be asked.”

The subjective, personal qualities do not have the importance in the evaluation scheme Jenny would like them to have – given the centrality they enjoy in her professional ethics. Her experience is that what defines a good nurse slips through the raster and is generally not acknowledged.

For Maite the problem with the professional career resides on another level. Although the main objective is to incite continuing education, for her it is not practicable out of the already mentioned working conditions. There is no support, no money, no encouragement to do these things: go to congresses, do courses, etc. Participation in research only happens upon invitation by doctors but support for own initiative is basically non-existent. Maite participated in a two day work exchange with Belgium which sure would give her points in the professional career, but:

“..."I think that there should be time and that there should be someone behind supporting you, saying, “OK, go on the, you do this... You need people? We need cash? Well here they are, get going”. But of course, otherwise... if you have to ask for a day of your holidays to go wherever. Listen, I come back from Belgium on Saturday at 10 p.m. and so I don’t have to get up on Sunday at 7 in the morning after being 2 days there I have to take a day out of my holidays. So instead of saying... I don’t know. I took a day from my holidays because I thought, “I am going to get back exhausted after two days shut in there”. Things like that, you see?”

Once more, initiatives for professionalization face a complex reality: lack of structures of support, confrontation of conceptions, imposed top-down strategies of change which aren’t valued by professionals... Even if the examples presented are very concrete, we hope they illustrate a wider gap between the personal accounts of the nurses of their professional identity a career and the professionalization attempts.

Another indicator could be the value assigned to knowing second languages. For Jenny, this would be utterly important; to be able to communicate with a patient in another language would greatly improve the service. During our observation we could witness the actual difficulties she encountered with immigrants that did not speak Spanish or Catalan. But knowing a second language apart from Catalan adds the same amount of points (0.2) to your “professional career” as getting the official certificate for Catalan.
One more example will hopefully reinforce this issue. One of the key aspects of the 90s reform was, as we saw, the reconfiguration of work relations around the work-team. In this respect, it is interesting to explore how the relation with doctors, the most polemical item, has changed over the years. In this respect, all nurses were confident about having their own autonomous sphere independent of doctors. Although the traditional image of the nurse as assistant to the doctor is still strong in the profession according to Jenny, it is in decline. Flor states that their territory and their own sphere are won on a daily basis through small struggles.

“Do I make myself clear? ‘I’ll go and get your medical records if necessary, I don’t mind. I’ll do what has to be done and I don’t mind doing any job. Now, because you are the doctor doesn’t mean you can tell me to look for the records for you, because I won’t go and get them, that’s for sure.’ They visit the patients, bring all the records and leave them on the table for you. And you think, ‘And that?’ ‘They are for filing’. Ah, I pick up the records and put them on their desk and they say: ‘These records, what are they doing here?’ I say: ‘They are for filing’. I’ve given you this example because a lot of the terrain we are gaining is won in this way. Making them see that everyone has their post, that everyone has their own job.”

For Flor, nurses have improved their status little by little. Doctors have started to realize that nurses have their sphere of influence and knowledge and they have theirs with the mutual goal to serve the needs of the patient. However, this complementary role rarely happens on the level of practice where seldom doctors would ask nurses for advice or their opinion. What clearly difficult this professional emancipation is the high percentage of women in nursing vs. a high percentage of men being doctors. The professional subordination gets thus reinscribed and reinforced by the classical hierarchy between men and women in gender relations. The fact that doctors can keep their casual cloth below the white coat and nurses don’t is a visual marker for the different professional roles.

“From the nurses' viewpoint, the relation with the doctors is very limited. Theoretically they form part of the work team, but their routines never coincide. Their paths cross in the corridor, but they never visit a patient together. There is no sign of tension, rather their relations are affective but always maintaining a certain distance. In the words of Maite 'they mind their business and we ours.' We should remember that they neither have breaks together nor do the doctors enter into the room where nurses have their break.” (Field Notes)

What is more, Maite and her colleagues usually take their break when the doctors make their visit on the ward. She also considers that weekends are better for working since almost no doctors are around. From this description, it follows that nurses’ work functions relatively autonomously without direct influence or supervision from doctors. As Flor stated, they have their own area of knowledge and field of action. Although doctors define for example the medication and treatment of a patient, the execution of it falls under the responsibilities of nurses, without the doctor even knowing how a certain cure is applied in detail. And it depends on the self-esteem and self-confidence of each nurse for taking advantage of this autonomy or in contrast, informing the doctor about every step she takes or irregularity that occurs.

This autonomy may include the interpretation of patient behaviour in relation to medication, or making arrangements for commissioning a medical analysis which has to be signed by the doctor. Flor already demonstrated that this autonomy in professional terms often has to be conquered in small steps. Maite gave us an example to what extremes this can go when refusing a doctors request to put further injections to a coma patient. In her opinion, the moment had come where disconnecting this patient should be seriously considered. Although the doctor got furious, she maintained her position and professional ethics. She is unsure what would have happened if another nurse wouldn’t have done the job; but the fact that there were
no consequences for her whatsoever shows that her professional autonomy and decision taking has a wide and not clearly defined reserve.

To what degree this advancement in autonomy and professionalism they all recognize is related to the 90’s progressive reform is difficult to asset. From the nurses’ point of view, it’s been a continuous war won through tiny battles fought everyday. However, one can think that the battlefield was somehow set by the legal reforms that obligated all actors to place themselves in a new scenario.

9.5 Concluding comments

As already outlined in the introduction of the WP4 report, by comparing our cases it becomes apparent how varied and often contradictory processes of “restructuring” are. They comprise many facettes, temporalities and scales. This impression is confirmed when setting the professions side by side. Although there is a certain overlap on the level of system narrative – where a relative late build-up of the Spanish welfare state during the 1980s gets under attack from the mid 90s onwards – the experience of teachers and nurses is quite diverse.

Privatization and marketization in health care are much more advanced than in education. Often this depends not even on the situation within the 17 different autonomous communities but on individual hospitals and health centres which implement a very tight regime of cost control and quality management as in the case of the hospital visited by us. That is, there is also a level of flexibilization on how individual hospitals are organized and run which is not comparable to education. A hospital is a quite self-sufficient unity which incorporates its own administrative and managerial sections. Nurses are therefore immersed in a large web with other health professionals and a localized administration that has the economic power. This means, that their work conditions can change considerably from hospital to hospital (as seen by the different and incompatible “professional careers” for example which rather pertain to the health centre than the nurse!)\(^{38}\). They have to respond to the hospital managers in a direct manner and only then to more general health authorities, etc.

This tight regime between the working conditions found in the hospital and its administration constitutes then a mayor difference to the educational context. Where hospitals constitute their own sphere of economic authority which is managed in the hospital by the hospital, schools rather paint a very different picture. Schools themselves have no power to contract staff or decide on their budget which is still managed centrally by the local government and the state. In the same way there are no direct mechanisms of control and accountability that would take hold of teachers work practice in their class rooms. School inspection poses no real threat. How work is organized and which educational orientation is implemented in a school depends to a large degree on the director, the directors’ team, and the teachers themselves but it always involves a great deal of consent and cooperation between all colleagues since the “real” authority in terms of policy, contracting, salaries is quite distant and slow. This means that where nurses’ experience directly changes of working conditions in relation to neo-liberal ideas of efficiency, the working conditions of teachers in public schools do not appear to suffer from market forces, privatization, or performance criteria as in Sweden or England for example. Other, non-market forces are more important for teachers (see WP4 Case Study Spain).

What appears interesting in relation to knowledge and the professions is a certain overlap in the way explicit, technical knowledge is treated and seen in tension to another type of

\(^{38}\) See WP5 Spanish Case Study, p.24ff.
knowledge which cannot distinguished very clearly from being personal preferences, attitudes, or a general way of being (with others). Both, the nurses as well as the teachers of the case study (and this may be due simply to the types of schools and hospitals visited) were concerned about converting social relations into work. Nurses saw their relation to the patient and to their families as an important if not the most important aspect of their work. Technical know-how, biomedical knowledge for curing is important but lies not at the heart of the profession. What is more important is to take the patient seriously as another human being with all his / her fears, anxieties, hopes, needs. But this implies, for some nurses, to precisely not “formalize” and “automate” the relation and to understand it rather as based on a personal attitude toward the patient as person that cannot be learned.

In the same way, some teachers make the being-with the students and other colleagues the centre of their work. It involves all the emotional and personal up- and downs of full-blown inter-personal relations. Engaging with others is the base of their work. In this sense one could circumscribe a common core between the professions as social labour. Independent from what nurses need to know and learn in Universities, independent from mechanisms of marketization of knowledge, or different types of knowledge, it would be our thesis that knowledge in this context is intimately tied to questions of identity. For both, nurses and teachers, their professional ideals and ethos appeared as tied to this field of “inborn” personal expertise. Giving it up or making it explicit is not a neutral process of memorizing or forgetting items on a shopping list but tied to the very sense of self as nurse and teacher. There may be different views within the profession to which degree one can learn “care” and “human touch”, or “being implied” in work with students. However, the main point is precisely that these questions are not just between different types of knowledge (explicit vs. tacit; cure vs. care; knowing-how vs. knowing-what) but that it is a question of identity.

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10 Sweden
Gun-Britt Wärvik in cooperation with Rita Foss Lindblad and Sverker Lindblad as co-authors to section 10.2.
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10.1 Introduction
Following the outline of the project the aim of this report is to integrate the previous work packages 1-5 and contribute to the following overall aims of work package 6.

1. To compare professional work and life between the professions of teaching and nursing in Sweden
2. To achieve a more developed view of professional knowledge in the fields of teaching and nursing
3. To analyse current restructuring in education and health care in Sweden from the point of view of teachers and nurses and their experiences from interaction with clients

The analysis follows the comparative grid decided by the consortium to be used for this work package, which also follows what is pointed out in the project description and the technical annex.

The construction of the different workpackages of ProfKnow means that we have created a system narrative and work life narrative. WP 2 presents a system narrative consisting of mainstream official discourses concerning restructuring of the educational system and the health care system. WP 3 (survey), 4 and 5 (life histories and ethnographies) also present work life narratives of teachers and nurses, and in relation to restructuring of their institutions.

10.2 The national case presentation
The Danish sociologist Gøsta Esping-Andersen (1996) has created a welfare state typology and places the Nordic countries in the so called “Social Democratic” category. This category is among other things characterised by publically funded and general social insurance benefits related to income but with a lower and upper limit for the benefits. However, as also is stated by Esping-Anderson, a welfare state is not a stable phenomena and its complex mechanisms are not easy to analyse and define according to some well-defined components.

The Swedish welfare state policy during the 1950s – 1970s is often characterised a combination of equity strivings and centralised State governance. Changes in political governance in terms of decentralisation and deregulation have taken place from the 1980s, including introduction of market mechanisms and privatisation of welfare state institutions as economic regulating incentives.

The early 1990s were characterised by an economic crisis, reduction of jobs and very high unemployment, but also a rise in the general educational level among the population. Demographic changes including an ageing population, an increasing number of immigrants and refugees seeking asylum is also part of the picture.

39 See also the Swedish report for WP 2:
In 1995 Sweden became a member of the European Union (Foss Lindblad, Lindblad & Wärvik, 2005).

10.2.1 The system of education, a brief introduction

The dominant educational providers in Sweden are comprehensive school, upper-secondary school, and higher education. There is also a long tradition in Sweden of additional offer of educational opportunities for adults; for example the municipal adult education, the folk high school, study circles, and labour market training. The nine year compulsory school is for all children between the ages of 7-16 years. Besides the regular school there are also Sami schools, special schools (i.e. programmes for hearing impaired), and schools for students with learning disabilities. The three-year upper secondary school is non-compulsory but around 98% of all children enter the school form after completion of the compulsory school. Other non-compulsory school forms are pre-school class, upper secondary education for pupils with learning disabilities, municipal adult education, and municipal adult education for adults with learning disabilities. All upper secondary study programmes qualify today to higher education studies. However, a government commission has got directives to consider a reformed upper secondary school, also including a track with a focus on apprenticeship (Dir 2007: 103).

Until recently there were almost no independent schools in Sweden and the amount of students are still relatively low within this sector. The proportion of pupils in independent schools is now around 8 percent (9-year compulsory school, grades 1-9). However, the number of schools has more than doubled during the last ten years, from 238 schools 1995/96 to 599 schools 2006/07. During the same period the number of pupils in independent schools have been increasing with around 200 percent, from 20 247 to 78 587. There are regional differences related to independent schools in that only 60 percent of the municipalities have independent schools and around 70 percent of the independent school pupils live in the three largest cities (www.skolverket.se).

Taken together, the educational system in Sweden includes many actors, with various institutional histories and norms. However for all, the general principles that have been governing education policy since the 1950s are:

- all citizens should have access to equivalent education regardless of age, gender, social class, and geographic background
- all public education should be free of charge
- curricula and grades should be valid nation-wide

These principles are still valid, but have been discoursed very differently in policy and reforms and have led to different – but always somewhat disputed – measures over the years.

Lisbeth Lundahl (2002) characterises the Swedish education policy up to the end of the 1970s as centralised and regulated. She argues that education reforms included regulating mechanisms such as detailed national curricula, earmarked State subsidies, and other regulations concerning organisation, resources, and staff etc.

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40 Rita Foss Lindblad and Sverker Lindblad are co-authors of this part, from WP 2 (Foss Lindblad, Lindblad & Wärvik, 2005).
41 A child my begin school at the age of six on request of the parents.
42 All children are entitled to a place in a pre-school class at the age of six years.
43 The total number of pupils in grades 1-9 (compulsory school) the school year 2006/07 was 962 349 (www.skolverket.se).
In the following, education reforms and State strategies are listed that are often described as related to deregulation of school and decentralisation, or as Lundahl, and others, write, a transition from governance by rules to governance by objectives. The first part of the list follows Lindblad & Lundahl (1999):

- Late 1970s: Teachers got what was discoursed as the ‘possibility to influence the local development work’. The schools got a wider responsibility for pupils (the so called SIA-reform, ‘the internal work of schools’). An increase of women on the labour market became an incentive for prolonging the school day and takes care of pupils also after classroom hours.

- 1980s: New national curricula guides emphasised decentralisation (Lgr 80). New systems of auditing: each school was from now on obliged to present a work plan for how to achieve centrally formulated national educational goals. Every school should be organised in work units and the teachers were expected to meet regularly in these work units. Local developmental work becomes a new model for development and renewal but also for control. 1989: Teachers and other school staff are employed by municipalities (and not by the State as before).

- 1990s: State subsidies to municipalities are given as lump sums; the municipalities should allocate the money to different sources. The State sets the goals but the teachers and the schools are expected to find their ways to fulfil these goals. A new curriculum guide was introduced (Lpo 94, Lpf 94). The guide encourages teachers to use the teaching they find necessary related to the need of the individual student. Introduction of a new marking scale. 1992: The school monopoly was broken up when a system of competition between schools on a quasi market was introduced. Independent schools can from now on be established with tax money. Independent schools are open for all and there are no fees. A voucher system implies that all pupils and their parents can choose between different schools. 1998: The preschool gets increased pedagogical responsibilities and a curriculum guide (Lpfl 98). All six-year old children can attend a pre-school class. Lpo 94 also comprises the pre-school class and the leisure time centre.

- 2000s: The Swedish National Agency for Education gets an official mission to develop quality indicators. A school development plan presented in a government bill (2001/02: 188) points out that the quality audits should focus”…on the school level, the mission of the professional level is at the centre”. These audits can thereby also be regarded as tools to create (teacher) learning subjects. The teachers are expected to change their dispositions to act and think in relation to evaluation results. A reflective way of acting and thinking is regarded as important.

The system narrative tells us about a transformation of the educational system related to changes in governance and directed towards teachers work. A school, governed by rules from the state, teachers who work in isolation with pupils in the classroom, and parents/pupils who do not have any other choice but the school they “belong” to, is gradually changed by reforms.

On one hand the “new” system narrative is about inquiring, responsive and flexible teachers’ communities who are governing themselves and their own work related to what they, as a teachers’ team, perceive as the best way of working. The local work unit (teachers’ team) is regarded as a rather autonomous body. Restructuring gives them freedom to act. On the other hand, the system narrative is about quality audits of different kinds. Such auditing systems could also be described in terms of undermining of teacher autonomy. The self-governing
Restructuring is also about changing relations between teachers and parents/pupils. The parents are for example free to move their children to another school, municipal or independent, if they want to. The citizens thereby become a part of governance of education, and of restructuring too, (by “voting with their feet” regarding choice of school). The teachers’ community are for example expected to improve practice in accordance with publicly published results of quality audits (for example outcome databases on www.skolverket.se – The Swedish National Agency for Education –, and municipal web pages), in a self-regulating system (Lindblad et al, 2007). Thereby they would attract parents/pupils to choose their school. A teachers’ community is also expected to improve daily practise to keep pupils already listed at the school. Otherwise they risk loosing not only “customers” but also the amount of money that is connected to these “customers”.

10.2.2 The system of health care, a brief introduction

The health care system in Sweden can easily be described as a complex web of specialisations related to diseases, organs, ages, gender, techniques, service functions, different providers, and different political levels etc. Different actors with their specific qualification provide measures ranging from general prevention to advanced acute surgery. All this is institutionally defined as health care. ‘A good health and good care under equal conditions for the entire population’ is an overall goal as defined by the Health and Medical Services Act of 1982 (SFS 1982:763). A good health care should be:

- offered on equal terms
- readily accessible
- founded on respect for the patient’s integrity and self-determination
- carried out in consultation with the patient
- promote good contacts between the patients and the health care personnel

The health care of today is often depicted as an organisation comprising three levels:

- primary care
- central county hospitals and district county hospitals
- regional hospitals

Primary care is described as the basic level. People can turn to primary care centres (outpatient clinics) with their health related problems. Expectant mothers and children under school-age can follow programmes for preventive care with regular check-ups (almost all of them do so). Primary care also includes long term care of elderly, long term psychiatric care, and care of physically and mentally disabled. This kind of care often takes place in the patient’s home but also in nursing homes or group dwellings, not in acute hospitals. The county hospitals and the county district hospitals are for conditions that require (inpatient and outpatient) specialist hospital care. The most advanced, and highly specialised, care is delivered at the nine regional hospitals.

