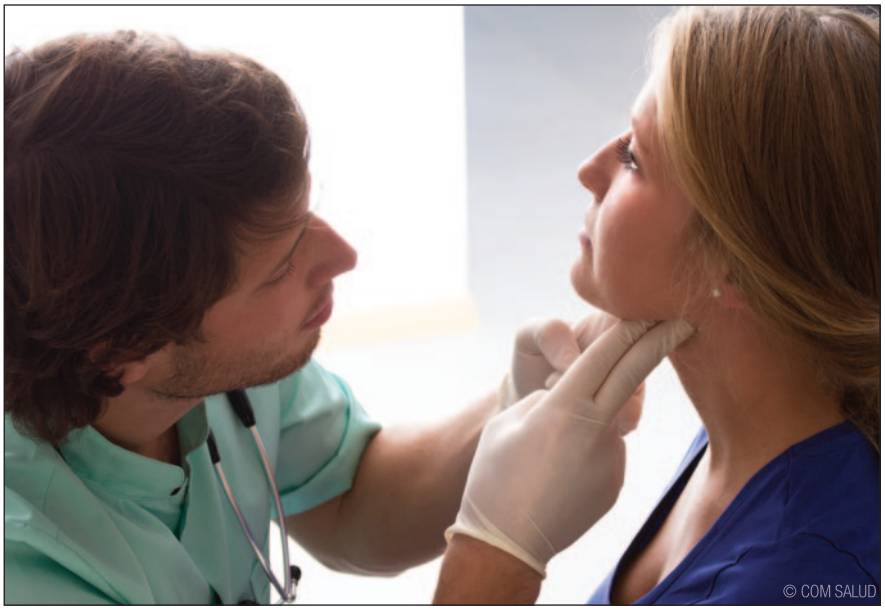
Dr Paul De Raeve, secretary-general of the European Federation of Nurses' Associations, outlines the design of a new EU workforce strategy that meets the needs of nurses as well as patients

Going beyond archaic metrics

The 35 members of the European Federation of Nurses' Associations (EFN) – consisting of national nurses' associations, regulators, and unions of nurses from across Europe – insist that a shift in existing EU workforce strategy is essential. This shift will benefit the mobility of healthcare professionals and strengthen co-operation at European level in the adequate design of a sufficient, motivated and highly competent nursing workforce. For this to happen, archaic and non-comparable data collection approaches need to give way to innovation stemming from the collective knowledge of the nursing profession that can guide member states in scaling-up existing best practices in workforce design and modelling. Ultimately, this will have a positive impact on patient outcomes as well as on the efficiency of healthcare systems.[1,2]

Dr Paul De Raeve

The EU institutions have already made attempts at developing a workforce strategy. For example, the European Commission drafted a green paper on the EU Workforce for Health in December 2008, and the European Parliament, supported by EFN, made a written declaration on the EU Workforce for Health (n° 40/2010) in 2010. In 2012, the Commission adopted a communication, 'Towards a job rich recovery', setting out a range of measures to encourage employment and strengthen economic growth in Europe. In this communication, healthcare was identified as one of three key sectors with a high employment potential, and it included an action plan for the EU health workforce. However, to date, these attempts have not translated into concrete actions and improvements in the day-to-day practice of EU nurses. The EFN believes this needs to change.



A workforce of highly competent, motivated nurses appropriately supported by EU policies is key to modernising current healthcare systems

The fallacy of existing metrics

The aim of the existing joint questionnaire (JQ) data collection is to provide relevant information on the number and composition of the nursing workforce in the different Organisation for Economic Co-operation and Development (OECD) and EU countries submitting data to the JQ. The current approach in the JQ to collecting data on nurses and 'nursing-related staff' is based on the ISCO-08 classification and related ILO definitions but not on EU definitions as set out in Directive 55 (2013/55/EU). Specifically, the JQ data collection distinguishes between two broad categories of nurses – professional nurses (ISCO-08 code: 2221) and associate professional nurses (ISCO-08 code: 3221) – next to one category of 'caring personnel' including both healthcare assistants (ISCO-08 code: 5321) and home-based personal care workers (ISCO-08 code: 5322). In their data submission, national data correspondents are invited to 'map' all the different categories of nurses and caring personnel that exist in their countries to these broad categories proposed in ISCO-08, and to provide information in the metadata on how they have allocated the different categories that exist in their country.

However, at European level, there is a clear and common understanding of the requirements for achieving the qualifications of a 'nurse responsible for general care', as requirements are set out in the Directive on the Mutual Recognition of Professional Qualifications (2013/55/EU). Beyond that category of general care nurse, there are two more categories totally ignored by the JQ, namely specialist nurses and advanced nurse practitioners.

