ASPECTS OF NURSE MANPOWER PLANNING
IN BRITISH COLUMBIA

by

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ABSTRACT

A study was undertaken to determine how the planning process for post-basic clinical specialty courses for nurses in British Columbia could be more effective.

In order to answer this question, it was decided first to examine the present planning process in its complexities. In so doing, the complexities in educational planning were described. The following agencies are involved: the basic nursing education programs, the university schools of nursing, continuing education providers, (the community colleges, the University of British Columbia Division of Continuing Education, British Columbia Institute of Technology), the British Columbia Health Association, acute care hospitals, the Nursing Administrators' Association, the Registered Nurses' Association of British Columbia, the British Columbia Medical Association, the British Columbia Ministry of Health, the British Columbia Ministry of Education.

In order to discover why all these agencies became involved, the nursing education issues in British Columbia are considered. The appropriateness of education and training for present day nursing functions was reviewed and the importance of clinical specialty training in a developed medical-technological situation discussed.

From time to time since the Second World War the "shortage" of nursing manpower has been a matter of concern to policy makers and planners whether groups of nurses, employers, educational bodies or governments.

Nurse manpower planning as it now exists is described. It is argued that manpower planning and planning for education and training of nurses can be improved only if the range of social roles and the behaviour of
individual nurses in balancing these roles is taken into consideration. Understanding where nursing roles fit together with other roles of married women is of crucial importance.

It would appear that individual nurses in British Columbia have been making particular demands upon employers, represented by the Directors of Nursing of hospitals, namely demands for positions with greater decision making autonomy and more life style advantages, to fit more closely with their other social roles.

Judging by the present career choices of nurses, it seems most do not want to be employed in a career structure which offers vertical mobility. Horizontal mobility at the level of "bedside" nursing care seems to be more attractive. However, in order to be attracted into and kept in jobs in bedside nursing care, nurses need to be provided with better preparation than at present, through more adequate clinical skills based on a comprehensive knowledge base.

Recognition of the changing activities of nurses and the implications of the changes should lead to revision of planners' views about accepted patterns in education, training and work organization. This revision of views could form the basis for:

a) more rational planning of education, training and manpower deployment

b) reconsideration of the importance of handling bureaucratic planning failures more effectively and

c) more attention being given to the growing interest of nurses in trade union bargaining in order to express their demands more forcibly.
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PART I

INTRODUCTION
INTRODUCTION

As Clinical Director of Medical Nursing at Vancouver General Hospital, it became evident to the author that there were some new difficulties in nurses' education emerging in the 1980's. Nurses, with special clinical skills, were not available in sufficient numbers to staff special clinical units. Discussions with other nursing administrators indicated that this was a general problem and, further, little training was currently available, in British Columbia, to prepare nurses to function in special clinical areas.

The professional association, educators and others had been cognizant of this problem and although a great deal of activity was going on, very little concrete action was being taken to solve this problem.

This situation led to a question which seemed to need an answer and it became the first theme of this study. The question was: how can the educational planning process for post-basic clinical specialty courses become more effective?

In order to answer this question, it was decided to examine the present educational planning process in its complexities. The following agencies seemed to be involved: basic nursing education schools (the community colleges, and the British Columbia Institute of Technology), the University of British Columbia Division of Continuing Nursing Education, the British Columbia Health Association, acute care hospitals, the Nursing Administrators' Association of British Columbia, the Registered Nurses' Association of British Columbia, the British Columbia Medical Association, the British Columbia Ministries of Health and Education.
Then, to understand why all these agencies became involved, it seemed to be necessary to look at the nursing educational issues in British Columbia, and consider the confusion in planning. This aspect is examined in Part II.

Because there were a number of different objectives being pursued by the educational planners -- raising the level of basic education and building upon it in order to train administrators, educators, researchers and clinical specialists in nursing -- it seemed to be important to examine two further questions. Were the objectives of educational planners closely related to nursing functioning? Were education and training plans likely to cope with nursing shortages?

There has been a concern by the nursing profession and nursing employers, about the "shortage" of nurses since the Second World War. This "shortage" seems to come and go but in recent years has been increasing in British Columbia. During the last few summers, in Vancouver, the acute care hospitals have closed patient beds, because not enough nurses have been available to provide staffing for them. But no one really knows if there is a shortage of registered nurses or only a shortage of nurses willing to come into the labour market.

The author, in her capacity as administrator and employer's representative, began to consider why the shortage was regarded as a matter for educational planning. Why did the planners and administrators look to education of new recruits to resolve the shortages? The reaction of the Nursing Administrators' Association of the Lower Mainland, at a meeting in February 1980, had been to look to training programs for the preparation of nurses for vacant clinical specialty jobs.

Do these planners understand the employment demands of individual nurses in British Columbia? Before committing themselves to being
recruited and agreeing to stay in a job, the nurses present their demands to the Directors of Nursing of specific hospitals. These employment demands appear to be greater for basic bedside care nursing positions than for administrative positions or for positions in which coordinating of the work of the less well trained assistants is to be done. However, basic care nurses (and, more particularly, clinical technological specialists among basic care nurses) need to believe themselves to be well trained and competent to take the responsibilities which have to be handled in these jobs.

The traditional model of a nursing career structure is pyramidal, not flat, but these individual nurses have their own logic which relate to their view of present day nursing functions and their perception of how these can best be fitted in with their other social roles. They have made Directors of Nursing aware that they prefer horizontal career structures. It seems that there may be misunderstandings about these employment demands and time lags in responding to them among manpower and educational planners.

A number of other questions occurred to the author but only the first two of these were educational planning questions. What competencies or standards should a nurse have in order to work in special clinical areas? Do nurses feel confident to perform the functions which they are being asked to do?

Others were more general employment/manpower planning questions. Have the nursing manpower planners clear definitions of nursing functions for special care areas? What effect does the fact that the majority of nurses are women have on their availability for work? Have the planners incorporated adequate demographic information about nurses into their planning? Many nurses today seem to be "leaving" nursing for
jobs in other areas. Have either the employers or planners considered the work environment and its relationship to other roles in attracting and keeping nurses on the job? Is it clear what the nurses who actually provide nursing care want? Why are nurses leaving nursing? What effects to organizational structures and career prospects have on the nursing manpower situation?

On further thought, questions about the relationship between nursing manpower planning and nursing education were raised. Why are so few post-basic clinical courses available in British Columbia? Have the nurse manpower planners not been able to be specific in identifying needs? Why are so many separate groups involved in this issue? How do they work together to develop the area of manpower planning and education? Who coordinates their activities? Do recommendations from the interested groups get implemented? If not, why not? Are resources available to provide the training needed to meet the manpower requirements? How is it decided which educational institution will provide which program where?

These questions caused the author to explore the overall problem rather than only a segment of it. This was begun by reviewing the evolution of nursing roles and women's positions in Canadian society and by raising questions about nurses' needs as women with other social roles.

The techniques of nurse manpower planning and application to British Columbia are described in Part IV.

In a final section after following through the questions and analyzing documentary evidence, prospects for improving nurse manpower planning (and educational planning as part of that) are reviewed, and recommendations made.
Since the focus is upon clinical specialties in nursing, specialties practised in hospitals, little attention will be given to other nursing activities such as public health and mental health in the discussion which follows.

Beginning with an interest in post-basic clinical specialty courses for nurses, the focus changed to manpower issues since it seemed that one could not be corrected without the other being dealt with.

A Note on Method

This is a study of planning in the field of nursing. The following methods were used:

a) analysis of documents - primary and secondary source materials,

b) discussion of the issues with planners in the nursing field,

c) discussion of issues with administrators in the nursing field,

d) evaluation of planning activities against a series of planning paradigms,

e) development of recommendations for change in planning approaches.

Definitions and Abbreviations

For the purposes of this study the following terms are defined as follows:

Basic Nursing Education Programs - prepare students to enter the practice of nursing in a generalist role in a supervised setting and qualifies them for registration. These may be diploma or baccalaureate degree program

Continuing Education - as a term, can be used broadly to describe all education which occurs following attainment of a basic qualification. For the purposes of this discussion it is defined as ad hoc or informal
workshops, conferences, seminars, night school courses of limited duration or inservice education (that is up to forty hours of full time study). It is designed to develop or maintain nurses' currency or competency in any area of practice.

Post-Basic Clinical Specialty Programs (Part of Continuing Education) - prepare nurses for positions beyond the basic level, focus on a clinical specialty role, and are of longer duration than forty hours (full time).

Post R.N. Baccalaureate Degree, Master's and Doctoral Degree - prepare nurses for upper level positions in clinical, administrative, or educational roles.

The following abbreviations are used:

- R.N. - Registered Nurse
- RNABC - Registered Nurses' Association of British Columbia
- RPNABC - Registered Psychiatric Nurses' Association of British Columbia
- BCHA - British Columbia Health Association
- UBC - University of British Columbia
- BCIT - British Columbia Institute of Technology
- CNA - Canadian Nurses' Association
- BCMC - British Columbia Medical Center
- BCMA - British Columbia Medical Association
- CMA - Canadian Medical Association
- HMRU - Health Manpower Research Unit at UBC

Direct quotes and references are numbered in the text and listed alphabetically at the end of the narrative.

Appendices include several sections which support the narrative but do not need to be included in the argument. Appendices will be referred to by letter, when appropriate in the narrative.
PART II

PLANNING FOR NURSES' EDUCATION AND TRAINING

IN BRITISH COLUMBIA
PART II

PLANNING FOR NURSES' EDUCATION AND TRAINING
IN BRITISH COLUMBIA

The problem which presented itself to the author was the shortage of nurses with adequate clinical specialty training failing to come forward for employment in a large general hospital in Vancouver.

There seemed to be a general agreement among nursing planners and nursing administrators that this was an educational problem, that the current shortage was at least partly due to the inadequacies of provision for continuing education in clinical specialties.

Although post-basic clinical specialty programs were the main focus of the study it seemed to be necessary to consider the relationship between the different parts of the system of nursing education in order to show how these clinical programs fit into the whole, how appropriate they are now and what are the problems associated with their development or lack of development.

A. Definitions

The discussion of present planning for nursing education must begin with a clarification of the uses of the words "education" and "training" for there are semantic problems.

In general use, "education" is a broader term which implies intellectual learning. In Canada today it often refers to a minimum of college or university education.

"to develop mentally and morally especially by instruction" (124)

Training is a term which implies learning of role modelling or learning of a technical nature. It does not mean simply rote learning of tasks, but encompasses conceptual thinking related to the proficiency achieved.
Dr. Helen Mussalem (85), Executive Director of the CNA differentiates between training and educating the nurse. She says that educating a nurse equips her mentally to work far beyond the role of a technician and develops a nurse's ability to function at a policy-making and at an administrative level. Traditionally, it has been CNA policy to encourage more emphasis on education of nurses, a policy strongly supported by the provincial nursing association.

But the majority of nurses do not function at this level, although every nurse makes many decisions every working day. Does this then imply that basic beginning level nurses are trained but not well educated? Nurses do not like the word training applied to their profession. It has a negative connotation since it is often equated by nurses with the apprenticeship system of learning, or the rote system of learning to perform skills without knowing the conceptual reasons behind them.

Today's nurses are engaged in strong discussion about minimum entry qualifications to practice nursing. One school of thought suggests that current preparation is adequate. The other school argues that a university bachelor's degree should be the minimum qualification.

The dictionary definition of training, "to be fitted, qualified or proficient" does apply to nurses at the beginning level and this is often the goal of nursing schools. Training used in this way has a very positive connotation. Possibly too much attention has been given to education rather than training in recent years for there has been a recent surge of concern about the adequacy of training for these clinical nurses, and the numbers available to provide technological nursing services in British Columbia.
Who, then, is responsible for planning education and training of nurses? Are these education planners in touch with the employment situation?

British Columbia has only prepared 35 to 40% of the total number of nurses it needs in the work force. It has depended on immigration from other countries and transfers from other provinces to provide sufficient numbers of nurses. As other provinces are reducing the numbers of students in their nursing programs, this province will have to provide more of its own basic nursing education.

The Foulkes' Report (60) - a review of health care in British Columbia - addressed these issues and recommended expanding the number of training programs in universities and community colleges. More recently, the Open Learning Institute has begun to offer some courses to students in isolated areas. Funding for nursing education continues to be a problem for some potential recruits. Whilst the RNABC set aside some money for bursaries this comes nowhere near meeting demand.

In two phases, 1968 and 1971, the RNABC developed reviews of basic and post-basic education of nurses in the province (93, 94). The report reiterated the continuing need identified in the Weir Report (125) in 1934 for nurses educated at the university level. The second report (93) reviewed the facilities available for post-basic education (only UBC School of Nursing) and suggested ways in which more candidates could be admitted to programs and how nurses could gain degree credits before entering UBC. It recommended a collaborative approach by Canadian universities to developing nursing Master's programs and also recognized the need for doctoral programs in Canada.

The educational planning process in confused and there has grown up a complexity of bodies responsible for different aspects of providing
education and training or providing funding for the purpose of evaluating and influencing education and training activities. The description of present day curriculum and course planning which following is concerned with explaining these inputs into education and training policy making and the gaps and overlaps in the process of planning programs.

B. Basic Nursing Education Programs

Entry into the practice of nursing in British Columbia is provided by four kinds of basic education programs. These are: (1) general nursing programs (diploma or degree)*, (2) psychiatric nursing (diploma), (3) practical nursing**, (4) nursing aide**.

Basic nursing programs are offered primarily in post-secondary institutions* except for general nursing diploma programs at the Vancouver, Royal Jubilee and Victoria General Hospitals.

General and Psychiatric Nursing Programs

General and psychiatric programs do not differ greatly in objectives for their graduates except in making them competent in the clinical areas in which they are prepared to function. Both types of programs expect graduates to assess, plan, implement and evaluate nursing care for individuals of all age groups.

*Degree programs are described in Section C of this chapter. The first two years of the baccalaureate curriculum at UBC have been similar to the diploma years, but this program has now been revised so that students must complete all four years of the program before they are qualified to enter practice and write the registration examinations. Nurses graduating from diploma programs are accepted for further education in degree programs in the province.**Practical nursing and aide programs are not discussed further because graduates generally have to start over in a general nursing program in order to advance in nursing.
General nursing programs focus on providing care for medical, surgical, pediatric, post-partum and nursery and psychiatric patients. Psychiatric nursing programs emphasize the care of patients with psychiatric illness and mental retardation. There are ten general nursing diploma courses and two psychiatric nursing programs. Programs vary from two to three years. The current trend is for programs to be longer to provide more clinical experience in various forms for the students.

Graduates of these programs receive a diploma and are eligible to write national registration examinations.

Responsibility for the control of education rests with the provinces in Canada; therefore, all educational programs for the preparation of health manpower must be approved by the provincial authorities. If an agency or institution is to obtain approval to conduct a school, the agency (or institution), must meet certain standards in regard to length of program, curriculum, faculty, and other aspects of educational administration. Under the health practitioner acts, authority to control healing arts has been delegated in most cases to the respective professional associations in the provinces which have established criteria. The associations set forth minimum requirements for the conduct of schools to prepare their practitioners.

Any educational body can provide a program to train nurses, but in B.C. only nursing students who graduate from a program which has been approved by the RNABC can write registration exams.

The graduates of these programs may also write standardized examinations for the purpose of registration. These are nationally set examinations, but allow for registration only within the province in which the graduate is writing the exam.
Curricula of diploma programs are structured in a variety of patterns, the most common being a six semester program in two years. The major part of the final semester is usually concentrated clinical practice to consolidate skills prior to graduation.

All diploma programs include instruction in nursing, the physical and social sciences and most include general education subjects. Courses in the physical and social sciences and other fields are usually taught by faculty in other disciplines. Nursing students rarely share common classes with other students because of scheduling complications, content needs not shared by other programs and institutional organization of separate programs in self-contained units. Nursing is the major component of all programs, compromising 72% to 93% of the content of each program. There are significant variations in the amount of time spent in nursing theory and practice from program to program. Laboratory and clinical time varies from 45.5% to 76% of the total programs in schools of nursing. The question arises as to whether this variance has a major effect on the final product, the graduate, and whether or not it is sufficient when looking at needs for continuing education.

Entrance requirements for diploma nursing programs vary with the institution providing the education. All schools except Douglas College require a minimum of grade twelve education, but subject requirements in grade twelve vary from college to college.

Funding for these programs is provided by the sponsoring institutions through the Department of Education. Students pay a registration fee which is in line with that paid by other students in the colleges. Most funding is from the government. Nursing schools are expensive because of the low ratio of pupil to teacher when students are learning clinical skills or practising in the clinical areas.
C. Degree Programs

1. Bachelor's Programs

The University of British Columbia instituted the first degree program for nurses in 1923. Since then, the program has undergone many revisions, the latest being in 1980. Students will complete a four year baccalaureate program before entering practice. This, in essence, adds a fifth type of basic education program.