The main employers of nurses are the county councils, and the county councils are the most common provider of health care. Also the municipalities are providers of health care and accordingly employ many nurses. In 2005, 9.8 percent of all health care purchased by the county councils was from a private provider (dentist care not included) (of which primary
The State is responsible for legislation, education and research. All nurses, like all health and medical personnel come under the supervision of a national administrative agency, the National Board of Health and Welfare. Nurses, like doctors and other regulated health care professions, get their legitimation from the Board and the legitimation can be withdrawn in cases of malpractice. It is not possible to get employment and work as a nurse without legitimation.

Over the years there have been several reforms aiming at changing the organisational structure and the responsibility of the health care system.

- **1970s**: The so called ‘Seven Crowns’ reform was implemented. The reform stated that the patients would no longer pay directly to the doctor for outpatient care, but a fee of seven crowns to the hospital. This also meant that no private practice was to be carried out within the walls of public hospitals.

- **1980s**: A State commission that got the name HS 90 (Hälso- och sjukvården inför 1990-talet) particularly pointed out the importance of preventive care. The Health and Medical Services Act of 1982 (SFS 1982:763) defined the health care activity as to prevent, search for, diagnose and treat illnesses and injuries. A supplement to the act in 1985 also introduced prevention of ill-health and the importance of health promotion and disease prevention. The act also regulates the administrative authority between doctors and nurses and stated that administrative authority could be separated from medical responsibility. Thus, nurses could have positions including administrative authority, e.g. positions as hospital department managers. A new patient record act (SFS 1985: 562) states that all licensed health care professionals must document the care of patients. This is a new obligation for nurses. All reports must be personally signed.

- **1990s**: The ÄDEL-reform implied that the care of long-term patients was transferred from hospitals, provided by the county councils, to the municipalities. The county councils still got the responsibility for patients in need of medical care given by a doctor. However every municipality must have one or more so called ‘medical responsible nurse’ (SOSFS 1997:10). The handicap reform – The municipalities are responsible for care of mentally and physically disabled. The psychiatry reform – The municipalities are responsible for long term psychiatric care. The title head senior physician (‘chefsöverläkare’) was introduced. The administrative authority could now not be separated from medical authority (SFS 1982: 763 updated until 1991:424). This was again changed in 1997 when the position head senior physician was replaced by a ‘manager’ (‘verksamhetschef’), the different authorities could be separated. This also means that not only doctors, but also nurses and people with other educational backgrounds, can have positions as heads of hospital departments or primary care centres (SFS 1982:763 updated until 1997:316). ‘Provisions and general advice’ from the National Board of Health and Welfare (SOSFS 1993:20) particularly points out that nursing care must be documented and that this is a nurse responsibility. Most of the county councils introduced some form of a purchaser/provider model during the early 1990s. A fixed annual allocation to the hospitals and to primary care was replaced by payment according to results. The county councils and their health care providers have made more or less extensive changes in their economic control systems since the 1990s to be able to follow up care paths and to be able to handle the situation as a question of rational decision-making. Quality assurance and care programmes.

- **2000s** – *Provisions and general advice* from the National Board of Health and Welfare
regulates the handling of medicine, including nurses’ obligations and responsibilities. ‘Provisions and general advice’ from the National Board of Health and Welfare publishes a new competence description for nurses, regulating the required competences for employment as nurse (Socialstyrelsen, 2005).

The system narrative tells us about a transformation of the health care system related to changes in governance, health care structure, and changing relations between health care professionals and patients, and between different groups of health care professionals. Gradually introduced reforms deal with medical and technological advances, a complex health care structure with difficulties to grasp the whole picture of the system, and an aging population. These aspects are described as sources of rapidly increasing costs. In other words, health care is too expensive, not enough effective (in economic terms) and there is no effective cost control. An idea of limited resources forces change.

The stream of patients should be steered away from the expensive acute hospitals to the cheaper primary care centres. Cross-professional teamwork and so called care-chains will make sure that “the problem” with an ageing population that does not have a single and well-defined disease but multiple health related problems is taken care of in a most cost-effective way. These changes should be met by changing competences among nurses (and among other health care professionals). Nurses should base their work on a multidisciplinary view, on scientific evidence of best care, and on economic responsibility.

Prevention and health promotion should be integrated in all contacts with patients. A fixed annual allocation to the hospitals and the primary care is replaced by payment according to results. Different models for managerial accountability are introduced together with quality indicators. This increases the pressure on the workplaces to act in a responsible way regarding resources. Patients should be given the best and the cheapest care, diagnostic procedures, and medical treatments when the health care staff, including nurses, are following the economic incentives. The health care should be steered towards open forms of care and delivered at the lowest possible “level”, but different providers on different levels need to cooperate. All patients should be treated at the most adequate level in the so-called care-chain with no overlaps and no unnecessary costs in a well-organised net of coordination. Therefore responsibility is shifted over to municipalities and primary care.

A changing staff mix and a new work organisation emphasising teamwork is introduced. A work organisation were the caring of patients was broken down in well-defined pieces and the nurses had limited contact with patients is replaced by team work. An increasing number of nurses are replacing a decreasing number of assistant nurses and auxiliary nurses. Nurses in hospital wards participate in bedside work together with assistant nurses.

On one hand we see a system narrative that demands a multidisciplinary view and teamwork. On the other hand, following the technological and medical advancements, there is a demand of highly specialised care. From this follows a specialisation of competences that fragmentise the care. This tension also refers to nurses’ work. Another tension refers to “the best” and “the cheapest” care.

The system narrative is also about patient involvement, not only for the benefit of the patients but also for the health care. The competent patients could for example in a future coordinate their own care-chain. The competent patients can also utilise their formal right to choose providers of care, (but not the level of care) and thereby putting a pressure on the health care community to restructure (Foss Lindblad, Lindblad & Wärvik, 2005).
10.3 Work life narrative

Work life narrative refers to analysis made in relation to WP 3, 4 and 5. WP 3 refers to the ProfKnow- survey that was directed to 8 800 teachers and nurses in four counties in Europe (Finland, Ireland, Spain, and Sweden), 1 100 nurses and 1 100 teaches in each country. The response rate for the Swedish sample is 77, 4 % for nurses and 77, 5 for teachers (Sohlberg et al, 2006). WP 4 and 5 refers to life histories and ethnographies. Three teachers and three nurses were interviewed twice and than shadowed during three workdays each. A group interview with teachers (at another school) and one with nurses (at the same primary care centre) was also carried out.

The text is organised under the following themes: Formal education, teamwork and cross-professional collaboration, professional accountability, supervision, and work process. The themes are chosen relatively teachers/nurses accounts of restructuring in these areas.

10.3.1 Formal education

Formal education has been used as a means of changing practice in education as well as in health care. During the decades there have been several changes in the educations of the two professions. A question therefore is how important these changes have been regarding teachers and nurses working life trajectories.

All teacher education and nurse education were integrated in the higher education system in 1977. Before, only secondary school teachers had a higher education degree, usually in two main subjects and complemented by a one year teacher training course. A “link” to research was now also introduced in the curricula of teachers and nurses. A higher education reform in 1993 (SFS 1993: 100) further strengthened the academic base in educations with non-academic traditions, and among other things stated that academic subjects and study programmes should be based on a scientific ground and/or “proved experience”. The Swedish higher education system is made up of universities and university colleges. Both teachers and nurses are educated at both kinds of institutions and there are no formal differences in qualifications related to kind of institution.

Teacher education in Sweden has had a long tradition of being closely connected to different school levels. In 2001 a new integrated teacher education was introduced (Government Bill 1999/2000:135) and the idea of different education programmes for different kinds of teachers was abandoned. The new education with intake to one programme replaced twelve previous programmes. The teacher students instead specialise through successive choices during their education. A main idea is to increase research connection in teacher education and stimulate the production of doctorates for teachers at work in new core subjects termed “educational sciences” and “educational work”. Teacher education is then a special entrance requirement for this research education. The link to research and the research competence of teacher educators have been discussed among others by the National Agency for Higher Education. An argument is that many providers of teacher education must strengthen this aspect.

The teachers interviewed have all different educations and all related to junior level/earlier years. The youngest teacher has been educated within the latest teacher education reform. She tells a story about conflicting ideas between teacher education practice and school practise. In particular she points out her lack of knowledge in teaching methods as problematic as being a novice in teaching. She has to imitate other teachers. The effect can be, she says, that she takes over ways of working with pupils that are old-fashioned and should be changed. She also says that other teachers do not understand her new teacher education:

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44 A Government Commission has got directives of developing a new teacher education (Dir 2007:103).
Teacher: /.../ But at last I became a teacher. And it’s both scary and exciting to have the new teacher education. The problem is that those who I work with don’t understand my education.

Interviewer: You said something about that on the telephone?

Teacher: Yes they think it’s too vague, strange new things. Oh, you do that kind of stuff. Many people here still work in the old, I think, today we have steering by goals, but they work in the old when you were told exactly what children in a certain grade should know. It’s difficult to change to steering by goals.

Interviewer: How does the old way of working become visible and the new way of working?

Teacher: I think the old way is when you take the book as the point of departure, the book rules the order instead of being a complement. And that many older teachers here emphasises to teach the children spelling. And spelling and a neat handwriting are important but the new way emphasises that the language should be based on the child itself. Like words that are not their own but are important to spell even if they never will use the words (comment: all children had an immigrant background). I can take lighthouse (sw: fyr) as an example. Many children can spell “fyr” but they don’t know what it is and they will probably never talk about it because there are not so many lighthouses, yes we got Vinga but.

Interviewer: Vinga fyr.

Teacher: Yes but, and they think one is fuzzy if you don’t want to, what do you mean, shouldn’t they be good at spelling? Yes they should but it’s not the most important from the very beginning. The most important is to start writing. It’s a crash there.

Interviewer: It’s different ways of seeing things?

Teacher: Exactly. And the new teacher education has been criticised for the lack of teaching methods. And that is something I can feel, I have no background as a teacher, no experience from the occupation. I don’t have so much teaching methods. It’s a difference if you had been child minder or a substitute teacher in the school. Then you have seen the teaching methods. But the teaching methods. Many evaluations say that this is what the students criticise. And I can feel that you have to look at the other teachers. But that is the point. I rather wouldn’t do as they do. But I have to look at them, because what they do isn’t wrong.

Interviewer: What do you mean? You wouldn’t do as they do?

Teacher: No, that is, I wouldn’t do it exactly the same way, because their methodology is based on the old theories about how one learn. Spelling first and reading the words in a right way.

Interviewer: Teaching methods for you is then

Teacher: How to practically do things

Interviewer: How to do things

Teacher: How to do things. Because at the teacher education, they want us to, as the way I understood it, develop our own teaching methods model. But it’s difficult to start from zero.

Of course the described situation can be related to experiences of a newly educated teacher and that it takes time to get authority in a workplace. But the teacher also says that changes in teacher education could live as conflicting elements among schoolteachers with different educations and pedagogical ideals.

However, the new teacher education does not change any formal requirements regarding possibilities to work as teacher.

The education of teachers takes place at higher education institutions and in school. The municipals are responsible for supervising during the work-based part of the education,
something that earlier was the responsibility of teacher education institutions. Earlier the teachers got reimbursement from the teacher education institutions for supervising teacher students; today this is a part of their employment agreement with the municipality, an agreement negotiated by trade union. A teacher with 35 years of experience talks about the different practises of the teacher education and the school when she argues against the new teacher education arrangement. Many teachers of today do not have enough experience, she says. Also in this quote conflicting elements of a new teacher education is visible:

Teacher: But we have also had, thinking about the teacher students, different directions between the junior level and the intermediate level teachers respectively. The intermediate level teachers lack the basic education that I think is very important, maths, Swedish, reading skills and how children learn to read. They’ve always talked about that when children come to the intermediate level and cannot read, that they (the teachers) have difficulties to continue. We have different approaches and qualifications, or knowledge. Or perhaps qualifications is wrong, but knowledge.

Interviewer: You have different educations?

Teacher: Yes, yes, we are trained in different things. Think about our teaching methods teachers (comment: at the teacher education). How important they were to us. And as I understand it, many teacher students miss this today, that they don’t get good teaching methods.

Interviewer: They should get it during their practical work period?

Teacher: Yes, yes (laughs) but that is to leave much to chance I think. And to what it looks like in the school. There is a beginning lack of supervisors who are old enough to have participated in teaching methods classes during their own education. And can understand that teaching methods is important, and understand where the difficulties are, the steps, both in maths and in Swedish, how completely you must have learned something before you can go on.

A conclusion could be that changes in teacher education have not passed unnoticed in a teachers’ community, both in relation to teacher students, employment terms, and being a new teacher. But these changes do not seem to have had any importance for the interviewed teachers’ work life trajectories. Teachers are qualified for their jobs regardless of kind of education.

Nurse education gives all nurses a common ground. Nurses can then specialise in different fields related to subspecialties of medical science. The specialist education is separated from general education. This also means that education for many nurses is divided in two steps. A nurse specialist degree was also introduced in 1998 in connection with these specialisations. Changing nurse education has been seen as a means to meet new demands on health care such as medical advancements, a need to pay attention to not only medical aspects but also social and psychological, and cost control (Socialstyrelsen, 2005). Political decisions regarding the higher education reforms of 1977 and 1993 are here one aspect of the story. The constitution of professional strategies also involves an attempt among many researching nurses to make “nursing” a unifying research education subject (see e.g. Andersson, 1984). This idea was also strongly supported by the Swedish Society of Nursing, and by the nurses’ trade union. The subject of “nursing” was in its earlier years seen in the light of medical research. A positivistic and medical – biological view on human beings was discussed against a humanistic-hermeneutic view (Wallén 1983). A programme specific sub subject for nurse education (nursing – “omvårdnad”) was introduced in 1993 together with possibilities to enter research education in this subject. The link to research and the research competence of nurse
The argument is that many providers of nurse education must strengthen this aspect.

Nurse education also formally prepares nurses for work as chief nurse and also for leadership of subordinated staff in the daily work.

The interviewed nurses had different general educations. When we talked about specialist education it also became clear that they all had very long education. Changes in entrance requirement in relation to specialist educations have had an impact on their work life trajectories, and so have also formal demands of qualifications for employment.

The oldest nurse, Nurse, was educated in the 1960s, a period when specialist education was integrated in the basic education. After graduation she started to work in an intensive care unit, a field that could be regarded as totally different from her specialization in psychiatry. She tells me that she did not have to take a new specialist education. She only had to follow a more experienced nurse the first period. She also worked as a nurse anesthetist interchangeably with the work in the intensive care unit without specialist education in this field. Her second specialist training was here made as a period of apprenticeship; something she says is not possible today.

Interviewer: Did you have to take another specialist education in intensive care?
Nurse: You could just start and work beside a more experienced nurse, and get a good training, or yes, a learning period, and then I started to work.

Interviewer: You worked together with a nurse?
Nurse: Yes, but that was not enough, we alternated between the anaesthetics and the intensive care unit. I worked as a nurse anaesthetist during long periods. I was an apprentice, and worked together with a nurse and administered anaesthetics to the patients. This was because you got to have up to date knowledge in both areas. But I was never alone, there were always people around, experienced nurse anaesthetists and anaesthetist doctors, so I was not alone. But I was allowed to do a lot.

Interviewer: What you are saying, as I understand you, is that it was possible to work in different specialties?
Nurse: Yes, that is what I’m saying.

Interviewer: And today, as a psychiatric nurse, would you be able to
Nurse: No, no.

Interviewer: be a nurse anaesthetist?
Nurse: It’s unthinkable.

Until the end of the 1970s, her education was sufficient. “This was a period when they said that five years of experience from practical work at an intensive care unit is the same as specialist education”, says the nurse. But after that she had to do something about her specialist education. She could not get a permanent position in somatic care without a specialist education. Therefore the nurse entered the specialist education in medical and surgical care. This education was one semester and because her children still were young, this was easier for her than the one year of education to specialize in intensive care.

The studied primary care centre had both primary care nurses and district nurses. In fact, these nurses talked about themselves as different occupational groups, even if both had a general nurse education before their specialisations.
The district nurse Nina had to complete her nurse education with a university course in research methodology (one semester) before she could enter the primary care specialist education. Nurse education had been extended to three years, in relation to the 1993 higher education reform and among other things to meet requirements from the EU. Nina’s nurse education from the 1980s did not give her the qualifications to enter the specialist education.

One of the interviewed nurses has around three years of different specialist educations after graduation from nurse education. Perhaps this does not make her an average nurse. But she tells me that nurses who work at primary care centers most often have longer specialist educations of different kinds. Also the nurses in the group interview had longer specialist educations. This can also illustrate a career path for nurses where formal specialist education as a complement to the basic education is highly important. The nurses in the group interview also mentioned university courses as a complement to specialist education as a means of negotiating salaries.

To conclude, change in formal education is a restructuring measure that can stop a career path if the nurse do not adapt to new requirements of educational level.

