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Between market and bureaucracy: public healthcare reforms in China and nurses' terms and conditions

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The public healthcare system of China has witnessed a series of reform since the 1980s, with considerable impact on the working conditions and well-being of its nursing workforce. This study examines the employment terms and conditions of clinical nurses in the public hospitals in China, using qualitative data from three case study hospitals. We explore issues relating to their employment contract, grading and work organization, remuneration and representation through an institutional perspective to highlight the role of various actors, existing or emerging, who co-shape the employment environment within the healthcare system. We also deploy hierarchy theory to identify sources of power, or the lack of it, of these institutional actors (e.g. the State, the hospital employer, the trade union, the clients and the nursing workforce) within the administrative and operational structure of hospitals to understand the relative positions of the nurses and their experience of work and employment outcomes.

Keywords: China; hospital; nurses; remuneration; representation; work organization

Introduction

Nurses are not only a major occupational group in national economy, but also a category of the workforce that has received a significant amount of research attention in the field of human resource management (HRM) and organizational psychology in many countries. A common challenge, as revealed by the growing number of studies on the management of nurses, has been the shortage of nurses, in no small part as a result of recruitment and retention problems. Poor terms and conditions (e.g. high work load, low pay and unfriendly working time) and the lack of respect from the employer and clients have often been cited as the main reasons for nurses' diminishing identification with the profession and increasing burnouts (e.g. Leurer, Donnelly and Domm 2007; de Ruyter, Kirkpatrick, Hoque, Lonsdale and Malan 2008; Baykal, Seren and Sokmen 2009; Laine, van der Heijden, Wickström, Hasselhorn and Tackenberg 2009; Rajbhandary and Basu 2010; Tourigny, Baba and Wang 2010; Bartram, Casimir, Djurkovic, Leggat and Stanton 2012). The deterioration of job quality in nursing has often been linked to the decline of public funding and national healthcare reform programmes informed by managerialism (e.g. Bach 2007b).

Compared with other major economies, few studies on the HRM of nurses in the Chinese context have found their way into publication outlets in the English language (e.g. Tourigny et al. 2010; You et al. 2012). Within China, nevertheless, numerous studies have been conducted on nurses' work and HRM issues. These can be broadly categorized into two types. One includes the more scholarly studies on the nature of work and well-being of nurses. These quantitative-oriented studies have mainly been conducted from a psychological perspective, with individual nurses as the focus of investigation on issues

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such as burnouts, job satisfaction and organizational commitment (e.g. Wu and Norman 2006; Lu, While and Barriball 2007; Yang and Mao 2007; Tao, Zhang, Hu, and Zhang 2012; Yau et al. 2012; You et al. 2012). The other category consists of a large number of studies on various aspects of HRM such as training, performance management, recruitment and retention. The majority of them, however, were practical accounts of problems and suggestions of solutions. They were mostly written by practising nurses for whom the publication of articles forms an essential criterion for promotion. Whilst these studies offer useful empirical insights, few have conceptualized how the deterioration of nurses' terms and conditions, and its related HR problems, has been underpinned by the significant institutional changes that have taken place in China as a result of waves of state-initiated healthcare reforms.

The implementation of successive public healthcare reform programmes since the 1980s in China has effectively turned public hospitals into a business on the one hand, and the patients and their families into 'clients' on the other. The marketization of the public healthcare services has given both the hospitals and their clients growing space in shaping the employment terms and condition of nurses and how they experience their work. The role of social care end-users as an emerging institutional actor in influencing the employment terms and conditions of those who provide the care services has been well observed and argued in other national contexts (e.g. Kessler and Bach 2011). But their role has hardly been included in the study of nurses from an HRM perspective.

Meanwhile, in highly regulated sector such as public healthcare, the role of the State remains central, as highlighted by Bach's (2007a) study of nurses' international migration in the British context. In the Chinese context, state intervention in HRM policies and practices at both the macro- and micro-level has also been well documented (e.g. Warner and Goodall 2010; Cooke 2011). What is less understood is how state policies and regulations on the healthcare sector may impact on the nursing workforce in different ways at the grassroots level, with particular reference to their employment terms and conditions. This is in part because hospital employers often respond to regulatory constraints and reform pressure through gaming behaviour and cost reduction strategy, which tend to have negative impacts on those with the least bargaining power in the employment relationships. As Miller (1992, p. 9) argued, 'institutions simultaneously determine the rules of the game and condition the choices of individuals under the rules'.

This study therefore fills a research gap by examining the HRM practices of hospitals within the broader institutional and organizational context and assessing what impacts they may have on clinical nurses. We do so through the case study of three large- and medium-sized state-owned hospitals in a city in southern China. We focus primarily on a number of HRM dimensions: employment contract, work organization, remuneration and representation. Specifically, our study is guided by the following research questions:

- (1) What are the employment terms and conditions of nurses in China?
- (2) To what extent the nursing labour market and the experience of work of nurses are shaped by the state policy and hospital employers' staffing strategy?
- (3) In what ways do patients and their families influence nurses' working conditions as a result of the marketization of public healthcare services?

We explore these issues through an institutional perspective to highlight the role of various actors, particularly the State, the hospital employer, the trade union and the clients, who shape the employment environment within the healthcare system. We also deploy hierarchy theory (Miller 1992) to identify sources of power, or the lack of it, of these institutional actors within the administrative and operational structure of hospitals in

China to understand the relative positions of nurses and their employment outcomes. For the purpose of this paper, we adopt Miller's (1992, p. 16) definition of hierarchy, which is seen as 'the asymmetric and incompletely defined authority of one actor to direct the activities of another within certain bounds'.