In 1976, the University of Victoria began its two year Bachelor of Science in Nursing degree program for registered nurses.

The overall objectives of both B.S.N. programs are similar; to broaden and enhance knowledge and skills, particularly in relation to problem solving or scientific method and to develop new skills; to provide nursing care to individuals, families and community groups; to function within a variety of settings within the community and to increase ability to function interdependently with other health professionals.

The scheduled time spent in clinical practice varies from 25% to 50%. Students have some choice in the selection of clinical areas within broad settings.

At both universities, nursing courses predominate, but courses in physical and/or social sciences are also required. Basic statistics and research methodology are included in both programs. Students have the opportunity to choose elective courses and/or independent directed studies in a selected area.

The UBC Bachelor Degree must meet the requirements for approval of schools of nursing by the RNABC. Then students are eligible to write the national registration exam written by other basic students. Students from both universities graduate with a Bachelor of Science in Nursing degree.
2. **Master's Program**

The Master of Science in Nursing program at UBC began in 1968. This program prepares graduates to give highly skilled care, utilize the scientific method of inquiry, effect change and assume leadership roles. As well, special courses in functional areas of administration, teaching or research or in clinical specialization are available, depending on the student's choice. Graduates are expected to assume upper level positions in functional or clinical roles.

The M.S.N. program is two academic years in length, and consists almost entirely of nursing courses. In the first year, students concentrate on systematic approaches to patient care and on research methodology. Clinical experience with selected patients is managed. Students study and work with individuals of a selected maturational stage. Students in the second year select from courses related to clinical nursing, nursing education, nursing service administration, consultation and clinical research. Clinical experience is planned with some courses.

Students graduate with a Master of Science in Nursing. Evaluation of the program is the same as the bachelor's programs.

Funding for these programs is allocated through University senates. Nurses pay the same registration fee as the other university students.

D. **Continuing Education**

1. **Continuing Education Programs**

Continuing education, as a term, can be used broadly to describe all education which occurs following attainment of a basic qualification. For the purposes of this discussion it is defined as ad hoc or informal workshops, conferences, seminars, night school courses of limited duration or inservice education (that is up to forty hours of full time study).
During the early sixties, RNABC staff presented continuing education workshops for nurses across the province. This became a very expensive undertaking. In 1966, the RNABC changed its policy and began to work to facilitate programs rather than provide them. It involved hospitals, community colleges and universities in presenting these programs to nurses for a reasonable fee which usually covered the costs of expenses.

In 1967, the RNABC facilitated the linking of nursing continuing education with an established, powerful University of British Columbia Continuing Medical Education body. Its recommendation was that "collaboration be undertaken with the Department of Continuing Medical Education to send a nurse with doctors presenting Medical Continuing Education programs, to provide related nursing inservice" (104). This was implemented in the next year when four courses were presented by doctors and nurses.

A further stop in developing continuing education for nursing was taken in 1968 in response to an Annual Meeting Resolution in 1967 (104, 105). The resolution passed by the membership read as follows:

That the RNABC offer to contribute $5,000.00 per year to UBC for a period of five years, to appoint a full time nursing faculty member to the School of Nursing, said faculty member to be seconded to the Department of Continuing Medical Education to assess the needs and resources for continuing education for nurses and to plan, develop, implement and coordinate projects for continuing education purposes.

Negotiations ensued with UBC and after initial difficulties, an appropriate appointment was made. The RNABC obviously thought the functions now being performed by nurses could not continue safely without increased education but it had not been successful in making this need known to the funding bodies, so it provided the funding. The RNABC continued to fund this position until 1977.
There has been considerable development within the province in continuing education within the last ten years. The UBC Division of Continuing Education has provided most courses to nurses, followed by the University of Victoria, BCIT and some of the community colleges, but entrepreneurial groups and special interest groups within nursing have also undertaken a number of courses.

In general, continuing education programs for nurses are self-funded through registration fees of participants. If individual nurses or institutions do not see these programs as meeting their needs, the attendance will be low.

Although there are areas of concern to be resolved in developing continuing education programs for nurses, such as standards, to most people with influence in planning nurse education, this is not an area of major concern at this time.

In general, continuing education programs will become more important if specific evaluations of nurses' competencies for the purpose of re-registration are to be undertaken.

E. Post-Basic Clinical Specialty Courses

1) Availability and Adequacy of Existing Programs

During the 70's a number of briefs and studies concerning the need for post-basic clinical specialty courses in B.C. were carried out. (See Appendix D for complete listing) Although they all strongly recommended that this currently lacking area of nursing training be provided, there was a lot of motion but very little productive activity.

The RNABC was very concerned about the lack of post-basic clinical specialty courses, so it decided that it had a responsibility to ensure that nurses received this education.
By 1973 the RNABC had met with the following bodies; the UBC Division of Continuing Nursing Education, the Royal Columbian, St. Paul's, and Vancouver General Hospitals, to develop and sponsor an Intensive and Coronary Care Course. British Columbia Hospital Insurance provided financial support for program development and implementation; W.K. Kellog Foundation participated in the developmental funding. The UBC School of Nursing funded the evaluation of this course. This course was repeated twice, successfully, in 1975 but further courses were cancelled because of the lack of funding.

The inadequate supply of nurses prepared to work in critical care areas became a serious issue in early 1980. The provincial Ministry of Health attempted to identify immediate needs so that crash programs could be developed, but the problem was too complex and involved more than simply a numbers identification. This attempt was not useful in identifying immediate need.

In a paper entitled "RNABC Views on Continuing Basic Clinical Nursing Education (1980)" (100) the RNABC identified current programming activity as follows:

As of February, 1980, there are programs either operating or proposed for all the known high need clinical areas except neonatal intensive care. There is almost no information to suggest how many nurses require training in each category. While there is evidence that the number of nurses requiring training are considerable, the numbers which can be immediately trained will be limited by a number of factors, including availability of qualified instructional personnel, ability of agencies to replace staff that can be released for training, the uncertainties connected with new and untried course offerings, availability of funds to compensate nurses for salary loss during training, and availability of funds for course development and operation. It appears that the most careful albeit optimistic, estimates of numbers of nurses that could be trained have been made by providers in their course projections. Until there is additional and better information which could alter these
estimates, RNABC should support these as immediate post-basic training goals and should caution against overly optimistic planning of "crash programs." The Association should also support the early development of a program for neonatal intensive care.

This same paper also identifies post-basic programs currently being presented or in the planning stages.

In a Post-Basic Nursing Programs Discussion Paper of March, 1980 (121) Dr. Sheilah Thompson, Coordinator of Health and Human Services Programs, Ministry of Education, lists post-basic courses and adds some courses in the planning stages.

These training programs themselves vary in length and level of specialization. For example, the Post-Basic Operating Room Nursing Course at St. Paul's Hospital is 24 weeks in length and includes material on all major O.R. services, post-anesthetic recovery room and some managerial information. The Okanagan College provides a program of 12 to 16 weeks to educate non-specialized Operating Room staff.

Most of the programs do provide some form of certificate for their graduates and efforts are underway to standardize the certification.

Although most of these post-basic programs now must submit their curriculum to the RNABC Continuing Nursing Education Approval Program, this is a voluntary activity, so programs can be taught without external evaluation mechanisms.

Although curriculum approach varies according to the group which is presenting the program, as well as what specialty the program is about, one thing in common to all clinical specialty post-basic courses is that clinical practice is seen to be as important as the theoretical aspects of the course.

Nurses who complete clinical specialty courses are accepted by the employing agencies to work in the specialty area for which they have been
trained. However, there is a problem for employing agencies because nurses from these courses in B.C., and others in Canada, may have been prepared to function at different levels, therefore, staff orientation programs have to differ significantly - both within the institutions and between the institutions.

ii) Funding Issues

Most post-basic courses are expensive. They are estimated to cost $25.00 to $40.00 per day per student, or from $50,000.00 to $60,000.00 per course.

Funding for post-basic courses is variable.* The courses can be paid for through student registration fees, through hospital funding, or by the Ministries of Education, Universities Science and Communication or Health. In general, continuing education has been paid for by students but clinical specialty courses have sometimes been funded from other sources.

Hospitals do provide a few post-basic courses, usually out of dire need. In some hospitals the student has been expected to provide service to the institution during the post-basic course period as a means of contributing to the cost of the course, but this type of payment for education is on the decline. According to Listing of Continuing Education for Nurses, published by the RNABC in October, 1979, no post-basic courses in the province are funded this way. Any British Columbia hospital providing courses, is presently supporting these courses by special grants or out of general hospital budgets. (Appendix A)

*This information has been taken from published documents. The current situation may be different, since documents were consulted only up to June, 1980.
In educational institutions, the funding problem is further compounded by the manner in which funding is allocated to community college nursing departments, BCIT and the UBC Department of Continuing Education.

Most community colleges with nursing departments are usually organized in such a way that all nursing education offerings stem from that department. If short term continuing education programs or post-basic nursing programs are to be presented, the resources available are those from within the department of nursing. Financially, these departments can submit proposals for post-basic courses (through their internal approval bodies) to the Ministry of Education who will approve or not approve funding. The difficulty is two-fold. One, the initial developmental work to present the courses for approval must be provided by the department's educators. These persons already have major responsibilities for ensuring the adequacy of basic education programs and have little, if any, time for other activities. This problem has been overcome by the RNABC Board of Directors. In January, 1980, they approved a policy of providing developmental funds for post-basic clinical specialty programs. Funds have since been made available and allocated for this purpose.

The second difficulty is that there are no set criteria to determine whether or not they might receive funding from the Ministry of Education. This approval process is an extensive one which can take up to two years to complete. (See Appendix B) By that time, others may have already met the identified needs, or other resources such as faculty or clinical space may no longer be available.

BCIT differs from community colleges in that it has a specific department whose purpose is to provide continuing educational offerings.
21.

Therefore the resources for basic planning are more available, and funding sources are more readily accessible from within that department's budget. If funding must be obtained from the Ministry of Education the same process is engaged in as the community colleges with one exception. Prior to the letter of intent being sent to the Minister, the proposal has to be fully formulated and the proposed programs must be approved internally.

UBC's Continuing Education in Health Sciences is funded in a different manner. The division is composed of an Executive Director of the division, Directors for each health science discipline and support staff. Each Health Science Discipline in the Continuing Education Division provides salary funding for its respective Director and one secretary. The School of Nursing also funds an Assistant Director. The salary of the Executive Director and other support staff plus any operating costs are funded from charges to participants in the various continuing education presentations, which must be self-supporting.

Therefore, each participant in a continuing educational program presented by the Division pays for the costs of the course plus a portion of the administrative and operating overhead. To sum up, funding for post-basic courses in nursing is haphazard, because priorities in need for programs for clinical specialties have not been identified.

With the lack of identification of program need, the Department of Education cannot budget for programs on an ongoing basis, even if the department were to accept the responsibility for funding them as part of total nursing education policy. Nor can it provide guidelines to the Academic Council as to the priorities of nursing education over other educational needs. Consequently, the energy expended in procuring these funds on an ad hoc basis, makes these courses very expensive. Teaching
material cannot be planned for continuing education courses but is continually being started from "scratch" which is not cost effective. Post-basic courses are expensive to develop and operate, since staff are required for development, formal instruction, and on-site clinical supervision. How much more expensive are they when each course begins at the beginning to recruit and orientate staff who will have to experience problems that might have been solved by previous staff had they continued to teach the course the second and third time?

iii) Clinical and Class Room Resources

Shortage of clinical practice area and classroom resources is a problem in presenting post-basic nursing education, particularly in the lower mainland where the clinical facilities which might provide sufficient experience for the students are located. The lower mainland agencies already have difficulty in providing clinical spaces for the current basic courses. Classroom space availability may create further problems but these are not as difficult to solve.

iv) Issues in Locating Courses

The location of courses provides added problems for nurses living outside the district who must pay extra for board and room as well as losing pay. This is difficult to accept when a nurse knows that she will not be financially rewarded for her efforts unless she wishes to acquire geographic mobility.

v) Availability of Teaching Expertise

Another major problem is the recruitment of teachers with the clinical expertise necessary to instruct in post-basic programs. Since there is not a clinical education career ladder, colleges must choose from educators who do not have clinical expertise or practitioners who lack teaching and programming skills. This becomes even more difficult
when programs are offered on an ad hoc basis because nurses do not prepare themselves for this level of teaching and job security is lacking for anyone who might be prepared and interested to teach because of the nature of the planning.

vi) Availability of Students

Potential students for specialty courses are often already working in special care areas. This is not desirable, but a fact of life. Hospitals would have difficulty replacing these staff members for the period of post-basic courses because they are already short of nurses in the specialty areas.

F. Pressures to Improve Continuing Education Specialties:
Who is Concerned?

As the confusion described in the previous sections must indicate, there are a number of different individuals and groups concerned about basic and continuing education for nurses. Their reasons for concern differ and will be discussed below. The nurses themselves are concerned about their education in a society where qualifications are becoming more and more important for attaining economic rewards and where educational opportunities are so closely linked with social opportunities. This is discussed in F(i).

The second section of the discussion F (ii) is concerned with the professional association's attitudes. Since other groups have not been effective in planning, the nurses' professional association has taken much of the initiative in educational development. Their spokeswomen in the professional association and unions have struggled to help nurses to attain greater recognition as a group, firstly, through pursuing professional objectives and more recently through union action.

On the other hand, the employers of nurses are concerned about standards and cost-effectiveness and efficiency. The third section
F(iii) considers the employers' attitudes to clinical specialty education. It must be pointed out that in B.C. the employers concerned are the hospitals acting as a consortium (the BCHA), or individually; the Nursing Administrators' Association speaks on behalf of the Directors of Nursing of the hospitals who are the principal executive officers concerned with the deployment of nursing staffs. The BCMA is included in this discussion of employers' attitudes, for whilst doctors are not employers of nurses they are much concerned about the quality of help provided by the nurses working with them.

The fourth section F(iv) is concerned with government planning. It has to be recognized that government has been entering the planning scene gradually as more demands have begun to be made for funding of programs rather than institutions.

1.) Nurses' Concerns about Clinical Specialty Courses

Post-graduate clinical specialty courses offer both advantages and disadvantages for nurses. Geographic career mobility is one possible outcome for those nurses taking post-basic courses. Nurses will be able to work in clinical specialty areas in nursing and can then transfer to a related clinical specialty in a way that nurses without post-basic training cannot do. A nurse who must move with her husband to another town will become immediately sought after by the local hospital.

Another example of within institutional mobility is the nurse educated in Coronary Care Nursing who is more easily able to transfer to a general intensive care unit, a post-anesthetic recovery room, or a burn unit than a nurse without such post-basic training. Unfortunately, however, once orientated into a special unit, a nurse does not have the same upward career mobility as nurses taking post-basic administrative
courses since clinical career ladders are rare or non-existent in the province.

The current collective agreement between the Health Labor Relations Association of British Columbia and RNABC, Labor Relations Division, does not either encourage or recognize a clinical career ladder. Clause 52:01 of the current contract does give financial reward for special clinical preparation, but only if the nurse has attended a course, of not less than six months, approved by the RNABC, and is employed in the special service for which she/he has qualified. These nurses will be paid an additional twenty-five dollars a month if they have utilized the course within four years prior to employment. At the present time, only nurses who have completed courses in Operating Room Nursing at St. Paul's and the Registered Psychiatric Nursing Course at BCIT qualify for this extra remuneration.

No other post-basic course offered in B.C. qualifies the graduates to receive this extra monthly stipend.

In operating rooms, therefore, nurses who have taken post-basic courses other than at St. Paul's Hospital, work for less money even though they may perform the same functions, accept the same responsibility and have the same sort of post-basic certificate from a B.C. course. Further, this same contract does not recognize any other level of practitioner than general staff nurses. Other positions identified in the wage schedule classification are either non-registered general staff nurses or administrative personnel.

Therefore, in terms of upward career mobility, the post-basic courses presently offered do not contribute in a concrete way towards nurses' career mobility. They offer the nurse further educational
challenge in special units, or special status in the general duty nurse hierarchy, but nurses are not financially rewarded for this.

2.) **Peer Group Concerns -- Competency**

The RNABC has long been actively involved in nursing education and sees it as a professional association's responsibility to be so. In the late fifties the Association's concerns shifted from concentration on basic education to the recognition that continuing education was essential for nurses. It became the first provider of continuing education in the province, a role which was filled until its policies changed in the early 1970's. After that time, the Association saw its role as the facilitator of educational developments for nurses rather than being the provider. During the 80's, the RNABC has continued to intensify its efforts in pushing for continuing education for nurses.

The RNABC has facilitated planning of continuing education by nominating members to serve on committees and planning bodies for post-basic courses. It has continued to lobby governments for provision of post-basic courses for nurses and assists in developing these courses in any other way it can.