A different way to approach the question of education is by asking teachers and nurses if their education was more appreciated at the beginning of their career. In the survey, 28 % of the nurses and 44 % of the teachers agree on this statement. Both teachers and nurses also state that their work require that they constantly learn new things. However, only 9 % of the teachers and 13 % of the nurses have supervisors that regularly talk with them about competence development. This seems strange in relation to the reported demands of learning new things. But on the other hand, teachers and nurses report that they are well aware of weak and strong sides of their professional competencies. 55 % of the Swedish teachers and 66 % of the Swedish nurses have additional education at university level after taking their exam as teachers/nurses (Sohlberg et al, 2006).

10.3.2 Team work and cross-professional collaboration

Teamwork is emphasised as an organisational ideal both in education and health care, and as such it can also be regarded as a restructuring measure. In the WP 3 questionnaire 79 % of the Swedish teachers and 70 % of the Swedish nurses reported more teamwork nowadays (Sohlberg et al, 2006).

Introduction to work and teamwork

Teamwork can be related to introduction of new colleagues. This was also a theme relevant for the interviewed teachers. The following quotes are about a new teacher who was left alone with a so called “difficult class”: 

Teacher: Later, when I came to the Willow school /…/ all the resources for Swedish as a second language, and special needs education were drawn together. And because of the large number of pupils with immigrant background the resources were so big that you could work two teachers in one class. /…/ When I came, there was a class that had no teacher at all, so I got my own class but nobody to work with.

Interviewer: You were alone?

Teacher: Yes I was alone. I got the list of pupils, and I could not pronounce one single name. And I thought that I will not be able to call the roll. But it turned out so that the teacher who had been my mentor said to me that ‘I will work with you in the new school’, so she came.

Interviewer: Yes.
Teacher: And we had the class together...and once again, thank you to this person. We could
together handle a rather difficult situation. The class was quite difficult to handle. /.../ And
afterwards one can think, how did they treat a new teacher?

The more experienced teacher was also interviewed:

And the Willow school was closed down. And who were the persons who couldn’t keep their
positions? The youngest of course. And who should have the most difficult positions? The
youngest. The others chose to have it better and the headmaster, the management, was weak.
The whole schools system is weak in this aspect I think. /.../ I asked her, what would you say
if we work together with the class? I asked her carefully because maybe she thought that the
idea was terrible. But she said that I know that there was a meaning with all this. So she
wanted me to come. So we moved to the Willow school together.

The older teacher took the initiative and changed workplace to the same school as the younger
teacher to help her, which was possible within the former so called headmaster area. Several
schools then belonged to one headmaster area and it was probably easier to change school like
Tina did, than it would be today with one headmaster (manager) – one school.

The teachers talk about a situation that took place in the beginning of the 1990s and it is of
course an illustration of lack of teamwork and how this can influence a teachers’ introduction
in an occupation. At the same time the quote illustrates teamwork as something possible
within a teachers’ community, as something valued.

The following quotes illustrate that teamwork in a two teachers system also can be a tool for
introduction of teachers to work. The youngest teacher has no class when I first meet her:

I have felt, how much energy should be spent? Maybe I have to leave this class within a
couple of weeks and take another class.

In the second interview she knows that she can stay with the class for the rest of the semester:

In a way I think this is good, we can look forward. We (she and the other teacher) must plan
our work. I can use more energy.

The teacher seems to be more satisfied with her life as teacher when she can stay with the
class and the other teacher.

The introduction to work did not seem to occupy nurses in the same way is it did in the
teacher interviews. To work together with a more experienced nurse seemed to be a more
“institutionalised” routine.

“Cross-professional” collaboration

The three teachers at the Rowan school and the teachers in the group interview all describe a
clear specialisation between teachers and leisure time pedagogues. Therefore it can make
sense to use the term “cross-professional”, even if both categories are teachers and today get
similar education. The interviewed teachers talk about barriers and different working
conditions such as salary and working hours. But the two teacher categories also work
together. For instance, one teacher refers to the so called integrated school day and talks about
the importance of closer collaboration between them. According to the researcher Jan
Gustafsson (2003) the discussion about cooperation and integration started already in the
1940s but did not gain impetus until the beginning of the 1990s with introduction of flexible school start (Government Bill 1990/1991: 115).\footnote{The national curriculum guide Lpo 94/98 is common for the compulsory school, the preschool class and the leisure time centre.} Gustafsson writes:

> This was a starting point for the idea that the compulsory comprehensive school, pre-school and recreation and leisure centres should become integrated that was fully asserted in Government Bill 1996/1997: 112, as one aspect of improvement of the first years of schooling /.../\footnote{My translation.}

The teachers say that the leisure time pedagogue is responsible for the children some part of the day and that the teachers and the leisure time pedagogue have to coordinate their activities. But they also argue that the integration between the two staff categories could be better.

The following illustrates a situation where a teacher and a leisure time pedagogue plan together and make some of their work public to each other.

(Notes from fieldwork)

11.30-12.00 I sit together with Tilde and Lars around a table in a little music studio at the leisure time centre. It’s time for planning. Tilde says that this is the only time they got together during the whole week.

There are two topics on the agenda: 1) children’s evaluation, and 2) discussion about some of the children. Lars has made an evaluation form with three questions which the children answer every week:

- What have I done that is good this week?
- What have I done that is not so good this week?
- What can I do to be better next week?

The children write the answers by themselves but Lars says that he sits with every child and discusses what they have written. He has told the children that he will show their writing to Tilde. This is what he does now. Lars and Tilde go through the forms and talks about the children. The children have written things like “be quiet”, “don’t be noisy”, “talked”, some children write that they have done something bad against a classmate. Lars says it is important that the children learn how to solve conflicts. They both say that they also see this as an exercise in writing; they can see how the children express themselves. Tilde notices that a girl seems to have started her writing. Tilde says that all the children in the lilac group are in need of extra support. Maybe they should notify three children on the pupil well-being meeting.

The meeting is also an example of changed work organisation in relation to restructuring measures.

Also the nurses talks about changes in work organisation in relation to restructuring. As mentioned earlier, it is a political ambition to steer the stream of patients to primary care. Over the years, the number of nurses (and doctors) has been rapidly increasing together with a decreasing number of assistant nurses, auxiliary nurses, and hospital beds. The Swedish primary care was developed during the 1970s and 1980s with the establishment of primary care centres and the district nurses, got these new centres as their base. Today primary care centres have different categories employed: primary care nurses, district nurses, doctors, assistant nurses, physiotherapists, social workers, occupational therapists, psychologists etc.
All the nurses at the studied primary care centre were highly specialised in the care of specific patient groups.

Earlier district nurses most often had had their base at district nurse centres and with responsibility for the population in a certain district. They had no regular contact with doctors. In smaller places the centre often was the same as one nurse with responsibility for the whole family and their health related problems. The Ádel reform in the beginning of the 1990s also meant that the municipalities now are responsible for care of the elderly that earlier was provided by the district nurse.

During the interview the district nurses (not the primary care nurses) talk about themselves as an occupational group not necessarily belonging to a primary care centre, that their work could be organized separated from the centre. They also say that the content of their work has changed.

Nurse 2: The work of a district nurse should have a preventive purpose, this is in our mission. But today we only work with ill patients one can say /…/ we do very little preventive work. Because there is no time left and the health promotion is left aside in a way. And now they are going to employ health coaches in every primary care centre to do this job. But this is really the mission of the district nurse, but we haven’t got any time for this /…/.

Nurse 1: But the district nurse is more involved with serving the doctors and answering the telephone. When I started to work in the primary care the district nurse could see patients rather free but now we have to adjust to appointment times and give service on the telephone. Be available in a different way, for the primary care centre. And this is not why I took my education, to give service to a primary care centre. But it was this (the prevention work) that attracted me. /…/ They take the district nurse to the Tele Q and to the waiting room work (comment: Tele Q and waiting room work refers to sorting of patients in need of care – or not in need of care). But a district nurse should not work like that.

The district nurses also talk about “health coaches” as a new occupational group that will take over the health promotion. They also say that they have to help the nurses to improve the availability of the primary care centre. The quotes illustrates talk about a changing a profession related to restructuring of overall health care organisation, that is development of primary care centres, a work that started some decades ago. The former single district nurse becomes a member of a cross-professional team but these nurses also describe a situation where this teamwork changes an essence of their work. They are not occupied by teamwork per see, but argue that their professional mission is changing and that they got a more subordinated position in a medical hierarchy, a position they also attribute to nurses.

**Formal meetings with colleagues**

Formal meetings within a team can be a tool of collaboration within and between professional groups as well as a tool of exclusion of other professional groups. Both teachers and nurses (WP 4 and 5) had intra-professional meetings for development of work and continuing education, nurses also with nurses from other primary care centres, and so did the district nurses.

Teachers’ team was a term used for a group of teachers meeting on a regular basis according to a schedule decided by headmaster, in one of the schools it was a team of grade 1-3 teachers and were pre-schoolteachers and grade 4-6 teachers had their own meetings. The

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47 The school where the individual interviews and shadowing took place.
teachers got a meeting schedule every week from the headmaster with topics to be discussed. They could also influence the choice of topics. The team at the other school\textsuperscript{48} was broader and included different teacher categories.

The nurses did not refer to themselves as a team during the interviews, even if my impression was that this could have been relevant. They shared work with patients and they created boundaries to other groups, among other things by help of team meetings. The nurses had their own meetings, so had the district nurses and so had the doctors, in all cases according to a schedule decided by the supervisor and with possibility to influence the choice of topics. The different staff categories had separate meetings for management information and for continuing education. I noticed when I participated in a couple of nurses’ meetings that communications from one group to another regarding work place matters such as routines of different kind often were mediated by the head of the primary care centre. The head has a background as a nurse, but is not a nurse any more. Instead she is a manager in a line of authority and is a manager of all staff categories at the centre, including the doctors.

\subsection*{10.3.3 Professional accountability}

\textit{Documentation}

A majority of the teachers and nurses who answered the WP 3 questionnaire also agreed (“somewhat” or “strongly”) that the demand to produce written documentation has increased. Documentation is an aspect of both teachers’ and nurses’ daily work. 92 \% of the nurses and 59 \% of teacher answered that the considerations and decision they make in their job need to be documented (Sohlberg et al, 2006).

Nurses and teachers document to be able to do their work. The work process is organised around meeting with pupils and patients respectively. But it is quite easy to notice that teachers have a long term relation to pupils; they often meet the same pupils every day during several years. Most commonly nurses meet patients on a more short term basis and nurses have to “share” the same patient with colleagues and other health care professionals. Documentation then becomes a tool of sharing information with others.

Teachers’ daily documentation of classroom work is well recognised for all who once have been a pupil and is here described as mainly a tool for the individual teacher for follow ups of pupils’ achievements. In the following quote a teacher comments the writing of R and the cutting of corners in the pupils’ exercise books when I asked her to explain a situation I had observed during the shadowing:

\begin{quote}
I correct the books, it’s a way to control that they know. Many teachers give an answer book to the pupils and let them check by themselves. But I don’t understand how (the teachers) know. Because if a child makes many mistakes I sit down with the child and go things through once again. It’s like an answer to me, this is how I managed to do my job. Oh, here are many mistakes, we must do this once again, if it’s a child that normally understands. Or else I can send some more exercises to the home. Or do something else, or do it in the whole group again if several of the pupils make mistakes. So this gives me different signals back.
\end{quote}

This is a kind of self regulating technique, not imposed from above, but in relation to evaluation of her own efforts, and not something management have ask for, but in relation to achievement of educational goals. The same kind of non-imposed documented self-evaluating was also observed among the nurses, for example when a nurse talks about the use of interpreters and also says that:

\textsuperscript{48} The school where the group interviews took place.
Maybe I have had a whole day with diabetes patients who don’t have taken care of their health. I can feel that I have given everything but they have not been listening. I can have that feeling, and that is very tough. And you can often mistrust yourself. It must be something wrong in the way I say things, or is it that they don’t understand?

This nurse has developed checklists and tables and shared these with colleagues to be able to communicate changing test values over time to diabetes patients and to get them to change their habits regarding food and exercise.

The teacher and the nurse also talk about these kinds of self-evaluative documentations as tools for communication with clients (pupils/parents/patients).

However, nurses’ documentation is also regulated by legislation. They have developed a standardized computer-based documentation tool, called the VIPS-system. Other staff categories can read the text and utilize it as facts about the patients, but it is only the nurses who write the VIPS records.

Nurse: /.../ we documented earlier too, we wrote a lot in the intensive care unit (her earlier workplace), everything we made with the patients, reports to the nurse on night duty, what had happened to the patients. But it was rather arbitrary with our own words and so on. The documentation became more precise, what do you refer to when you use that word? So it could be used internationally in a report, so we all know what we referred to when we used a word, that everybody referred to the same thing. And that is very good.

Interviewer: Internationally, you mean?

Nurse: Yes in the different models that were growing. The VIPS model, you got search terms and so on.

Interviewer: Do you still have this?

Nurse: Yes we have models, caring models that we follow. It’s a part of the education today. The nurse education. How to do the documentation. It is very well developed in comparison to the sixties seventies when we wrote by hand, stories. The problem was that we didn’t know if we were referring to the same thing, no, personal valuation. It’s strange but it worked, it turned out well. No one can say that things happened because of the careless documentation. Or maybe it is so that one can do that, but I don’t know. Many of the questions of responsibility are related to insufficient documentation. There had been no time for documentation. But I think it is important, I try to teach my students how to do the documentation. And not because you must protect yourself but that it’s important for the patient, medical security.

The short contact with patients, the continuity and the fact that people cannot remember everything about a patient from time to time if they see them only one hour every sixth months for example, make this public communication necessary. If a nurse leaves her position another nurse quite easy should be able to control the patient with diabetes, lung disease, high blood pressure etc. The work at the primary care centre would not work without tools that make nurses exchangeable. However, as the nurse says in the quote, documentation is also related to nurses’ legislative accountability and to patient’s security.

Also the teachers talk about demands of documentation in a more formal sense, in relation to pupils’ wellbeing meetings and pupils’ development plans.

In the following quote a teacher talks about pupils’ wellbeing meeting (she refers to them as “EVK”):

49 “They” refers here to the nursing community in a general sense.
Teacher: It was a boy, he acted like a ‘BamBam’ in the class with his fist, like this, hit the other children in their heads. And he was big, much bigger than the others, it was dangerous. So I asked for an investigation. /…/.

Interviewer: To whom do you turn when you want an investigation?

Teacher: You ask for *EVK* as we call it, pupil wellbeing meeting, the headmaster and the school nurse, the psychologist, the parents and I participate in a meeting. First I must have made a program of measures to be taken in the class, before I can ask for an EVK. What I do and how I’ve tried to change things, and the result of this. And next step the EVK. But often you don’t get any visible effects like more resources of at worst, no help at all.

/…/

Interviewer: What would you need then?

Teacher: I think that a psychologist /…/ should be able to say that this child has difficulties with this and that. But as he said, you know the child’s problem.

Interviewer: It turns back to you?

Teacher: Yes I have to handle the situation in any case. I cannot say that this child cannot stay with me. He’s in my class anyway yes.

Interviewer: Yes.

Teacher: Despite the problems. I must learn how to handle the problems, the class, I try different ways. A lot of contacts with parents, different plans. The effect of EVK is that I have taken my responsibility, to show that here is a child with problems, or could be.

The teacher talks about a responsibility to report measures she has taken if she thinks a pupil are in need of extra support. But she cannot hand over the responsibility to someone else. She also talks about making her work public as a responsibility.

Teachers’ work is also made public by the individual development plan (IDP). The teachers explained their working procedure and showed me the forms they use. The teachers collect the pupils’ tests, drawings and other achievements in a file and also agreements made with the pupil and the parents during development talks. In the end of the school year the teachers summarises data concerning the single pupil and this summary follows the pupil to the next school year. The documentation is presented by the interviewed teachers as a tool to communicate with other teachers and with patients/parents.

In the following a teacher shows me how she has used the IDP-forms. The city district board had just recently decided that the school should use IDP. Some teachers have visited other schools to find out how they have used IDP. The forms they use now are taken from another school.

Teacher: As you can see, we have got new, our city district has decided (shows me an IDP file) how this should be done. This is taken from, I don’t remember which school it was, but some people have travelled around (to different schools) and then decided to use this one. We are going to learn how to use it.

Interviewer: It’s a whole file.

Teacher: Yes.

We are looking through the file:

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50 “EVK” is the Swedish acronym for ElevVårdsKonferens.
Personal data

Social development (categories: seldom, sometimes, often: self confidence, empathy)

Swedish: different steps

Teacher: The pupil and I for example talk about step six. Then he should tell me if he thinks he knows about this or not or if he is on his way to manage. And then I fill in what I think, and then I sign with date of the day.

Maths

English

Teacher: I haven’t done this yet. I have not written anything here because it’s difficult for these children to use correct sentence structure, they will never be finished if I do.

Teacher: Sometimes I wonder how long this model will last, I’m not quite sure this will be the one we will use in the end.

Interviewer: Have you had something like this before?

Teacher: No, there are different methods for documentation, but this one is questioned by my colleagues.

Interviewer: Is it difficult to use, is that the reason why it is questioned?

Teacher: It takes a lot of time, and the steps are questioned.

Teacher: The idea is that the steps should lead to the goal. It’s our school governed by goals, I don’t like our school governed by goals.

Interviewer: What is it you don’t like?

Teacher: I think that the children come to the school with different preconditions, they are different people, different human beings, they should leave the school differently.

The teacher here also talks about accountability in terms of standardising procedures and a tool developed by teachers. Teachers from her school had been in contact with teachers from other schools in this process. She also says that she is not quite comfortable with the procedure, that it should be developed in relation children’s different need. However, there are no legislative procedures related to documentation demands.

