Nursing Grievances

II: Pay

TONY DELAMOTHE

I've been nursing for nine years now, and my wages are absolutely ridiculous. I've got a cousin who's a copy typist who's just left school. She's 16, she's got no experience, and she started with wage higher than mine.

STATE ENROLLED NURSE

For me the reward isn't the money, the reward's when somebody walks out the door. But I need the money to live.

STAFF NURSE

We're such a large workforce: if they gave us a decent rise it would cost the health service an enormous amount of money, which would come out of the fabric of the buildings.

SISTER

Since 1979 spending on the National Health Service has increased by 29% in real terms. Since 1979 the salary of a staff nurse has increased by 34% in real terms. Both these statements purport to settle arguments about this government's commitment to the NHS. Neither does, and for similar reasons. For spending on the health service the correct comparison should be with other developed countries in 1988 rather than with the United Kingdom in 1979. For nurses' salaries the comparison should be with those of similar occupational groups today. When this comparison is made (figs 1 and 2) nurses would seem to have an unanswerable claim for higher salaries.

Some 40% of all nurses earn less than the Low Pay Unit's threshold (£132.27 per week).¹ The salary of a nursing sister exceeds the basic average earnings of non-manual workers (£202.82)² only in her fifth year in that grade. Starting salaries of police constables (£8352) and firemen (£8892) approximate to the maximum paid to staff nurses and midwives (£8600), achieved only after eight or nine years in nursing.

Given these salary levels it is difficult to counter the assertion that nurses' salaries reflect assumptions that nurses are either single women who will soon leave to get married, confirmed spinsters who do not need much money, or married women who are working for "pin" money. The sexism these assumptions betray should not need countering. If it does ammunition is provided by many studies. One recent study commissioned by the National Union of Public Employees showed that more than one in three nurses had one or more children living at home and more than half were supporting an adult. In seven out of 10 nurses' households their pay made up 40% or more of the total household's income.³ In another study one district health authority found that 11% of its trained staff headed one parent families.

Fig 1 shows that annual increments stop early: after five years for staff nurses and midwives and after six years for auxiliaries, enrolled nurses, and nursing sisters. Further qualifications gained by nurses on the ward are not rewarded. Together these mean that there are no financial incentives to stay in nursing at the bedside or to improve

one's standards. This pattern—low starting salary, slow ascent to low plateau—is exactly what could be predicted from the "easy come, easy go" model of manpower movement (see article I). If anything is to be done about the high wastage of nursing staff salary will have to be the starting point.

How much do low salaries matter to nurses?

Good evidence now exists that low salaries affect recruitment, retention, and return—the three R's of nurse manpower planners. Careers officers have expressed their concern that students with

suitable academic and personal qualifications are now likely to consider other careers in preference to nursing.⁴ During its recruitment drives the English National Board has been "told by youngsters that they do not want to nurse because they have a relative (usually a mother or sister) who is a nurse and they have been advised by that person not to consider nursing as a career." Others have told them "that they would like to nurse but the salary and poor image has put them off."⁵ With fewer school leavers in the future with the necessary minimum educational requirements for nursing (article I) this "image" problem will have serious consequences.

Salaries also seem to be having an increasingly important effect on the retention of nurses. The most recent poll (September 1987) to ask nurses why they had considered leaving found that low pay was the most important reason (article I).⁶ Of all nurses questioned 88% were dissatisfied with the 1987 pay award, which had been the largest for 5 years.

In a study by the Royal College of Nursing nurses were asked what would be an important influence on their return to nursing if they had left or were considering leaving nursing. Some 79% nominated pay as "very important." (Only "realistic staffing levels" at 89% was nominated by more nurses.)⁷

A belief exists in some quarters that nurses will be interested in either pay or patients' welfare, and what looks like a preoccupation with pay recently is evidence that things are changing for the worse. Those who believe this should be partially reassured by the last study, in which nurses rated "realistic staffing levels," which benefit the patient as much as the nurse, more important than pay. They should also ponder the price nurses have paid for their dedication to their patients' welfare.