At the January, 1980 meeting of the Board it was decided that the remainder of the $100,000.00 unspent for educational loans in 1979 would be made available for development of post-basic clinical nursing courses. A maximum of $5,000.00 is available for each course. Courses receiving the development funding are the Critical Care Level II for ICU, PAR, and Emergency Nursing being provided by UBC, and Obstetrical Nursing Level II course and General Operating Room Course sponsored by Okanagan College, an Emergency Nursing Course sponsored by Douglas College/Royal Columbian, a Psychiatric course sponsored by UBC, a Long
Term Care Course sponsored by UBC, and an Occupational Health Course sponsored by Douglas College/Royal Columbian. Most of these courses are planned to start in late 1980 or early 1981.

At that same Board Meeting, a further decision was made that the RNABC would undertake a study to identify competencies and skills required in a number of clinical nursing specialties, viz; critical care, maternity, psychiatry, operating room, recovery room, long term care, emergency, pediatrics, palliative and neonatal nursing. Information gathered by the committee from nursing education program planners indicated that a list of competencies would be useful in planning new post-basic nursing courses to ensure greater standardization in various educational settings. As a result of this decision, a paper was developed in April, 1980. It was called "Clinical Specialties Competencies Report" (99). The terms of reference were: to identify major specialties and sub-specialties within the practice of nursing, to specify the competencies required for their safe practice, and to indicate the type of specialty preparation required for practice in the major special patient care units and services which exist in B.C.

Early in the spring of 1980, the RNABC published a paper called "RNABC Views on Post-Basic Clinical Nursing Education" (108). It reviewed the state of post-basic courses for nurses and then stated what was seen as the RNABC's primary role/responsibility as follows:

As the professional organization and registering body, RNABC is vitally concerned with the competencies of R.N.s and hence with the quality and content of their continued professional education.

1) Required competencies for the various clinical specialty areas should be set up and regularly reviewed for currency by the professional organization, using consultation with other concerned groups.
2) All post-basic clinical courses be reviewed via the Continuing Educational Approval Program, and one criterion for continued funding should be CEAP approval. Decisions re continued funding should also rest on results of post-program evaluation. This approval could be built into the CEAP process.

In January, 1979, a consultant was hired to evaluate the effectiveness of CEAP and in September, 1979 the board referred her report to the Joint Continuing Education Approval Committee asking for its recommendations.

In January, 1980 the Board decided that the Continuing Education Approval Program would continue, that it be widely advertised that the consultation service was available, and that simplified approval standards be developed for short courses which do not offer clinical instruction or award credentials.

3.) Employer's Concerns - Effectiveness and Efficiency
   a) B.C.H.A.

The BCHA as a representative of employers of health care workers has been concerned about the manpower issues particularly in hospital care in B.C.

As a result, a Standing Manpower Committee was established in late 1979 to address manpower issues on an ongoing basis, to set priorities for the Association and to develop the role of the Association in manpower planning. The primary mandate of this committee is to ensure that employers are involved in the definition of manpower needs.

The first action was to inventory research efforts of the BCHA, the Health Manpower Research Unit, professional associations and Managerial Engineering Units in order to identify what had to be done and by whom and to ascertain any areas of manpower planning not currently
being addressed. In May, 1980 the committee published its Manpower and Research Inventory of Activities and Reports. (20) Included in this listing are a number of nursing manpower reports and studies. The BCHA is working with the Health Manpower Research Unit of UBC on the difficult-to-fill positions survey. (13)

b) Hospital Activities

Individual hospitals or groups of hospitals have lobbied the Health Ministry re the shortage of general duty nurses and in particular, nurses with post-basic preparation to work in special clinical areas. As a result, the Ministry of Health circulated a questionnaire in the spring of 1980 (19) to attempt to discover what urgent needs might be, with the hope of establishing some crash courses for those particular specialties.

Since hospitals have had to rely on recruiting inexperienced nurses and providing good orientation, they are discussing providing their own specialty courses with support and funding to be requested from the Ministries of Health and Education. Currently St. Paul's Hospital in Vancouver is providing some post-basic courses in Operating Room and Enterostomal Therapy.

A major discussion point in hospitals is "who should control educational activities for post-basic courses?" Some comments indicate that respondents see this as a role for hospitals to develop with seconded assistance from the community colleges and universities.

c) Nursing Administrators' Association of British Columbia

This organization encompasses other than hospital nursing administrators but the majority of the membership is nursing administrators who are employed in hospitals. It has not been a strong organization but is presently re-organizing its forces.
The nursing administrators presented a "Reaction Paper to the Nursing Education Study Report." (1979) (Appendix C) The Nursing Administrators' Association strongly supported recommendations relating to improving basic standard educational and degree programs and making degree programs accessible for nurses in other parts of the province. Recommendations which dealt with post-basic education were strongly supported by the Association. The Association also supported recommendations which suggest the development of career streams in clinical nursing. Recommendations which dealt with planning for needs for nursing were also endorsed.

In October, 1979, the Association presented a brief to the Minister of Health entitled "The Registered Nurse Shortage in British Columbia: An Increasing Problem for British Columbia Hospitals." (88)

The recommendations from this brief are as follows:

The Nurse Administrators urge the Ministries of Education and Health to combine efforts for implementation of the following recommendations:

I. To provide sufficient separate funding to meet nursing staff orientation and continuing education for job requirements.

II. To immediately increase the number of seats available to refresher courses.

III. To continue funding of the University of British Columbia/Vancouver City College Level I Critical Care Course.

IV. To provide funding for the following post-basic courses:

Cardiothoracic Care
Coronary Care
Emergency Care
Gerontology
Level I and II Intensive Care
Neurological Care
Neurosurgical Care  
Obstetrical Care  
Operating Room Care  
Post-Anesthetic Recovery Care  
Renal Care  
Spinal Cord Injury Care  

V. To increase the number of seats for basic nursing programs.

The Nursing Administrators' group of the Lower Mainland invited Mr. R.E. McDermitt, Senior Assistant Deputy Minister, Professional and Institutional Services, Ministry of Health, to a special meeting in March 1980, to discuss with him their concerns about the shortage of specialty trained nurses and lack of post-basic courses to train nurses in special clinical areas. In meeting with Mr. McDermitt, this was their attempt to make clear their consensus to the Ministry of Health.

d) Colleagues' Concern - Doctors' Attitudes Re Effectiveness

The BCMA has long been interested in nursing education. Until recently, it was highly involved in participating in nursing education, its members often giving nurses lectures in anatomy, physiology, disease pathology and medical treatments. More important to the physicians of B.C. is that graduates of nursing programs, in caring for patients, work closely with physicians.

Therefore, the physicians are directly affected by the outcomes of nursing programs.

In December, 1979, it was brought to the attention of the Board of the BCMA that a serious shortage of nurses was developing and also that nursing needed support in obtaining funding from either the Ministry of Health or Ministry of Education for post-basic courses. There had also been concerns expressed by physicians as to the competence
of nurses educated in the two year programs. As a result, the BCMA Hospitals Committee was asked to study the effectiveness of nursing education in the province and to report back to the board.

Dr. D. MacPherson, who chairs the Hospitals Committee, wrote to the RNABC and several directors of nursing to try to ascertain the scope of the problem. Essentially, answers he received indicated that there was a problem but that adequate data had not yet been obtained. It was indicated that attempts at corrective action were being taken through the Health Manpower Research Unit, the RNABC and the BCHA.

The Hospitals Committee presented the following recommendations to the Board of Directors of the BCMA in January, 1980 (15):

1) That the Ministry of Education give immediate and serious consideration to the dangerously neglected area of post-basic clinical nursing education in critical care areas.

2) That the Ministry of Education respond to the need for an ongoing dependable source of funding to be utilized for the development and implementation of quality post-basic nursing courses.

3) That a source of revenue for consistently assisting hospitals with the cost of staff replacement for nurses attending post-basic courses be identified.

4) Government Involvements in Planning Post-Basic Clinical Specialty Courses

Since delivery of hospital services is not a direct government responsibility but delegated to the hospitals themselves, the Health Ministries did not become directly involved in the nurse manpower planning until the seventies (The development of this involvement after the introduction of National Health Insurance is discussed in Part V.)
Equally, the involvement of the Ministries of Education grew slowly, as was described earlier in this chapter. Consequently, until very recently, governments were not involved in supporting post-basic nursing clinical specialty courses. A policy for funding this area of nursing education on an ongoing basis did not exist, nor had the governments taken leadership in coordinating inputs from interested groups so that ongoing needs could be identified. Instead they had moved in and out of the planning process as the pressures from the interested groups had demanded their attention or fallen off. The planning focus had only been on the strongly identified program needs not on an overall assessment of needs.

Further, governments had not clearly identified what the roles of institutions should be in presenting post-basic clinical specialty courses, so a competition of sorts had developed in terms of who would get the ad hoc individual program funding which was available.

In 1977, in B.C. a mechanism to review requests for additional funding for clinical specialty programs was set up, but neither on-going need for programs nor program priorities was to be on a one time basis. As a result, funding for a program might be approved on a one time basis. Continuing to present the program meant reapplying through the mechanism requests for additional courses, for further one time funding. This was not only time consuming but often resources were dispersed or unavailable by the time the second approval was granted.

As demands have been increasing for nurses with special clinical preparation, the government has begun to be more involved with the planning process through attempts to identify needs and, through funding and guiding the HMRU, it has begun to play a coordinating role.
5. Discussion: Who Has the Power to Make Decisions Relating to Nursing Education?

The last two decades were the time when most earlier plans regarding nursing education were implemented. Basic education programs came under the control and funding of the provincial education departments. Baccalaureate nursing courses increased quality and quantity. Masters’ programs were started in many universities. Yet education for specialization in nursing is still in the early planning and implementation stages despite the fact that these two decades were characterized by increasing technology and specialization in nursing.

There is still discussion within the profession today about nursing education needs - about the difference between "service" and "education." This may well be related to the lack of clinical models in nursing. Because the practitioner is not highly regarded or rewarded within the nursing profession even today, the question of who decides what nursing practice is and what education is needed to fulfil this role is an important one.

The status in the nursing profession has not been with those people who provide nursing service, but, rather, with those who administer the service and those who educate for it. To advance in nursing, one had to specialize in education or administration. Until the last few years, the educators have had the most power. Many nurses who gained their higher education chose the teaching role because teachers tended to have better working conditions, salaries and status than nursing administrators. They had more freedom to control and make decisions about the educational environment. They were also in an environment where new ideas and concepts are expected. The educators
were able to advance in their thoughts about what nursing should be and what various educationally prepared levels of nurses should do.

The nursing administrators were looking for nurses who could perform the established nursing practices well, not nurses who had new ideas that the nursing administrators could not possibly implement. Within the hospitals, many nurse administrators themselves were not given real power but were often delegated tasks to carry out. They had little control over their working environment because hospital administrators controlled the budget and physicians controlled the quantity and quality of workload. As a result, they were often unable to do much more than follow orders while trying to advance nursing as best they could.

But who should determine what nursing really is? The educators? The administrators? Or the practitioners who provide daily care for patients?

Attempts were made by the professional associations to pull together varying views about the objectives of nursing education. Mussalem (85) for long the Executive Director of the CNA, has put forward her interpretation of the reasons for slow progress in attaining the objectives identified by the professional association by quoting King (76):

Throughout the first part of the century, organized groups closely associated with health care, for one reason or another, appeared to favour maintaining the narrow custodial image of the nurse. This coupled with the apparent inability or unwillingness of nurses to interpret developments in both education and service, further strengthened the accepted image of the nurse. The situation was all the more unfortunate when translated from public confusion to government bewilderment. Since university nursing education has always depended on funds channeled through the provincial government, it is essential that the needs of nursing be
interpreted clearly to their level of government. It was inevitable that through the lack of clear interpretation of the need for, and the role of the baccalaureate prepared nurses, there would be financial difficulties for university degree programs. The question may well be asked why, if the general public was confused, nurses were content to accept this situation. Over the same period other professional groups successfully recognized the need for involving new educational approaches and interpreting these changes to the public. Unfortunately, the mass of nurses were apathetic and lacked understanding of both the need for, and the character of the change in basic nursing education controlled by the university.

Is this a useful interpretation of the present nursing situation? Certainly it focusses attention on the individual nurse's reactions to their general situation in society though these reactions may well have changed in recent years.

In the next section the development of nursing functions in hospitals and women's roles in society are considered, as a basis for making an assessment of the appropriateness of education and training in nursing today and in interpretation of reasons for the "shortage" of nurses.
PART III

HISTORY OF NURSING FUNCTIONS IN THE CONTEXT
OF CHANGING WOMEN'S ROLES IN CANADA
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It would appear that individual nurses in British Columbia have been making particular demands upon employers, represented by the Directors of Nursing of hospitals, namely demands for positions with greater decision making autonomy and more life style advantages to fit more closely with their other social roles.

Nursing is a women's profession. In manpower discussions, this is identified as a characteristic of the nursing profession. To explore the problem of nursing shortages, women's roles must be examined to understand any impact this characteristic may have on the availability of nurses for the labour market.

A. The Beginnings

Nursing functions today have evolved as a result of many factors. Increasing knowledge and technology are obvious in themselves. Less obvious, but very important, are changes in the values on which nursing is based, changes in roles of women in our society, and the development of our society. External, economic and social pressures as well as internal searchings to adapt to the changes has created a state of uncertainty in nursing as to what is the scope and function of nursing.

For the perceptions of nursing today have been determined by its traditions as well as more recent influences:

Uprichard has identified heritages from the past that have tended to inhibit progress in nursing as a profession. These are: the folk images of the nurse brought forward from the primitive times, the religious image of the nurse inherited from the medieval period, and the servant image of the nurse created by the Protestant - Capitalistic ethic of the 16th to 19th centuries.
These images, while appealing to the humanistic side of man's nature, show nursing in a subordinate position to all other professions, omni-present and uncomplainingly dedicated, with little thought of personal gain. (78)

The values of the nursing profession are closely intertwined with those thought to be a part of the woman's role. It is, therefore, difficult to separate the two, so they will be discussed together as the changing values in nursing are identified.

During the period from the early settlements in Canada until the 1920's the values in nursing were simple. Nursing was a servant's role and thus a duty.

Canadian nursing began in the early years as a "labor of love" for the religious orders in Canada, family members or neighbours who volunteered their services. These nurses were untrained and did what they could for the comfort of their patients. Rewards for nurses were based on the value of the dedication to patients. They also valued praise from the physicians for their work.

In this period in Canada's history, the normal roles of women were to be wives and mothers staying at home. Women were seen as needing protection and therefore dependent on men. Their status was much less than men's and they were not welcome or accepted when working in society in competition with men. However, they were accepted in jobs as teachers or as nurses because these were seen to be extensions of the "woman's role." Nursing as an occupation was also valued by women, as a way of putting time, hopefully, until they were married.

As Canada became more settled, hospitals were set up and the larger ones opened schools of nursing. Since women had very few career opportunities, nursing was a popular choice, and many women considered themselves fortunate to have been accepted into a training school.
At this time, nursing care was aimed at cleanliness, comfort, maintenance of nutrition, and easing of symptoms for the patient. Medical care was minimal and often treatments consisted of family remedies. Very little nursing care during this period was aimed at illness prevention or health maintenance. Most care was directed at those already ill.

Since most nursing care was provided on an individual basis to patients in their homes, nurses, besides providing illness care, also did the cleaning, cooking and generally provided the extra care the family might need. They tended to live in when they were with a family and provided care on a twenty four hour basis.

During most of this period, many nurses worked as independent entrepreneurs. They were self-employed and accountable to their employers for the quality of care they provided, although the physicians might oversee some of their work. As independent practitioners, they assumed responsibility and accountability for their practice and their continued learning to keep skills up to date, even though there was minimal increase in knowledge in this period. If one were to review the criteria used to designate an occupation as a self-regulating profession, nursing at this time probably most clearly approximates the description of a true professional group.

A few nurses worked as administrators of hospitals and as such, usually assumed total responsibility for the internal management of hospitals. These administrators may have had an assistant who helped them with business and finance matters on behalf of the board, but they were definitely in control. As well as their administrative functions, they were often expected to teach the students how to provide nursing
care. Living-in, they were responsible for the twenty-four hour operation of the hospital and were often called upon to assist with direct care to provide "expert advice" to the student nurses who provided most of the nursing care. They were very attuned to the "real world" of nursing.

Because the hospitals were staffed mainly by apprentices, most trained nurses were isolated in private duty nursing and in the early 1900's this stimulated the graduates of the training programs to band together in alumni associations to support one another in whatever ways they could, including socializing and sharing clinical information. This was their form of continuing education, and ultimately protection.

It was in these groups that nurses began to talk about organizing themselves, and establishing basic standards for nursing education. They were not greatly concerned with levels of renumeration. Although nurses might ask for specific amounts for payment for their services, they often would work for little or nothing because "they were needed."