Evaluation of work

The municipality publically presents so called balanced scorecards for every school in the city. Four aspects should be measured, but only the underlined categories present data from the Rowan school51: a) Pupils and parents: satisfied pupil; satisfied parent (no data from the Rowan school); parents confidence (no data from the Rowan school); presence of pupils; near-accidents and injuries (no data from the Rowan School), b) Co-workers and development: (no data from the Rowan School), c) Function and economy: (no data from the Rowan School), and d) Activity and processes: norms and values (no data from the Rowan School), Learning, Goals (no data from the Rowan School), ICT competence (no data from the Rowan School) (www.goteborg.se).

51 Not the real name, the school where the individual interviews and the shadowing took part.
The lack of data from the Rowan School could indicate that the use of balanced score cards is not fully developed yet. During the group interview at the Forest school I ask the teachers about the balanced scorecards. They all laugh a little, “yes the balance is important”. They discuss for a while how often they have to fill in the questionnaire but conclude that this is not a big issue for them.

An official evaluation report from an inspection in 2004 by the Swedish National Agency for Education (www.skolverket.se) says that the Rowan school has too many pupils that do not reach the national educational goals decided for the fifth school year. The agency states that the school should analyse why there are so few pupils who do not reach the goals. Both the activity plan and the quality plan of the school, presented on the school’s homepage, refer to the problem to the pupils’ lack of knowledge in the Swedish language. This could also be regarded as an answer to the agency. Further more, the Agency report states that the school should give the pupils further possibilities to influence and also that the pupils should be offered a more varied and individualised teaching. However, the ground for these claims is unclear in the text.

The National Agency for Education also presents result from tests related to national achievement goals in grades 5 and 9 and also average marking level in grade 9 and year three of upper secondary school on a school level.

In the following quote a teacher talks about these evaluations:

   Teacher (WP 4): /…/ there are no rules you can claim, about the children’s right. This is much weaker in the new curriculum guide. The new curriculum guide is just a frame. That should be filled with something. And all the schools fill it with theirs. Yes it’s a weakening. And the Swedish National Agency for Education is a toothless tiger, roars sometimes, but not so much really happens. They don’t see much. They were here and talked to us, but they didn’t notice anything of what we think they should have noticed.

   Interviewer: Can you point out what they should have noticed?

   Teacher: They should have noticed the educational level. The children here don’t reach the goals. They should have emphasized this much harder. We should have more resources to divide the children in groups. To do other things. Of course you can use resources in different ways but these reductions, going on since the nineties are troublesome. More and more happens in the society, also because we don’t take care of children in a right way. The school is a good institution for taking care of children. We have them here for a long time. We have them from that they are little. And we reach the parents, in most cases. And the independent schools caused problems, a little. Yes, we can have independent schools but now you cannot say so much to children and parents any more. Because then they move to an independent school or another municipal school.

This is an illustration of how a restructuring tool aimed at improving quality of school is described as not trustworthy regarding quality. But this teacher is also willing to help pupils if they need extra support:

   (from field notes)

   (The teacher) has around 15 minutes break which she uses to help a boy in grade 4 with maths. He was in her class the year before but “the school” recommended him take grade 3 once more. But he didn’t want to stay in grade 3 and his parents had found a school that was willing to accept him in grade 4. The teacher now helps him with exercises in his maths book once a week during her break. This is my own initiative she says, nobody have asked med or told me to do this. She says that she does this so the boy could go to grade 4 and also stay in
the school. She says that the boy had to travel a long way to the other school and that he was travelsick.

This is a teacher’s way of acting when she does not accept circumstances that she feels affect pupils in a negative sense. The situation maybe not has so much to with publically published quality indicators but more with the parents/pupils possibility to chose school. But it is also a quote that illustrates a professional orientation toward pupils’ wellbeing and a teacher who do not wait for headmaster’s initiative, or evaluation results. To utilize this space of action however the teacher uses her lunch break.

The quality indicators of the primary care centre are not publically published by authorities (if not the health level of a city district could qualify as an indicator, but it most likely does not). However, the local newspaper often writes about availability and publishes ranking lists of primary care centres and their availability. If it is possible to get an appointment in reasonable time or if nurses answer the telephone are such aspects mentioned.

Nurse: One gets furious when reading the newspapers saying that at this and this primary care centre they manage (the achievements). And then I know about the populations there (not so many unemployed, unhealthy people, immigrants and refugees). You know, I get furious. /../ here you get the list /…/ the debate is so untrustworthy

The WP 3 questionnaire reports that evaluation of work is a factor that influences every-day work for teachers and nurses to a certain extent. 67 % of nurses and 77 % of teachers answered rather much or a little. 20 % of nurses and 10 % of teachers report no influence of evaluation at all.

The risk of being sued is a question related to professional accountability. 28 % of nurses and 55 % of teachers report no risk at all as an influential factor of their everyday work. 30 % of nurses answer very much or rather much. The same figure for teachers is 6 %. For nurses this question is related to legislative routines.

**Demand from management**

Demand from management is here related to the teachers’ ambition to get a dialogue with the city district management. Many pupils have left the school and they take the school money with them. There have been reductions of teachers. The teachers protest against these reductions of teachers and other resources. They argue that the pupils are so demanding that they need all the resources they could get. The teachers here fail to get the contact they want:

From field notes (teachers meeting):

During the Bamba-break I sit in the staffroom. It’s empty. A paper signed by the teachers, addressed to the highest school responsible manager of the city district, hangs on one of the notice boards. It says that the teachers are dissatisfied with the dialogue between them and the school management outside the school. It also says that the pedagogical work in the school is characterised by constant conflicts because of cultural differences and language difficulties. The teachers invite the manager to come to a meeting at the school, they suggest two dates in the letter.
Another paper on the wall is from the (invited) school responsible manager. It says that he has got a new job and soon will leave the city district. When the school day is over Tilde mentions the paper from the teacher. She says that the teachers protest against reduction of the number teachers.

However, the invited manager did not come. A teacher said that the argument was that he wanted to communicate with the headmaster (field notes from a teachers’ teaches meeting). Later the city district executive came to a meeting with teachers on his own initiative. But then he wanted to discuss the qualifications of the new school responsible manager and not the situation experienced by the teachers (field notes from a teachers meeting).

The teachers want to invite him again:

From field notes (teachers’ meeting):
All (1-6) teachers from the school are gathered in the staff room for the weekly Tuesday afternoon meeting.

The teachers discuss an invitation to the city district manager. They want him to visit the school and discuss the situation.

/.../
Teacher: Should the invitation come from the management (here: the headmaster).
Answer from several teachers: No.
Teacher: Refers to mail from the city district manager where he welcomes viewpoints from everybody.
Teacher: He doesn’t see this as line thing.
Teacher: Should the invitation come from the trade union?
Teacher: No, this is not a question for the trade union.

A teacher talks about consequences of the reductions of teachers in the following quote from an interview and thereby also refers to the municipality as a new employer since more than 15 years:

Teacher: It was a big change when the school changed from the state to the municipals. And even bigger when they divided the city districts in Göteborg and made city districts boards. /.../ The municipals could employ teachers as they liked, larger parts of the rules system disappeared.

Interviewer: For the employment?
Teacher: Not only the employments but for the demands in school. The pressure is not the same and the children don’t get the same education everywhere, any more. It depends on where they live and this became more obvious when dividing into city district boards. The city district boards don’t know so much about the school as the old school administration did. They are mishmash, they do as good as they can, but they are not able to do so much. Maybe the former municipal school administration didn’t do so much either. The school is governed by the economy. And it is much more governed by economy today than with the municipal school administration.

The teacher also refers to the competition between schools and to the voucher system, that pupils and parents can move to another school if they want to. Teachers can do nothing she says.
But everybody wants the money. And everybody accepts children anytime, I think. It has been much more difficult to handle, that the children move. You get questioned in a wrong way. It’s no problem to be questioned but it should be right I think. We lose 72 000 every time a pupil moves.

Interviewer: And you have seen the result of this?

Teacher: Yes we have seen the result. /…/ at Christmas, in the middle of a school year. They have divided a class and taken away the teacher. That’s what they are after, then they can save money. Some children to that class, some to that class and some to that class. No matter. And teaching is rather personal, really. You are not the same teacher as I am. You cannot be and should not be. But the children must adapt here and there. And small children need security.

Interviewer: It’s something different?

Teacher: It is totally different. But it’s really different in the whole Sweden. They save money.

The teachers seem to have no tools to coop with the situation of reductions when pupils leave the school. The managers do not listen to their views, they have no counterpart. Teachers are subordinated the headmaster. However, the headmaster is not a teacher any more, but a manager in a line of authority.

Also the interviewed nurses refer to an economy related to result but in a somewhat different way. The result of the primary care centre is among other things measured in relation to the number of visits by patients to doctors and district nurses. However the doctors see fewer patients than they should. There is no lack of people who are willing to be a patient at the Haglunda centre. On the contrary, the waiting room is full and many are refused because there are no appointment times. In the economy system a visit by a patient is referred to as ‘a stick’. The reporting goes directly from the patient-record to the economy system. As indicated in the interview with a primary health care nurse, the ‘achievement is also measured per individual. For her this is no problem, she does more ‘sticks’ than the agreement says. However, this is no help for the result of the centre.

Interviewer: Do you get feed back?

Nurse: Yes we get monthly and quarterly reports.

Interviewer: How are you doing?

Nurse: Very good, almost too good because we have been understaffed.

When patients call the nurses at the primary care centre to get an appointment or advice, the telephone is connected to a computer (“Tele Q”) and the nurses can easily see on the screen

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52 The purchasing procedure decides what the primary care centre should achieve. The nurses talk about the patients as ‘sticks’ in the economy system. Every time the doctors or the primary care nurses see a patient the primary care centre gets a ‘stick’. But only if they see patients for purposes that follow the care agreement. The primary care nurses can for example not develop their interest in health promotion. This will not be reimbursed by the responsible political level. The computer-based booking system, the patient-record, and the Tele Q (a computer-based telephone system) are connected to the economy system. Thereby the actions taken by nurses, when documented, also are used for other purposes than for the benefit of patients or facilitating nurses’ work. The booking system, the patient-record, and Tele Q make it easier to organise the work when giving the patients appointment times or making notes of patients’ conditions. But Tele Q also generates lists of the availability that nurses can react on almost immediately. And the booking system and the patient-record also generate ‘sticks’. By measuring the ‘sticks’ and the availability the management controls the activity. Nurses get feed back during meetings with the supervisors of the primary care centre.
how many phone calls they have been able to answer, different bar charts give them immediate response on their work. A nurse also says that:

Nurse: /…/ they (the district nurses) answer the telephone between 8 and 9. This is new since two weeks. The politicians want to increase the availability and we try this way to do it. The patients should reach us by phone. Now it is so that about sixty percent of all phone calls don’t reach us, they are thrown out of the system.

Interviewer: Do they measure this?

Nurse: Mm, but we will be able to decrease the share I think.

Interviewer: How come?

Nurse: Last Tuesday on a network meeting we were told that we can adjust the number of calls you accept per hour. If you increase the numbers you open the queue. And that means that people don’t have to call again. Because we don’t know if it’s the same persons who call several time.

Interviewer: Yes

Nurse: We have the network meetings (nurses from district Hisingen meet regularly) so we could share tips and advice. Those who had longer experience from Tele Q had noticed a decreased pressure in the afternoons when they opened up the queue. We were afraid not to handle so many phone calls, 40 per hour, we have therefore accepted a lower number to be able to answer them. But now we have tried the other way and it has turned out well.

The nurses can manipulate the Tele Q system and thereby also affect the outcome of their work measured as number of phone calls. This is also an example of a self-evaluative tool at work.

All care must be purchased by the region. This also implies that the district nurses, or anybody else employed at the primary care centre, cannot start up new kinds of activities without a purchasing procedure. Time is measured during the working day, i.e. every appointment with patient gives a certain amount of money, up to a certain number of patients. If the primary care centre staff sees fewer patients they get less reimbursement and if they see more patients than the agreement says, they got no reimbursement for the extra patients. Also visits to the district nurses are purchased by the region and so are the nurses’ consultancies. 53

Two of the nurses talk about the end of 1980s and beginning of 1990s as a period when the management demands on nurses changed. Both of them worked as head nurses in an acute hospital at that period. One of them says that:

The demands on the head nurse were high. Earlier it was a kind of retreat position for a tired nurse. If you had worked for a long time in a ward you sooner or later became a head nurse. And this is wrong. It should be the person fittest for job that should get it.

She also says that the economic aspects that appeared in the 1980s/1990s were not only a change for the worse:

Nurse: But of course it was good to be aware of this, it was quite comfortable in the 60s and 70s. You just did your job, and it was of course important to do a good job and you got (your

53 The patient also pays 60 SEK to the region when they see Nina and her primary health care nurse colleagues or have a consultancy appointment with a nurse. A visit to a doctor costs around 120 SEK.
continuing) education from the doctors and so. But when you become aware of what things cost.

Interviewer: Become aware of? What happened?

Nurse: How to say it, for example if something should be done, call the porter to change the oxygen cylinder, it was always like that, nobody knew anything but everybody just came and did these tasks. And the lab came and took the tests, we had no idea of how much it cost to take tests and so on. But suddenly everybody was responsible for their own budget. We were not allowed to call the porter, we had to learn how to change the oxygen cylinders, and we had to learn how much it cost to take tests. We just cannot take a lot of tests if the tests are not motivated.

/.../

Nurse: /.../ This was a new way of thinking for us in the health care. But it makes no harm, but sometimes maybe one could have wanted not so much focus on the economy, but this is what happened.

During an interview a nurse shows me a letter concerning strategic goals for the primary care centers in the area. The letter is sent by e-mail to all employees and says that an economy in balance is the superior goal. The nurse is angry when she shows me the letter. She says that she has heard this before but never seen it in print before. She also says that the demands from the patients and the demands from above are conflicting.

Nurse: /.../ We are reimbursed in relation to how we do the documentation (shows me on the computer screen).

Interviewer: Someone is measuring your work? Because this must be connected to the economy system?

Nurse: Yes we are measured against how much money we generate and they can also see what we actually do by looking at our notes.

Interviewer: Do you get feedback?

Nurse: Hmm, do we get feedback? Not yet, I cannot answer this. We have just made a point of getting the money. But the demands from above and from the patients, they are incompatible. It’s impossible. I don’t know how a person should be like to handle this. You must have blinders on and a good fellowship within your work group and try to survive the day. And now we were told by our head district official that the economy should be prioritised before the patients. It’s clearly stated in the text.

Interviewer: It says?

Nurse: That the economy is more important than the patients. I’ve never seen this in print before. Now it is stated that the economy goes before the patient.

Interviewer: From the region?

Nurse: Mm.

Interviewer: What kind of text is it? Do you know that?

Nurse: It’s here in my e-mail. I’ve seen a lot. But never so harsh statements…strategic goals, could it be this one? Mm (opens the document).

Interviewer: Yes, strategic goals 2006, (reads from the document) there, “in the year 2006 two strategic goals are superior, namely an activity in balance regarding economy and increased accessibility but the economy is superior to everything else”.
A nurse says that she never had a feeling that there was a lack of resources during her previous work. There could be long waiting lists but they gave priorities to certain patients and asked others to wait.

But I never felt that we were not good (= have resources) enough. It is not an alternative at a primary care centre to ask people to wait, they close every evening. But that we must be the police in an organisation we cannot influence, this is different. It’s not about economic consciousness, because this I think is good, it’s something else.

Both teachers and nurses talk about an economy system they have no possibilities to influence but that highly affect their working conditions. Nurses also encounter self-evaluative tools such as the Tele Q introduced to increase the availability. This can also be related to steering of the stream of patients to the primary care centre.

In the WP 3 both teachers and nurses state that competition between schools and hospitals have increased (76% of teachers and 60 % of nurses agree). An explanation of the difference can be that nurses employed at bigger hospitals are not immediately affected by less income related to loss of patients as school teacher are. A big organization can “hide” the competition for frontline workers not involved in the purchasing procedure. Or maybe there is not so much real competition between big hospitals even if the design strategy tells something different?

10.3.4 Supervision

The teachers say that the situation in the school is difficult. A teacher often talks about how important it is that teachers say “no”, when the situation does not hold any more. But she also says that teachers seem to manage even if they say that the situation is impossible.

Teacher: Yes, but at the same time we must be self-critical in relation to how we organise our complains. I’m afraid that many teachers are so tired that they often say that it’s so heavy, it’s so heavy, but this will take us nowhere. We must be better in how we say no, we will not do this. /…/ I didn’t participate in the meeting where we should discuss our professional no. But I think this is important. And the trade union says that you must learn how to say no, that this is more than we can do.

Interviewer: I noticed in the report on your homepage that many pupils don’t reach the educational goals in school year 5.

Teacher: Yes, we say so, we don’t reach the goals. But there are lots of things we can change, to be better organised as a group when we complain, I think. More unified, be more clear and distinct. And some of us are like that. And then we got a fuzzy mass in between. So I think we can change, Us. And have to do so. But then it is also, as we talked about when he (the city district manager) was here, the management must change and be clear. To think about what damage they cause when they make certain statements, such when it wasn’t eleven positions that should be taken away but seven. And as our, what’s her name? At the city district management, in the press says that the teachers must sharpen their pedagogy. This causes a great deal of damage, to do such statements, I think. So it’s a crisis of confidence between management and teachers I think.

The teacher concludes that there is a crisis of confidence between teachers and management. One reason for this is that management sometimes has used the press to complain about the teachers, that teachers must change and do a better job. Another reason is the reductions of the number of teachers, and earlier rumours from municipal officials about reductions that were partly wrong.
Both teachers and nurses interviewed describe a work situation where the supervisors do not interfere in their daily work practice.