Literature review

Public healthcare reform and the changing role of institutional actors

Existing studies have shown that many national healthcare systems are grappling with the challenges of escalating healthcare costs, ageing populations, staff shortages and rising expectations from those being cared for (e.g. Townsend, Wilkinson and Bartram 2011). National governments have responded to the challenge by embarking on various programmes of healthcare system reform to 'modernize' the public health provision with the aim to improve services on the one hand, and contain costs on the other (e.g. Potter 2010). Whilst characteristics of the reform programmes vary across national settings, two key features appear common: one is the decentralization of budgets to the local authority, hospital and clinical unit level, and the other is the introduction of multiple agencies to perform various, and broadening, functions, such as quality monitoring and service delivery. A shift towards a patient-oriented care model underpins the efforts in improving service quality. Decentralization of budgets is a popular policy option as it distances the central state from the service provision by making the local healthcare providers more accountable. The responsibility for 'market shaping' is therefore placed on the local authorities and hospitals to increase their efficiency (Martin 2012).

Institutional reforms such as those encountered in the public healthcare services impact on the stakeholders in different ways, and often lead to changes in social relationships, mutual expectations amongst those who provide and receive services, and the psychological contract of the care workforce (e.g. Bach 2007b). At the policy level, the quasi-marketization of public health services poses a direct challenge to the development of a unified national public healthcare system in which hospitals are required to be responsible for both the patients and the public on the one hand, and self-financing on the other. At the operational level, hospitals are blessed with varying levels of resources across the regions, and opportunistic behaviour may emerge in the process of fulfilling demands from the upper authority. Where the healthcare service budget/cost is directly linked to individual service recipients, these end-users may play a significant role, directly and indirectly, in shaping the nature of work of the individuals who deliver the services (e.g. Kessler and Bach 2011).

Indeed, the front-line healthcare workforce is often the most affected by the reform programmes, since they are the key to improving service quality on the one hand, and are often seen by hospital management as the cost of service on the other. Research evidence suggests that healthcare reform programmes have had negative consequences on the healthcare workforce, particularly nurses. Deteriorating job quality, rising level of work intensification, stress and declining morale are amongst some of the most notable impacts (e.g. de Ruyter et al. 2008). An HR consequence of these is the acute recruitment and retention problem as experienced by many countries (e.g. de Ruyter et al. 2008; Laine et al. 2009; Forest and Kleiner 2011).

In the Chinese context, the national health system has experienced several waves of reform since the opening up of the country's economy in 1978. These reforms consist of two main aspects: reform in the medical health insurance, and reform of healthcare services through reforms of hospital structure and management. During the state-planned

economy period (1949–1978), the national health system in China provided full medical insurance to children and those who were employed by the state sector. Those who worked outside the state sector in the urban area might be entitled to partial coverage, whereas rural residents had little coverage. During the 1980s and 1990s, the state sector had undergone radical changes in its employment system, including the reform of medical insurance. The employer, the employee and the medical insurance company form a tripartite insurance scheme with various levels of coverage contingent upon the insurance premium contributed by the individual workers and their employer. In the latest reform programme that started in 2009, the government announced the embracement of a people-centred principle in order to build a harmonious society through a more inclusive and balanced economic and social development. A three-prong medical insurance system was adopted that provides different coverage for the following: employees with employment-based insurance schemes; urban residents without any employee insurance; and rural residents through a cooperative medical plan (Hsiao and Hu 2011). These health insurance schemes share one thing in common, that is, patients have to bear a proportion of the cost, and for some it is a significant proportion. For example, in 2006, individuals were bearing nearly 50% of their healthcare expenses (Wang 2009). The increase in health cost sharing by individuals engenders consumerism that is often expressed in raised expectations of services and demands.

In parallel to the medical insurance reform, public hospitals have experienced several rounds of reform that are market oriented (see The World Bank 2010, for an overview). A central element of the successive hospital reform programmes prior to the 2009 reform has been the continuous reduction of state funding on the one hand, and the retaining of administrative power by the State, including staffing decisions, on the other. According to Ramesh and Wu (2009), the government contributed nearly 50% of public hospitals' revenues in the 1980s; this was reduced to less than 10% by 2000. The arm's length relationship between the State and the hospital, despite the State being the employer and part funder of public health services, effectively forces hospitals to operate as a business in order to raise fund for infrastructure and facilities investment to attract patients and to provide competitive salary packages for staff. As Hsiao and Hu (2011, p. 117) observed, 'hospitals raced to introduce high-tech services and expensive imported drugs that have higher profit margins'. 'Instead of focusing on the quality of patient care, most hospital directors focus on setting revenue targets for each service department, which then sets revenue targets for each physician' (Hsiao and Hu 2011, p. 118). Doctors' pay is linked to the revenue they generate for the hospital. Hospitals and doctors also receive kickbacks from pharmaceutical companies for prescribing their drugs. As a result, overprescribing drugs, medical tests and treatments are common in order for individual doctors to increase their pay and hospitals their revenues. It is therefore not surprising that The Economist Intelligence Unit (2011) concluded that China's public healthcare system was gutted during the economic reforms of the 1980s and 1990s, leaving a system that essentially forced individuals to take responsibility for their own health funding requirements.