The leaders in the nursing associations were concerned that anyone could offer herself for hire as a nurse, whether she was trained or not. Although many nurses were concerned with the control of quality of nursing care, others were concerned with the competition for jobs that the untrained nurses created.

Whatever the reason, most nurses became interested in developing some form of control over non-trained nurses. It became important to nurses to have formal recognition for their training and they valued nursing registration as a way to gain this recognition. So they began to value the need to be linked together in professional associations and they began to work for effective professional organization.
B. The Depression Years

In the period from 1920 to 1940 there were few changes in women's and nurses' values and in nursing functions except that, in the depression years, it became more acceptable for women to work outside the home in order to add to family income.

However, less home nursing care was carried out because, with the depression, people were unable to afford to pay nurses and they trusted hospitals more because of the improved infection control (2). More people went to hospitals when they were ill, but, there was very little money to pay more nurses for their services. This sometimes resulted in more students being taken on or sometimes those that were there had to work harder. Some hospitals began to find students expensive and did hire a few more trained nurses for hospital work, but, not many were able to do this because of scarcity of funds.

Provincial associations had formed across Canada and were struggling to set and improve standards of basic training programs and to develop higher education programs for nurses. For the first time the associations were given control over nursing registration by the early twenties. They also began to work to develop public funding for nurses' training and thus remove it from the apprenticeship system. More nurses were unemployed and could concentrate on further education as a way of keeping up their skills while waiting for employment.

C. The War Years and After

Towards the end of this depression period, as war began in Europe, many nurses were sent to nurse soldiers in combat, others sent to organize nursing services for other countries. This left a shortage of nurses on the domestic scene. To increase this shortage, many injured
servicemen were sent home for treatment in government hospitals. The need for nurses, in Europe as well as at home, increased faster than nurses could be trained. Auxiliary nurses were introduced to help overcome this shortage. The impact of introducing practical and other auxiliaries was that registered nurses began to practice in a different way. Besides being a bedside nurse, the R.N. was now expected to guide and supervise another category of nurse.

Doctors were also in short supply at home. Nurses began to take over procedures which had previously been performed only by doctors. As well, the development of new medical technologies, new drugs, such as the sulphonamides, meant that more severely ill patients survived and required to be nursed through intensive illnesses as they had not before. The increased duties of nursing more patients who were intensively ill, and taking on more medical functions, increased the nursing shortage.

In 1943, the Heagarty Committee, set up by the federal government, (69) proposed that Canada should adopt a National Health Insurance Scheme. Although it took thirty years for all the programs in the scheme to be introduced, it was made clear in the National Health Survey of 1943 (29) that 90,292 more hospital beds were built and gradually as the National Health Scheme was implemented (33), the demand for nurses increased.

Despite the increase in the numbers and size of hospitals and changes in their technological activities, nursing organization structures in hospitals did not change at this time. Clinical models of advancement were not introduced as specialties began to develop. Post-basic specialty courses did allow nurses horizontal mobility but upward career mobility still consisted of moving into administration or
education. However, nurses acquired increased geographic mobility once they had taken a course. To summarize, during the 1940's to 1960's, nursing functions in Canada changed drastically. From giving simple tender loving care as their only function, nurses were required to engage in other tasks. First, many became involved in highly complex and technical diagnostic and therapeutic procedures. They also moved away from spending time with patients as another category of employees began to assist them on the wards. The second major change was the finalization of the move away from individualized home nursing care to institutionalized care for groups of patients. There was a great demand for increased numbers of registered nurses to take on these new functions.

Nurses still saw themselves as dedicated to serving others but they also began to be aware that they were important to the health care system. They began to realize that more education was required and should be paid for the society which wanted their services and that they should be paid more appropriately for their work. Whilst the older forms of recognition were still valued, new rewards began to be appreciated, namely, 'reasonable' monetary renumeration, higher status in supervision of others who took over some of their tasks and pleasure in learning new techniques and working more closely with other professionals.

Whilst the professional groups still emphasized educational objectives and nursing standards as their principal concern, they were beginning to become interested in collective bargaining. In 1946, for example, the RNABC set itself up as the bargaining body for its members.

The role of women changed drastically during this period. Women were in the labour force and expected to be. They now did many jobs that
previously had only been done by men. Educational and career opportunities expanded. The expectation that women who married should quit work, and stay in the home faded. Women began to be more involved with public life at every level. The status of women was still below that of men, but the gap was less wide than it had been.

D. The Last Two Decades

The 1960's and 1970's were characterized by a major social revolution in Canada. The prosperity after the war, the explosions in knowledge and technology, the increasing educational opportunities and the demands of minority groups for their rights all combined to create this revolution. The Women's Movement stimulated discussions of women's roles in society and because of the Women's Movement, all sectors of society have attempted to begin to move towards greater equality of the sexes. Women have gained status and if nothing else, are no longer taken for granted as automatically belonging in the "homemaker role."

Educational opportunities are now more open to women who are attending university in greater numbers than ever before, because of the social value now attached to being a university graduate.

In Canada 98% of nurses are female, so nurses have been able to echo women's general goals within their own profession. As well, nurses have become more assertive and vocal. Gradually they began to see nursing education and training as an expectation rather than a privilege and were no longer willing to pay for this with service.

Nurses have begun to set great value on university education. It is a way to increase social mobility and to meet young men. It provides opportunities of moving out of nursing into other occupations. Nurses have become unwilling to work in restrictive, authoritarian institutions and they have begun to value recognition of their knowledge and skills.
Nursing administrators gained strength in this time period. More and more they are beginning to be seen as institutional administrators with nursing backgrounds becoming involved in top administrative decisions. This is not yet the norm throughout the industry, but the precedents have been set and it may now be necessary for more nurses in senior positions to prove that they are capable of taking broader responsibilities.

During the seventies, several changes in health care delivery have intensified specialization in nursing. A few of these significant trends are:

1) more patients are being treated on an outpatient or day care basis. Those patients that are admitted to hospital are more seriously ill than they have been in the past.

2) There is increasing specialization resulting from expanding knowledge and technology, radical intrusion into the human body and treatments which have been developed for severe trauma.

3) Shifts in the population structure with more emphasis on the elderly and the ramifications of the aging process.

E. Development of Clinical Specialty Units

Nurses began to value (and to be valued for) technological abilities rather than basic bedside nursing care. The specialty areas evolved gradually in hospitals as new information and technology developed. As new machines came into use, places were found for them to be set up in hospitals and nurses were trained to operate them. These areas gradually became recognized as "special care areas" or "intensive care areas" where the sickest patients were gathered for concentrated nursing care.
The equipment and personnel in these specialty areas were expensive to fund. The technological advances might not have come so quickly had not governments first taken over payment of capital and operating costs of hospitals and then salaries of physicians.

The 1957 Hospital Insurance Scheme and the 1966 Medicare programs (33) provided funding for doctors to spend more for "esoteric" areas of health care. Since the patient no longer had to "foot the bill" for these expensive services, "nothing was spared" to provide patients with life-saving care. Physicians with regular payments being received from governments, had to "donate" less free care to indigent patients and could afford more time for explore new techniques.

The Nursing Administrators' Association of British Columbia presented a position paper on budget restraints to the Ministry of Health in November, 1979. (86) Although this paper was mainly concerned with financing, the group described the changed function of nursing.

The level of sophistication of patient care in health care facilities continues to rise. This level of sophistication and increased technology, as well as the continuing "transfer of medical functions" to nursing, increases the workload and demands on nursing.

Physician specialists in most communities are demanding more and more highly sophisticated diagnostic and treatment procedures which require increased costs in equipment and supplies, and highly skilled nursing personnel. The nursing role has also expanded in the areas of patient and family teaching with increased emphasis on ambulatory care and health promotion. Also as well as more sophisticated patient care, the handling and care of expensive diagnostic and treatment equipment must be taught, i.e. circular-electric beds, endoscopes, respirators, monitors.

Today the function of nursing is extremely complex. Few patients today have the nursing needs as simple as those provided by nurses prior to 1950. Even the patients on the general wards have numerous needs that are complex and those in special care areas may need two or more highly
knowledgeable and skilled nurses around the clock to care for their needs.

Specialized units are increasing in numbers and size. A Ministry of Education Sub-Committee on Nursing Education, Kermacks' (1979) (73) reported that:

an examination of the positions in which R.N.s are employed indicated that approximately 30% of those positions require preparation beyond the diploma level. Most of these positions would require a preparation at least at the baccalaureate level because they demand a broader scope of nursing knowledge and a range of complex skills (teaching, counselling, administration, consultative and research) not provided in diploma programs.

The Statistic Canada data indicated that at least twenty percent of the full time equivalent positions for graduate and registered nurses in hospitals are in specialized areas. Few nurses have or can obtain this preparation.

TABLE 2

Number of Full-Time Equivalent Graduate Nurses Employed in Specialized Units in B.C. Hospitals and as Proportion of Total Employed Graduate Nurses, 1976

<table>
<thead>
<tr>
<th>Specialized Units</th>
<th>Full-Time Equivalents</th>
<th>Percentage of Total F.T.E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive Care</td>
<td>367.0</td>
<td>4.4%</td>
</tr>
<tr>
<td>Labour and Delivery</td>
<td>187.7</td>
<td>2.2%</td>
</tr>
<tr>
<td>Operating Room including PAR</td>
<td>810.0</td>
<td>9.7%</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>275.6</td>
<td>3.3%</td>
</tr>
<tr>
<td>Total Employed</td>
<td>8,389.5</td>
<td>19.6%</td>
</tr>
</tbody>
</table>

1 Other specialized units in medical - surgical, psychiatric, nursery and other areas could not be identified from data.

2 Full-Time Equivalent - graduate or registered nurses - One F.T.E. is based on 1,950 hours worked per year (37.5/wk/52 weeks/yr).
Nurses today value different rewards. Conditions of work and salaries are now far more important to nurses. As well, the age of technology has affected nurses. Understanding machines -- their operations and effects -- has become very important to nurses. Those nurses who work in special care areas have a higher status among nurses and physicians than do other nurses, although it is not because of extra monetary rewards.

One can look at the reward system to attempt one explanation of the phenomenon. Physicians have more power, make more money, are more independent in functioning than nurses. Nurses seeking to gain some status with the higher status physician group can do so more easily through understanding the technology (machines) than in any other way.

The Age of Specialization is highly organized in the physician group. Many physicians do not understand the intricacies of the technology in the special care areas. They usually refer their patients to physicians specialized in these areas, who are minimal in numbers and considered the elite of the profession. Those who assist these specialized physicians are the nurses who work in these areas. The nurses are not rewarded for the tender loving care they give the patients in special care units, but, rather for their ability to understand and operate the technological equipment and thus support the specialist physician. In developing a partnership with specialist physicians these nurses gain recognition and respect that is not evident in other nursing areas. Thus, status is increased in the eyes of physicians generally and particularly with the specialist physicians. Clinical specialty nurses are able to work in a much more independent manner and have more social power than non-technical nurses who are not educators or administrators.
The rewards are greater for these nurses as their self worth is enhanced on the job.

There are some concerns in the profession about whether nurses' proper functions are to nurse patients or to nurse machines. As well, to some older nurses, the "younger" nurses do not seem to be as dedicated to nursing. This is suggested, for example, when these nurses are said to "leave right on time." This may be a way in which the older nurses describe change in nursing which they find difficult to accept or more correctly, is at odds with their values. In today's society, leisure or non-work time is highly valued. To most nurses, nursing is only one role among their many varied roles.

F. Unionization

It took over thirty years for many nurses to accept the idea of building a strong union for bargaining purposes because of the strong "vocational" ethic which Nightingale had built into the idea of nursing. In British Columbia, around the mid-seventies many nurses would not admit that they belonged to a union. They did admit to having a professional labour organization. The idea of professionalism for many nurses was not in harmony with the concept of unions and therefore, unionism was denied.

However, the Labour Relations Division of the RNABC has recently become very strong. In a strike vote, taken by nurses in over eighty hospitals in the province, in 1979, over 90% of the nurses voted to strike. This is a major change in values by nurses in the province within the last few years.

Union activity is evolving in another direction. Baumgart (8) suggests that collective bargaining is beginning to and should, become a
vehicle for advancing professional concerns of nurses as well as socio-economic interests. Nurses, as professionals, have a responsibility to safeguard human lives. To accomplish this, the quality of services has to be assured. Where the responsibilities of employment and professional standards are in conflict, nurses have a right and a duty to point out the conflict. To negotiate disputes of this nature, collective bargaining can be the instrument which should be used by nursing. In fact, nurses can be the agency nurses use to promote their professional values.

G. Implications of Changing Attitudes

The United States is in the midst of a major nursing staffing problem. In a study done by the University of Texas at Austin (1980), prompted by the acute shortage of nurses in Texas, it was found that undesirable working conditions were the major cause for widespread shortage (8). The reasons cited by nurses for job dissatisfaction included lack of support by hospital and nursing administration, lack of autonomy, inflexibility of working hours, being "pulled" from a familiar unit to work on short staffed units, need for child care, conflict with family schedules, frequent overtime with no additional compensation, limited help in keeping up professional skills, indifferent or inadequate personnel and low salaries.

Texas nurses are refusing to work for hospitals full time because hospitals decide the number of hours, shifts and days which the nurses will work. An alternative has been provided for the nurses by nurse staffing companies. A nurse can sign up to work with a company and she will then be able to decide how many hours, what shifts and what days she wishes to work. Nurses have flocked to these companies. Hospitals are
in dire straits and are being forced to offer the nurses remaining on staff many concessions to retain them.

The aspirations of individual nurses in the profession are a challenge to the previous elite groups of educators and administrators. Are these new-style nurses necessarily those who know the most about and give the best personal care or, rather, those who play a handmaiden role in promoting the technological aspects of caring for the patients? Has this implications for the future nursing structures and reward systems in Canada? Are nurses going to continue to seek individual solutions or contract solutions for their employment conditions?

It is important now to consider whether the nurse manpower planners have recognized and addressed themselves to these changes. The next chapter will explore national and local nurse manpower planning efforts.
PART IV

HOW CAN THE PLANNING PROCESS BE MADE MORE EFFECTIVE?
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A. From Sectoral Educational Concerns to Comprehensive Manpower Planning Activities

The present confused situation in educational planning was outlined at the beginning of this paper and the reasons for the confusions have been explored, at least to some extent, through considering first the issues in nursing education and second, the development of nursing functions and their relationships to nurses' changing roles in society.

The shortage of nurses, now having become a political problem the administrators in government have, as their first step, gone back to the nursing manpower planners to try to justify the need and determine the scope of the problem, provide the means of rationalizing nursing preparation and the use of nursing skills. But who are the manpower planners?

Alford, in Health Care Politics, (1) has suggested that there are three groups of planners involved in hospital planning in New York -- the entrepreneurs, the corporate planners and advocacy planners. This way of dividing planning interests provides a helpful indication of how sectoral planning approaches in nursing in Canada may be viewed. In manpower planning in Canada and British Columbia we can identify:

1) the "entrepreneurs" who were at first the trained nurses who set up in private practice from the earliest days until approximately 1940. Thereafter, this group disappeared. They, or their successors, became employees and began to be represented by the professional association speaking on their behalf. Although the nurses are no longer self-employed, the association still represents the nurses' interest.
Because of the heavy 'vocational' overload, these representatives of nurses concerned themselves with discussions about education and training more often than about rewards in the period up to the mid seventies. Now that nurses have become unionized, and are beginning to push more strongly for improved economic standards, the relations between professional (standards) and union (economic) activities has become a real issue for the associations to manage.

2) the corporate planners who have been consortia of employers, institutional interest groups or government sponsored groups in Canada and in British Columbia. The activities of corporate planners have been sporadic and ad hoc until very recently. For example, the shortage of nurses in World War II, led the federal government in 1946, to set up the "Joint Commission of Nursing" (30) with representation from the Canadian Hospital Council, Canadian Mental Health Association, Department of National Health and Welfare and the Department of Veterans' Affairs to consider the acute shortage of hospital personnel.

Much of the planning by institutional interest groups or employers' representatives has continued, as was shown in the narrative above, but it has not been very effective since the principal loyalty of committee members has been to their sponsoring organizations and not to the ad hoc planning groups.

Corporate planning was given a major boost by the federal government deciding to fund health services. In 1948, the provincial governments had to produce hospital plans before they could tap the national health grant funds and at about this time they also reviewed their public health and mental health programs and developed plans. But at that time there were no strong administrators who were employed by the
provincial governments (available to implement plans) except in Saskatchewan, and outside consultants' plans tended to be pushed aside by provincial politicians who had different objectives than the visiting planners.

The National Health Grant Program (1948) provided for hospital construction grants which greatly expanded the number of hospital beds. This in turn, created great problems in raising enough funds to keep these hospitals operating. The Hospital Insurance and Diagnostic Services Act (1957) further increased access to health care for Canadians and utilization of hospitals continued to rise. The passage of the Medical Care Act (1966) continued government's involvement in funding health care. Before this act could be implemented, costs had risen alarmingly and the governments became concerned. The Task Force on the Costs of Health Care in Canada (32) was established in 1969. This committee made recommendations which can be summarized as:

1) change the federal-provincial funding system to close the open-ended "funding of health care" system.