Doctors are not supervisors of nurses’ work and it was interesting to note how separate the work processes of the two professions were, even if they had contact with the same patients. Mostly they communicated by nurses’ messages to doctors on the computer. The nurses often talked about the terrible work situation for the doctors. Nurses’ actions affect the doctors’ work load. The nurses say that they try to protect doctors and give them a better work situation but also that the pressure from the region is hard to increase the number of visits to see a doctor.

Nurse: /…/ But you cannot go on so long here, to say no, say no and say no, it’s heavy for me, for the body and mind so to say. Even if I know that we do as good as we can, we actually do that. But we can change small things on the surface, like changing the booking system, different projects, as now we have the breakthrough method, how to become more effective. 54

Interviewer: What is it?

Nurse: Yes they try, the region, they try to change our way of working with the appointment booking to see a doctor and the way we plan. How to plan emergency appointments in relation to next visit appointments. To make things more effective. But if you are a little unkind you can say that this is about whipping a dog that already lay down. But maybe this is not so serious, I don’t know. I don’t know, maybe it would work, because that are successful primary care centres. But how to change from twelve, fifteen patients a day to 25, I don’t know how to do it.

Interviewer: A day?

Nurse: Yes, and I don’t know how to manage with this. They (refers to the doctors) are already tired with the number of patients they see today. But of course, some of the meetings, administration. Yes you must have administration. But how to make consultancy work more effective, that’s what it means.

Interviewer: So your job governs the doctors’ work situation too?

Nurse: Yes.

But the situation contains more than the dispute about the appointment time. According to management demands every patient only should get 15 minutes appointments. During the shadowing I could notice that the nurses often booked 30 minutes. They knew that 15 minutes was too short for some patients. Both Nancy and Nurse said that the job turnover among doctors is high. If a doctor leaves, the situation will get worse with even less windows in the booking system. The nurses also worry about the doctors’ health; they say that some of them have been reported long term ill because of the pressure from workload.

One day, when I came to the centre to talk to the supervisor, a doctor was in her room. The supervisor asked me to stay and listen to what the doctor had to say. She complained to the supervisor that the nurses gave only fifteen minutes to patients with for example depression. Sometimes it also takes fifteen minutes for an old patient to undress before the examination, she said. The supervisor told me when the doctor has left that the demands on her from management was to only give patients 15 minutes, never answer a patient that there are no appointment times to see a doctor left. This is the message she has to give the nurses – and the

54 A nurse says that this method has not changed any routines yet and they have not got a report from the work group yet (a nurse, a doctor and the head of the centre are involved in the project).
doctors. This conflicting situation often created problems for the nurses when encountering patients.

Referring to WP 3 questionnaire, a majority of the Swedish teachers and nurses maintain that their own conception of how work should be done is highly influential in their every-day work. Both teachers and nurses agree that control from their supervisors have rather little influence; however teachers report less influence of supervisors than nurses. This difference can of course be related to work organisation where the nurse in charge of a hospital ward is physically closer to the activity than a headmaster of a school. Teachers and nurses do also not regard themselves as particularly controlled by management. However, only 5.6 % of the nurses and 12.9 % of the teachers participate directly in general policy decisions about the distribution of funds within the overall budget of the place where they work. Few participate in decisions about employment-policies but more of them in issues concerning decisions about the modeling of actual work to be done. Not so many participate in issues that deal with changes in services delivered by their institution. Regarding the question if it is less hierarchies today 62 % of nurses agreed and 32 % disagreed. The same figures for teachers were 47 % agreed and 36 % disagreed (Sohlberg et al, 2006).

10.3.5 Work process and relation to clients

Long-term relationship with pupils appears as an important aspect of teachers’ community of practise. Teachers have daily contact with the same group of pupils, often during several years.

A care for the children, that children should feel when they are well is important aspects in the stories told by teachers.

Teacher: /…/ I am very concerned about the children, that they should feel well, and feel happy in school. I have seen this as number one, and I still do, indeed, that they should feel safe, and go to school without fear, dare to ask me things. Try to create an atmosphere. I feel well here and I want to be here. I still feel that this is the most important.

Interviewer: Nothing has changed?
Teacher: No, because, if you don’t have this, you’ll get so many other problems. Yes the problems become bigger if you don’t work a lot with this, the social, and care for the children a lot /…/.

The following are contributions to the discussion during a teachers’ team meeting, in a chronological order and deals with the parents’ situation as immigrants and being unfamiliar with the Swedish society:

Teacher: /…/ The parents are scared too. The children threaten them to call BRIS the parents know that they are not allowed to beat their children but the children scream, even if they are not beaten. The parents get scared of what the neighbours would think. They need to know how to stop the children. That they are allowed to stop the children.
Teacher: There are children who say that we live in a democratic country when someone tells them stop fighting. There are children who believe that they are allowed to do just anything they like.
/…/

The teachers come to an agreement that they have to find out a way to include the parents, the discussion continues:

Teacher: I think we must work with the mothers.
Teacher: But it must be fun to do it.
Teacher: We must make this fun and easy so that we could coop with this after a full school day.
Teacher: In the evenings.
Teacher: No.
Teacher: But they can’t come otherwise, they are at work.
Teacher: But maybe it’s most important to reach the mothers who are at home?
Teacher: Maybe the children and the parents come together?
Teacher: Many of the have seven children at home.

It seems to be quite difficult to arrange. One problem is the teachers working hours and that also parents have the same working hours. In other words, teachers’ working hours can regulate relation with parents. Parents’ expectations can sometimes turn into a problem. One teacher tells about parents who wanted to arrange activities for children but with hopes to get an employment at the school. An employment was not possible and the whole thing came to nothing. The meeting continues, maybe the teachers could meet parents when they participate in other activities, for example parents’ education or in the preschool.

Teacher: In the Maple School, we had meetings and gathered all parents to the beginners. We presented the staff and expectations from the school when your child comes to the school. It was good, one becomes visible. We just let everything flow.

Teacher: Good.
Teacher: This is something we can do, we who get school year one and four.
Teacher: Maybe we can start here, if it becomes too big, it all ends in nothing.

The meeting is interrupted by children who fights in the corridor ”I get crazy if its my children” says one teacher and three teachers run to the corridor and stop the fight, the other teachers try to see who the children are, if they “belong” to them. The meeting continues:

Teacher: We could present school year one in the spring semester.
Teacher: Don’t forget that we have the preschool class that should be introduced.
Teacher: We could gather people in different groups with interpreters, because we are talking at cross-purposes.

The teachers’ solution is to have contact with parents before the children start school. This is maybe not so difficult for them to arrange and maybe they do not regard this discussion as a big issue either, but rather an aspect of normal life at work. But the topic they discussed is quite complex: it is about contact with parents who are not familiar with the Swedish school and with an ambition to make school life easier for the children. Not so many years ago this discussion would have seemed exotic, almost all parents had own experiences of the Swedish school. What the teachers try to do here is to develop their own tools to handle the demands from parents. They do this because they have experienced the problems in their contacts with pupils and parents, not because of demands from management.

Nurses’ relation to clients at a primary health care is more episodic. A contact can last for several years for example when nurses are involved in long term follow up of a patient, but it can be six months or more between patients visits.

People who are in need of care should get care, be taken care of as patients and not be refused. However, the nurses must refuse people partly because some of them do not need medical care but partly also because there are not enough appointment times to see a doctor. This situation can be conflicting for a nurse with a focus on patients’ wellbeing:
Nurse: We prioritise, we make an assessment of people who come to the primary care centre because there are not enough appointment times to see a doctor. And I don’t know if I can stand up for that assessment, maybe we have appointment times for around sixty percent of the patients who are in need of care.

Interviewer: But how do you know which patients to give an appointment time to see a doctor?
Nurse: Yes that’s my responsibility as a nurse.

Interviewer: And you must say no to some of them?
Nurse: Yes.

Interviewer: But if some of them?
Nurse: Yes this is so scary. I must know how to ask the right questions and all the time read between the lines. Because there are not appointment times to all who see us and all of them should not have an appointment time. Many people see us for small things that they can take care of by self-care. And our task is to give them an appointment time or not give them an appointment time, give advice, sometimes tell them to come back for a follow up, we can book visits to the district nurses, and in cases of emergency to the psychologist, or social worker, for example if the patient express suicidal tendencies. We usually send these patients to an acute psychiatric clinic but sometimes you don’t dare to do that, because you have a feeling that the patient has serious suicidal thoughts. It’s the same with chest pain, we must take care of them even if we don’t have appointment times.

Some of the patients’ relation with this health care community can be described in terms of continuity. Continuity is related to patients that make visits rather often and most commonly for the same problem. One way the nurses can make continuity is to arrange meetings for the patient with the same district nurse or doctor every time. But this is impossible if the primary care centre has to send the patient to a private provider for a first and acute visit. The following is from the nurses’ waiting room work, where they decide if patients should get an appointment to see a doctor or not. They have access to a computer with the booking system and the patients’ medical record.

(from field notes.)

9.07. The nurse asks questions to find out about the problems and what have been done. The husband interprets. Tells the patient that there are no times left today and also that she will need a longer appointment time with the doctor for examination. If she needs a time very soon she can call tomorrow at 7.45.

The patient wants a time booked for tomorrow. But the nurse says that she is not allowed to make a reservation for tomorrow. She has to tell the patient to come back early next morning or preferably contact the primary care centre by phone. The patient is not satisfied with this. The nurse suggests them to visit a private care giver close to the centre but the patient wants a long term contact.

The nurse describe a pressure from the patients, in particular related to her work with the sorting of patients in the waiting room and the Tele Q system. As has been described above, there are not enough appointment times to see a doctor for the patients who are in need of care. Daily she must tell the patients that they cannot see a doctor, even if they need to see one. The patients’ must try to get an appointment somewhere else. Many patients get angry.

Nurse: The hard thing is not the telephone but to treat the patients in a way that they feel satisfied, even if they have got nothing. That’s the trick of our job.

Interviewer: Yes I saw that, it was pretty tough (referring to shadowing).
Nurse: Mm, mm. Sometimes they get angry, regardless of what we say. It’s frantic here sometimes. /.../
In the WP 3 questionnaire a majority of teachers and nurses do not feel more questioned by pupils/parents nowadays. Only 5% of the teachers and 6% of the nurses agreed to the statement (Sohlberg et al, 2006).

10.4 Concluding comments

10.4.1 Higher education reforms and changes in formal requirements of nurses and teachers

Teachers and nurses act in institutional settings that differ in several respects, for example concerning regulation, legislation, work organisation, employment terms and relations to clients. There are also similarities. One example is the relation to higher education in that both became integrated in the higher education system in 1977.

The number of registered students in any kind of teacher education during the academic year of 2005/06 was 46,330 (of which around 13,000 was admitted that year) which makes teacher education to the largest professional degree program. Nurse education had 16,770 students, and nurse specialist education had 3,480 students during the same year (around 5,000 was admitted to basic nurse education). In total, 389,100 students were registered in Swedish higher education the academic year of 2005/06 (Högskoleverket, 2007). This means that as much as around 16,2% of all higher education students belonged to the categories of teacher and nurse students respectively. If teacher and nurse educations are regarded as a means to change practice of education and health care this also means that higher education should be regarded as an influential actor as well.

In both education and health care, restructuring is discoursed as related to a phenomena that often got the term knowledge society. In health care the medical and technological advancements demand not only new nurse competences but also new patient competences. The competent patients are well-informed about their illnesses and are an active part in prevention and treatments. Restructuring demands nurses to have competences in the theory and practice of nursing, research, development work, teaching, and leadership. Some health care areas are depicted as more demanding. Nurses who work in such specified areas should have a specialist education (National Board of Health and Welfare, 2005). In education, preparing pupils for a learning society demands new teacher competences, thereby fostering new competences of the whole population in the “lifelong learning society”. The competent teacher is expected to have competences in how to do goal analyses, how to organise learning processes, how to evaluate, how to decide to reach the goals of the school in cooperation with pupils and other teachers, how to apply the school law, how to understand how pedagogical processes are governed by rules and ideologies, and how to analyse pedagogical work from an organisational perspective (Government Bill 1999/2000:135).

Higher education reforms regarding the educations of teachers and nurses respectively could be understood against ideas of life long learning, intra-professional ambitions, and changes in governance of the public sector. There is a demanding complexity in changes of formal requirements and in higher education reforms and with many institutional settings intertwined. However, a conclusion in relation to these case studies might be that changes in formal educational requirements have to a larger extent interfered in nurses’ work life trajectories than in teachers’, not least because of the close connection for nurses to the legislative framework of the profession. There are also changes in formal requirements that decide possibilities to enter nurse specialist education. Nurses educated before 1992 have to complete their education with research methodology (one semester long course). There are still no legal requirements of teacher education and legitimation for work and employment as teacher, even if the issue is a part of the political and the trade union debate.
10.4.2 Reforms and changes in work organisation

Another similarity between teachers and nurses is the demands of market-like production of education and health care, even if services are tax financed. However, the WP 4 teachers express more pressure from clients than from restructuring of education system. However, they express a need of more resources. The WP 5 nurses also express pressure from clients but mostly in relation to restructuring of the health care system and economic incentives to steer the stream of patients and the reimbursement system. The WP 4 teachers do not seem to be under so much pressure from the quality control system, a pupil left behind will not legally affect an individual teacher. There seems to be no direct transformation pressure from school inspections. Nurses on the other hand have individual responsibility for malpractice.

Political ambitions can be “translated” (Latour, 1998) to the design of work organisations and tools “at work”. It makes no sense to say that organisational changes or restructuring measures do not have an impact, even if the teachers and nurses sometimes say so. On reason is that much is taken for granted in organisational life. Another reason is that when teachers or nurses talk about organisational changes or restructuring measures they have at least noticed that something have happened. But of course this is not the same as a direct implementation of a design strategy. Therefore the concept of “translation” could be useful when analysing restructuring and professional life.

10.4.3 Nurses and steering the stream of patients

The State ambition of steering the stream of patients to the cheapest care possible can of course be very tricky to fulfil. The politicians do not just tell the patients to go to the cheapest doctor, instead they open the primary care centres with a hope that the patients will follow the ambitions without giving the economic rational a thought.

But how to convince a population that the specialist doctor at the highly advanced specialist hospital is not the best person to see if you feel that you are in need of health care? That they as patients will get the same care, or even better care, at the primary care centre? Most likely it will not help to advertise in the big morning newspaper (but they advertise of course) and tell patients how to behave in relation to health care or give information in other ways. Perhaps some of the patients will change their minds and go to the primary care centre instead of to the acute hospital but maybe not so many as the ambition says. Another way is to make it much cheaper for a patient to turn on the primary care centre than to the acute hospital. But this is still not enough. The patients seem to prefer the emergency department even if they only have a quite simple disease.

During the life history interviews organisational tools of different kinds were mentioned, here analysed as means of steering the stream of patients and in relation to nurses’ work. Such a tool is the introduction of the position of nurses in addition to the previous district nurses. These new nurses then become equipped with telephones, computers with booking schedules etc. People can now call the centre, talk to a nurse and get advice etc. The trick is to make primary care more attractive for patients in terms of availability and to tighten the possibility to see an acute hospital doctor. The message is different, it is now a message of a possibility to get a family doctor and easily accessible health care staff, but the original message of cost control still is “at work”, but through the new message. However, if primary care centres demand that you call them before the visit to get an appointment time but “never” answer the telephone? If you, when the primary care centre answer the phone, get the message that there is no appointment time to see a doctor left behind today, please come back tomorrow? Most likely it will also not help to ask nurses to answer more phone calls either. They do as good as they can under the given conditions, and they are emphasising their concern about patients.
Just like the political ambition cannot trust patients, the political ambition cannot trust nurses either. More things have therefore to be added to the original message, like a computer-based patient record also aimed for economic follow ups and thereby also self-regulation regarding the number of patients, or the Tele Q system with immediate follow ups of availability rate, or manipulations of the booking system to make the work process more effective. Even more, a purchasing procedure regulates the limit of number of patient visits, and thereby also a budget limit. The state can neither force patients to choose the primary care centre, nor force patient-oriented nurses to increase availability. The new message says that if you do not fulfil your obligation as a primary care centre you will lose economic resources and thereby also positions as nurses/district nurses/doctors etc. From the staffs point of view this is nothing they can resist. The district nurses have to work as nurses as well to cope with demands related to the purchasing procedure. Still the message about the cheapest care level is “at work”. However, the control is now in the hands of the health care staff, not least the nurses/district nurses when sorting the waiting room patients and answering the Tele Q. Steering the stream of patients is therefore also an aspect of a narrative of a re-configuration of the making of nurses’ professional knowledge.

The narrative of steering a stream of patients is but one of several that can be told in relation to restructuring measures. Another possible narrative is about intra-professional strivings and exclusion of others. For example the nurses’ documentation system VIPS is a powerful global classification tool, not only to categorise patients or to use for economic purposes but also for stabilising a nurses’ community of practise by indicating what nurses should pay attention to and what they should document. The system of documentation holds the profession together. Nurses get a standardised professional language of their own.

10.4.4 Integration of teachers

The narrative for teachers and organisational change is different in that it is not about steering the stream of clientele. It is still about the relation between teachers and clients, that children should learn something decided by the stat/the school and that the school have responsibility for pupils during more hours than there is class-room time. However, as expressed in the new teacher education reform and also much earlier, a political ambition is integration of school day and of teacher categories. The section “team work and cross-professional collaboration” also is quoting field notes from a meeting between a teacher and a leisure time pedagogue. The interviewed teachers say that the collaboration seldom works and that there are barriers between the two positions. These statements imply that teachers have noticed something here, that the question is a real issue. If not, they would probably not have raised it at all, or if I had asked them, answered like “what”? “What are you talking about”? etc. But they did not. The issue was definitely something “living” in their communities.