The tension between serving the interest of the patients and the self-interest of the hospital emerged following the public health reform in the 1980s. By the late 2000s, the patient–hospital relationship has perhaps reached its worst point (see Yip and Hsiao 2009; Potter 2010; He 2011; Wang, Gusmano and Cao 2011; and Lin 2012 for detailed analyses of the problems in the Chinese healthcare system and its latest reform). Outraged, patients and/or their families have increasingly taken radical actions to protest against the difficulty in obtaining adequate healthcare services and the soaring cost for receiving them. They have also developed a compensation-seeking culture and actively pursue the hospital for

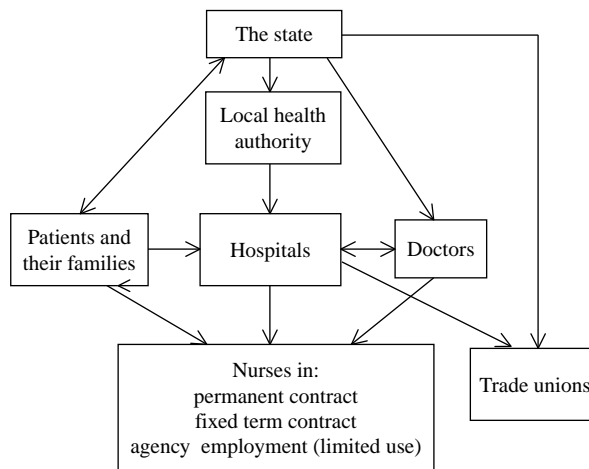
compensation when things go wrong or diverge from their expectation. In the interest of maintaining social harmony to seek greater political stability, the government exerts pressure on hospitals to settle disputes promptly by compensating the patients or their families disregarding the legitimacy of their claims. It was not until 2012 that an administrative regulation was issued by the government to illegalize protests organized by patients' families at the hospitals.

The 2009 reform programme – 'New Healthcare Reform Plan' (新医改) – is considered to be ambitious with three tenets: strong role of the government in healthcare; commitment to equity; and willingness to experiment with regulated market approaches (Yip and Hsiao 2009). The ultimate goal is to establish a strong national healthcare system in which each and every citizen is able to access affordable basic healthcare. This reform is government-led, which 'marks a major departure from the heavy reliance on the market that has been the hallmark of the financing and organization of China's healthcare system for the past two decades' (Yip and Hsiao 2009, p. 615). According to Gu (2012), China's latest healthcare reform has made significant achievement in extending the health insurance coverage – by the end of 2010, 94.7% of the population were covered by some basic form of health insurance. However, the reform has put public hospitals on a tight balancing rope between re-administration and de-administration. In other words, it is semi-state-controlled and semi-marketized (see Gu 2012 for more detail).

It is clear that a series of reform and the introduction of market mechanism have placed public hospitals and other institutional actors in China in an intricate hierarchical network (see Figure 1). Each behaves in ways to maximize their interests within their contractual relationships (loosely defined) with other actors by leveraging their power. Within this hierarchical network, the nursing workforce as an institutional actor is low down in the hierarchy and possesses the least bargaining power, as we shall discuss below.

Nursing in China

Nurses have been at the receiving end in the previous reform programmes as they are often seen as a cost by their hospital employer and treated as a punch bag by their aggrieved



—> Direction of power exercised from one actor to another

Figure 1. Power relationships between key actors within the paradigm of healthcare hierarchy.

clients (see below for further discussion). In 2008, the 'Nursing Act' was issued to deal with major problems in nursing. The Act is regarded as a milestone in the development of the nursing workforce in China. It emphasizes on nurses' rights on a number of aspects including the following: better wages, benefits and social security rights, health protection and healthcare services, improved personal development opportunities and professional development. In addition, the Act specifies the encouragement and reward for outstanding nurses (Hu, Shen and Jiang 2010). An important element of the 2009 reform programme is the espoused determination to develop and sustain cultures to retain nurses. Between 2006 and 2010, the nursing workforce had experienced a sharp increase. According to the Ministry of Health, China had a total of 2.244 million registered nurses by the end of 2011, representing a 66% increase from 2005 (cited in Wang 2012). During the same period, the educational attainment, professional skills and service methods of the nursing workforce had also improved significantly (Wang 2012). However, are these recent policy and regulatory interventions sufficient to reverse the deepening problems in nursing that have accumulated for nearly three decades? And what have been the main problems encountered by clinical nurses in China?

Like many countries, China suffers from severe nursing shortages and related HR problems, such as low level of job satisfaction, poor retention and burnouts (e.g. Lu et al. 2007; Qiao and Fang 2007; Jiang, Wang and Crawford 2008; Tao et al. 2012). Research evidence suggests that nursing shortage-related HR problems have a detrimental effect not only on workforce morale and well-being, but also on the quality of patient care. For example, You et al.'s (2012) study reported that 38% of the nurses experienced a high level of burnouts and 45% were dissatisfied with their jobs. In particular, 'working environment and resources' and 'workload and time' were identified as the two biggest stressors. Jiang et al.'s (2008) study of 202 nurses in a hospital in eastern China found that in addition to high workload, work demands from doctors and patients are major factors contributing to Chinese nurses' burnouts. Similarly, Yau et al. (2012, p. 60) argued that the job stress level amongst nurses working in China is higher than their counterparts in developed countries because of the rapid growth of the economy and 'the ever-changing healthcare environment'. According to Yau et al. (2012, p. 60), 'Chinese people articulate a high demand and expectation in seeking healthcare services in terms of the quality of care, the knowledge of healthcare professionals, and the advancement of technology'. And nurses have to 'develop new skills to serve the needs of the higher income group who demand better care' (Tourigny et al. 2010, p. 2742).

Existing research found that nurses have relatively low social status in China, despite the fact that nursing is traditionally regarded as a noble vocation and that nurses have the image of 'white clothes angels' (Tao et al. 2012). Lack of respect from the doctors, administrative staff and patients is a common feeling shared by nurses. They also reported being abused by doctors and patients/their families (e.g. Yau et al. 2012). Similar to their counterparts in developed countries, the job satisfaction level of nurses is relatively low in China. For example, Yang and Zhang's (2011) survey of 3311 nurses in 9 provinces in 2010 found that nearly 62% of the nurses admitted that they 'rarely' had a sense of achievement and 35% felt that they 'sometimes' felt a sense of achievement. The main causes of their dissatisfaction include low pay, high workload and pressure, high level of stress and poor health, and the lack of opportunity to develop and utilize their skills and competence.

