Dr Paul De Raeve, the secretary general of the European Federation of Nurses Associations, explains why the EU should think outside the box when investing in health

Think outside the box

The provision of comprehensive health and social care services is key for modern societies where the demand for health and social care is constantly changing due to an ageing population and increasing morbidities. However, although this scenario calls for deeper attention from policymakers, following the economic crisis, the healthcare sector has suffered, and still is suffering, from the austerity[1] measures, with the consequence of a dominant efficiency principle mostly applied in terms of cost-reduction. Still now in 2017, governments perceive investing in the nursing workforce and better working conditions a luxury, and as such keep on making cuts. This leads nurses to quit the job they loved.

From medicine to care

Under these circumstances, it has nowadays become crucial to rethink the model of investing in health and to focus further on people, citizens, and patients' needs. In societies where a growing number of people live with comorbidities and noncommunicable diseases, and need complex care interventions, a people-centred approach will be essential, based on tailored continuity of care and people's/citizens'/patients' empowerment. But how do you make this happen in a budgetary culture of cuts?

To this purpose, new strategies are needed to invest in sectors that mostly affect people's/citizens'/patients' life and care experience, leading to a high-qualified and motivated nursing workforce 'fit for purpose'. Moving away from 'personalised medicine' towards 'personalised health and social care' would be such investment. In effect, unless a people-centred and integrated health and social care approach is adopted, health and social care will stay fragmented, inefficient, and unsustainable, and citizens will be unable to access the high-quality health and social services that they need. People-centred care based upon needs has been gaining momentum in health policy and the workforce. It is an approach that consciously adopts individuals', informal carers', and communities' perspectives as participants in, and beneficiaries of, trusted health and social systems that respond to their needs and preferences in human and holistic ways. People-centred care requires an adequate level of education and support to enable people to make decisions about and participate in their own care. This is a model organised around the health and social needs and expectations of people rather than diseases.

The high-level political discussions under the banner of 'personalised medicine' take place at EU and national level, driven by the industry, arguing that a paradigm change in medicine is happening, shifting from a one-size-fits-all approach to one which is personalised and targeted to the individual. Nevertheless, the mindset stays old-fashioned with

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continuous references to the 'medical community', instead of 'health and social care community'. But can we fix an old-fashioned mindset with disruptive models?

Leading causes of fragmentation and poor co-ordination in the EU are related to programmes targeting specific diseases, risks, and populations without integrating into the health and social system; approaches to the decentralisation of health and social services that result in fragmentation of the level of care; an absence of incentives and financial policies conducive to strengthening the co-ordination of care; and a lack of evidence-informed pathways for the whole continuum of a care episode (WHO Regional Office for Europe 2012a).

In that same line, the 'personalised medicine community' keeps on arguing that while there are many barriers to innovation in clinical practice – including market access, scientific, and/or regulatory challenges – the biggest challenge across the healthcare system is 'continuing medical education (CME) for healthcare professionals'. Perhaps CME has challenges; CPD (continuous professional development) for nurses, supported by the concept of LINK nurses, has been well developed in the EU, knowing that Article 31 of Directive 2013/55/EU[2] has strengthened nursing as a profession,[3] by installing the bachelor level for general care nurses, and the EU nurse. According to recent research,4 a greater participation and close interaction of health professionals have a strong impact in the overall improvement of the health workforce governance. Therefore, nurses and health professionals should be given greater autonomy in terms of the number of issues that require independent decisions. Needs-based care is the model that responds better to these needs and has positive consequences for their practice. When it comes to investment in the

health and social care sector, the nursing workforce gets streamlined, focused, and outcome-oriented, due to the numerous DG Employment and DG Grow projects and legal initiatives. Where does DG Sante stand when it comes to investing in the nursing workforce?

Nurses have never operated in a culture of one-size-fits-all. In contrast to the medical profession, the nursing profession has been operating into value-based health and social care systems, with clinical pathways outcomes driving the modifications of the care plans. However, and unfortunately, outcome measurement has never been taken as seriously as the diagnosis-related group (DRG) system, often connected to financial models, which has dominated policymakers' and politicians' (often doctors) strategies to reduce costs. So, were DRG financing models the best choice in the 1990s? Are governments willing to give up these financial models and move towards outcomes, quality, and safety indicators?

Foster innovation to enhance quality of life

The chronic care model has shown that good management of patients with chronic diseases and complex needs can greatly improve care and patients' quality of life. Developing new roles for nurses and/or advance nurse practitioners (ANPs) is thought to be a way to increase the efficiency and efficacy of the existing resources and improve health outcomes. These new roles have the double aim of better integrating primary and secondary care on one hand, and health and social services on the other hand, according to the people-centred model of care.