In addition, in the existing data collection classifications (ISCO) there is a blurry line between the category of healthcare assistants and nurses responsible for general care, with an in-between category of 'associate professional nurses'. This introduces an

element of bias and error in the interpretation of the data since there are no clear distinctions between these categories. This has already led to mistakes when reporting data, resulting in mixed and cumulative categories, and in this way leading to unsafe workforce policies. The current intention of the OECD, Eurostat and World Health Organization is to conflate all of the categories of nursing care into one; this will create further confusion and introduce even more error into the data, thus hindering the development of meaningful workforce policies and science.

A coherent EU-wide approach concerning the categories of nursing care, with a clear set of competences for each category, is an imperative for meaningful workforce design. For this reason, the EFN developed a 'Matrix 3+1' on the three categories of nursing care (general care nurse, specialist nurse, advanced nurse practitioner) underpinned by a set of future principles for the development of healthcare assistants (HCA).

The EFN Matrix 3+1

Directive 2005/36/EC, amended by 2013/55/EU, on the recognition of professional qualifications stipulates minimum education requirements and competencies for 'nurses responsible for general care', set out in Article 31. Whatever educational pathway a person chooses to follow, in order to become an 'EU nurse' – a 'Directive 55 nurse' – they have to fulfill the same minimum requirements and be able to meet the stipulated competences. This means that for workforce planning and forecasting purposes, including the migration and mobility trends (DG Internal Market and Internal Market Information system), the EFN members agreed that the 'enrolled/registered nurse', 'assistant/licensed practical nurse' and 'registered/licensed nurse' categories can be safely merged, as all of these need to comply with Article 31 of Directive 2013/55/EU. If a person's training does not comply with the requirements of Directive 2013/55/EU, they consequently fall into another category, called 'healthcare assistant'.

The EFN advocates for three categories in nursing care in order to provide clarity on the nursing care categories in Europe and build on developments on this topic by the International Council of Nurses. These three categories will provide clarity and help to collect comparable data for planning and forecasting. Next to the three categories in nursing care, it is important to take HCAs into account and nursing leadership in their development.

EU institutions 'can't see the wood for the trees'; a new EU workforce strategy should be based on innovation stemming from the collective knowledge of the nursing profession

The definitions of the three nursing categories are:

1) General care nurse – Directive 2013/55/EU Nurse: a self-regulated healthcare professional who works autonomously and in collaboration with others, who has completed a nursing education programme and is qualified and authorised in his/her country to practise as a general care nurse (ref. Art 31, Directive 2013/55/EU);

2) Specialist nurse: a nurse prepared beyond the level of a general care nurse and authorised to practise as a specialist with specific expertise in a branch of the nursing field; and

3) Advanced nurse practitioner: a general care nurse who has an advanced knowledge base, complex decision making skills and clinical competencies for expanded clinical practice, the characteristics of which are shaped by the context and/or country in which they are credentialed to practise.

Furthermore, the EFN recognises that the education and development of HCAs is an important issue for patient care across Europe. Healthcare systems are relying more and more on HCAs carrying out an ever-increasing number of duties due to more pressure on health budgets and increased task shifting. Nurses play a crucial role in the supervision of HCAs and ensure an effective line of accountability between the registered nurse and the HCA. As the representative voice of nurses across Europe, the EFN is working on setting out its position in relation to the development of HCAs in the future, further to our work on developing three nursing categories. Due to major differences in the regulation of HCAs, the EFN calls for a new EU approach. Due to the fact that the regulatory environments and the expectations on the role of HCAs vary widely among the member states, the development of a

	Current approach in JQ (based on ISCO-08)
Category	**Name**
1	Professional nurses (code 2221)
2	Associate professional nurses (code 3221)
-	*No data collected*
-	*No data collected*
1+2	**Total number of nurses**
3	Caring personnel (healthcare assistants and home-based care workers) (code 5321 and 5322)

	Proposed EFN alternative approach
Category	**Name**
1	Nurses responsible for general care
-	*Not compatible with EU Directive 55*
2	Specialist nurses
3	Advanced nurse practitioners
1+2+3	**Total number of nurses**
4	Healthcare assistants

Comparing the current approach in the JQ with the proposed EFN approach

common EU training platform is unlikely to become a mechanism for mutual recognition. Rather than focusing on a common EU education and training platform for HCAs, the EFN believes that EU activity will be better placed on focusing on the common challenges of the development of HCAs in each member state. The EFN would instead emphasise that future EU work should focus on taking forward some core principles which would underpin the development of HCAs in individual member states and ensure the right system architecture is in place across the EU for regulation.

For the purposes of the workforce classification, the following definition was agreed: healthcare assistant: an auxiliary that assists directly in nursing care in institutional or community settings under the standards and the direct or indirect supervision of the general care nurse.