Whilst existing studies of nurses in China have pointed out many similar HR problems to those found in other countries, not least the low level of job satisfaction and the high level of burnouts, few studies exist that carried out in-depth investigation on key aspects of

the employment terms and conditions to understand how these are shaped by institutional and organizational factors and by the key actors in the healthcare system. Given the markedly different role of institutional actors in employment relations and the distinct characteristics of HRM in China compared to those found in other economies, it is important that we carry out detailed studies to shed light on these matters. In other words, whilst the employment outcomes of nurses may be shared to some extent in different parts of the world, the processes through which these outcomes are reached may be unique across national contexts. It is these distinct processes that reveal the relative power of various actors in the healthcare system, which in turn determines the experience of the health services, as providers and/or as recipients. In the rest of this paper, we fill part of this research gap by examining nurses' terms and conditions in the Chinese public healthcare sector.

Research method

A case study approach was adopted for this research. Two comprehensive hospitals and one maternity hospital located in an inner city (named City A here for confidentiality) in Guangdong Province were studied. We located the study in one city in order to avoid inter-regional differences. City A was selected because it is representative of China's cities in that it is a medium-sized and declined industrial city; therefore, it is not rich and the hospitals may encounter difficulty in attracting and retaining talent. These three case study hospitals are the main hospitals in the city (see Table 1), providing some 70% of the medical services to its residents and visitors. Findings of this study therefore have implications for not only City A but also other cities of similar status in China.

Semi-structured interviews were the main method for data collection. This was supplemented by hospital documents and a limited amount of observation during site visits for fieldwork. For the purpose of this paper, the three hospitals are referred to as Hospitals A, B and C (maternity hospital). A total of 42 interviews were conducted. These included interviews with one hospital vice-president from Hospital A, director and deputy director of the nursing department of each of the three hospitals (six interviews in total) and 35 clinical nurses (15 from Hospital A, 12 from Hospital B and 8 from Hospital C). Amongst the 35 nurses interviewed, nine were head nurses of various units (4 from Hospital A, 3 from Hospital B and 2 from Hospital C). The units were selected to represent the busier and less busy units, as well as the better-resourced and less-resourced units. The nurses within these units were invited to participate in the study with a briefing document. Volunteers were then selected by taking into consideration a balanced mix of different clinical grades, age and employment contract status in the sample. Interview with the vice-president lasted 55 minutes. Interviews with the director and deputy director of the nursing

Table 1. Background information of the case study hospitals.

	<i>Hospital A</i> (<i>comprehensive</i>)	<i>Hospital B</i> (<i>comprehensive</i>)	<i>Hospital C</i> (<i>maternity</i>)
Year established	1886	1939	1952
Total no. of employees	Approx. 2200	Approx. 1350	Approx. 250
No. of beds	Approx. 2300	Approx. 1500	Approx. 200
No. of doctors	Approx. 500	Approx. 370	Approx. 60
No. nurses (including nurses working in non-clinical positions)	Approx. 1000	Approx. 740	Approx. 120

department lasted between 60 and 80 minutes each. Interviews with the head nurses lasted about 50–60 minutes each and about 30–40 minutes each with the nurses.

The interviews were conducted face-to-face by the authors and a research assistant during April and July 2012. No recording was used due to the reluctance of the informants to be voice recorded. In order to capture as much information as possible, at least two researchers (two authors or one author and one research assistant) attended each interview. Detailed notes were taken by the interviewers. Interview reports were typed up as soon as possible after the interview. An interview schedule was developed by the authors and distributed to the informants prior to the interview so that they had time to prepare, and provide answers as detailed as possible.

Interview data were manually content analysed (Miles and Huberman 1994) by the authors. Discrepancies in the understanding of the data were discussed and clarifications were sought from the informants where necessary. Common interpretations and themes were drawn from the data to construct a reality of working life for nurses in the case study hospitals.

Findings and discussions

Whilst our study has yielded rich data, for this paper, we focus on four key aspects of the HRM that have been less well explored in depth but are vital in understanding nurses' work and well-being. These include contractual arrangements, grading and work organization, remuneration and workforce representation. We analyse these thematic findings based on a framework of hierarchy within which key institutional actors in the healthcare system are positioned and function (see Figure 1). Throughout the discussion of findings, we highlight tensions between the state control and market forces that underpin the behaviour of key actors and the impact this may have on nurses' work and employment outcomes in various ways.

Background of the case study hospitals

Hospitals in China are graded by the national healthcare authority according to their size, level of medical competence and operational capacity. Hospitals A and B are Grade 3A (the highest grade) hospitals and Hospital C is Grade 2A. Hospital A is the largest hospital amongst the three (see Table 1). At the time of the fieldwork, it had a quota of 2300 beds from the local authority, but in reality 2400 beds were being used due to the high patient load. Compared with Hospital A, Hospitals B and C have a slightly higher proportion of outpatients.

Types of employment contract

Nursing jobs are full-time in China as part-time jobs are uncommon in the labour market (Cooke 2012). There are two main types of employment contracts for nurses: open-ended contract and fixed-term contract. Nurses holding an open-ended contract are permanent employees of the hospital. This was the dominant mode of employment prior to the healthcare reforms. Since the mid-late 1990s, fixed-term contract has become an increasingly popular form of employment adopted by hospitals. Nurses employed under this type of contract are usually new graduates with nursing certificate or diploma qualifications. They are given a one-year contract initially, which is renewable contingent upon their on-the-job performance and progress in their part-time continuous education to upgrade their qualifications. According to the nursing managerial informants, fixed-term

contract nurses make up an increasingly large proportion of the clinical nursing workforce. For example, in Hospital A, only about 48% of the nurses are on permanent contract. Hospitals B and C also reported a similar ratio of permanent versus temporary nurse workforce. This finding reflects the national pattern. As Qiao and Fang (2007) observed, in spite of the fact that the 11th Five-Year Plan of China (2006–2010) required hospitals to improve contract nurses' terms and condition and to reduce the proportion of contract nurses to no more than 10% of the total nurse workforce by 2010, many hospitals continue to employ contract nurses as a main staffing mechanism. Our study revealed the extent to which contract nurses are used in some hospitals.