ANPs operating within a people-centred model of continuity of care have been proven to make health and social care systems and services more responsive, safer, effective, and efficient. In particular, ANPs have shown benefits for not only individuals and their families but also health and social care professionals and community workers. Increased satisfaction, improved access and health literacy, co-decision-making with professionals with increased involvement in care planning, improved job satisfaction, and better retention of staff with reduced workloads and increased direct patient time are measurable benefits. Why not invest in something that has already proven to be successful? Within this context, the implementation of Directive 55 on nurses has a great potential in underpinning the role of an ANP.

However, disruptive or not, society is clearly changing and so are health and social care needs, as we move from an emphasis on acute diseases to more chronic, lifestyle-related 'diseases' with the additional burden of comorbidity. Therefore, when designing the future EU health and social care ecosystems, supported by e-health services, it is crucial to leave the mindset of 'diseases' behind. By giving the right treatment and care, to the right patient, at the right time, outcomes have to adjust to online clinical pathways, as nurses' observations of complications will be essential 24 hours a day, seven days a week, 365 days a year.

When moving away from the medical approach to a more advanced practice setting and continuity of care strategy, non-disruptive innovation becomes the driver of successful change. This, in the realm of health, means the translation of knowledge and insight into what we can call 'value'. Values and innovation can lead to sustainable and better outcomes for people/citizens/patients.

As care providers represent one of the main drivers of the health and social care systems, investments in their values are part of the innovation principle. Special attention should be devoted to the continuity of care and to the workforce composition that makes it possible, in particular nurses. With EU health and social systems expected to give greater importance to health promotion and prevention, nurses' advanced work is crucial as they play a major role in influencing people's health, not only through their hospital care but also by promoting a healthier lifestyle for individuals and communities. In this sense, the ANPs in the municipalities are the key innovator for designing people-centred systems, requiring more competencies in the field of behavioural sciences, social care, and public health. Hence, proper investments are needed to make sure general care nurses can move up towards an advanced role, co-ordinating care where people live and work. As such, the advanced role is not a specialist nurse.

Making the frontline workforce valued

Directive 2013/55/EU, the modernised outcome of Directive 2005/36/EC,[5] brought considerable beneficial effects for nurses, making free movement a human right, and moving the education of nurses, women, towards a higher EU standard, hopefully leading to better wages and better pensions for nurses. But it cannot stop here: that's where the Proportionality Directive comes in, a tool that would let nurses further design their profession, bringing in new roles and skill mixes, strengthening teamwork to make it all happen, with the ultimate goal to make health and social care resilient. As the proposal foresees that any new or amended regulation of professions should be based on proper public interest justifications, and not just economic arguments, nurses are in favour of the proportionality test with stakeholder engagement (Article 7) the key principle and not an exception.

Delivery of hands-on care for patients, co-ordination of the care process in order to achieve better outcomes is safeguarded by Article 6.2. Nursing cannot be outsourced. Given that nursing is a profession where any

mistake or misconduct can have grave consequences for citizens, clients, patients, and the functioning of the health and social care system in general, those guarantees often need to be cumulatively imposed with the objective to protect public health and patient safety (Article 6.4). National governments seeking to introduce/modify provisions aimed at creating parallel nursing professions alongside general care nurses (DIR55) would need to assess and justify how: 1) the creation of a new type of nurse, qualified at a lower level, could be suitable to guarantee the adequate quality of services without compromising patient safety, while taking into account regulation in comparable areas; and 2) how such measures might affect the free movement of DIR55 nurses, so that Directive 2013/55/EU is not devalued of its main aims.

Furthermore, as a key element of the proposal, and essential for nurses and nursing, Article 7 makes it clear that before introducing new regulation, all interested parties, citizens, service recipients, representative associations, and relevant stakeholders, other than the members of the profession, would have to be informed and should be given the possibility to express their views. Strengthening people/citizens dialogue, the Proportionality Directive proposal clears the way for a people-centred model of care to be promoted.

Digitalisation needs to support frontline

Implemented continuity of care, not a mere speculation, is one of the main challenges of the health and social ecosystem. The clinical pathways have become so complex that artificial intelligence (AI) is perceived as a way forward. However, more attention should be given to not 'replacing healthcare professionals' and not pulling nurses away from the bedside due to electronic health records (EHRs) 'unfit for practice'. Digitalisation has deeply changed all the sectors of our life and investments in e-health revealed to be beneficial in dealing with the societal challenges. Nevertheless, it is becoming obvious that the frontline is pulled away from care and has moved behind computers. Call centres, heavily promoted in some EU regions with EU funds, represent a good example of dealing with dementia patients in the community by pulling nurses into ivory towers, in front of screens, and probably getting EU awards for it. The same is happening to police officers and even fire brigades, often all together in one building platform. Is this the trend EU citizens need?