In the presented quote several tools were “at work”. Examples are the schedule that give them time or not give them time to meet, a form to evaluate the pupils, and of course also their long term planning of the pupils lessons.

If the headmaster tells the teachers to work together, or if he puts a note on the notice board, maybe some teachers would listen to him and do as he told them. But of course he could not be sure. Another tool is to organise the school day so that teachers and leisure time teachers share some lessons. The message can now be another, and also interpreted differently by teachers and leisure time teachers, but it would still work. They can for example struggle with issues of pupils’ behaviour, goal setting regarding school subjects or planning an excursion or a visit to a museum, but still the original message of integration is “at work”. The message is translated to plastic “boundary objects” (Star & Griesemer, 1989), such as the mentioned evaluation forms, or development of standardised documentation forms as mentioned in the
section “Documentation”, and that binds the two teacher categories together. The power of the tools becomes even stronger when the number of pupils per teacher is added. When the number of pupils become too many in relation to lesson-hours, and demands of half-class etc, it becomes very difficult to resist integration. This is of course not the same as to recommend larger groups of pupils to stimulate integration. The situation is much more complex and simplified to illustrate how restructuring tools can be part of different narratives.

Also for teachers the described example can be narrated as teachers’ striving for intra-professional development, for example when developing a common tool and with a standardised language for documentation of pupils’ development. Of course such a standardised tool can be used for exclusion of others as teachers as well. Integration can also be a part of a teachers’ narrative of a re-configuration of the making of their professional knowledge.

10.4.5 Teachers relation with clients

Parents can move their children to another school. This was a problem for the teachers at the studied WP 4 school. They could choose another municipal school or a private school, financed by tax money. A school that looses a pupil, also looses the money connected to the pupil. In this particular school, restructuring therefore also was working through changes in the relation between teachers and pupils. The school has to adjust the number of teachers to the number of students (the school had lost around 60 pupils the last school year, out of a total number of around 400 pupils). The teachers’ space of action in relation to pupils become limited, they must please parents and pupils so they do not leave.

The teachers at the school also face parents with lack of experience of the Swedish school system. It is reasonable to believe that this is a quite new experience for many teachers. They cannot take for granted that parents know what schooling of pupils is about. This is a quite new situation for teachers, at least in a perspective of teachers with very long work experience. The teachers talk about the school situation as pressing with many pupils at risk of falling behind. The economic incentives are the same for all pupils, even if teachers say that there are pupils in need of extra resources.

The relation between teachers and pupils is changing in relation to the voucher system. The relation is based on choice and can easily be broken. Parents not being familiar with the school can also be described in terms of a changing relation. It makes it more difficult for teachers to communicate with parents, parents then think that the school is bad, and that children do not learn enough, and move their children to another school. The teachers cannot expect that all parents know what (the Swedish) school is about. Like one teacher said, teachers are sometimes the only Swedish people pupils and parents meet.

The constitution of professional strategies within a teachers’ work life narrative can be about giving extra time for some pupils, for example during lunch breaks. Demands from management and demands from pupils/parents are conflicting within a community of practise and a professional configuration built around creation of long term relationship with pupils. Decentralisation is often described in terms of increasing the professionals’ influence over the work situation. However, decentralisation can also be the same as centralisation. The

55 The WP 4 school and WP 5 primary care centre are chosen, not because they represent average Swedish sites, but because they are situated in a so called “heavy area” with high employment rate and a high rate of people who get compensation from Social Insurance Board. It can be easier to study what teachers/nurses struggle with at work in terms of restructuring in such workplaces.

56 The group-interview was carried out at another school, situated in a middle class area. The teachers said that very few pupils moved to other schools, it happened sometimes but they got new pupils as well.
teachers’ space of action is here limited; they have no direct channel to the city district manager. Their strategy is to call for more resources by writing letters and consequence descriptions. This strategy can also be regarded as a call for “more of the same”, that is, to meet the demanding situation when with the familiar instrumentation. But teachers are not controlling the resources, and they are excluded from the line of authority. The demands from state and citizens turn back to teachers to solve.

Teachers can plan and work together, and they also do so. Documentation in terms of pupils’ individual development plans is an important aspect of this work life narrative. Teachers also used other tools for follow ups of pupils in their daily work, tools developed by themselves as individual teachers. But this is not the same as a collective teachers’ community where one teacher easily can replace another by help of extensive documentation, as we for example can see among nurses (and other health care professionals as well like doctors, physiotherapists etc). The making of a configuration of a teachers’ community of practise involves the long-term relationship with pupils. The professional strategies are oriented to handle pupils’ behaviour and achievements in the classroom.

10.4.6 Gap rhetoric and control of efficiency

Restructuring in teachers’ narrative implies that the school monopoly has been broken up, integration of teacher categories, and quality controls. In nurses’ narrative restructuring implies steering of the stream of patients, control of efficiency, changed staff-mix, demands of documentation, and quality controls. Restructuring works through organisational tools introduced by management and by legislation. Some of these tools are also used for the purposes of intra-professional development.

The tools aiming at economic control and self-evaluation are working differently in the two studied communities. This could be related to one of the main differences between teachers’ and nurses’ relation to clients, namely the long cyclic character of the teachers, and the short-cyclic and sometimes episodic of the nurses. Quite simply, if achievements are measured by patient visits as single “sticks” and number of phone calls answered, the profession and the health care community in one sense is much easier to control.

However, this is of course not the whole truth. Indeed, health care is a regarded as very difficult to control regarding costs and the simple measurement of “sticks” is also an illusion. By taking the interviewed nurses accounts as a point of departure, the “sticks” measure nothing. They argue that the resources should be adapted to the need of the patients. And in fact, the teachers give us exactly the same message regarding pupils. Resources cannot be related to a person without a thought of who this person is.

The design strategy of restructuring relies on a re-configuration of nurses’ and teachers’ professional knowledge at work. Nurses and teachers have to adapt to changes in society and respond to these in a responsible and efficient way. The idea is that the health care would work well (preventive work, no waiting lists, lower costs etc) if only the different health care communities could coordinate their efforts in an efficient way. No pupils would be excluded from “the knowledge society” (or what to call it) if teachers integrated their work, developed their work in classrooms to become more learning promoting, etc. Re-configuration of professional knowledge is embedded in a rhetoric of “gaps”, between something wanted and reality, that should be filled by help of the professionals responsible acting.

In this sense the state steps back and relies on the front-line professionals. However, at the same time the narrative is about tight control of work tasks. The district nurses as an example have given up parts of their main professional interests in relation to measurements of achievements. They are only reimbursed for what is agreed upon in the purchasing procedure.
We can also talk about creation of new relations with clientele for the two studied professions, or about re-regulation of the regulation. For bad and for good from their own perspective.

10.4.7 Generations

Generation in the ProfKnow-project refers to the idea that a group of people can be regarded as a generation to the extent that they share same experiences in relation to crucial political and social changes, in a chronological sense. A was argued by Sohlberg et al (2006) it could be useful to concentrate on how long period a professional has worked in the profession of teaching and nursing respectively. Work trajectories are more related to length in occupation than to age. The ambition in WP 4/5 has also been to interview and “shadow” teachers and nurses with different length of work experience. This requirement of different years in occupation was fulfilled with the teachers. However, it could not be met regarding nurses. This because we had chosen to study a primary care centre and there were no newly educated nurses.

The concept of generation had an impact on nurses work life trajectories and in relation to educational demands. There was no such impact on teachers’ work life trajectories in relation to teacher education in the case studies. However, educational restructuring resulting in changes in the educational level of the total Swedish population has changed entrance requirements to enter teacher and nurse education.

10.5 References


### Appendix, the Swedish case (summary)

**System narrative, teachers (WP 2).**

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Work life narrative, teachers (WP 4)

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<td>Steering the stream of patients</td>
<td>Measurement of telephone availability and possibility to get an appointment</td>
<td>Manipulation of the booking system and the telephone system to increase availability (&quot;self-regulative&quot; tools)</td>
<td>Cooperation</td>
</tr>
<tr>
<td>Control of efficiency</td>
<td>Earlier referral of patients from acute care to primary care (economic incentives – another caregiver gets the cost)</td>
<td>Self-regulative tools such as a computer-based booking system and feedback from supervisor</td>
<td>Cross-professional cooperation (but could be more developed according to the nurses)</td>
</tr>
<tr>
<td>(breaking up of health care provider monopoly – but patients cannot chose level of care)</td>
<td>Measurement of patient visits</td>
<td>Participation in development projects to increase availability</td>
<td>Cooperation with actors outside health care community</td>
</tr>
<tr>
<td></td>
<td>The primary care centre looses money if they do not fulfill their agreements with the purchaser of care. Risk of staff reductions</td>
<td>Participation in development projects directed to increase the care and the preventive work related to specific patients groups and groups in society (such as health improvement, alcohol prevention)</td>
<td>Must say no to patients in need of care (nurses talk about an unacceptable situation in relation to patients) (According to managers, nurses should not say no to patients, doctors should see more patients instead).</td>
</tr>
<tr>
<td></td>
<td>Changed staff-mix</td>
<td>The family oriented district nurse becomes a position at primary care centers, separation of district nurses’ and primary care nurses’ duties, work together with many other health care professionals</td>
<td>Reconfiguration of the district nurse to primary care nurses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>District nurses have to do Primary care nurses’ work to increase availability</td>
<td>The former single district nurse thereby becomes a node in a chain of other health care professions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not enough time for district nurses preventive work</td>
<td></td>
</tr>
<tr>
<td>Quality control</td>
<td>Demands of documentation</td>
<td>Development of a documentation system (VIPS)</td>
<td>Competences in goal-setting, planning, evaluation of care</td>
</tr>
<tr>
<td>(documentation also generates economic information and have therefore several purposes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence based care and medical care programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legislation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| for nurses with internationally valid search-terms |
| Individual responsibility according to law. Nurses have to sign their own notes. Documentation is used by other nurses and other staff at the centre as well, but only nurses use the VIPS-system. The documentation is also used in case of malpractice. |
| Continuity is highly valued but documentation makes exchangeability possible. |

| Computer competences |
| Continuous updating of medical knowledge to be able to follow the medical care programs |

| Patients with socioeconomic problems; patients seeking asylum; |
| Many patients have multiple and not so well-defined problems |

| Give patients the time they need |
| Interpreters |
| Give up and leave the centre |
| Try to see the nice aspects of work |

| Multicultural competences; competences in meeting patients with traumatic experiences from war |

| Despite demands of cross-professional cooperation there is a strong hierarchy related to a) management and b) to medicine. The line of order follows the managerial hierarchy (and where nurses have strong positions in this case) |
11 Concluding comments and development of a conceptual framework

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11.1 Introduction

In the PROFKNOW project we have previously presented a number of results and conclusions on professional work and life under restructuring in education and health. We will here summarise these findings with a focus on comparisons over national contexts, professions and generations. As will be shown the comparative problematic is very complex in this field of study, which makes it important to develop a theoretical framework for dealing with relations between ongoing restructuring and professional work life.

This final chapter has two organising thematics. The first is the comparative grid presented in chapter one. The second is two sets of hypotheses that were put forwards based the research reviews summarised in the same chapter. The restructuring set of hypotheses dealt with in terms of innovation, dissolution and decoupling, while the profession hypotheses presented alternatives as professionalisation, de-professionalisation and professional reconfiguration.

The comparative grid was organised around the notions of system narratives and professional work life narratives. System narratives stands for policy discourses on education restructuring and change often assumed to have an impact on professional work life. Professional work life narratives concerns professional work life in change from the professionals’ point of view – based on their organised experiences. These narratives are assumed to intersect – but in what ways and how is an empirical question – as our results will show.

Moreover working with the grid provided crucial insights into how restructuring initiatives emanating from governments intersect with the work life perceptions and narrative accounts of practitioners in the field. We judged that this intersection is crucial in developing our conceptual understanding of how restructuring works in the zone of professional knowledge.

The comparative complexity is very high concerning professional work and life in different professional and national contexts. Thus, it is problematic to present results and conclusions in a more detailed way. In this final report we have let the national reports serve as a basis for comparisons. Thus, we have seven national reports presenting and comparing professional work life under restructuring in their specific contexts. These give rich insights in the comparative work done in PROFKNOW. We will here not re-present the findings in these reports as such. Instead we have chosen to put forwards a number of comparative conclusions concerning professional work life of relevance here.

We start with the system narratives which we put into different national contexts in order to compare similarities and differences. Then we turn to the work life narratives with a special interest in the interaction of those with the work life narratives over professions and generations. This is then turned over into a theoretical analysis of relations between system narratives and work life narratives and potential reconfiguration of the teaching and nursing professions in a knowledge society. We end up with an analysis of the outcomes of our research in relation to our restructuring and professionalisation hypothesis.
11.2 System narratives in comparison over national contexts

Policy discourses were captured in the PROFKNOW report on national cases studies edited by Beach (2005). Summarising these discourses Beach presented the following chart of outcomes of public service restructuring as in table 11.1.

Table 11.1: The noted outcomes of public service restructuring in the case studies

<table>
<thead>
<tr>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decentralisation</td>
</tr>
<tr>
<td>Development of an emphatic discourse of privatisation and marketisation (habituation)</td>
</tr>
<tr>
<td>Company formation</td>
</tr>
<tr>
<td>Conversion of public services to private</td>
</tr>
<tr>
<td>Business takeover of education and care supply and teacher and nursing supply</td>
</tr>
<tr>
<td>The creation of quasi markets for consolidating the processes of privatisation</td>
</tr>
<tr>
<td>Authorities forming agencies for contracting out services to private suppliers</td>
</tr>
<tr>
<td>Costs of administration shifted from costs of public ownership and control to costs of managing and monitoring outsourced delivery</td>
</tr>
<tr>
<td>Increased costs from franchise effects (un/under-employment) on public employees</td>
</tr>
<tr>
<td>The increased objectification of labour and increases in the value form of labour</td>
</tr>
<tr>
<td>A dissemination of a view of learners and care recipients as economically rational, self-interested individuals and the reconstruction of supply in line with this vision</td>
</tr>
<tr>
<td>A redefinition of democracy in terms of consumer choice</td>
</tr>
<tr>
<td>An increased objectification of teachers and nurses, learners and patients, care and curricula and (increasingly) professional education and educators as factors of production</td>
</tr>
<tr>
<td>The creation of a labour buffer (surplus army of labour) in the education and care sectors at the same time as (at least in some education sectors) posts are increasingly difficult to fill and notoriously difficult to maintain continuity in</td>
</tr>
<tr>
<td>Increased class differences in terms of education and care supply and consumption: i.e. in terms of who provides care and to/for whom</td>
</tr>
<tr>
<td>Increased inequalities in service work conditions</td>
</tr>
<tr>
<td>Increases in quick training programmes to maximise economic gains</td>
</tr>
<tr>
<td>Increases in judgement of performances according to consumer values</td>
</tr>
<tr>
<td>Standardisation of instruction and assessment</td>
</tr>
<tr>
<td>Sacrifice of the critical mission of professional education/training to practical and technical training in economic interests</td>
</tr>
</tbody>
</table>

Presented in this chart are a number of conclusions made from policy discourse studies where restructuring turned up as a world movement with a number of implications for the public sector, their clients and professionals as well as for society at large.

A next step in our studies was to deal with trajectories of such a world movement in different national contexts. These are presented in detail in this report in the different national reports based on context specific analyses of restructuring at work.

These national reports present quite different trajectories in terms of periodisation. These trajectories show distinct specific ingredients in what we here label system narratives. To our understanding these trajectories are not only making a difference in the system narratives. They also serve as a potential background for understanding the variation in work life narratives as life histories.
Because of the complexity of historical periodisation we asked each national team to prepare their historical analysis. Their periodisation tells us important facts about changes in education and health care in their respective national contexts. But they also tell us about the manner in which different national teams organise their ways of dealing with these state institutions. Their perceptions of welfare state developments are themselves therefore periodised. In table 11.2 we show a summary chart of these perceptions.

Table 11.2: Periodisation of state structures over national contexts.

<table>
<thead>
<tr>
<th>National Cases</th>
<th>Periods</th>
<th>Basis for distinctions</th>
</tr>
</thead>
</table>
| ENGLAND        | 1945 - 1979: Progressive narrative on welfare state expansion.  
| FINLAND        | 1945 - 1969: Preparatory phase building the welfare state.  
                 | 1991 - 2007: Restructuring.                                               | From dictatorship to welfare state building                                 |
                 | 1987 - 1997 - Envisioning the future partnership a new approach.  
                 | 1985 - 2007: Restructuring                                               | After a dictatorship over revolution to welfare state restructuring         |
| SPAIN          | 1939 - 1976 Dictatorship.  
                 | 2000 - 2007: Restructuring                                               | From dictatorship to welfare state building                                 |
| SWEDEN         | 1945 - 1975 Welfare state expansion - services for all.  

Although we have employed the term dictatorship in the Southern European cases, our national team has pointed to internal ‘transitions’ within those periods and to growing patterns of modernisation. Nonetheless the late evolution of welfare states in the South stands in sharp juxtaposition to the post-war social democracies in the North. Sweden and Finland and England see fast expansion after 1945. But England, and Ireland, move rapidly into reform mode through the 1980’s. This neo-liberal style of restructuring then becomes a broad-based movement across all countries but building on sharply different trajectory foundations.
Comparing the periodisation of structural change we find important differences in the ways transition stories are organised. In three cases dictatorship is a distinct ingredient – though in somewhat different ways – and in four cases welfare state reconstruction. These ingredients are overlapping in different ways, e.g. in the transition “from dictatorship to welfare state”. To this is added the simple fact of the variation in timing of restructuring measures in different national contexts – early in Finland and rather late in Spain.