In general, fixed-term contract nurses are less well qualified, young and inexperienced. They accept this type of employment contract in order to gain their first job and get on the career ladder. According to the nurse managers, this route offers employees career hopes so that they are more willing to withstand the hardship (i.e. demanding working conditions and studying part time). It also enables the hospitals to employ better-qualified and well-behaved nurses on a long-term basis through this screening process. As the three case study hospitals are the best hospitals within the 100-kilometre radius, they attract a large pool of less well-qualified new nurse applicants from nearby townships. These hospitals are therefore rather ruthless in dismissing contract nurses if deemed unproductive/unsuitable. At the same time, City A, being a less developed inner city, suffers from brain drain to developed cities such as Guangzhou, Shenzhen and Zhuhai (200–300 kilometres away) in the same province.

The extensive use of fixed-term contract nurses is also a mechanism to overcome the constraint of quotas of permanent nurses set by the health authority. Each hospital is given a quota of the number of doctors and nurses it can employ. Due to the rising workload and the need to create medical services to generate revenue, hospitals are increasingly relying on temporary nurses to carry out the work. As work pace intensifies (see work organization below), hospitals have the incentive to keep a young and efficient nursing workforce. There is a general consensus amongst the informants that nursing is an occupation for young people. Nursing managers interviewed revealed that nurses of 45 years old or above are encouraged to take early retirement (internal retirement) as their skills and knowledge level is relatively low and obsolete, and their work pace is also slow due to poor health after years of hard work. As the nursing director of Hospital B put it: 'Nursing is mentally and physically demanding work. We need our nursing workforce to be fit and efficient'.

Whilst discriminative practices in recruitment and dismissal/retirement as revealed above are not unusual in China (e.g. Cooke 2012), the adoption of these staffing practices nonetheless suggests that hospitals are actively pursuing a strategy that simultaneously bypasses administrative constraints as well as minimizes staffing cost at the expense of the nursing workforce. Such a strategy also exhibits itself in other aspects of HRM, as we shall see below.

Grading and work organization

There are five broad grades in the clinical nursing occupation. A nurse can get promotion in their clinical grade by passing the national exams even when they are on fixed-term contract. Permanent nurses are also expected to study part-time if they wish to gain promotion. An informant from Hospital B revealed:

I started to work as a nurse in 1991 after graduating with a nursing certificate at the age of 20. I have studied part-time on and off for 18 years to gain more qualifications until I obtained my university degree qualification in nursing two years ago. I got my promotion to the top clinical nursing grade last year. We need university degree qualification to get the promotion.

However, informants revealed that the clinical grading for nurses is largely an administrative formality. There is no work organization structure to reflect their different levels of skills, because all nurses in the same medical unit perform similar tasks (if capable of doing so) and are rewarded accordingly. The only differences that reflect the grading level are the basic wage component and bonus (see below on remuneration).

There is no detailed job description for nurses, nor would they be adhered to if one existed, as noted by Jiang et al. (2008). Work organization in the three case study hospitals appears to be simplistic, team-based and 'non-scientific', as the informants put it. All qualified nurses share the same type of work and responsibility disregarding their seniority, grades and educational qualifications. According to the nursing directors interviewed, despite its drawbacks, this egalitarian approach makes it simpler for reward distribution and allows for more flexible use of staff due to staff shortages. Front-line nurses interviewed also believed that sharing the workload without seniority differentiation engenders better team spirit as they all do the work that needs to be done. As nurses' pay is closely linked to the tasks they perform and since their wages are low, many junior nurses want to do more work and perform higher level tasks that are set with a higher rate of pay.

A major negative impact of this mode of work organization is that some junior nurses may find it difficult to cope with the amount of work and responsibility due to their lower level of competence, whereas some senior nurses may be demotivated as their experience and expertise are not valued and rewarded accordingly. From the workforce development point of view, this generalist approach to deploying and developing nurses' skills is not conducive to nursing specialization. The waste of nursing resources does not stop at this. In order to save the cost of hiring non-clinical staff, nurses have to do all sorts of work in the unit, for example receiving and taking stock of medicines and medical supplies, sending samples to laboratories (a porter's job in the UK), reception, security, clerical work and so forth. There are few nursing assistants or carers to perform personal caring tasks to release registered nurses to focus on clinical work. The relatively narrow wage differential between nurses and non-nursing staff does not incentivize hospitals to create non-clinical positions to better utilize human resources.

Work intensification due to staff shortages is a collective outcry from the nurse informants. According to the labour law, a full-time nurse should work no more than 40 hours a week (5.5 days). In reality, over two-thirds of the nurse informants reported that they have to stay behind after their official working hours to finish their tasks. They do so for two reasons: to obey the norm of not leaving one's work to others; and to receive the full amount of bonus conditional to the completion of daily work tasks. Head nurses also reported that they often help out their nurses in the team so that they can complete their tasks sooner and go home without too much delay.

Poor allocation of staffing level across different medical units is a factor contributing to work intensity for some nurses. For example, a nurse in the cardiac ward in Hospital A revealed: 'Officially, I finish work at 4 pm, but I usually have to stay behind until 7 or 8 pm before I can go home. I cannot look after my family at all. My parents have to help me out'.