2) try to move away from treating so many persons in hospitals by closing beds and moving towards more outpatient care.

3) investigate other methods of organizing health care systems.

The main difficulty with government planning is that the delivery of services is usually delegated to groups authorized by legislation and funded by government to provide services - groups which are only indirectly controlled.

Judge (1978) (71) was distinguished between financial and service rationing. Governments can only control the legislation and funding of direct services, although they have been trying to find ways of making
the indirect service deliverers more accountable. However, the service deliverers have been resistant to these controls.

Consequently, the Task Force recommendations were very threatening. Obviously, the first two recommendations had special implications for nursing and they were strongly supported by allied health professionals.

The medical establishment and hospitals resisted both of these recommendations as it would mean a major change in a structure with which they were comfortable.

Alford (1) states:

Groups are usually reluctant to yield rights and privileges that they have exercised, and will resist significant restructuring unless it appears that there is something in it for them.

Closing hospital beds was not conducive to the status of the hospitals, nor to the practice potential of the physicians, who had become used to treating their patients in the now-sophisticated hospital environment.

The third recommendation led to other activities. The federal government called two Health Manpower Conferences in 1969 and 1971 (23) (24). Following this, federal-provincial manpower committees were set up in 1972 and gradually, inventories of health personnel and their distribution were built up.

As well, the government began to look at ways of utilizing current health care manpower more effectively, nursing manpower included. Physicians wished to remain the primary contact with their patients and work on a fee-for-service basis. Ambulatory care was not attractive since the physicians have had fairly ready access to more convenient
hospital beds. The Community Health Centres Concept is at odds with concepts of physician control over the work situation. Although some of the physicians seemed to support the recommendations of the Boudreau Report to develop nurse practitioners, in general the medical profession has strongly resisted this concept and after demonstrations had succeeded, no more was done to develop the position except in the far north.

3) advocacy groups are groups of consumers who come together because of specific concerns. They attempt to utilize public support to cause changes. In the health care system in British Columbia the Social Planning and Review Committee performs this role but it has not been interested in nursing problems. Professional interest groups may also seek public support for their concerns. The nurses from the Vancouver General Hospital in 1978, played this role. They successfully used public support to gain changes at the Vancouver General Hospital.

Generally though, the public is asked to support so many different causes and issues that the role of advocates in planning is effective usually only in "crisis" types of situations. On an ongoing long term planning basis they have little effect in British Columbia.

B. Nursing Manpower Planning in British Columbia

In British Columbia, manpower planning began in 1949 with studies by Hamilton and Elliot (65) (18). The government did not implement these studies immediately because it did not have a strong civil service to follow through and political decisions were incremental decisions rather than planned decisions.

In 1959 - 60, Dr. J. McCreary, Dean of Medicine, managed to find resources to finance the Metropolitan Hospital Planning Council and two
epidemiologists working out of the Department of Health Care and Epidemiology prepared reports on hospital utilization. It was hoped that the Minister of Hospital Insurance would pick up this activity (after it had shown itself to be useful), and provide funding to carry on with it, but there was no help forthcoming and the Council went out of existence. The government moved more effectively into health care planning in 1966 when the Regional Districts Act was passed together with a Regional Hospital Districts Act to control hospital facility planning.

In 1966, Dr. McCreary persuaded the Honourable Judy LaMarsh, Federal Minister of Health of the necessity to set aside some funding for the development of health manpower training facilities. British Columbia was slow to pick up its share of the money. The provincial government showed a great reluctance to get into planning so voluntary planning bodies continued to act. In 1968, the RNABC joined the British Columbia Medical Association, the British Columbia Pharmacy Association and the British Columbia Dental Association to form the Council on Health Resources and Manpower. Subsequently, the RNABC supported a study by Williamson called the "Nursing Manpower Study in the Province of British Columbia" (126). The goal was to attempt to identify what nursing manpower was available. The other disciplines were studying their profession's manpower availability at the same time. The name of the council was subsequently changed to the British Columbia Health Resources Council. It was closely related to the Department of Health Care and Epidemiology and later to the Division of Health Services Research and Development at UBC which was headed by Dr. D.O. Anderson. (The Division of Health Services Research and Development is the site of the current Health Manpower Research Unit.) Although not in any way
effective in introducing changes, the council had made people aware of the issues.

Dr. Anderson continued to research health manpower issues on research grant funding from the federal government, and established the Health Manpower Research Unit (HMRU) in the Division. When the federal government became involved in health manpower planning in 1972 (following the two national conferences in 1969 and 1971), they involved the provincial government as well. The Federal government formed four continuing committees, one of which was the Federal/Provincial Health Manpower Committee, to advise the Council of Ministers, and Conference of Deputy Ministers of Health for Canada.

Dr. Anderson was asked to represent the province on the Federal/Provincial Health Manpower Committee.

When the NDP government came into power in 1973, they set up the BCMC which was meant to do teaching hospital facility planning primarily, but it got involved in sorting out the students' practicum placements and therefore into manpower planning.

The Division of Health Services Research and Development under Dr. D.O. Anderson, then became involved with the BCMC in a formal way. First the Provincial Council, responsible for advising the Ministries of Health and Education on facilities and programs for health manpower production, was established under the legislation which created BCMC. Second, the Health Manpower Working Group, consisting of senior officials in the Ministries of Health and Education, was created to advise the Ministers on health manpower requirements for the provincial health care system.

Each of these bodies has a special research and development unit. The Provincial Council was supported by the Division of Educational
Planning reporting to the Council through an Educational Committee of Deans and Academic Directors. The Health Manpower Working Group was supported by the HMRU at UBC. These two units, dealing respectively with production and requirements were linked by cross appointments. The Director of Health Research and Development played an official role; its director Dr. D.O. Anderson, was secretary to the Health Manpower Working Group, the representative of health officials on the Education Committee of the BCMC, and the provincial representative to the Federal/Provincial Health Manpower Committee (3). Thus the director became the corporate planner for the manpower section.

The Division of Health Services Research and Development was given the responsibility to study and model nursing manpower requirements of all types of nurses, taking into account population needs, nursing functions and categories, positions available, vacancies, unemployment rates and labour force participation. The goal was to advise on location and size of new schools of nursing (3).

Meanwhile the RNABC had published a report in 1973 entitled "Registered Nurse Manpower in British Columbia" (110). This was in response to public concern in 1970 and 1971 that there was an oversupply of nurses resulting in unemployment for nurses. In the summer of 1972 and 1973 the press again were concerned with the supply of nurses and this time, there was a shortage.

This reports states in summary:

The data presented identify current needs in relation to the present health care system and as such should provide a starting point for manpower planning to meet future needs as the system begins to change.
The problems identified by this examination of the registered nurse manpower situation in B.C. emphasize the need for further study in the context of total health manpower and total health care for the people of the province.

This recommendation from the RNABC had not yet been carried out.

The RNABC became involved in provincial manpower planning through the BCMC. The past president of the association, Margaret Neylan, became an employee of BCMC. The association was asked to send a representative to the first planning meeting and other nurses sat on planning committees for specialty areas.

But in 1975 the government changed, BCMC was dissolved and the manpower planning process was considerably diminished in scope. The nursing study was not completed although some information was useful later on to determine school of nursing locations.

The Director of Health Services Research and Development Division of UBC resigned and the unit took some time to be reorganized.

The concern with shortages of nursing personnel continued.

The Kermacks Report (73) states:

As was discussed earlier, the demand for R.N.s is increasing. Cycles of very short supply and then adequate supply seem to characterize this work force. Indications are that the province is now moving toward another short supply period. Two cycles have occurred since 1970. These findings definitely indicate the need for serious manpower planning as registered nurses represent a large portion of the health care workers. Their absence creates a crisis in health care. The number of nurses prepared for administrative, teaching and specialized clinical positions presents an even greater problem. The lack of qualified nurses for these positions has been a persistent concern of nurses and employers for years. An immediate and defined course of action is required.
Shortages of nurses have obviously affected the health care system. The effect is most obvious during the summer months when full time nursing staff are taking vacations and when many nurses tend to transfer to other positions. For the past several summers, beds have had to be closed in hospitals in B.C. This has been most noticeable on the Lower Mainland.

The current 1980 situation in B.C. is that there is concentration at this time on nursing requirements and supplies. This concern is with quantity but also with quality of nurses needed and available.

Many groups have made their concerns known to the Ministry of Health through reports, briefs and meetings.

Experience in the current summer has only supported these concerns as hospitals throughout the province have closed beds for the summer or until they have sufficient nursing staff to re-open these areas. Some areas have not closed beds but have encouraged their medical staff to admit only urgent cases as they are "working short", which means they are stretching their nursing staff to dangerous limits. Vancouver General Hospital, the major tertiary care referral hospital in the province, closed 200 patient care beds from June 1 to September 15, 1980. As well, special areas have reduced some of their services. The heart surgery unit has reduced beds and some of the O.R.s are not open for the summer.

Dr. M. Petreman, President of the BCMA, in the association's brief to the Hall Commission, March 11, 1980 stated: that the BCMA is aware of inadequate hospital funding with its resultant deterioration of care. He maintained that whenever hospital budgets get 'clamped on' there is an immediate cut-back on nurses. He claimed there is inadequate remuneration for nurses in B.C. and a shortage of nurses is developing.
In the same brief the BCMA also recommended a review of current nursing training and continuing education programs; reasonable working conditions and compensation for nurses.

These notifications of problems with manpower supply of nurses are useful to help identify and focus on the problem. They are not useful to help solve the problem because objective data is not provided in the submission.

It has not yet been identified how many nurses with what expertise, knowledge and skills are needed where in the province.

Not only has this current need not been identified, but predictors for future needs are only beginning. Since considerable time is required to plan and provide nursing education programs, current trends may be indicative of future crisis.

Recent development in manpower planning have occurred on three fronts. The Social Credit government, concerned with cost saving, initiated a study on physician manpower which was carried out by the Hon. W. Black (former Minister of Health), recommending cut-backs in training of physicians. The Minister of Universities, Science and Communication, the Hon. Dr. P. McGeer, is extremely interested in developing technology. As Minister of Education before the Ministry was divided (See Appendix B), he recommended increasing the size of the medical school at UBC to provide more physicians. In the last few years, the Ministry of Education has become increasingly involved in health manpower development. The Ministry of Education, through Dr. Sheilah Thompson, coordinator of the Division of Health and Human Service Programs, has begun to sort out the nursing care system, by identifying the various levels of nurses and the competencies which these levels must
have. Major concentration to this point in the definition of competencies has been on nursing aides and practical nurses, although as mentioned previously, funding is now being sought to work on post-basic clinical specialty courses for registered nurses.

The post-basic specialty courses have become an issue because of demands by entrepreneurial groups that something be done to solve problems in this area and the HMRU for the Health Manpower Working Group has been delegated the task of sorting out nursing manpower issues related to clinical specialties. The group has begun two major activities. The first is the Health Manpower Vacancy Monitoring Project (13). This project is being undertaken by the BCHA and the HMRU. A monthly survey is conducted which collects data on the difficult-to-fill positions. These are positions which have been vacant for thirty days or more. The purpose of this survey is to identify the shortfall on a monthly basis of R.N.s and other occupational groups in acute care settings. This is a beginning attempt to determine what current demands are for registered nurses and others.

The second activity is being carried out by the HMRU for the Manpower Working Group. It is a project to review the post-basic nursing problems in the province (123). A Steering Committee has been set up and a preliminary questionnaire designed to ascertain the numbers of R.N.'s providing special care services in acute care hospitals is in the process of tabulation.

C. Ineffective Cooperation Between Sectoral Groups in British Columbia

Alford (1) has argued that the ideologies of the sectoral interest groups in New York Hospital Planning were so much in conflict that the planning which went on was "dynamics without change." It seems that in
B.C., interest groups were prepared to get together from time to time to pursue common objectives. But planning of nursing manpower in British Columbia has never really evolved to satisfactory levels. On the one hand models for nursing manpower planning have not been clearly identified, or if identified, not clearly shown to fit the circumstances of British Columbia. In nursing manpower there has not been a clear identification of the need for numbers and levels of nurses required for British Columbia. Part of the problem is the lack of standards for the various levels of nurse and the various employment areas.

Another reason why nursing manpower planning is not highly developed in British Columbia may have been the lack of commitment by the government to utilize the data generated, possibly because those concerned have not seen where best to.

It has been pointed out to the provincial government in many briefs over several years that this province only graduates forty per cent of the nurses registered in British Columbia because it is an intake province, but no one has determined what the requirements actually are. As well, nurses with post-basic clinical expertise have been identified as scarce in this province.

Very little has been done to date about either situation. It may not be politically expedient to promote nursing manpower planning in British Columbia or the funding may not be available to utilize the data. The educational bodies involved have not sorted out who should be providing either education or training or when, how and where this should be provided. These groups are part of the corporate government group but have not been properly incorporated into the planning activities. Nor has a coordinated approach been developed either in long term planning or
in those involved in the planning. Plans, to now, have not been developed, over a period of time in an orderly way. Rather there have been "starts and stops" or ad hoc plans developed, often in isolation from what has gone before or in relation to future needs.

Interested groups remain uncoordinated. There are still many groups, entrepreneurial, corporate and advocacy, trying to solve the nursing manpower planning program in their own ways or from their own interest bases, but up to now they have been ineffective.

D. Possible Reasons for Ineffective Planning

Marmor (83) in the "Politics of Medicare", suggests another model for planning. He suggests that timing is important and at a specific time, one of three decision making methods may be most appropriate. He describes the three methods as Rational Inputs, Bureaucratic Adjustments and Negotiation Adjustments. Rational Inputs are obvious - as pointed out above, there is a lack of models, standards, clear objectives in nurse manpower planning. Rational planning implies identification of goals and purposes, because decisions regarding which actions should be undertaken are related to the optimal means in reaching those goals and purposes. Are the purposes and goals of entrepreneurs, corporate and advocate groups the same for nursing manpower planning? Have they ever been clearly identified by any or all of the groups? Can they be and should they be the same? Can some goals and purposes be the same and yet others differ? Will short term and long term goals of various groups differ? Further involved in rational planning is a characteristic model of description, explanation, prediction and evaluation. Are these areas in which all three interest groups can agree on these activities so that nursing manpower planning can proceed?
Before rational planning can develop basic facts and data must be available. Are these data available now? Can the Rational Inputs, Bureaucratic Adjustments and Negotiation Adjustments groups cooperate in developing this data base? Do they want to develop a similar or the same data base?

The concern with adequate numbers and qualities of nurses is a North American problem at this time. An article in the American Journal of Nursing, March 1979 (5), states loudly and clearly that there is a serious shortage of both quantity and quality of nurses. It further states that enrolments in schools of nursing is declining. The article lists four distinct problem areas:

1) there is a geographic maldistribution of nurses
2) expanding health care operations have created a need for registered nurses with additional education
3) certain positions remain unfilled (those in which there have always been less than desirable working conditions)
4) the number of voluntarily inactive nurses is high.

These same problems are present in the British Columbia nursing scene.

These are negative statements. Positive models are less frequently discussed but one which has had considerable currency is the pyramidal model considered by the WHO/ICS/MCU (128) group as the right model.

In Britain and in Australia, a rational plan for delivery of nursing care has been developed. It involves the use of equivalents of practical nurses for a great deal of nursing care delivery. In Canada, nurses have not accepted this delegation role and have not been forced to do so because the government funds hospitals by global budgets and does not
determine what level of nurse the hospital must hire. Further, the government has not had a rational plan for its introduction. Do the "entrepreneurs" - the professional association planners - understand and accept the implications of asking for a rational plan?

Since all three groups have a different interest base, do any of these groups really want rational planning? The "entrepreneurs" have been trying to initiate or develop a manpower plan for years. If there were a surplus of nurses would they still be committed to rational planning? Would a rational plan remove flexibility of the profession's development?

The bureaucratic planning model is concerned with the present situation over which any planning group has control and ways of moving incrementally towards change whilst making the best use of its existing departments or sectors. The bureaucratic planners have to consider what implications a rational plan would have in nurse manpower planning. Shortages in nursing, particularly clinical specialty prepared nurses exists. If the bureaucratic planners were to develop a rational plan adjusted to fit existing institutions would they have to commit the resources and/or would they be able to, to implement the plan? The corporate planners involved in nurse manpower planning are at a disadvantage because no one group has attained the power to provide an overview of the situation and to pursue it.

The Ministry of Health, through the Health Manpower Working Group can identify service needs for nurses, but the Ministry of Education may have different priorities for spending the budget for educating nurses for these services. The Ministry of Health controls the manpower deployment in operating institutions only through the budget and use of
consultancy advice. Therefore, the Health Ministry is limited in its ability to pursue manpower planning and implement recommendations.