Over the past few years the government has told all occupational groups in the National Health Service that further increases in salaries can be made only at the expense of other hospital services. Only the nurses, however, seem to have taken this to heart—certainly they are the only health care workers who quote this verbatim when asked why they are not paid more. The reason for this may be that nurses spend more time with patients than any other group and are therefore the best witnesses of what has already happened to patients' services. Justifications for the necessity for wage restraint, that all must tighten their belts, seem particularly persuasive when made to workers in environments whose stock has already deteriorated fast. Manoeuvred into a position of having to "choose" between pay increases and service developments, no nurse wishes to be "responsible" for further cuts in those services. There is a growing realisation now that the underfunding of hospitals (a shortfall of £1600m between 1980-1 and 1986-7 in England alone^{8a, 8b}) has been by political choice rather than economic necessity—over a similar period income tax has been reduced by £8100m in Great Britain.⁹ Nurses, however, have not benefited from these reductions in taxation—the proportion of their salaries that goes on taxation and national insurance was 21% in 1979-80 and 24% in 1987-8 (fig 3).

Pay awards and their staging 1984-7

Year	Pay review body's recommended average increase (%) from 1 April	Implementation	Actual annual increase (%)
1984	7.5	Full from 1 April	7.5
1985	8.6	5% From 1 April, remainder from 1 February 1986	5.6
1986	7.8	Full from 1 July	5.8
1987	9.5	Full from 1 April	9.5

The stagings of the award in 1985 and 1986 deprived a ward sister of £364 to £822 depending on seniority.

Pay review body

Until 1982 the Whitley Council set the salaries of nurses, midwives, and health visitors. In 1982 there was a prolonged pay dispute in many sectors of the National Health Service; nurses twice rejected what they regarded as an insufficient offer. Their eventual settlement included the setting up of a pay review body by the government. It was presented as recognition of nurses' special condition within the NHS and "in particular the fact that the great majority of staff in these groups have not engaged in industrial action. Accordingly the Government must reserve the right to exclude from the scope of the review body recommendations any groups that do resort to industrial action."¹²

This was the imposition of a no strike agreement through the back door.¹³ Only the nurses have consistently honoured it: in two out of the four years the review body has reported the government has not fully implemented its recommendations (see table). This "unilateralism" contrasts with arrangements made between the government and other workers in essential services—the police and firemen—whose acceptance of restrictions on their rights to take industrial action has been rewarded with index linked salaries.¹³

For three out of the past four years some of the money to fund the nurses' pay increases has had to come out of existing hospital budgets. Meant to be provided by cost improvements these have invariably caused further cuts to services for patients—hence nurses' reluctance to push hard for what they think they deserve.

The fact that the announcement to fund the 1987 award in full was made just 18 days before a general election was called attracted much cynical comment, not least from nurses. In its evidence to this year's pay review board the Royal College of Nursing hopes "that those who decried the government for blatant electioneering will be able to see from this year's pay increase that last year's award was not a political sweetener. The RCN welcomes the precedent set during an election year, and urges that the review body's recommendations

for 1988 are implemented in full.”¹⁴ Those recommendations should be known in April.

There is nothing new about attempting to make political capital out of being seen on the side of the “angels.” The temporal relation between elections and pay awards is interesting (fig 4). Fig 4 also shows the “saw tooth” pattern of nurses’ salaries, drifts followed by sharp upward corrections. It is true that nurses’ salaries are now higher, both relatively and absolutely, than ever before, although if past patterns are reproduced this will not obtain for long.

Overtime

I don’t think we’ve interviewed one nurse who didn’t do about two and a half hours of unpaid overtime each week. And none of them were given the option of time back or pay at overtime rates. People’s attitude to this varied from I don’t want to do this but I have to, to most of them saying it’s part of the job. When you add up all those hours of every nurse in the country, look at what we’re being fleeced out of. It’s because this is the way nurses are brought up. Nobody’s suggesting that if you’re in the middle of something you should leave dead on, but if you have to stay you get paid. Not that it’s assumed you’re going to stay out of the love of doing it.

SISTER

Working for low wages is bad enough, but some nurses are working for nothing, regularly. With shortages of staff and an increased nursing workload now fixed features of the landscape, there is a predictable need for nurses to work overtime. Yet in 1986 overtime increased the earnings of trained staff by less than 2%.¹⁵ (Overtime is paid at a rate of time and a half Monday to Saturday and double time on Sundays.) The proportion of the 1986-7 pay bill that is estimated to be paid for overtime is 1.22%.¹⁶ How do hospitals manage to keep their bills so low?