In addition to the need to stay behind to complete daily tasks, nurses may be requested to work overtime during public holidays or due to staff shortage. This type of overtime worked is rewarded with time in lieu in principle. In reality, however, nurses generally reported that they do not have the time to take accrued leave. For example, a nurse (senior-ranking in Hospital C) reported that she has accumulated nearly one full year of leave entitlement, but there is no way she will be able to take the full amount of leave. No financial compensation is given as an alternative.

Whilst exiting the profession and insufficient number of new nurses entering the profession may be the key reasons for nursing staff shortage in developed countries like the UK and Australia, the worsening nursing staff shortage in China is to a large extent caused by the unwillingness of hospital managers to recruit more nurses. This is because, as a director of the nursing department pointed out:

Nurses don't make profit for the hospitals, but doctors do, through (over) prescription of expensive drugs and medical tests involving expensive equipment. There are now more hospitals nation-wide, more beds in each hospital, more treatments for each patient, but nurses' increase lags well behind this development.

The nursing staff shortage problem is exacerbated by the fact that some 15–20% of the nurses are in administrative role rather than doing front-line nursing work (在编不在岗). Competent nurses and those who have nepotic connections have found their way to these positions to escape from the front-line battle.

Work intensification leads to the decline of service quality and triggers patients' discontent. According to a nurse from Hospital C:

Eighty per cent of the patient complaints are to do with the lack of communication between the nurse and the patient/family. We have to deal with so many patients in each shift, we have no time to explain to them. If we had more time to explain to them, we would have much less complaints and tensions.

Work intensification has also led to various health problems for nurses. Most nurses reported that they suffer from a range of illnesses to various degrees, including the following: bladder infection, spondylitis, lumbar muscle strain, gastritis (due to irregular meal times), myocarditis, great saphenous vein, neurasthenia (due to stress- and shift-related poor sleeping patterns) and so forth. As one nurse from Hospital B remarked: 'nurses are more prone to developing kidney stones and bladder infection because we have no time to drink and dare not drink because there is no time to go to the toilet'.

Our study also revealed the interdepartmental differences in the level of responsibilities and, relatedly, stress encountered by nurses. According to the nurse managers interviewed, the most stressed medical units in the hospitals are intensive care unit (ICU), accidents and emergency unit, paediatric unit and maternity unit. In particular, there is a much higher level of nurses from the ICU than other units who request transfer to another unit. Paediatric unit is perhaps the second most demanding unit in which to work, as the director of the nursing department of Hospital C remarked:

Most children are now the only child of the family and parents are very demanding and awkward. Most hospitals now don't want to have a paediatric unit because it is very difficult to make any profit out of it and parents are very difficult to deal with. They tend to scold and bully medical staff easily. For example, a child's face got swollen because of the intravenous injection, and the father got very angry and smacked the young nurse in her face so hard that her mouth and nose bled. Young nurses are also the only child in the family, they cannot bear this kind of treatment, and no one can or should.

Whilst the latest healthcare reform has led to the increased number of nurses and eased off nurses' workload slightly in the last two years in Hospital A, changes were much less evidently felt by nurses in Hospitals B and C. Some measures, however, were taken by the hospitals to increase efficiency. For example, nurses are given an iPad to type up their notes in the ward directly and more quickly, instead of handwriting the notes after they have visited the wards.

A common finding across three hospitals is that nurses have very little autonomy at work for two main reasons. First, workload is very high; second, they must follow the medical and operational procedures strictly in order to avoid making mistakes due to the

tensed hospital–patient relationship. They are extremely cautious in what they do and what they say for fear of patient complaints. As Gottschang (2011) noted, nursing practices are increasingly under the scrutiny by hospitals due to the accelerating medical liability claims from patients. Record keeping and instrument organization have become a more serious part of nurses' routine work and responsibilities. This formalized procedure and close monitoring of nurses' work for fear of malpractice claims has added further constraints to nurses' work and their stress level.

The obedience of nurses to do any tasks assigned to them and work any time as required reflects both the Chinese cultural tradition and labour market situation. Under the paternalistic norm and altruistic work ethics that still prevail in the public sector, employees are expected to obey orders from their superior and devote themselves to the public good. As Tourigny et al.'s (2010) study of 239 nurses in Japan and 550 nurses in mainland China revealed, Chinese nurses are less likely to take absence leave than their Japanese counterparts to cope with their mental health problems (e.g. emotional exhaustion and depression) due to institutional constraints and cultural reasons (mental health problem and sick leave are perceived differently in the two societies). From a labour market perspective, whilst many nurse informants are dissatisfied with their working conditions, they feel that they have invested too much time and energy in the 'noble' profession to throw away. Career change is still uncommon in China for those in their mid career. Mid-career nurses therefore feel somewhat trapped in the nursing profession, because they do not want just a job that does not provide intrinsic value and meaning to what they do on the one hand, but they have no means to build another professional career from scratch on the other.

Remuneration

The remuneration package of nurses typically consists of three main components: basic wage, tasks-related pay and bonuses. The basic wage level is determined by the health authority that is linked to the clinical grades of nursing. On top of that, nurses are paid according to the number of clinical tasks they perform during their shifts; each task has a set rate based on the level of difficulty. This pay mechanism is akin to piece rate and forms a considerable proportion of the nurses' total wage income. A third component is monthly and annual bonuses that are related to the revenue generated by the clinical unit – the heavy reliance on bonuses to top up wage level is a distinct feature in the Chinese reward system (e.g. Takahara 1992; Cooke 2012). Despite being a public service, bonuses play a central role in nurses' pay package in order to boost their low basic wages. The hospitals studied cream off 60–70% of the profit generated by each clinical unit. The latter retains the remaining as bonuses, half of which is shared by the doctors and the other half by the nurses. As there are more nurses than doctors, this means that individual doctors take a larger share of the bonuses than nurses on average. Nurses divide the bonuses based on a ratio that reflects their clinical grades, level of responsibility and performance, shift patterns, the number of patients treated etc.