As can be read from the results presented in Table 11.2 there is a large variation in the national trajectories. Thus, there are important differences over national contexts, meaning that the notion of a massive transnational “political neo-liberal agenda” ruling welfare state restructuring is misleading. However, as can be read in Table 11.2 as well there are increasing similarities in the periods closer to our times in terms of restructuring measures. Given these differences and similarities we are identifying a harmonisation in the welfare state trajectories, sometimes formulated in terms of a political neo-liberal agenda and sometimes “de-centralisation of centralised welfare states”.

11.3 Comparative notes over professions and work life narratives

The cross-professional problematic has been dealt with in a number of ways. Sohlberg, Czaplicka, Lindblad, Houtsonen, Muller, Morgan, Wärvik, Dupont and Kitching (2007) presented a number of comparative conclusions from the PROFKNOW survey studies of importance here. The conclusions of this study are summarised in the following way by Sohlberg et al (a.a., p. 107-108)

- Both nurses and teachers have had a rather strong position on the labour market, but there is a great discrepancy between the occupations in that nurses to a higher degree have a positive expectation to get an alternative job.
- There is a great discrepancy between the holistic subjective experience of control of the work-situation and the actual influence on substantial decisions influencing the everyday-work.
- Even if there is a trend of decentralisation (as well on a legislative as an organisational level) it is not the case that the average nurse or teachers have the opportunity to participate in crucial decisions concerning her/his work-place
- There is a great discrepancy between nurses and teachers concerning their estimate of the authority of their own profession.
- The social field of nursing and teaching have an organizational structure with few promotions and career-trajectories and where production of knowledge applicable in the own field often is missing.
- The “Scandinavian model” of nursing and health-care seems to be as heterogeneous concerning professional education and work-tasks of nurses and teachers, as to make it reasonable to question it as a unitary model.
- In light of the low possibilities of promotion and few systematic opportunities to update the knowledge one can question the professional capacity of the labour-market of nurses and teachers.

The thorough analyses by Sohlberg et al of an extensive empirical material based on PROFKNOW research present significant results concerning professional work life restructuring in education and health. For further considerations we refer to their report. However, we would like to put forwards two main conclusions. Firstly, it has to be underlined that large parts of the professionals are experiencing a work life that is characterised by a combination of individual conceptions of control over work and on the other side by lack of participation in organised decision-making at the workplaces of these individuals. Thus, we have a combination of statements about individual professional autonomy and control and
exclusion from decisions on resources, development of strategies and so forth. Second, considering development and maintenance of professional knowledge this seems to be outside the realms of professional careers and possibilities to promotion. In that sense professional knowledge is conceived of as external to professionals who at the same time claim that basic for their work is their own conception how the work should be done.

Concerning teachers’ life histories Muller, Hernández, Sancho, Creus, Muntadas, Larraín and Giro (2007, p 3) put forwards common themes as well as distinct differences over national contexts:

- Literally all teachers reported the difficulties they face through a more and more heterogeneous student population involving students with disabilities, immigrant students, or simply students with different learning needs.
- Teachers also reported their students to be more rebellious, harder to control and discipline.
- All teachers across the countries were distressed with a loss of prestige and respect of their profession. Loss of class barriers, a consumerist attitude towards education, or public blaming of teachers (in mass media) for the “failures” of the younger generation all contributed a sense of status-loss.

There are rich examples of these common themes in the national reports presented in the previous chapters concerning changing students and a social position in change. However, there are less of analyses concerning these changes in teachers’ life histories.

In contrast to these commonalties between the cases, teachers reported very differently on their working conditions.

- Virtually all teachers reported an increase in terms of documentation and paper work they had to fulfil. However, real impact in terms of accountability and evaluation were very diverse and ranged from “control by the educational authorities coupled to consequences” to simply “formal compliance and paper work.”

- Educational, state initiated reforms occurred in all participating countries; however their effect and impact on teachers were very diverse. No simple, one dimensional process of professionalization or de-professionalization can be described. What appears to be common between the cases is rather a certain “tiredness” of educational reform by teachers.

- Very different levels of infrastructure (equipment, building) were found and described in all cases as “improvable.” The most decisive factor for working conditions, however, remains tied to class size and competent, professionally committed staff. The entry into the profession was reported by most teachers as being especially difficult and unstable due to the precarious types of temporary contracts.

What Muller et al (op cit) present on the common thematics is a picture supporting notions of teachers’ work and life as preoccupied by their everyday interaction with clients – similar to so called “street level bureaucrats”. Furthermore, what is noted in a number of work life narratives is the increase of tasks in the teaching profession – such as documentation and evaluation – implying a change in content of professional work life.

However, when considering differences in working condition these seem to be varying over contexts. In the survey studies Northern European teachers (Finland and Sweden) present themselves as more autonomous with less of external control compared to Western Island Europe (Ireland), a fact that corresponds to the work life histories.

Concerning teachers’ professional knowledge Muller et al (a.a., p 3 ff) argue:

- Teachers appeared to be fairly confident in terms of their academic knowledge. However, they have to demonstrate expertise in many more fields that go beyond the traditional subject matter of
their discipline. Their main request for knowledge concerned tools and techniques for teaching strategies. This mirrors their preoccupation of being able to continue teaching when students have become more diverse and demanding.

- But teachers also voiced their lack of knowledge when having to deal with all the new players in the educational community such as the new managerial authorities, parents as clients, or teaching assistants and specialists. Most teachers were not satisfied with their initial education. In contrast, they learn on the job during in-service training, by being with students and in cooperation with colleagues. Despite the importance of learning during work, very few formal channels are in place that would support and catalyze this process. Mainly it happens in an ad-hoc manner which somehow is in sharp contrast to the importance attributed to this type of learning by teachers.

- What emerges from the case studies is also a certain duality between a notion of professionalism tied to successful teaching of competencies/skills on the one hand, and a notion of professionalism that gravitates primarily around a concern for the formation and development of the individual (pupil) as part of larger society. This implied different types of knowledge: skills in following government directives in the first case and more encompassing knowledge of the wider social and educational dimensions of teachers work in the second. It has to be noted, however, that both types of knowledge are equally embraced and valued by teachers.

What we witness is an occupation in change in terms of expansion of tasks and social relations as well as demands on a “modernised” professional knowledge not achieved in their professional training.

Going over to nurses’ life histories Kosonen & Houtsonen et (2007, p 9 ff) put forwards the following conclusions concerning work life under restructuring:

While it is admitted that the widespread neo-liberal and new public management doctrines and policies often drive these changes, the case studies show how the process and outcomes of restructuring vary across the national/regional contexts. Moreover, it is not only the calls for economic efficiency and accountability, but also the rationalisation of administration (bureaucracy) and scientific/technological progress that contributes to the change of nurses’ work, work lives and professional knowledge.

Even though there is convergence of the contexts due to the common trend of restructuring, the different histories and trajectories of the national/regional contexts contribute to how this trend refracts in each respective context, producing different outcomes at the level of various localities and nurses’ everyday work.

There are two general major sets of conditions that contribute to nurses’ everyday work, with different emphasises in each national/regional context.

- The contracting model of employment is becoming more general and the civil service model of employment is decreasing.

- The management and administrative models for hospitals, clinics and health care system as a whole is driven by demands for increasing cost-efficiency, throughput and results, accomplished through guidelines, standardization, evaluation and rewards.

For practicing nurses these two factors mean precarious careers and the tight resources contributing to increasing experiences of workloads and haste, stress and exhaustion. Such conditions of work and life have implications for nurses’ professional knowledge and their notions of expertise.

The comparative study investigates the notions of curing and caring, and theory and practice, as well as a number of other related categories.

- What the nurses consider that nursing knowledge and expertise, that is, the core of their professional self-understanding and self-definition, is often in contradiction with what is required by the changes at work, namely by restructuring. Particularly, they feel that they do
not have time to care, to be with the patients and respond to their personal, social and emotional needs holistically. It is not the professional culture or rigid attitudes that cause inertia in relation to restructuring, rather the nurses may have internalised the new expectations and requirements well. Yet, they still may feel that they are not able to work according to their professional ethos, which is embedded in the idea of caring.

- Moreover, tightening of resources and increasing workload coupled with the shortage of staff may lead to negligence of required guidelines. Thus, expectations and requirements are often in contradiction with the real possibilities to realise guidelines in practice due to various shortages. Consequently, nurses are often in between the demands of the management that is increasingly concerned of economic standards, goals, and efficiency, and the patients, that are increasingly knowledgeable about health care and more demanding about their rights.

- The findings also indicate that the centralized, external and direct managerial regulation and control with clear hierarchies between different professional groups has been replaced by more decentralised regulation and control operating locally and in-directly through various guidelines and instructions. The nursing profession has become more independent and functionally distinct with its special area of practice and expertise.

- Parallel to this is the increasing self-regulation and self-organisation in the form of planning and evaluating one’s activities. These regulative instruments are in many contexts connected to financial systems aimed to control the health care costs and increase efficiency and output. Many case studies, most clearly England, report on various restructuring measures, which can be characterised as neo liberal, being activated.

While there are notable similarities in the patterns regarding how the nurses experience the effects of restructuring, the case study contexts also vary, and different issues surface as focal and typical in each respective context. In similar ways the national reports present nurses work life stories in different national contexts. For instance we note in the Spanish case the importance of a system of contract agreements making nurses living for years on very unsure conditions. We also noted contradiction in Portugal between the professional education of nurses and their work life recognition.

When comparing teaching and nursing there seem to be distinct similarities as well as differences, indicated above by the different ways of organising professional work life in education and health. The previous chapters present a number of distinct comparisons in the different national contexts. Here, we often noted that documentation is regarded by teachers as an end in it self, a task that takes time from more important aspect in teaching, as noted in the Spanish chapter:

“There is a lot of absurd paper work, useless which takes up a lot of time [...] you just photocopy and that's it. Who is going to look at all this? This is just impossible. Where does this go to? What is it good for?”

For nurses, documentation is regarded for professional work life and important to present in professional teamwork. However, as pointed out in the English case, nurses as well as teachers seem to appreciate documentation of work, for instance in order to improve professional control over student progress.

Another feature concerns evaluation and supervision over professional work life. We noted for instance that such issues were considered to be of little importance in the Finnish case conceived of by teachers in terms of:

….feeble work supervision and that the evaluation of the work developed has an essentially formal nature and does not have any impact on their professional trajectory.
Here, we will use the possibilities from the survey study and consider the responses of teachers and nurses considering the impact of different factors on their professional work life. In table 11.3 we exemplify this over countries and professions.

Table 11.3: How much are different factors conceived of having an impact on the professional work life of teachers and nurses?* Percent that state that the respective factor has large or very large influence.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Sweden Nurses</th>
<th>Sweden Teachers</th>
<th>Finland Nurses</th>
<th>Finland Teachers</th>
<th>Ireland Nurses</th>
<th>Ireland Teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td>My own conception of how work should be done</td>
<td>46</td>
<td>61</td>
<td>61</td>
<td>74</td>
<td>73</td>
<td>80</td>
</tr>
<tr>
<td>Other factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control of supervisors</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Demands of documenting work</td>
<td>36</td>
<td>15</td>
<td>32</td>
<td>4</td>
<td>53</td>
<td>25</td>
</tr>
<tr>
<td>Competition with other institutions</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Evaluation of work</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>5</td>
<td>26</td>
<td>21</td>
</tr>
<tr>
<td>Planning will colleagues</td>
<td>17</td>
<td>16</td>
<td>17</td>
<td>13</td>
<td>32</td>
<td>19</td>
</tr>
<tr>
<td>Opinions of clients/students</td>
<td>25</td>
<td>25</td>
<td>29</td>
<td>8</td>
<td>46</td>
<td>14</td>
</tr>
<tr>
<td>Risk of being sued</td>
<td>8</td>
<td>2</td>
<td>24</td>
<td>5</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>Mass media coverage</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>17</td>
<td>6</td>
</tr>
</tbody>
</table>

* Question: How much would you say that following factors influence your everyday-work as teacher/nurse? (n = 4 309 with a response ratio = 68.3). Go to Sohlberg et al (2007, p 39) for further technical information!

Comparing the figures teachers seem to emphasize their own conceptions of how work should be done, compared to nurses, while nurses as a group emphasize cooperation at work, here represented in terms of planning. The large differences we find in the often related aspects in terms of documentation and potential legal problems emanating from e.g. clients that regard themselves as mistreated. Nurses are here emphasizing such issues to a much higher extent compared to teachers. To us it seems that these differences open up for different kinds of restructuring measures and decreasing the possibilities for professional loose coupling from restructuring measures. As pointed out by Kosonen & Houtsonen (2007) these differences are due to differences in the of organising education and health care, were the former still is based on a cellular organisation while the latter still is based on hierarchical division of labour between health care professions, and where formal organisation matter much in work.

The PROFKNOW studies were designed to identify and analyse professional work life histories based on the concept of generations as capturing cultural changes over time, referring to the work of Mannheim (1952) and to Ortega y Gasset (1948). Work life restructuring was regarded as significant changes in the professional work life of teachers and nurses. When considering comparisons over generations these were carried out in the different work-packages as well as in the national team reports showing some, but rather little of support of the idea of distinct professional generations. Within PROFKNOW special studies by De Lima, Houtsonen and Antikainen (2008) and M. Lindblad (2007) was carried out. De Lima et al did a special study on teacher generations based on the life stories in PROFKNOW. They found little of evidence of the generation concept making a difference in these life stories and discuss this negative outcome in relation to different potential reasons:
There are several possible reasons for the small number of observations of facts that could illustrate the operation of generational factors in the PROFKNOW project. First, we researched in-depth a very small number of cases of teachers in each country. It was obvious that we were not prepared to find such a strong social and cultural diversity in Europe, as our results reveal. Second, the abstract concept of generation was not properly brought down to more concrete observable indicators, for instance by focusing on the style of teaching, such as teachers’ relationships to children. … Long-term observations at work could have produced more productive data for generational analysis. … Finally, one might also admit that – despite contrary arguments by some previous research (Goodson et al. 2006; Hargreaves 2005) – there may have simply not been any really generational differences in teachers’ relation to the issues that we studied in the PROFKNOW project. (op.cit, p 13-14)

M. Lindblad (2007) took another way in analyses of generation impact on teachers’ and nurses work life orientation. He used the survey material for exploratory multivariate analyses presenting different patterns for teachers and nurses in their responses concerning control at work. Teachers born before 1950 turned out to be a distinct category here and nurses born 1970 and after. However, he concludes that this pattern is not very distinct in both professions.

In a word, given the way of work in PROFKNOW, the generation concept did not matter much in these two studies. It is of course problematic to state that a lack of generational differences is a finding as such. But is make sense in two ways: First, we noted the different trajectories in system narratives which make restructuring events over time rather heterogeneous over national contexts making it problematic to talk about European generations of teachers and nurses. Second, as noted in the different studies of teachers and nurses experiences and strategies, policy discourses were not actually part of the common thematics of work life changes presented in the life histories by Muller et al (2007). The results are a bit more diversified when considering nurses work life histories as presented by Kosonen & Houtsonen (2007). Given the notion of decoupling in professional work life, work life restructuring does not seem to be such distinct events having an impact to produce different generations of professionals.

Referring to gender issues these are in contrast to generations highly visible in the PROFKNOW studies. 57 First, the feminization was not surprisingly noted in the teaching and nursing professions, in terms of recruitment as well as in hierarchical relations at work (Beach, 2005) and the PROFKNOW studies give to some extant their support to previous studies on the issue. But, and according to the survey done in WP 3, the PROFKNOW studies show also the importance of nuances, and give information of national differences. For example, while the teacher occupation has been feminized during the last forty years in Ireland, this is not the case in Finland and Sweden, where the gender balance has been more stable over the years.

Second, gender is in several ways inscribed in the accounts and conceptions of the practice of teachers and nurses and several of the PROFKNOW studies shows the strength of gender stereotypes – such as the feeling/knowledge dichotomy and a tension between what teachers consider their caring and educating duties and nurses consider being their caring and curing duties. The pressures that teachers and nurses more generally seem to adhere to, in all the countries under study, could in fact be read within such gender stereotypic schemata which indicates that not only are both professions essentially given feminine significations (“care” as the essential duty of both professions) but, also, that the feminine signification of the professions prevails under pressures of changes.

57 We are here referring to the work in the profknow project by Foss Lindblad, Muller & Zambeta (2007, manus in preparation).
Thirdly, the PROFKNOW studies show that differences in the gender structures of well-fare systems are important for the work-life balance of the professions. One finding is that the perceived advantages of the professions tends very much to be related to family strategies in Greek and Spain, but less so in Sweden and Finland.

11.4 Conceptual development of narrative relations

In the different national reports the national teams identified work life narratives over different national contexts and professions. A first notion here was that everyday interaction with clients – students or patients – was a predominant basis for common tendencies in work life narratives. In the themes similar over all contexts restructuring measures were mostly not translated into work life narratives in most national context – England and Ireland being somewhat exceptional here.

We have been able to discern a range of responses when juxtaposing systems narratives and work life narratives. In the next section we provide examples from most of our case study countries. But this should not be taken to mean countries react monolithically to restructuring initiatives. There are a variety of points of refraction or milieu membranes through which restructuring policies must pass: national systems, regional systems, school board systems – right through to individual schools and individual classrooms and teachers. This means that a wide range of responses are possible even if certain national characteristics of response can be evidenced.

The following chart provides a framework for analysing the various main configurations found when juxtaposing systems narrative and teachers and nurses’ work life narratives.