EFN members have worked together and developed a set of competencies for the two nursing categories (specialist nurse and advanced nurse practitioner) not yet regulated at EU level, as well as principles for HCAs (the CONTEC project, led by DG SANCO, defined the qualifications and competences of HCAs). The European Commission (DG EMPL) in the framework of ESCO – an EU platform which defines and categorises skills, competencies, qualifications and occupations in a standard way, using standard terminology in all EU languages – the EFN Matrix 3+1 has been adopted, complemented by the information provided by the EFN members on the categories of specialist nurse and advanced nurse practitioner. In line with international developments, to plan the EU health workforce the EFN takes as a starting point the 'qualifications' and 'competencies' of nurses and not the 'tasks'. The latter would hinder the possibility to plan the health workforce because the tasks undertaken by nurses differ from sector of employment (hospital or community) and even between employers in the same EU member state. It is therefore more relevant to focus on the qualification and competencies rather than the tasks undertaken.

A new EU workforce strategy responding to professionals' needs

EFN members urge the EU institutions to take action toward the development of a new EU workforce strategy that responds to professionals' needs in day-to-day practice. In the context of national budget cuts and nurse workforce shortages, a new strategy is essential to protect the safety and quality of EU healthcare services.

Across Europe, EFN members warn that many nurses do not feel adequately valued and that this is the main reason for them leaving the profession. This affects experienced nurses in particular, and therefore the EFN emphasises that any new strategy needs to consider both new recruits as well as those nurses currently in the profession. Investing in the continuous professional development of the existing nursing workforce and introducing career opportunities for experienced nurses, such as development towards advanced practice nurses, must be a key ingredient of this new strategy.

At times of budget cuts and population crises – such as infectious diseases of high consequences and mass migration – nurses are finding themselves overworked and under-resourced. Such crises are not simply temporary but are recurring in different forms. Therefore, improving nurses' working environment must be a continuous effort; nurses need to work in environments with

Nurses Street: in order to move towards a more capable health workforce, steps should be taken to ensure more applied workforce research is undertaken

adequate staffing levels where the implications of overtime working and longer shifts on nurse wellbeing are carefully monitored.

Future-proofing the nursing workforce requires adopting a long term view. For example, shifting care from acute hospitals into the community is slowly becoming a reality for which nurses, new and existing, need to prepare. A longer term view also means taking into account the changing needs of governments, nurses and patients. The future patient population will have different, more generic needs and equally pay attention to the diversity of conditions. A new EU workforce strategy should help to prepare nurses for the culture shift that is taking place in healthcare in response to changing needs. Nurses will need to be more mobile; to manage the provision of community: primary care in urban and rural areas; and have the necessary competencies to work, communicate with, and co-ordinate inter-professional teams.

Finally, the new EU workforce strategy needs to be more gender sensitive. Women across Europe are feeling the effects of a 'sandwich generation' – managing the dual pressure of caring for their children as well as their elderly parents. Nurses, most of whom are women, have the added pressure of caring for their patients. Principles of flexible working, which do not compromise career progression, should be engrained in the new strategy.

Horizon 2020 – why do we need more applied research on the EU workforce?

It is alarming to see how little healthcare research is undertaken with a view to improving local workforce practices. Without applied research – research that aims to utilise, apply and empirically validate theoretical advances and recommendations – there is little promise in funding more abstract reports that end up recycling older recommendations and 'solutions' that have not been systematically examined at a practical level.

During the past decade there have been many attempts at designing workforce-related research, most of which remained theoretical, and in this way lacked empirical application. Whilst there are many potential theoretical solutions to the workforce crisis, there is little work undertaken on practical solutions that can improve the day-to-day work of EU nurses. For example, whilst North American research has shown the patient and organisational benefits of the Magnet approach (http://www.nursecredentialing.org/Magnet.aspx), there has been little empirical validation of this work within the EU.

Similarly, whilst there is a consensus on the importance of the primary and community care workforce, there has been little research into understanding the needs of this group. For example, we still have little knowledge about how many primary and community care nurses there are in Europe; how well they are resourced and staffed; and about the barriers and challenges they face in their day to day practice.

Nurses, as the professionals who work most closely and intensely with patients, are ideally placed to inject some much-needed applied research ethos in large scale projects – such projects tend to be channelled through large research centres and are often dominated by interests and professions other than nurses. Nurses, through their day to day interaction with patients, know what patients value from the workforce and how quality care can be delivered.

Conclusion

A workforce of highly competent, motivated nurses supported by high quality EU workforce policies can stimulate free movement and is key to modernising current healthcare systems. Based on comparable workforce data that reflect the reality of EU nurses, drawing from the EFN Matrix 3+1, a new EU workforce strategy can be designed that meets the needs of nurses as well as patients. Complementing this new strategy with more applied workforce research can contribute to changing existing conversations on the same issues in order to move forward towards a more realistic and practical approach to improving the capacity and capability of the EU health workforce.

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