Head nurses are responsible for making sure that their (all head nurses are female in the study) team members complete their tasks at a satisfactory level in order to receive the full amount of bonuses for the team. It was reported that head nurses also received a secret bonus pack from the hospital president at the end of the year if her performance is deemed satisfactory. This team responsibility and reward associated with it displays strong hierarchical features. As Alchian and Demsetz (1972) argued, the organization of the team carries hierarchical characteristics, in which one central member monitors subordinates, possesses the

authority to punish and reward subordinates, and reaps the profits generated by the team's collective efforts. In this hierarchical arrangement, organizational efficiency is enhanced by aligning individuals' self-interest with group and organizational interest (Miller 1992).

More than 80% of the informants believed that the distribution of bonuses is very fair and transparent amongst the permanent nurses within the same clinical unit. However, inequality is highlighted for nurses who are on fixed-term contract – they receive only about half of the amount of income as a permanent nurse for doing the same type and amount of work simply because they hold a lower level of educational qualifications and a fixed-term contract. Our finding echoes that of Hu et al.'s (2010) study, which revealed that a contract nurse earned about half of the bonuses of a permanent nurse and that many hospitals have reclassified some of their nurses and paid them reduced salaries in order to cut costs. Contract nurses also received inferior entitlement to public holidays and hospital sponsorships for continuous education to advance their qualifications that will lead to their permanent position and higher pay. Here, the labour market constraints encountered by contract nurses have been exploited by hospital employers to strengthen their hierarchical control of the nursing workforce.

Low-wage income has been a common problem for nurses in China, and our findings reveal the extent of the low pay. According to the informants from Hospital A, a mid-ranking nurse was paid a wage of about 1500 yuan a month plus another 1000 yuan as bonuses. Their total annual wage income was around 33,000 yuan at the time of the interviews in 2012. In Hospital C, the total income of a newly graduated nurse was just more than 1000 yuan per month. As a new nurse interviewed remarked: 'A worker washing dishes in a restaurant earns more than that and with much less responsibility'. The annual average wage for the health sector in 2010 (latest figure available) in Guangdong Province where this study took place was 52,308 yuan, and the national average wage of all sector was 36,539 yuan (National Bureau of Statistics of China 2011). The majority of the nurse informants felt that their financial reward does not reflect the level of efforts, physical and mental demands of their work, and the maltreatment they receive from demanding clients and sometimes doctors.

Representation

In developed countries such as the UK, Canada and Australia, the nursing profession has relatively strong unions that have played a significant role in campaigning for nurses' rights and interests, including improved working conditions and remuneration (e.g. Thornley 1998; Tailby, Richardson, Stewart, Danford and Upchurch 2004). By contrast, trade union in China has been heavily criticized for being powerless and useless in defending workers' rights and interests (e.g. Warner 2008; Pringle and Clarke 2011). Whilst the unionization level is low in the private sector, where unionization level is high in the public sector, grassroots unions often play a welfare role. As Cooke's (2008) study revealed, instead of fighting against redundancy, hospital union representatives found themselves preoccupied in counselling laid-off nurses and persuading them to accept the management decision and depart without causing any fuss.

According to the informants (five of them are also union representatives) in all three case study hospitals, the trade unions' role is largely welfare oriented, and their activities are aimed at providing relaxation to the workforce, for example organizing flower arrangements lessons and sports competitions. The level of activities is minimal because, as many informants admitted, there is no time or energy to organize or participate in these events. Nurse informants also disclosed that trade union officials are the mouthpiece of the hospital president because they are appointed by the latter. In all three hospitals, an annual

staff and workers' representative congress (an official workplace representation body that is set up to support the trade unions under the Trade Union Law) is held, in which opinions and suggestions are voiced, but few are acted upon by the hospital management. As the director of the *nursing department of Hospital A* remarked:

There is no workers' voice. Only the nurses in management positions like myself have the opportunity to raise concerns on behalf of the nurses to try to improve their terms and conditions. Some suggestions are accepted but many are not because of cost reason.

Nonetheless, more than 80% of the informants reported that the nurse–line management relationship is generally good. Both recognize their respective positions and responsibilities and behave accordingly. In particular, there is a general consensus that the head nurses are quite competent and good team leaders. This is partly because head nurses' position is not permanent. Instead, candidates need to compete for the post and are voted into the position by nurses and approved by the hospital senior management.

Despite poor terms and conditions and the lack of collective representation in its real sense, no self-organizing collective actions by nurses have been reported in this study or elsewhere nationally. Whilst the Chinese industrial relations landscape has been marked by the rising level of labour disputes and self-organizing industrial actions in recent years (e.g. Wasserstrom 2010; Watts 2010; Cooke 2012), it seems that manual workers are far more likely to take confrontational actions vis-à-vis management prerogatives than their professional counterparts like nurses.