The Ministry of Education, through various educational institutions, whose roles in nursing education have not yet been clarified, may identify and plan for educational needs for nurses but if these do not meet the priorities of the Ministry of Health approval will not be given.

Circles run in circles. The confusion which exists today results in large part because of the vested interests of these corporate planners and the lack of an overall coordinating mechanism which has the power to force them to plan together. The negotiations adjustments model is concerned with seeking bargained solutions between parties with power to plan. The bureaucratic planning model in B.C. seems to be almost more of a negotiations adjustment model, for the corporate planners have developed mechanisms within their groups for negotiation and discussion. An example is the Health Manpower Working Group which has representation from the Ministry of Education and the Ministry of Labour. Members of this group have worked reasonably well together to try to solve nursing manpower problems. By contrast, in the Education Ministry, approval for funding of programs is through the Academic Council, which is not part of the civil service, reports only to the Minister of Education and is not represented on the Health Manpower Working Group (although there is some attempt at cross referencing discussion since the chairman of the Health Manpower Working Group attends the Education Health Committee of the Academic Council). But the Health Manpower Working Group can not be sure that its recommendations will be carried out by that Ministry.

The effectiveness of this inter-Ministry group is questionable overall because its members do not have control of the institutional or
professional resources and have not set up a formal negotiation system with the "entrepreneurial" (professional association) groups.

Marmor (83) says that this model develops from the position and power of the principals and focuses on the understandings and misunderstandings which determine the outcome of the games.

In planning for nursing manpower, which group has the greatest power? Since advocacy groups are not active in supporting nursing manpower, they have only potential power at this time.

The "entrepreneurs" - the professional association - have attempted to identify the needs and to lobby for nursing manpower planning since 1973, but up to now have not been very effective. However, this group has been successful in raising consciousness about the issue and in focusing the current interest on post-basic clinical specialty courses. Apart from their general concern about raising the general educational standards of their members, professional organizations, have in the past, tended to react to external pressures. As a result, they have planned on a short term basis for immediate crisis needs. Therefore the overall directions in which they see nursing progressing have not clearly been determined. To develop a plan for nursing manpower, the interest of all levels and groups of nurses must be considered, which is difficult to do if the current crisis relates to only one area of nursing (the R.N.'s). The vested interests, then of the professional association, being focused on crises, have less force in nursing manpower planning. This group does gain strength in the short term because it can concentrate its energies in a bounded area of concern, but its long term self interests may be compromised.

The government corporate planning group, sometimes working with employers' organizations (or HMRU), is the most powerful group since it
controls the funding and the approval mechanisms. But government interest has not, until recently, focused on nursing manpower. This government corporate planning group is made up of at least two separate provincial ministries, each of which has interests other than nursing manpower planning. This group has never been sure that it wanted to grasp manpower planning until recently and there are still many discussion within the ranks. The Health Manpower Working Group has not been unduly concerned with nursing manpower until 1980 and therefore its resources have not been focused in this area.

Since corporate planning in B.C. must be concerned with bargaining with the "entrepreneurs" what mechanisms have been set up to facilitate this activity for manpower planning? Have they been effective mechanisms?

There has not been a formal mechanism set between the professions and the corporate planners to deal with nursing manpower. The RNABC meets with the Minister of Health on a regular basis, but to discuss all concerns related to nursing not just the manpower planning issue; however through this mechanism the association has been able to bring the manpower issue forward as a concern. The RNABC is now represented on several planning groups, but tends to act as a consultant about needs and standards rather than as a policy setter because it does not control resources. The RNABC is the agency which keeps the register of nurses, thus it has available some of the information about the supply of nurses which it willingly contributes.

Because the RNABC has decided that standard setting is its responsibility (approval of programs for continuing education), and this seems to be accepted by corporate planners, it has a subtle power to shape the
planning, and to determine its effectiveness or ineffectiveness. In 1980, the UBC Health Manpower Research Unit was delegated the task of nursing manpower planning for post-basic nursing. A steering committee for this group has been set up. The RNABC has appointed two members to this steering committee. This group provides a mechanism for formal discussion among different planning interests but is just beginning its task.

The negotiation adjustments between the groups is in its infancy. Although the corporate planners should be able to lead negotiations, it has been hampered because of its internal competing interests.

To be effective, these groups must be aware of their relative powers, and become politically astute re their bargaining bases. They must also recognize each other as actors in this activity and set up formal mechanisms, with decision making powers, to begin progress in manpower planning.
PART V

TOWARDS MORE EFFECTIVE PLANNING
Marmor's thesis (83) is that at certain times one type of plan is more effective than another.

1) When is the appropriate time, if any, for rational decision making to occur in nurse manpower planning activities?
2) Can bureaucratic planning be improved?
3) What is likely to be the future of negotiated planning?

A. Rational Planning

Should nursing manpower planning continue without discussion and decisions related to rational planning?

The customary way of making change in democratic societies is by incrementalism. This may be shapeless and incoherent unless the policy makers can draw upon a plan. Donnison (56) has argued that it is helpful for policy makers to know of a standing rational plan. That plan may change or be implemented in a different manner once the practical application is begun but that can only happen if there is a basis of understanding. In applying this to nursing manpower planning, a rational plan should be the foundation for any decisions on trade offs.

If such a plan were developed it should be the starting point to solve the confusions and disorganization in nursing manpower planning.

Various models have been used in the past to predict nursing needs. (79) (See Appendix E) The measure of their lack of success can be seen in the current arguments about whether or not there is a shortage of nursing personnel. Although theoretically, many of these models have
indicated that there should not be a shortage, in practice, Directors of Nursing who are not able to recruit nurses indicate that there is a severe shortage.

Nursing manpower planning has been going on in the province, but the results of this work have not been definitive enough to facilitate action.

No clear picture of current or future supply has been identified for general or special clinical areas. This can be related to the fact that specific definitions of levels of hospitals and health care are not yet established. Nevertheless there are some commonly accepted specialty areas where work could begin. Presently there is no clear picture of current demand or predicted demand for nurses. The hard-to-fill positions survey is an attempt to try to determine what the current nursing needs are in general nursing areas as well as in special clinical areas.

The provincial government provides operating costs for hospitals in the province. It should be possible to identify the number of full time equivalent positions the province is currently supporting. This could then be broken down by nurses employed in general nursing areas and those employed in special clinical areas. In Canada, the average percentage of nurses needing education for special clinical areas is 20%. The British Columbia average is currently unknown.

Standards of competency for nurses working in special care areas have not been determined. Perhaps nurses could be provided for the lower level special care areas more easily by means other than post-basic courses, were these standards set. The demand for specialty clinically educated nurses might then be clearer.
The provincial government has developed a Bed Matrix Model for the province. (62) This identifies the beds which are to be in operation and the types of services which are to be offered for 1981 and 1986 by provincial hospitals. These data could provide a basis for estimates of current and future demand for nurses. To date these data have not been used in nurse manpower planning.

The current supply of general duty and special clinical nurses is unknown. If evaluations of competencies were to occur this would provide a beginning base.

The following information was taken from the Kermacks' Report (73). The majority of nurses are women. Only 1.6% of the registered nurses employed in 1978 were men. The majority of nurses are between the ages of 25 to 34 years. Most nurses are married. Only 36.3% of the R.N.s are single. Most married R.N.s are employed on a part time basis particularly between the ages of 30 and 39. The highest percentage of full time employees are single, between the ages of 20 to 24 and 55 to 64. A total of 76.7% of all R.N.s are employed on a full time basis.

Characteristics of nurses should be considered when discussing supply and integrated in the planning information. The social characteristics of nurses have an impact on how, why, and where they remain in the nursing work force or why they might be leaving nursing. By reviewing these characteristics, specific factors can be identified which should be considered in manpower planning, particularly in identifying supplies of nurses.

The new graduates provided by the education system are a part of supply information. The nursing schools have a certain number of "places" for entry of students. Should this number be increased to make
up for the high attrition rate (30 to 40%) of nursing students, so that schools designed to provide 100 graduates for the system are able to do so? Is it necessary to increase the "spaces" or merely to oversubscribe?

Can this province continue to count on others to provide "up to 60%" of our nursing manpower? The schools of nursing should be included in discussions on supply of nursing manpower.

The preparation of nurses to work in specialty clinical units is one area that has lacked concrete attention. The Ministry of Health has not officially recognized the need for inclusion of post-basic nursing courses as a part of publicly funded education. This is partly because the specialty and sub-specialty care units, where these nurses work, have not yet been clearly identified. This will be difficult to determine until the roles of hospitals, and the level of activity to be provided in each, is clearly defined.

The government, in allocating funds to hospitals, has neglected to consider the orientation and inservice costs for nurses in hospitals. Nurses in special care units have often not had sufficient on-the-job training and orientation to perform effectively the competencies required of them in special care units. As a result, there is not at the present time a pool of knowledgeable and well qualified nurses available to work in these areas, nor is there money available to prepare new nurses in this way for their responsibilities. Even if money were available for this activity, it may not be the most desirable method of preparing nurses. Standards would vary greatly from one hospital to another and cost effectiveness could be questioned.

One other area of funding is currently lacking. Support of nurses to attend post-basic courses and costs of replacing staff while they are
at courses has not yet been sorted out. This is an important question which needs to be addressed before planning for post-basic courses can proceed.

B. **Bureaucratic Planning**

A number of problems in bureaucratic nurse manpower planning in British Columbia were identified. The first is that of commitment to planning, the second jurisdictional boundaries and failures to resolve the difficulties associated with these.

C. **Negotiation Planning**

Whilst government involvement in nurse manpower planning in British Columbia can be criticized for its ineffectiveness, it can be applauded for its openness in negotiating with other interest groups. However, these negotiations tend to be ineffective, because of the current planning models and also because of the different values that nursing administrators, nursing educators and practitioners have. In the past, educators were most powerful because they had the most education, time to think, time to develop support networks and the status given them by the nurses themselves. Nursing administrators have begun to overtake that power, as they are now becoming more educated and are much closer to the real world of nursing and the dispensation of dollars to provide nursing care. Practitioners have had least, if any, power because of their submissive employee status, but today they have begun to realize that they have a great deal more power, simply by withholding their work. It is important to ask if these three groups involved in the negotiations have thought about or identified where the power lies or what their power base is. If so, have they clearly identified this rather than working on assumptions which may have derived from traditional stereotyping?
D. Conclusions

The failure of nurse manpower planning in British Columbia can be attributed to lack of a rational basis against which to measure performance, bureaucratic ineptness, and failures in negotiation.

Although nursing is regarded as an important activity in health care, nursing in British Columbia has not been considered carefully enough. International models for nurse manpower planning may be quite inappropriate for planning here.

Stereotyped characteristics of nurses are commonly described in writings about nursing manpower planning. Rarely do authors come to grips with what effects changing characteristics of the occupational group actually have on nursing manpower, because it is not easy to do so.

What does it mean to nursing manpower planning in British Columbia that nursing is almost totally a woman's profession? What effect does most nurses being married have? What do the ages of nurses mean? It is important to know about part time and full time employees but what does this mean if we are trying to plan for nurses' manpower here?

One of the concerns of nursing, described earlier in this paper, is the different interpretation or definition of nursing made by nursing educators and nursing service people. The educators are seen to identify and teach nursing according to one set of standards. The nursing administrators and practitioners seem to say "that's not how it is." Does the same type of situation exist in manpower planning?

The practitioners provide the majority of nursing manpower. Have we examined the basic value system of practitioners? Since most practitioners are women, and married, they often have competing roles of wives and mothers. Have we looked at commitments of practitioners to
these varying roles? Have we asked them what they want and what they are prepared to give in nursing? Have they been able to communicate effectively enough with the planners? Have we understood and been able to utilize this information in manpower planning? Would it be valuable? These questions remain to be answered.

The practising nurse, in the past has had little, if any formal power except to work or not to work — she could vote with her feet but not make herself heard. Do the changing values and roles of the nurses who actually provide the care now begin to matter as they increase their formal power with the development of unions which no longer pull their punches for 'vocational' reasons?

In the past the nursing practitioner has negotiated directly with the hospital Directors of Nursing about available jobs and her willingness to fill them. She has made it clear that what she wants is not a pyramidal structure of power with promotion upwards and delegation downwards. She wants to be a primary care nurse in charge of her own patients with the potential for horizontal movement within the same hospital or within the locality (or if her husband moves she wants to be able to pick up a job in the local hospital in the new location). She wants to know she is competent to do this work. If she feels uncomfortable she will move out into some other sphere. Directors know this. Do health planners?

E. Recommendations

It is recommended that:

A model of rational planning, that considers the current situation of nurses in British Columbia, be identified for nurse manpower planning.
a. A rational plan for nurse manpower planning in British Columbia be developed and implemented. This plan should include attention to post-basic clinical specialty courses.

b. The bureaucratic negotiation process for nursing manpower in British Columbia be sorted out and all involved parties be made aware.

c. The negotiating process involved in nursing manpower planning be continued, but all parties be aware that with increasing union involvement this process will become more fierce.
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APPENDIX A

POST-BASIC NURSING PROGRAMS

Table A: Post-Basic Nursing Programs Based in Education Institutions

Table B: Post-Basic Nursing Programs Based in Health Care Facilities

Table C: Proposals for New Post-Basic Nursing Programs

Source: Kermacks, Claire; A Report to the Health Education Advisory Council: Nursing Education Study; Ministry of Education, Science and Technology, Province of British Columbia, Vancouver, April, 1979.
**TABLE A: POST-BASIC NURSING PROGRAMS BASED IN EDUCATION INSTITUTIONS**