Although e-health should contribute to enhancing patient safety and patient empowerment as well as facilitating nurses' work, with electronic tools supporting them in their daily work and allowing an easy and fast collection of relevant data, we see the opposite happening. The findings of a recent US study 'Providers spend more time in front of computers than patients'[6] show that primary care physicians spend more than half of their workdays in front of computer screens, reducing the amount of time they spend with patients. Researchers found that primary care physicians spent an average of 5.9 hours on data entry and other tasks with EHR systems during and after clinical hours. Looking at European trends, we would find the same and even worse timings for nurses spending on data collection, although the industry promised their tools would free up time for nurses' bedside care. This situation is likely to lead to work-life imbalance, dissatisfaction, high rates of attrition, and burnout rates. Poorly designed and implemented EHRs, without any significant engagement of the health professions, make the system unfit for practice. The systems are politically sound, but not professionally. It is difficult to understand how return on investment will work out. Would DG Connect and DG Sante, or an e-health EU presidency week put this on their agenda? Anyhow, this is nothing new, as expressed in a letter to the European Commission (20 March 2017), to which we never received an answer:

Dear EC Official,

We are writing to you on behalf of the Council of European Dentists (CED), the Standing Committee of European Doctors (CPME), the European Federation of Nurses Associations (EFN) and the Pharmaceutical Group of the European Union (PGEU) expressing our concern about exclusion of European healthcare professionals representing organisations from eHealth and in particular from ongoing projects on digital skills.

On 15th February 2017, we received an invitation to respond and promote a survey on eHealth Workforce Development. The healthcare professionals represented by our organisations welcome the Commission's initiative in the context of eHealth to consider the development of a digitally skilled health workforce. However, we believe that in this and similar initiatives more can be done through a meaningful involvement of the relevant stakeholders, especially ones representing healthcare professionals. We are sceptical of the chosen instrument to achieve some of the survey objectives, for example to capture information about one's health digital skills, available curriculum and/or workplace training programmes, educational needs, trends. We believe that the active involvement, participation and commitment of healthcare professional organisations early in the development of the methodology and content as well as in the dissemination of the initiative would be necessary for its success.

We would like to bring your attention the fact that we represent the people who use eHealth tools in their practice on a daily basis. This places us in an ideal position to detect educational needs, trends and expectations

among healthcare professionals. There are opportunities for the collection of curriculum and training programmes and skills assessment tools via our networks and we regret that these opportunities are missed.

Therefore, we believe that in order to succeed, European institutions and national governments must tackle issues around eHealth development, deployment and use with an active participation of health professionals. The health professionals should be guaranteed at least as good access as the industry to eHealth initiatives at national and EU level.

With this letter, we would like to express our interest in working together with EC in the matter of digital skills of health workforce on behalf of the European community pharmacists, dentists, doctors and nurses.

However, EFN believes e-health has the potential to support continuity of care throughout the patient's journey and make health and social care ecosystems resilient. The application of modern ICT to the health and social care sector and its effects on the patient's care experience will boost the process to shift the focus towards person-centred care, enhance patient empowerment, and ensure continuity of care across primary and secondary health and social care sectors. But there is a need to engage the frontline and think outside the box.

Conclusion

EFN members have reported at several occasions that their national governments plan downgrading[7] nursing education by developing a 'cheap nurse'. Although the research evidence of Linda Aiken that "Every 10% decrease in nurses' bachelor's degree was associated with 7% increased mortality, implying that nurse staffing cuts to save money has adverse effects on health and patient outcomes"[8] cannot be ignored, national governments are creating new legislation and services with lower level nurses, often called 'medical assistants' or 'auxiliary nurses'. Due to austerity keeping nurses down, European legislation, in particular Directive 2005/36/EC (modernised by Directive 2013/55/EU), complemented with the Proportionality Directive, can strengthen nursing as a profession. The engagement of nursing stakeholders in the proportionality assessment process can hold national governments back from creating a cheap nurse, preferably not complying with the DIR55 requirements (4,600 hours, 2,300 hours practical training), so they cannot benefit from the automatic recognition of their qualifications in another EU member state. Should member states' justifications be limited to 'saving money' and 'shortage of nurses', member states would not comply with the requirements for the proportionality test and might face subsequent enforcement action.

Achieving the goals described above – such as the development of people-centred care, the design of an ANP in the EU nursing workforce consortium, moving care to the community, and achieving a sustainable health and social care service for future generations – implies having the right fit for purpose legislation and regulation in place across the EU and Europe. The Proportionality Directive, considered as bylaw of the modernised Directive 2013/55/EU, strengthens nursing as a profession, delivering personalised, preventive, integrated, and high quality and safe services. In order to make that happen, it is necessary to invest in and support the frontline nursing workforce, and empower the health and social care sector as an investment for wellbeing, productivity, and growth. Future health and social care systems do not need more medical specialists but a more generic health workforce together with CPD, which are key to strengthening public health. There is an urgent need for less medicalisation, fewer disease-specific approaches, and more generic, continuity-, and value-based health and social care systems approaches to make people-, citizen-, and patient-driven person-centred care.

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