**Table 11.4: A framework for analysing work life under restructuring**

<table>
<thead>
<tr>
<th>POLICY DISCOURSES AS SYSTEM NARRATIVES</th>
<th>RESTRUCTURING TOOLS AND STRATEGIES</th>
<th>WORK-LIFE NARRATIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restructuring Policy-making</td>
<td>Integration</td>
<td>Translations in Professional Work Life</td>
</tr>
<tr>
<td>Restructuring Policies</td>
<td>Contestation</td>
<td>Contested Professional</td>
</tr>
<tr>
<td>Restructuring Policies</td>
<td>Resistance</td>
<td>Resistant Profession</td>
</tr>
<tr>
<td>Restructuring Policies</td>
<td>Decoupling</td>
<td>Decoupled professional</td>
</tr>
</tbody>
</table>

A number of national case studies highlight the different juxtapositions but as noted this is not to argue that national responses are monolithic.

The English case study for instance finds compelling evidence of integration and of restructuring effecting professional change towards what we are calling ‘re-framed’ professionals. ‘Traditional professionalism was contested under Thatcherism with the rise of...
Market narratives and socialist discourses were silenced to a great extent during this period... Under New Labour teachers and nurses have become re-framed to work in new circumstances.’ The report adds.

‘In the last ten years under New Labour professionals have been re-framed. Teachers and nurses are now more flexible professionals, their authority has to be earned through team-working, collaborating with clients and life long learning. Meanwhile increased regulation has been introduced...’

‘Hence integration and restructuring have happened but not uniformly, not without contestation and not at all monolithically; contestation, resistance and decoupling can be found in places.’ The report notes.

‘Teachers and nurses are trapped in the gap between government rhetoric and political narrative about choices and entitlements and the reality of the classroom or the hospital situation.

The interviews highlight the unease of professionals with overriding national policies in England. Using choice and competition as methods of raising standards in public services is seen as intrinsically contradictory and causing greater inequalities in society and taking professionals away from the aims of putting clients first. However the lack of a national underlying oppositional ideology (with socialism having been dropped by the Labour Party) leads to inward motivation and increased professional localism.’

England poses an interesting case given the historical periods and trajectories we have evidenced earlier. One of the countries to build up a strong welfare state after 1945, England became a leader in neo-liberal restructuring initiatives aimed at transforming, if not dismantling, this welfare system.

In Sweden and Finland the welfare system has proved more durable and politically sustainable. Hence both the Swedish and Finnish studies show how restructuring has been contested and often, if attempted, sidestepped by professionals.

‘The slogan personality is the most important instrument of work is predominant among Finnish teachers, indeed the practicing teachers emphasise that the long science-based teacher education, except practical training periods, provides only a theoretical foundation for professional work. For them the most important source of knowledge is the practical activities, common sense, everyday experiences and learning by doing. In addition, personal hobbies and activities outside the school are valued as well. Indeed according to some recent studies the opportunities to draw on personal interests and to exercise independent judgement are among the most important motivations for being a teacher’.

This example is common in the established welfare societies of Sweden and Finland as they once were in England. The belief in professional autonomy as motivation and creative leaves loosely-coupled or decoupled restructuring strategies. Significantly Finland, where professional autonomy is deeply entrenched and restructuring policies least intensive, produces highly successful educational indicators. This appears to be an efficient and motivated professional system which builds on a belief in professional expertise, judgement and commitment. Without these elements is difficult to see restructuring working smoothly however intensive and politically promoted it might be.

Certainly restructuring has the features of a world movement that political elites are promoting but we can see how the different historical periodisations and trajectory crucially refract this process. In Sweden and Finland deeply entrenched systems of social democracy and professional expertise appear to enduring.

Now let us turn to the very different historical periodisations and trajectories in Southern Europe. As we noted these countries: Portugal, Spain and Greece, came late to welfare
systems and social democracy. Hence the restructuring world movement enters these societies at a different stage, and so to speak, at a different angle. The result of this trajectory of engagement is clear in the way that restructuring initiatives are refracted. In Portugal contestation and resistance seem endemic. The report is eloquent and very clear:

‘The strategies developed by the teaching profession have been mainly reactive: they express mostly a systematic rejection of the initiatives proposed by the central administrator than a proactive and anticipatory presentation of new forms of structuring and promoting the professional group….Only recently (since the end of the eighties have the unions discussed a structure for the teaching career, but even then, they have done so… in a primarily reactive manner, trying to keep things the way they were and resisting any attempts of change, rather than proposing structural changes that might improve the quality of professional practice and its outcomes.’

This Portuguese response shows how the role of periods and trajectories is a vital conceptual tool in understanding how restructuring initiatives are received by professional groups, received and then refracted. The periodisation and trajectories in Greece have considerable similarities and for the older generation who knew the revolutionary period can be clearly evidenced. Here though, generational restrictions can more clearly be drawn than was the case in Portugal where generational conformity seems more substantial.

Generational differences in the professional strategies towards restructuring are expressed as differentiated attitudes towards intensification of working conditions. Senior teachers and nurses tend to ignore the pressures and they use experience and collegial learning as the main way to cope with new demands at work and compensation for the lack of up-to-date knowledge. Working conditions are experienced as more intense and pressurising on the part of the middle aged teachers. Hierarchies among this age group are more peculiar since their formal qualifications vary substantially (some of them having two years initial education, some others four years plus additional university ‘equation’ training). Younger teachers and nurses tend to come from a richer socio-economic background and they all have university qualifications. They experience restructuring not as part of historical consciousness regarding the transitions the profession is undergoing but as a frustrating client oriented working environment. Personnel shortages add to this feeling.

Substantial generational differences refer to the confidence in syndicalism as an effective professional strategy. In both the teaching and the nursing profession, the older generation is aware of the contribution of collective action in proposing and defending professional strategies. However, the younger generation of nurses and teachers are not interested in syndicalism and do not become active members partly because the image of syndicalism has faded as part of the more general mistrust in politics.

The Spanish case study is a beautifully constructed analysis of some of the complexities and refractions of restructuring when viewed from below at the local level. Their analysis confirms the essential point about periodisation and trajectories and generations.

‘Talking about restructuring both in education and health requires us to talk briefly about structuring. As we have already said, the very late development of Welfare State in Spain has to be acknowledged when dealing with restructuring. Only doing this one can understand the specificity of the Spanish case, which is something like a compressed and anomalous history of the Welfare State in Europe. Public health and education institutions were firstly developed in democracy in the 90’s. Before that, as we know, there were timid build-ups by Franco’s regime. Up until 1967 in health and 1970 in education there wasn’t a comprehensive system for providing basic services to most citizens. So basically what we see during the nineties is the building of the kind of welfare institutions that most European countries developed after the Second World War. A decade later, the first clear symptoms of their dismantling were manifest.’
The report shows responses that are quite like aspects of the Portuguese and Greek (certainly older generation) work life narratives.

‘The recent history of the Spanish educational system just mentioned provided a quite concrete picture of restructuring from a system’s narrative. However, it failed to be identified as a meaningful player for the teachers themselves. A high degree of scepticism and cynicism was observed regarding the impact of policies in everyday practices. First and foremost the material tells that the three teachers perceive their profession and their work on a daily, personal basis rather then embedded in large socio-political contexts. Therefore, restructuring wasn't thought of as a kind of local expression of global dynamics, so a very interesting gap remains between their conception of the system and the theoretical causes and explanations some theorists of the field may put forward. Even when drawing explicitly the attention to changes in the legislation from our side, this was not perceived as influencing day to day business, either because changes are too cosmetic or lacking the necessary time to become applied practice. The educational projects associated with the different political parties were met with a dismissive shrug, unable to affect their working conditions towards the better. What happens on the level of politics is perceived as having little or nothing to do with the real necessities in the school.

‘Sophia (5): I don't care about a lot of political things, but on your daily life ...That's also why I believe a little less each day in political things. I mean, the little I know, they disappoint me so much that beyond my daily life, why should I care about politics’

Rosa’s view is similar:

‘In her eyes it is not that the actual laws don’t function but rather that they are missing the necessary resources to be actually implemented’.

The Spanish case points up to conceptual complexity of professional responses, highlights the difference between the teachers noted above and nurses, and between diverse local settings. Their warning is important, a health warning against conceptual over-generalisation.

By comparing our cases it becomes apparent how varied and often contradictory processes of ‘restructuring’ are. They comprise many facets, temporalities and scales.

Thus having been said it is clear how historical periods and trajectories operate in identifiable ways to refract restructuring initiatives. We have clear evidence that the main responses delineated in the earlier chart of restructuration, contestation, resistance and decoupling can be found in our case studies. Moreover our work on generational periodisation and trajectories is of great utility in understanding the pattern of responses.

Theory is always of specific rather than general use. We too need to be parsimonious with our general ambitions. But if there is a message to those in governing agencies who sponsor restructuring initiatives it would be to advise a similar caution in promoting over-centralised, over-generalised expectations and edicts. We have seen how a world movement like restructuring has been widely promoted in Europe. We have also seen how the response has varied immensely and how sensitivity to periodisation and national trajectories helps explain the process of refraction.

At the end point of the multi-layered refraction process sits the individual or professional. Still we should remember a key player, probably the key player in the process. Alienate your professional groups and your restructuring rhetoric will remain just that – political rhetoric. Let us end then with a recognition of the central and inestimable value of the professional contribution of teachers and nurses in the actual delivery of that about which the rest of us merely pronounce. The professional teacher was described in this way by an experienced Finnish teach education and remember Finland’s exemplary performance in education.
‘Good teacherhood is a personal quality, not a skill learnable by heart. Already at the classroom door one could see if the teacher trainee had enough charisma, enthusiasm, aura and know-how. That was completed by an easy and respectful attitude towards the pupils. Theory could not help if the sentiment was wrong.’

Indeed theory could not help if the sentiment was wrong - neither we are tempted to add will restructuring if the professional sentiment is wrong.

11.5 The PROFKNOW studies as research in progress

The PROFKNOW research approach had as a distinct characteristic that a bottom-up strategy was used, with a focus on teachers’ and nurses’ experiences, perspectives and strategies to deal with ongoing changes in their working life. Such an approach has distinct constraints and opportunities by studying professional work life as codified by the professionals at work in the periphery of welfare state institutions. Within the frames of such an approach the PROFKNOW studies resulted in a number of distinct findings. An example of this was the rejection of generation as an organising concept as presented previously based on the works of de Lima, Houtsonen & Antikainen (2008) and M. Lindblad (2007).

In the introductory chapter we put forwards a number of hypotheses concerning work life restructuring in education and health. We will now present and discuss the status of these hypotheses in relation to the results of the PROFKNOW studies with their specific approach.

The innovation hypothesis:

Frequent in the introduction of restructuring measures were statements that such in measures in different forms would produce a more dynamic and innovative educational system. For instance deregulation and autonomous schools were expected to increase variation in ways of working in these schools in combination with distinct estimates of success, which in turn would lead to renewals in education (e.g. Chubb & Moe, 1992; Pappagiannis et al, 1993). However, our studies showed no signs of such innovative dynamics. What mattered was instead to deal with everyday work life, with its encounters, often in combination with lack of resources and a bit more problematic relations to clients. An eventual source to more innovative work could be found in increased teamwork and increasing demands on documentation. But we found little of evidence here in results presented above as well as in the national team reports in the previous chapters and the research presented by Muller et al (2007), Kosonen & Houtsonen (2007) and Sohlberg et al (2008).

The dissolution hypothesis:

In a number of critical studies on restructuring in education and health care distinctively summarized by Beach (2005) it is expected that restructuring would be translated into a number of technologies – league tables and information systems for consumer choice as well as quality indicators and audits – technologies in use that would increase tight disciplinarisation and regulation of professional work life. Though our results differ over national contexts – as presented in the previous section – a main tendency is that professional work life experiences are focussed on what is going on interaction with clients within preconditions of work that is demanding in different ways – time pressure, conflicting demands, and intensification and so on – in combination with changes in relations to their clients

A number of observations in different contexts point in the direction that consumer choice, or management supervision and evaluation are not experienced as being of vital concern from the professionals point of view. Thus, on the basis of work life narratives educational restructuring measures or rationales are not the main thing in “professional work life under
restructuring”. Given the current bottom-up approach a rejection of the dissolution hypothesis would fit best with professional work life narratives.

Thus, we got a seemingly contradictory combination of system narratives pointing towards a thorough restructuring of education and health care and work life narratives pointing in another direction that these measures do not matter much. In order to deal with this combination we are going over to the de-coupling hypothesis.

The decoupling hypothesis:

A starting point is the combination of system narratives of restructuring welfare state institutions and work live narratives rejecting the impact of such restructuring. How do we understand this seemingly inconsistent finding?

A first answer – based on for instance theories on policy implementation from a weberian point of view – is that restructuring measures have failed since the professionals do not experience or behave in a way that corresponds to the prescriptions put forwards in restructuring measures, for instance adjust themselves to market demands.

However, as pointed out by e.g. Meyer & Rowan (1977), it is reasonable to expect that there is a difference between technical activities (such as teaching or nursing) in an organisation and its proclaimed institutional rules (such as adjusting to markets and parental choice or quality indicator improvement) and that this difference is more or less inherent in institutional change due to conflicts between rules, demands to solve tasks at hand in specific and unique situations and so forth. Such differences are dealt with a number of decoupling issues such as professional delegation, ambiguous goals, ceremonialisation of evaluation and inspection and so forth, making organisations work and correspond to institutional rules introduced. Meyer & Rowan (op cit., p 357) state

The advantages of decoupling are clear. The assumption that formal structures are really working is buffered from the inconsistencies and anomalies involved in technical activities. Also, because integration is avoided disputes and conflicts are minimized, and an organisation can mobilize support from a broader range of external constituents.

Based on such understandings of organisational change it is possible to claim that decoupling is what is expected to happen – that the celebration of restructuring rules is living side by side with autonomous professional activities in a way that makes the organisation of work more flexible and sustainable.

The hypotheses of innovation and dissolution were constructed on the basis of communication – that restructuring measures would are being implemented and making a difference in teachers’ and nurses’ professional work life. The decoupling hypothesis is questioning such an implementation, stating that boundaries are at work making professional autonomy possible and at the same time facilitating the introduction of institutional restructuring. This is also a way of reformulating relations between system narratives and work life narratives as parallel stories.

Professionalisation, de-professionalisation or professional reconfiguration:

When considering the professions and their positions under restructuring the PROFKNOW research presented a number of findings. Thus, Muller et al (2007) noted a loss of prestige and respect for teachers, which can be read as an indication for de-professionalisation. Similarly, Kosonen & Houtsonen (2007) note experiences of increasing workloads and stress among nurses. However, both research teams are hesitating to conclude that a depprofessionalisation are at work in the teaching and nursing professions related to state reforms as such. Instead, Kosonen & Houtsonen (op. cit.) point to a more independent and
self-regulating nursing profession compared to previous stronger managerial control. This finding is confirmed by Sohlberg et al. (2007, p 84) who find that e.g. much larger shares of nurses – in different national contexts – state that they have achieved more of authority at work. On the other side, nurses seem to experience a less autonomous job situation than teachers as presented above.

Given such findings in combination with other analyses in the PROFKNOW research we would like to abandon the professionalisation-deprofessionalisation argument as such. Instead we would like to put forwards a professional reconfiguration hypothesis, arguing that the professional positions are in transition. Thus, Foss Lindblad & Lindblad (2008) state that professional distinctions as such (autonomy, knowledge base, monopoly, etc) are in change in general, and that notions of self-disciplinarisation and trust (see also Fournier, 1999 and Harvey, 1989) are put forwards in organisations becoming more flexible. This they relate to issues of accountability and deregulation with a focus on the teaching profession. So far our studies point in similar directions for the nursing profession, as noted by Kosonen & Houtsonen (op.cit.). Given such notions of reconfiguration, current professionalisation discourses – referring to professional traits and functions and re- or de-professionalisation – can be considered as somewhat out-dated.

Actually, though we have put forwards a de-coupling stance above, we noted some professionally experienced changes pointing in a reconfiguring direction, for instance increasing demands on documentation, more of collegial teamwork and communicative interaction with clients. Thus, there are quite a few indicators that are possible to interpret in terms of reconfiguration of the nursing and teaching profession.

In this text from the PROFKNOW project we have presented a number of results concerning professional work life of teaching and nursing under restructuring. We have learned about professional work in the intersection between the welfare state and the citizens in societies in transitions in terms of demography and social structures as well as authority relations. We have compared work life over national contexts as well as over professions and generations and we have tried to capture ongoing institutional changes in relation to professional strategies and organisation of experiences. In our work notions of knowledge has been frequent – in terms of knowledge distinctions and different demands on professional expertise. Quite a few of our studies (such as Foss Lindblad & Lindblad, 2007) have dealt with professional work life in a knowledge society (Stehr, 1997) and changing demands on education and life long learning.

In this final chapter we have not only put forwards such findings. We have also presented a set of arguments of professional work life under restructuring which are summarised in the following theses:

- **National differences turning into harmonisation**: Welfare state restructuring in different European national contexts is based on a variation of trajectories with similar end periods.

- **System narratives differ from professional work life narratives**: Policy discourses on welfare state restructuring correspond to little extent with professional work life experiences.

- **Institutional restructuring is combined with professional decoupling**: Differences between system narratives and work life narratives are understood as organisational decoupling making professional work life autonomous and conflicting rules in restructuring workable.
Reconfiguration of professions: The teaching and nursing professions are not being one-dimensionally professionalised or deprofessionalised. Instead we are noting indications of professional reconfiguration in terms of autonomy, client interaction and governance.

These arguments are put forwards as a contribution to professional knowledge under restructuring in health care and education.

11.6 References