**REPORT FOR BRITISH COLUMBIA, 1979**

<table>
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<tr>
<th>NAME &amp; DESCRIPTION</th>
<th>LOCATION</th>
<th>LENGTH</th>
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<td>Advanced Nursing Care of Hospitalized Child</td>
<td>VCC</td>
<td>14 wks</td>
<td>Jan</td>
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<td>&amp; 4 wks full-time Clinical Practice</td>
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<td></td>
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<td>R 1</td>
<td>12</td>
<td>acute care experience satis. clin. evaluation</td>
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<td>6 mos.</td>
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<td>Diploma in Psychiatric Nursing</td>
<td>BCIT</td>
<td>34 wks</td>
<td>Jan pend</td>
<td>Priority B.C.</td>
<td>$505.00</td>
<td>BCIT</td>
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<td>Program specially designed for R.N.s</td>
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<td>34 wks</td>
<td>R 2</td>
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<td>Includes practicum in acute and long term psych., Mental Retardation and Psychogeriatrics</td>
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Remarks: Graduates eligible for registration as psychiatric nurse (RPNABC)
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<td>Critical Care Nursing Level I</td>
<td>VCC</td>
<td>6 wks</td>
<td>R 3-15</td>
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<td>Recent satis. VCC</td>
<td>or clinical evaluation. UBC</td>
<td>$250.00 VCC</td>
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<td>Lower</td>
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<td>OR Nursing to prepare beginning level R.N.s for OR's</td>
<td>BCIT (B'by)</td>
<td>10 wks</td>
<td>F.T.</td>
<td>R 3-12</td>
<td>Recent Clin. BCIT</td>
<td>exp. Intent to work in B.C. Satis med. exam</td>
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<td>Health Care</td>
<td>BCIT</td>
<td>3 yrs p/t</td>
<td>R 2 appr no restrictions</td>
<td>BCIT in co-operation with BCHA</td>
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<td>Sept 5</td>
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<td>to develop &amp; improve skills, of department heads, supervisors, head nurses, assist. head nurses in hosp. &amp; other health care facilities</td>
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<td>R 2 appr. priority</td>
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<td>Ed Cent.</td>
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<td>3 hr/wk</td>
<td>15 to B.C. residents</td>
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<td>course designed for nurses &amp; other health workers wanting to prepare for supervisory positions. Includes theory &amp; practice on fundamentals of supervision</td>
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<td>Enterostomal Therapy</td>
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<td>8 wks</td>
<td>R 5 3-4</td>
<td>f.t. 4</td>
<td>1 yr exp. &amp; confirm of f.t. job on completion</td>
<td>SPH</td>
<td>approx $1000</td>
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<td>to prepare R.N.s to function as enterostomal therapists</td>
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<td>R 2 6</td>
<td>f.t. Sept Mar</td>
<td>1 yr nursing exp</td>
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<td>to provide knowledge &amp; skills so that optimum nursing care can be given to patients before, during and after surg. intervention</td>
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<td>Radiotherapy Technology for Nurses</td>
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<td>Remarks: Program lead to eligibility to sit national exams for Canadian Assoc. of Medical Radiology Technologists</td>
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<td>Industrial First Aid Certificate</td>
<td>St. John's</td>
<td>10 wks</td>
<td>R 2</td>
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<td>Remarks: a week full time for A &amp; A Ticket Holders only</td>
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<td>4 wks</td>
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<td>Remarks: a week full time for A &amp; A Ticket Holders only</td>
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<tr>
<td>Industrial First Aid</td>
<td>ABC</td>
<td>2 wks</td>
<td>R 2</td>
<td>20 yrs</td>
<td>WCB</td>
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<td>self-funding</td>
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<td>Theory &amp; practice in emergency care</td>
<td>Indus-</td>
<td>f.t.</td>
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<td>of age</td>
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<td>Remarks: on completion of program students eligible to sit WCB exams R.N.s eligible for B ticket.</td>
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<td>equipment &amp; CPR</td>
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<td>Remarks: on completion of program students eligible to sit WCB exams R.N.s eligible for B ticket.</td>
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<td>Remarks: on completion of program students eligible to sit WCB exams R.N.s eligible for B ticket.</td>
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<td>Remarks: on completion of program students eligible to sit WCB exams R.N.s eligible for B ticket.</td>
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<td>Remarks: on completion of program students eligible to sit WCB exams R.N.s eligible for B ticket.</td>
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<td>Remarks: on completion of program students eligible to sit WCB exams R.N.s eligible for B ticket.</td>
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<tr>
<td>Critical Care Nursing Level II</td>
<td>VCC &amp; UBC</td>
<td>3 mos.</td>
<td>2 6</td>
<td>Critical Care Course I or equiv.</td>
<td>VCC or UBC</td>
<td>VCC</td>
<td>Min. of First Course Ed./UBC Sept/80 or Jan/81</td>
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<td>advanced knowledge &amp; skills common to specialized Critical Care areas with courses in specific specialized fields, e.g. cardiac, spinal injury, emergency, etc.</td>
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<tr>
<td>Obs. Nursing Level I</td>
<td>VCC Van. Distance Educ.</td>
<td>20 wks p.t. + 6-8 wks f.t.</td>
<td>1 16</td>
<td></td>
<td>VCC</td>
<td>VCC</td>
<td>Min. Of Ed.</td>
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<td>Normal mother &amp; newborn with emphasis on intrapartum period</td>
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Remarks: First course Sept/80
Two courses at one time - one local - one distance
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<tr>
<th>NAME &amp; DESCRIPTION</th>
<th>LOCATION</th>
<th>LENGTH</th>
<th>PROGRAM INTAKES</th>
<th>SOURCE OF PROG. OPERATING</th>
<th>STUDENT FINANCIAL SUPPORT AVAILABLE</th>
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<td>Level II</td>
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<td>as</td>
<td>1 16</td>
<td>Obs Nrsng Level I</td>
<td>VCC</td>
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<td>high risk mother &amp; newborn with emphasis on intrapartum period</td>
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<td>or equiv.</td>
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<tr>
<td>Psychiatric Nursing</td>
<td>BCIT</td>
<td>p.t.</td>
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<tr>
<td>Infection Control</td>
<td>UBC</td>
<td>p.t.</td>
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<tr>
<td>Certificate Program in Gerontology</td>
<td>UBC</td>
<td>½-1 yr</td>
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<td>Occupational Health Nrsng.</td>
<td>DC Ed.</td>
<td>12 mos.</td>
<td>1 20-25</td>
<td>R.N.'s working in occup.</td>
<td>DC</td>
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<td></td>
<td>Centre</td>
<td>p.t.</td>
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<td>health</td>
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<td>New West</td>
<td>6 parts</td>
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<td></td>
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<td>of 10 wks</td>
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<td>Emergency Nursing</td>
<td>DC Ed.</td>
<td>16 wks</td>
<td>15-1st course</td>
<td>2 yrs exp.</td>
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<td>Centre</td>
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<td>30 there- after</td>
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APPENDIX B

PROCESS FOR COURSE APPROVAL AND FUNDING IN THE PROVINCE OF BRITISH COLUMBIA, 1980
APPENDIX B

PROCESS FOR COURSE APPROVAL AND FUNDING
IN THE PROVINCE OF BRITISH COLUMBIA, 1980

To begin to understand this process, it is important generally to know the organizational structures of the Ministry of Education and the Ministry of Health as they relate to the approval process and to know specific functions of bodies within the ministries.

THE MINISTRY OF EDUCATION

The Ministry of Education is headed by a Minister of Education. Reporting to him are three deputy ministers one of whom is the Assistant Deputy of Post-Secondary Education. The post-secondary department has three divisions: programs services, continuing education and management services. Each provides support services for the councils in addition to performing in specific areas outlined.

The program services division participates in the development of new programs for colleges and institutions. It implements research into subject areas in which new needs have been perceived and if a program appears desirable, proceeds to curriculum design. It also regulates procedures by which institutions develop programs, monitors their effectiveness through regular reviews of the need of both students and employers, and initiates a five-year review of each institution. The programs services division supplies selected support service to the Academic and Occupational Training Councils. The programs services division, again, is divided into three areas of responsibility. The Academic/Technical Directory is the division which deals with nursing programs. This division has appointed a Coordinator of Health and Human Services Programs who is currently Dr. S. Thompson.
One other important group in the Education Ministry relevant to the approval system is the Councils Advisory to the Ministry. These councils are three in number. The one of concern to post-basic nursing education is called the Academic Council.

At the post-secondary level, the governing boards of institutions have complete management authority. Provincial councils have been delegated responsibility for recommending levels of support to government and allocating financial resources.

The councils are funnels through which the financing requests of the institutions flow into the Ministry and to the government, which bear the ultimate financial and legislative responsibility.

These bodies are the Universities' Council of British Columbia, the Academic Council, the Occupational Training Council and the Management Advisory Council.

The intent of this system is to free all post-secondary education institutions from direct government control while at the same time providing the tools to enable everyone concerned with post-secondary education to meet two imperatives.

The first is the provision of knowledge and skills to the people of the province to enable them to live enriched and useful lives and earn satisfactory compensation for their contribution to society.

The second is to accomplish this ideal at a cost that is reasonable in relation to the total revenue available to the government and, at the same time, acceptable to the taxpayers of the province.

The appointment of members of the councils and members of the boards of provincial institutes is the prerogative of the Lieutenant-Governor in Council, while the appointment of the members of the governing bodies
of colleges is the prerogative of the Minister and involved school districts. This ensures citizen involvement in educational decision making.

The practice is to appoint lay people with managerial experience and a strong sense of fiscal responsibility, who have attained success in their own particular fields, and who have a broad interest in, and dedication to, education and career training.

In 1963, a new Universities Act established the Advisory Board to make recommendations to the government on the allocation of public monies among the universities and an Academic Board to advise on academic matters.

In 1974, the functions of the two boards were combined into a single intermediary body, the Universities Council of British Columbia. This recognized the need for an even stronger voice between the government's policy-making and directional roles and the three public but independently-operated universities. A body with clear legislative authority was required, one that could have the confidence of the government yet be close enough to the universities to distinguish between their needs and the needs of the province as a whole.

It could also serve to eliminate unnecessary duplication of services among institutions in close physical proximity, and coordinate their activities on matters of common concern.

Similar reasoning was instrumental in the decision of the government in 1977 to set up three additional councils to liaise with the Ministry and the individual colleges and provincial institutes which complete the post-secondary spectrum.

The Universities Council of British Columbia consists of 11 members who are appointed by the provincial government and employs a full time
director and staff.

The Universities Council reviews the budget proposals and other requests for funds from the three universities, examines their financial requirements, and advises the government on the total amount of money they need.

The Council distributes all operating funds from the provincial governments to the individual universities. The Universities Council also reviews the Academic Council recommendations regarding requests for money from colleges and provincial institutes to pay for programs for which the Academic Council is responsible.

Demands for capital funds are assessed by the Universities Council for the Universities and recommendations are made to the Ministry.

The Universities Council also examines plans for academic development, and approves the establishment of new faculties and degree programs. It may require the universities to consult with each other to avoid unnecessary duplication of faculties and programs and can establish procedures to evaluate university departments, faculties and programs.

The Universities Council and the Academic Council work together on questions of program articulation and course equivalencies between programs.

The Academic Council consists of five members appointed by the provincial government.

The council is responsible for coordination and funding of academic transfer programs offered by the colleges, technological programs offered by BCIT and various other career programs at colleges and institutes.
The programs related to the humanities, social and natural sciences. Included are career programs in the managerial, administrative, secretarial, clerical, health, applied arts, electronics, aviation technology and such service related areas as criminology, police training and administration, fire fighting and legal assistance.

The Academic Council required institutions to provide it with proposed budgets for the designated programs. It makes recommendations to the universities Council and the Ministry concerning those requests and allocates funds provided to it by government amongst the various institutions.

The Council also establishes Academic Advisory Committees to assist the Council and Ministry in developing program content and standards. It depends upon articulation committees to provide advice on the equivalency of courses given at one institution compared with another.

The Council may require institutes to accept equivalency decisions, and may recommend to universities' senates that they be accepted by the universities. The resulting interchangeability of program credits is designed to facilitate movement of students from college to college and from college to university.

The Academic Council has a subcommittee called the Technical Advisory Committee. Members of this committee are appointed and they are specialists in a given field. The Education Health Advisory Committee reports to the Technical Advisory Committee.

When discussing this process, it is important to note that a change has occurred in the education field in British Columbia. The B.C. Government News, Volume 24, Number 9, December 1979 reported that
Premier Bill Bennett announced major cabinet changes on November 23, 1979. Among these were a division in the Ministry of Education into two ministries.

The Ministry of Education was to have responsibility for public schools from kindergarten to Grade 12, colleges, vocational schools, the B.C. Institute of Technology, and the Open Learning Institute.

The newly created Ministry of Universities, Science and Communications was to have responsibility for the administration of the University's Act and the promotion of science and technology within the province.

In discussions about the funding process with Sheilah Thompson, Co-Ordinator of Health and Human Services Programs, Ministry of Education in March, 1980, she indicated that jurisdictional matters between the two ministries were still being worked on and evolving. For that reason, very little information is provided about the Ministry of Universities, Science and Communication.
MINISTRY OF EDUCATION STRUCTURES AS IT RELATES TO FUNDING OF ADDITIONAL COURSES

MINISTRY OF EDUCATION

Minister of Education

Deputy Minister of Education

K-12

Post-Secondary

Assistant Deputy Minister Post-Secondary

Management Services Division

Research and Development Director

Program Services Division

Technical/Trades Director

Continuing Education Division

Academic/Technical Director

Continuing Education Division

Academic Council

Occupational Training Council

Management Advisory Council

Councils Advisory to the Minister

Dr. Sheilah Thompson
Coordinator of Health and Human Services Programs
Ministry of Education
March, 1980
THE MINISTRY OF HEALTH

The Minister of Health is responsible for the work of the Ministry of Health. A deputy minister reports to the Minister of Health and is responsible for seven divisions of the Ministry. One of these divisions is the Planning and Development Group. The Health Manpower Working Group is an intra-ministerial committee of the Ministry which is chaired by the Executive Director of Planning and Development and reports to the Deputy Minister of Health.

HEALTH MANPOWER WORKING GROUP

Terms of Reference

1. To recommend and advise on appropriate policy regarding the growth, development and control of health manpower in the Province.

2. To establish priority areas for health manpower research in the Province and arrange for this research to be conducted.

3. To advise the Deputy Minister on appropriate action regarding the results of research conducted in the area of health manpower.

4. To address or respond to specific manpower concerns, consulting with expert committees, professional associations, the Ministries of Labour and Education, and other agencies or Ministries as necessary.

5. To receive reports addressing specific concerns and take action where necessary or advise the Deputy Minister on appropriate action with regard to these concerns.

6. To act as liaison with other Ministries and to discuss with and recommend action through the Deputy Minister on matters of inter-Ministerial concern regarding health manpower.

7. Through the chairman and/or his appointees, to provide representation on behalf of the Provincial Ministry of Health to
federal/provincial, inter-provincial and intra-provincial committees concerned with health manpower, advising the Ministry of Health on matters of concern and appropriate action.

8. To review proposed health manpower legislation for its implications regarding the distribution, control and supply of health manpower stock and advise the Deputy Minister of any concerns.

9. To advise other Ministries, outside agencies, licensing bodies, and associations of existing policies regarding health manpower.

10. To be aware of, and where necessary assess, proposed health care programs for implications for health manpower and where necessary, advise the Ministry of Health of these implications.

11. To review proposals regarding the establishment of new types of health care workers and advise on policy with regard to the employment of these new types of personnel.
MINISTRY OF HEALTH

MINISTER OF HEALTH

Hon. K.R. Mair

Deputy Minister

Dr. C. Key

Executive Director

Director

Health

Promotion and Information

L. Chazottes

Senior Administrator

Professional and Institutional Services

C. Buckley

Senior Administrator

Community Health Services

Dr. G.W. Bonham

Senior Administrator

Support Services

J. Bainbridge

Chairman

Forensic Services

Chairman

Alcohol and Drug Services Commission

Dr. F. Tucker C.B. Hoskins

Chairman

Community Health Services

Dr. H. Richards

Source:
Clair Buckley
February, 1980
THE APPROVAL PROCESS OF ADDITIONAL NURSING PROGRAMS

The sponsoring institutions determines the need and feasibility for a nursing course. The proposing department follows whatever internal procedures are appropriate for that institution. Once the sponsoring institution has accepted the proposal, it initiates the procedure for approval of government funding.

First, a letter of intent is sent to the Director of Program Services Division. Information required in a letter of intent is spelled out in the statements of operating policy. From here, if it is deemed reasonable by the Director of Program Services Division, it is sent to the Academic/Technical Director who delegates it to the Health and Human Services Programs Coordinator for preliminary investigation.

The proposal is assessed at this point for duplication and need. Need is determined by reference to health Manpower Working Group which will determine whether or not there is a need for this program in the health care system. The HMWG will utilize the resources of the Health Manpower Research Unit to legitimate the need for this proposal.

If there is a need for this program and it is not already being presented, the proposing institution is notified and a detailed proposal is then prepared by the institution.

The process then begins again with the detailed proposal sent to the Director of Program Services who delegates review of proposal to the Director of Academic/Technical Programs. Nursing proposals are automatically referred to the Coordinator of Health and Human Services Programs who thoroughly investigates the proposal. At this point, the procedure has been adopted that the proposal is automatically referred to the RNABC, RPNABC Continuing Education Approval Committee. If the
committee gives it approval, a report is submitted by the Coordinator of Health and Human Services Programs to the Director of Program Services. The Director submits the proposal and accompanying report to a Monthly Program Services Review Committee. Consideration of financial needs are reviewed in this committee. When this committee approves the proposal, their recommendations is sent to the Academic Council.

The Academic Council is responsible for allocating resources if it approves the proposal. If financial commitments are approved by the council, the institution is notified and planning can continue for implementation of the proposed program.

This is a very complex and time consuming process. Moreover, the approval process does not have stated criteria for determining priorities for any one proposal over any other. As a result, decisions approving funding for courses are not based on rational planning but in the end are political decisions.

Lack of rationality of this process is evident at several points, because, up to this point, priorities for programs in nursing have not been determined, policies have not been set by the Minister of Education for allocation of education dollars to health care and within that to nursing programs. The Academic Council members are responsible only to the Minister and therefore they do not have to answer to the public or any particular sector, if it is politically loud enough, could affect the decision in the Ministry of Education, Ministry of Health or at the Academic Council.
APPENDIX C

NURSING ADMINISTRATORS' REACTION PAPER TO NURSING EDUCATION (1979) STUDY REPORT (KERMACKS' REPORT)

RECOMMENDATIONS PERTINENT TO CONTINUING EDUCATION

SOURCE: Kermacks, Claire; A Report to the Health Education Advisory Council Nursing Education Study; Ministry of Education, Science and Technology, Province of British Columbia, Vancouver, April, 1979.
APPENDIX C

RECOMMENDATIONS PERTINENT TO CONTINUING EDUCATION

RECOMMENDATION 32

That highest priority in nursing education be given to the development of post-basic clinical courses.

We strongly support this recommendation, as the need for nurses adequately prepared to work in specialty areas is acute in this province. We sincerely hope that the funding will be consistent and immediately available, and that the courses will be accessible to nurses in outlying regions.

RECOMMENDATION 33

That developmental work commence immediately on post-basic clinical courses for registered nurses in:
- critical care (intensive and coronary care)
- emergency and trauma care
- long term care (including extended care and gerontology)
- obstetrical care (particularly during labour and intensive care for newborns)
- operating room and post-anesthetic recovery room care
- psychiatric care

Our association heartily endorses this recommendation.

RECOMMENDATION 34

That innovative approaches be taken in the development of post-basic courses based on the following principles, that courses be:
- developed on validated competencies required in the work setting
- made more accessible on a province wide basis
- designed to meet a variety of learner needs in various geographic areas
- evaluated through a built-in evaluation process.

We heartily endorse this recommendation.

RECOMMENDATION 35

That the Ministry of Education award contracts to interested educational institutions for the development of post-basic courses; and that coordination and consultative services be available through the Ministry.