Although the Nursing and Midwifery Staffs Negotiating Council

unambiguously states that overtime should be paid to nurses who are required by their employing authority to work more than 37½ a week and for whom extra off duty time cannot be granted, many hospitals have found ways of avoiding this. One common policy is that to be paid for working overtime a nurse must have applied in advance to have overtime sanctioned. If a hospital requests a nurse to work extra time from previously unforeseen “need,”—for example, during a meal break or for an extra hour at the end of a shift—time off in lieu is offered, but not overtime. As the original request has probably been made because of chronic staff shortages few nurses want to increase the workload for those on duty by taking time off. A survey by the Institute of Manpower Services showed that in the week before its study 60% of nurses had worked some overtime—three quarters of them did not expect to receive full time off compensation; one third thought it unlikely that they would receive any time off in lieu.¹⁷

The great nursing agency swindle

Agencies have an ambiguous place in the economy of nursing. Draining scarce financial resources that should be going elsewhere, they would not exist in an ideal world. They are justified from necessity, and those nurses who indulge in agency nursing are thought of as not “proper” nurses—acting as they are out of self interest.

The “sophisticated” explanation for the existence of agency nursing is akin to that for prostitution—regrettable, of course, but perfectly understandable for financial reasons. It is another damaging myth that nurses allow to circulate about themselves, diminishing their self esteem while at the same time leaving the unworkable ideal of selfless sacrifice intact. The simple truth is that

if nursing agencies closed tonight then hospitals would start closing tomorrow. As the gaps have been opening up agency nurses have been filling them. Two health authorities surveyed their nurses last year and found that four fifths of their nurses had extra jobs, most of them for nursing agencies.¹⁸ A chief nursing adviser told her management board that her authority "is highly dependent on agency nurses; without them ward closures would be necessary. Our own staff form a substantial core of agency staff, using holidays, days or nights off or working an extended day. While this arrangement has advantages for the continuity of care it cannot be considered desirable on personal grounds."¹⁹

The millions of pounds that hospitals are paying agencies each week are not being "wasted": cost conscious hospitals hire nurses from agencies rather than employ them directly because it saves them money. In a system built on the exploitation of nurses the hospitals' use of agencies still stands out as cynical. As the chief nursing adviser confirmed, most agencies now place staff back in their own hospitals, often on their own ward. To employ nurses directly the hospital would have to pay them overtime rates for any time over 37½ hours a week. Not so the agencies, which pay the basic rate (see box). The agency pays the employer's contribution for national insurance, but does not pay for superannuation, sick leave, maternity leave, annual leave, or expenses related to the provision or cleaning of uniforms. The nurse working overtime through an agency earns less per hour than she does in regular NHS employment. "Overtime" rates do not enter into it.

Do agencies give an idea of how a free market in nursing labour might operate? Not really—free market forces are not allowed to operate here. The amount an agency can pay is fixed by law (unlike medical agencies). Competition is permitted, however, among agencies in setting their rates of commission—usually 10-12%.

A penny for the nurses

Nursing salaries are a scandal—one in five qualified nurses now has one or more additional jobs, in 70% of cases solely from need.²⁰ If good reasons exist why nurses deserve lower salaries than either policemen or firemen then the public, which seems to value nurses

equally highly,²¹ should be told what these are. In return for no strike agreements made in the late 1970s policemen and firemen enjoyed large salary increases and then subsequent index linking of their salaries.¹³ If such arrangements are good enough for policemen and firemen, then surely they are good enough for nurses.

Such a solution would not come cheaply. For enrolled nurses and staff nurses (and pupils and students) to track along the same salary path as constables (fig 2) would cost an additional £1250m each year, or an extra one penny on income tax.²² What would the public think of that?

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Conversations with Consultants

Mr Q the surgeon

TONY SMITH

This is the second in a series of recorded interviews with consultants (the first appeared on 2 January, p 45). Mr Q is a surgeon in a teaching hospital 100 miles away from London. His district is a RAWP gainer.

I've looked at your questions from three angles: from my own personal point of view, as part of a unit of three consultant surgeons, and as part of being a paid consultant at the hospital along with everyone else.

On a personal basis I've been very fortunate. I used to be an adult

urologist with a great interest in paediatric urology and for a variety of reasons I am now a full time paediatric urologist. Because it is a relatively minor specialty I don't need vast numbers of beds so I'm well off in comparison with the adult side of our service. I do clinics throughout the whole region and thus I do a lot of driving. I see the children with paediatricians in the outlying hospitals and bring them back to my unit to operate on them. So from my own personal point of view my morale hasn't deteriorated; indeed, it has gone up as it is a very satisfactory job I now have. If I go away I tend to postpone the clinic as I don't want anyone else making decisions about the children which may not be helpful. Job satisfaction is enormous and morale high.

From the unit point of view we have myself doing paediatric urology and two other urologists dealing with the adults. The adult