Conclusions

This paper investigated nurses' employment terms and conditions in a period of ongoing public healthcare reform and marketization in China. It contributes to our understanding of the management of the nursing workforce through the lens of hierarchy theory. It does so by examining the evolving role of key institutional actors in the healthcare system and how their respective role has co-shaped nurses' experience of work and employment outcomes. Whilst western literature has often polarized the bureaucratic hierarchy versus the liberal market (e.g. Williamson 1975; Miller 1992), this study reveals that the Chinese public healthcare sector operates within a marketized bureaucratic hierarchical system. On the one hand, despite the Chinese government's attempts to inject market mechanisms in the operation of hospitals to increase their efficiency, hierarchical control remains a central feature in hospital management. On the other hand, granted more autonomy, hospitals use their power as an employer to force individual nurses to upgrade their skills and knowledge as a condition for employment security and pay rise. In doing so, they effectively shift the responsibility of human capital development to individuals and align their self-interest with that of the hospital. This strategy is in part a response to fulfil the state-driven goal of developing a well-educated and well-equipped nursing workforce as an integral part of a modern healthcare system. In addition, wage rewards are closely linked to the performance level of individuals and teams. The transparency of nursing tasks means that each individual's performance is constantly monitored and assessed. Therefore, individuals are, again, forced to pursue their self-interest, and are compelled to work in cooperative manner at the same time in order for the team to maximize the reward from which they benefit. Here, a dual strategy, i.e. the pursuit of self-interest and coordinated play amongst team members, is designed by the management and accepted largely uncontested by the nurses. In addition to the pragmatics of political inaction due to the lack of organizing power, an added factor contributing to nurses' self-discipline is the Chinese collectivist cultural norm, in which cooperation is essential as a social behaviour

expected of individual members in the team (e.g. Hui, Law, Chen and Tjosvold 2008). Both prongs of the strategy have the potential to maximize efficiency, for individuals and the team, in order to survive the environment.

In spite of the high level of interdependence, institutional actors in the healthcare system possess different strengths of bargaining power. Within this hierarchical system, the rights of the nurses are relatively vague and hardly enforced, and their responsibility even less clearly defined or adhered to, as Miller (1992) depicts in other national contexts. It becomes evident, based on the findings reported above, that the nursing workforce is at the bottom of the authority hierarchy amongst the key institutional actors in the Chinese healthcare system (see Figure 1). Each main actor exercises its official and/or unofficial authority over the nursing staff, often in coercive, and sometimes unlawful, manner. Trapped between the bureaucratic state control and the hospital management opportunism, disempowered by the absence of any form of systematic and effective organization and representation, and confronted by the consumerized and increasingly militant patients and their families, nurses have to either put up with the deteriorating, and increasingly casualized, employment terms and conditions or give up their career. If the perceived benefits such as higher pay and improved flexibility are the key factors that contributed to the growing attraction of agency employment in the nursing profession in the UK (e.g. Manias, Aitken, Peerson, Parker and Wong 2003; de Ruyter et al. 2008), then nurses in the Chinese context end up in the precarious labour market not by their own choice but by employers' deliberate staffing strategy to cut cost and shift risks to those at the bottom rung of the career/job ladder. As a result, unlike other major professions in the public service sector (e.g. doctors, teachers and police force) in China, nurses as one of the largest occupational groups has experienced a continuous decline of job quality, measured by job security, other terms and conditions and well-being indicators.

Gottschang's (2011) ethnographic study examined how nurses 'negotiate the imperatives of health policies and laws within the spaces of the hospital' (p. 129) in the mid-1990s and found that 'nursing in China embodies ideals that extend beyond the duties associated with western medical care and treatment and incorporates ways of engaging with patients' illness experiences that call on familial and socialist dimensions of caring' (p. 143). However, she raised the question if nurses would become more focused on tasks related to preventing negligence, as new regulations were being introduced regarding medical negligence from the early 2000s. And if so, whether or not such a focus would minimize the value placed on caring for patients as fictive kin. Findings of our study suggest that on the one hand nurses are subject to increasing pressure from both their employer and clients to show more care to the patients, but on the other, the space for them to do so is rapidly diminishing due to intensifying work pace and the straining relationship between the supplier and the recipient of healthcare services.

This paper has a number of policy and managerial implications. At the policy level, the State is seen directly responsible in the western world for nurses' terms and conditions and the quality of national healthcare provision, as found in the UK. In China, treating hospitals as a business enterprise with contracting state funding has made hospital management directly responsible for the workforce as well as the service quality. By doing so, the State has distanced itself from the chaos that emerged. It is clear that the State needs to reassume some of its overdevolved responsibilities, if major improvement is to be made in its national healthcare provision. Indeed, important steps are being made towards this direction, as reviewed earlier in this paper. However, our research evidence suggests that the positive impact of the latest reform on the nursing workforce has yet to be felt in more tangible ways and by more nurses.

At the organizational management level, the process of healthcare system reform in China has not only reshaped the nature of work of the nurses, but also reduced their identification with and commitment to the nursing profession, particularly amongst the younger generation of the nursing workforce. This is in part a result of the widening inequality in the healthcare workforce due to differences in their bargaining power and what is seen as value-added by hospital management from a financial perspective. There is also a compelling need for a more humanistic approach to managing and caring about nurses in order to reverse the level of demotivation and stress experienced by nurses. Our research findings revealed that the HRM capability of hospitals is seriously underdeveloped, at least for those in our study. The majority of nursing managers have not been through formal management training and development. Whilst most of them are trying their best to lead and manage, they do so based largely on their intuition and mutual experience sharing. None of the hospitals have a formal and comprehensive set of HR policy in place beyond individual policies that cover specific aspects of the HRM functions, such as recruitment and training.

This study contains a number of limitations. One is its relatively small sample size with three hospitals, although they are typical and representative of those in the third-tier cities in China. Whilst findings of this study echo some of those from other studies in the country, we need to be cautious in the generalization of them, not least because of the regional differences in a vast country like China. As Tao et al.'s (2012) study on the differences in nurses' job satisfaction between hospitals in the northern and southern part of China revealed, nurses in hospitals in the north tended to be older and had higher educational qualifications, but received lower pay in comparison with their counterparts in the southern region. Despite this wage difference, nurses in the north consistently rated their job satisfaction higher in all areas except professional opportunities. Tao et al. (2012) believed that this difference is associated with differences in the mentality, culture and level of economic development between the two regions. Therefore, future studies on the topic should be extended to other regions of the country in order to provide a fuller picture.

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