We support this recommendation.
RECOMMENDATION 36

That employer and employee groups given serious consideration to the development of career streams in clinical fields so that the career progression for clinical nurses is possible without having to shift administration or education.

We agree with this recommendation in principle as a method of rewarding clinically competent nurses at the bedside instead of promoting them away from the bedside.

Studies need to be carried out regarding the financial implications, labor relations implications and impact on health team relationships.

RECOMMENDATION 37

The Joint Ministerial Health Manpower Planning between the Ministries of Health and Education be examined; and that consideration be given to a single organizational structure involving policy makers and planners who will identify the supply and requirements, project future supply and requirements, and effect a balance between supply and requirements.

Our Association endorses this recommendation.

RECOMMENDATION 38 and 39

That the Ministry of Health (and Human Resources where indicated) identify the kind of health care workers required and areas of special need and priority for manpower planning with input from employer groups, unions, professional/licensing bodies, consumers, etc.

That the Ministry of Education identify needs for Health Education programs based on manpower planning and coordinate development, implementation, and evaluation of programs through cooperative planning with educational institutions and organizations, professional/licensing bodies, consumers, etc.

We endorse these recommendations but put emphasis on input from all groups affected.
APPENDIX D

ACTIVITIES IN THE 70'S IN BRITISH COLUMBIA TO SUPPORT CONTINUING EDUCATION FOR NURSES
In 1973, the RNABC published a "Proposed Plan for the Orderly Development of Nursing Education in British Columbia, Part III: Continuing Nursing Education." This document provides a comprehensive review of the problems involved and the resources available. It identifies a plan for continuing education in B.C. within the context of the total nursing education system and recommends several actions which provided leadership for development in continuing nursing education. This document clearly identifies that the "professional association (RNABC) assumes primary and overall responsibility for planning to meet the educational needs of nurses." It goes on to indicate that others, as the post-secondary educational institutions, health care agencies, appropriate government agencies and the individual nurses should be involved in the planning. It specifically states that appropriate government agencies should provide supportive services plus direct financial support for the development of continuing nursing education.

This plan states that "implementation of continuing nursing education is largely the business of the educational institutions in cooperation with appropriate sponsoring group."

"The professional nurse must be willing to invest time, effort and money in continuing education activities."

Shortly before this document was published, the government of the province changed from Social Credit to NDP. This had a major impact on the role of the RNABC in continuing education. The NDP government within a matter of days of taking office, through an Order in Council, appointed Dr. Richard G. Foulkes as a special consultant to the Ministry of
Health. His terms of reference were simply to "present recommendations which could lead to a rationalization of the Health Care Services of the province." The effects of his report "Health Security for British Columbians" were widespread on nursing through his recommendations on nursing education but more so for this recommendation of the creation of the B.C. Medical Center.

The B.C. Medical Center was formed in July, 1973 to serve for the teaching of undergraduate and post-graduate students in all professions including nursing. Foulkes indicated that multi-disciplinary task forces should be created and given specific objectives related to the programs and to provincial needs. One of these committees was an Education Committee. A sub-committee was the Continuing Education Sub-Committee. The terms of reference for this committee was appended. Essentially, the sub-committee was to recommend to the Education Committee on appropriate administration mechanisms and adequate and appropriate educational resources in continuing education at the BCMC.

The development of a formal government sponsored body responsible for organizing continuing nursing education allowed the RNABC to withdraw from the role they had assumed because no one else had.

The RNABC as an association was active in BCMC Planning for continuing education. In July it prepared a paper commenting on the principles identified by the sub-committee, the terms of reference and the membership of that committee. In essence, it reaffirmed the plan and recommendations identified in Part III of the Proposed Plan for the Orderly Development of Nursing Education in British Columbia. Standards for nursing care must be stated; manpower needs identified through evaluation; learning needs identified and met through educational
programs and programs evaluated and appropriate actions taken. It continued to see continuing education as a joint responsibility of individual, health agencies, education institutions, government and the association. It indicated that consumers should be members of the planning committee.

In October of 1974, the RNABC presented a brief to the sub-committee on Continuing Education, BCMC dealing with administrative mechanisms within the BCMC for continuing education planning. It reviewed the rational approach for identifying needs on an ongoing basis and providing appropriate continuing education programs. Evaluation at all levels was also recommended. The RNABC listed areas in nursing requiring continuing education opportunities. These included OR, Maternity, Extended Care, Psychiatric, Critical Care and Primary Nursing.

The BCMC joined with the Health Manpower Working Group to study and review the nursing education needs. This joint group was called the Advisory Committee on Nursing Manpower. In January of 1976 this group approved a number of recommendations for presentation to the BCMC Education Committee and the Health Manpower Working Group. These recommendations dealt with post-basic clinical nursing education and suggested ways of rationalizing the system. Before any actions could be taken on these recommendations, the BCMC suffered a political demise with the defeat of the NDP government. The newly elected Social Credit government discontinued the concept developed by Bill 81 of an overall planning, organizing and coordinating Medical Center for British Columbia. Planning for continuing education in the province was not ended but seriously set back.
With the change in government and a new minister of education, a number of studies were initiated which had a direct impact on nursing. These commissions were:

1. The Winegard Commission to advise the Minister of Education on providing higher education in non-metropolitan areas of the province.
2. The Goard Commission to advise the Ministers of Education and Labor on vocational, technical and trade training.
3. The Faris Commission to advise the Minister of Education on all aspects of community education.
4. The Hall Commission to enquire into the training of practical nurses and related hospital personnel.

The RNABC presented briefs to all these commissions. One point, reinforced in their briefs to the first three commissions, was the urgent need to develop a system for post-basic nursing education programs in the province.

The Winegard Commission report was delivered in September to B.C. Education Minister P.L. McGeer. This Commission developed a series of twenty-four recommendations. Addressing the overall problem of providing higher education in non-metropolitan areas, the commission report recommends that SFU became multi-campus, degree granting institution to serve the B.C. interior.

Specifically discussing nursing, the report states on page 26:

"There is no question about the demand outside of Vancouver and Victoria for degree-completion and post-basic courses in nursing. Since nursing is offered by the UBC and University of Victoria it is recommended that the universities cooperate in the delivery of necessary programs to the non-metropolitan areas. SFU can provide some Arts and Science courses needed for the training of nurses but the major load must be borne by the other two universities."
The report makes no recommendation on continuing education "since this matter is before the committee chaired by Dr. R.L. Faris." A member of the Winegard Commission, Faris was named in July to head a separate study of continuing education needs.

The Goard Commission, in its report, submitted in January, 1977, recognized the need for more clinical experience for two year nursing graduates and post-clinical courses, but there were no specific recommendations related to these concerns. It was recommended that consideration be given to providing a supporting grant to assist in the operation of upgrading programs in nursing but it was not identified in what way.

It may be important to note that the major concern of this commission was the lack of organization and coordination and overall control for planning these programs. They were concerned about the number of agencies and people that were involved before a course could proceed and the overall lack of planning.

This same situation exists with the nursing education in British Columbia. There may be some implication, from this concern of the commission, that nursing does not have special problems but is simply part of a problem that affects all of the education system of the province.

The Faris Commission Report was presented to the Minister of Education in December, 1976. The commission recommended more money for adult education and higher priority for community and continuing education.

While it recommended fiscal control of continuing education by the provincial government, the commission sought to keep control of
programming with local school districts and community college regions. Provincial input would come with more education staff and a provincial or ministerial council to provide leadership.

In assigning priorities, the commission report placed career continuing education below three other varieties it said have an impact on "functional illiteracy" in the province: basic education for adults below grade twelve levels, language programs for Canadians who have difficulty with English, and teaching citizens about their roles in public affairs. The needs in these areas were particularly stressed for the disadvantaged, the handicapped, women, the elderly and immigrants.

Professional associations should continue to be involved in career continuing education, according to the commission, but funds for this kind of educational activity should also come from the government ministries most involved. (e.g. Health)

Two separate commission recommendations called for investigation into the possibility of paid educational leaves and into funding for private organizations which provide educational programs.

Reviewing educational needs outside major B.C. population areas, the commission recommended government investigation of a provincial "open college" that might use radio and television as well as development on a priority basis of other "distance educational methods" for sparsely populated areas.

The commission recommended that institutions that provide the original entry training for the profession also be the main provider of continuing education in cooperation with the professional association and where appropriate with the community colleges. This recommendation did not help in sorting the roles of continuing education departments at the UBC and BCIT from nursing departments in community colleges.
Another activity at the provincial level was important to nursing. B.C. Education Minister P.L. McGeer established a Health Education Advisory Council in mid-September (1976) to continue some of the activities of the education committee of the now defunct BCMC.

The seven member council was to advise Dr. McGeer on education in nursing, medicine and health technologies, make recommendations on new programs, and study the requirements of all health occupations.

In November, 1977, the B.C. Ministry of Education approved a study of nursing education as proposed by the Health Education Advisory Council. The six month study was to cover the education of registered nurses, registered psychiatric nurses, licensed practical nurses, and other categories of nursing care workers. Its terms of reference were establishing with the Ministry of Health long term projections of B.C.'s nursing needs.

The nursing community was assured when the Ministry of Education released this study. The Ministry called the study "A Discussion Paper: Nursing Education Study Report." This report was initiated by the Health Education Advisory Council and funded by the Ministry of Education. The report listed forty-three recommendations dealing with nursing education. The report attempted to rationalize the system of nursing education by organizing all nursing personnel into five-part functional classification system by eliminating the category of registered psychiatric nurse, by introducing a student competency based core curriculum for basic nursing education, closing hospital schools of nursing, developing post-basic continuing education at specified educational institutions, and by providing baccalaureate level education for nurses outside the metropolitan areas, by utilizing manpower.
planning as a basis for identifying needs for educational programs and by supporting the post-basic educational needs for nursing.

The majority of the recommendations, or the concepts involved in them, can be supported in part wholly by policy statements made by the CNA or the RNABC in the last ten to fifteen years but the reaction of the professional body was generally not favorable. The RNABC News (April/May/June, 1979) page 7, describes the report as follows:

"Educational Bomb Shell" "Controversial Nursing Study Released" "It burst all over the B.C. nursing scene like a bombshell." "Heated Discussion" "The report by nursing consultant, Claire Kermacks of North Vancouver was labelled a "discussion paper" by the Ministry of Education. That is precisely what has been generated, heated discussion with little apparent middle ground between criticism and praise."

The nurses reacted mostly to the methodology, the lack of precise supporting data for the recommendations, and the seeming encroachment on the association's legislated authority over basic nursing educational programs.

The overall effect of the document was positive, not so much in what was recommended, but more because of the generated interest and discussion about the nursing educational system.

The long term effects of this document are yet to be seen:

The RNABC has contributed in other ways to continuing nursing education in the province. The RNABC Library (1969) was improved for membership use and a part time librarian was hired. The association was providing facilities for self learning rather than providing learning experiences.
Beginning in 1959, the RNABC provided yearly loans/bursaries for nurses seeking to continue their education. These monies were available for post-basic courses, certificate courses and university education. They were well utilized by the membership.

In 1979, the RNABC increased its loan fund for continuing education to $100,000.00. A non-profit society, the Registered Nurses Foundation of B.C. was being set up to promote nursing education and research in the province. The loans funds have been transferred to this foundation which is expected to administer the educational loan program and funding for clinically oriented post-basic nursing programs.

The purpose of RNF is to promote the advancement and improvement of nursing care, practice and education.

A joint effort by the RPNABC and RNABC initiated a voluntary continuing nursing education approval program. The purpose of this program was fourfold. It was to provide guidelines for those developing programs, provide a mechanism for evaluation of course plans, assist participants and/or employers identify programs most likely to meet their needs and provide recognition and credibility for the programs approved and the participants in them.

This was an important move for the association. The RNABC had identified one of its roles in continuing education as providing standards and this was one way of doing so. It is also important to note the cooperation between the associations.

The Health Education Council created by Education Minister P.L. McGeer (1976) was to continue some activities of the BCMC. The coordinator of continuing education was not included. In an attempt to pick up this function a group began to plan to establish a B.C. Council
for Coordination of Continuing Education. The RNABC, RPNABC, the Licensed Practical Nurses' Association, the Pacific Medical Technicians Association and representatives of a number of educational institutions and agency inservice departments were involved as voluntary participants. They saw the goals of this council as identifying learning needs, setting priorities, allocating resources, developing a resource bank and acting to control the quality of continuing nursing education.

The committee discontinued in November, 1978, because it could find no new ways to attack basic problems. The members did decide to ask the RNABC to continue publishing its list of continuing nursing education programs, and to authorize an ad hoc committee to "maintain a watching brief" of the continuing education situation, and, convene another conference at its discretion.

In March, 1977, the RNABC published a document titled "Competencies Required and Recommended for Registration of Re-Entering Nurses." This was a comprehensive guideline for planners and sponsors of refresher courses for graduate and registered nurses and a basic standard for nurses coming back into the work force.

The RNABC Guideline for Orientation of Registered Nurses was completed in 1978.

Continuing nursing education developed a great deal in this period, although post-basic clinical programs are still not organized or funded. The RNABC, through its various activities, provided strong leadership because of the beliefs of the need for continuing education and the association's role in setting standards but most importantly because no other body was assuming this role. Because of the association, organized nurses were very powerful in determining direction for nursing continuing education in British Columbia.
APPENDIX E

THEORETICAL WAYS TO DETERMINE MANPOWER NEEDS
Theoretical Ways to Determine Manpower Needs

Levine, in an article called "Measuring Nursing Supply and Requirements: The State of the Art," indicates that various methodologies available have generally fallen in four types.

First are those that rely on comparative standards, or criteria based on existing practice. These methodologies use medians, or averages of state-nurse population ratios or ratios based on existing practice in hospitals.

Second, methodologies are in effect, that attempt to develop optimal ratios or levels for use in determining nursing requirements. These studies, while interesting have had difficulties arriving at clear cut results.

Third, models tend to identify requirements based on the supply and demand model utilized by economists. One application is the counting up of budgeted positions, which can yield a measure of demand. The problem is that the budgeted positions have to be legitimized in some fashion since the hospitals may be over-budgeted or under-budgeted to provide safe nursing care. Many times, these models identify how well off or poor an area is rather than predicting future needs of nurses.

The fourth approach embraces comparative standards. It uses demand and includes attempts to apply optimizing criteria by using the results of certain research studies that measured the relationship between nursing care and patient welfare. In the conclusion to this article, Eugene Levine says:
It must be kept in mind that determining supply and requirements for health manpower is not a scientific exercise. Even the most precise quantitative model involves a certain degree of subjective judgement and is influenced by personal values. Many scenarios can be written of the future and in the final analysis each depends on one's view of the health care system and how nursing will be utilized in it."

What methodologies have been used in the past to determine manpower needs and what are current proposals for identifying needs. In determining theoretical models to determine manpower needs, supply of personnel is usually easily measured. But the essential component to know whether or not there is a problem is to identify the requirements. Models are currently being looked at to attempt to identify this component.

The Division of Nursing, U.S. Public Health Services, attempted to develop models for identifying requirements for nursing manpower. They are described as follows in an article by Eugene Levine and are described as follows:

1) **System Dynamics Model**

   This model was developed using a set of techniques known as system dynamics. The model is concerned with changes taking place and likely to take place in nursing and in health care generally by the year 1990. It focuses on the impact those changes will have on the supply, demand and distribution of nursing personnel and services. The model produces simulations that are a sequence of calculations describing how a system of relative factors will behave over time.

2) **Vector Requirement Model**

   The purpose of this model is to assess the impact of three anticipated changes in the health care system on the requirements for nurses.
i) The introduction of national health insurance (NHI)

ii) the increased enrollment in HMO's

iii) the reformulation of nursing roles

An overview of the model is shown in the figure. Beginning with a base of 1972, projections of R.N. and L.P.N. requirements through 1985 were made using linear regression techniques.

Similar to the system dynamics model, various scenarios of the future are postulated.

**The State Planning Process**

This method consists of a procedure for arriving at decisions concerning key elements in current and future nursing resources and requirements and an integrated data base for assisting in the decision making process. The method has been developed for use at the state level. In the requirement area the process consists of the following steps:

1) differentiating the client population

2) assessing the health needs of the population

3) formulating a health strategy

4) choosing the level and mix of nursing staff

5) staffing schools of nursing

**The Micro Model**

This project is aimed at developing and testing a model that incorporates health services utilization factors affecting nursing demand and supply into a framework determining shortages or surpluses. The model contains specific institutional characteristics and is capable of predicting demand and supply for nursing manpower at country and state levels.
These models used for manpower planning are examples of some of the latest techniques utilized for manpower planning. In reviewing these models, the complexity of the problem is obvious. It will not be an easy task to determine what future nursing requirements will be in B.C.

Nursing supply is easier to identify but there are still problems related to this because of the characteristics of nurses.