THE POLITICS OF **HEALTH WORKFORCE PLANNING** AND FORECASTING

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Summary: Planning the health workforce is key when modernising health care systems throughout the European Union (EU). As health policy-makers and researchers have long argued, current data collected at national level on the health workforce tend to be fragmented, incomplete, and not comparable. Therefore, a comprehensive picture on how to plan and forecast the nursing workforce at EU level can be obtained by deploying four categories: health care assistant, general care nurse, specialist nurse and advanced nurse practitioner.

Keywords: *Health Workforce, Health System Reform, Comparable Data, Planning and Forecasting, Nurses*

The **European Federation of Nurses Associations** (EFN) was established in 1971 to represent the nurse's voice and the profession's interests at European institutions. The EFN is the independent voice of the nursing profession. EU policy outcomes will impact on three million nurses all over Europe as EU legislation will need to be transposed into national legislation. www.efnweb.eu

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The EU Political Workforce Agenda

The European Federation of Nurses Associations (EFN) engaged in the EU Health Workforce Agenda in 2008 through the Green Paper on the EU Workforce for Health.[1] In 2010, EFN moved workforce up the political agenda of the European Parliament, launching a written declaration (n°40/2010) that was presented at a European Parliament roundtable. It was an occasion to present individual testimonies from nurses and doctors who had experienced professional mobility and administrative challenges associated with the recognition of their professional qualifications. These policy initiatives were the crowning moment for EFN to collect comparable data within its membership and explore which categories and methodologies were needed for forecasting the future nursing workforce. Planning the nursing workforce, the largest occupational group in the health sector, necessitates innovative strategies and policies, as the current data collected and methods used are not fit for purpose.

The Council Conclusions[2] provided a pathway for the 2011 and 2012 EU Presidencies to create several policy initiatives on the EU workforce, among which are the Action Plan on EU Workforce for Health in 2012 and the Joint Action on EU Health Workforce in mid-2013.[3] One of the objectives of this Joint Action is to analyse the gaps in quantitative data collected through the Joint Questionnaire of WHO-Eurostat-OECD. The categories for the nursing profession currently used in that Joint Questionnaire to collect data at national level are based on the ISCO-08 code, focusing on tasks and occupations instead of qualifications and cause concerns regarding compliance with EU legislation (Mutual Recognition of Professional

Qualifications Directive 2005/36/EC, amended by Directive 2013/55/EU,[4] hereinafter called the PQD Directive). If the quantitative and qualitative data sets aim to plan and forecast the workforce in relation to future needs in health care systems, the policy-makers at Eurostat, WHO (World Health Organization), OECD (Organisation of Economic Co-operation and Development) and International Labour Organization (ILO) will need to take into account what the profession sees as accurate data and 'fit for practice' methodologies. Using the ISCO 08-code for nursing care leads to inaccurate data collection, inappropriate comparison of the nursing workforce and, finally, to unrealistic planning for the future.

To have a coherent approach to workforce planning and forecasting across the different EU-led initiatives, EFN is engaged in the ESCO project (European Skills/Competences, Qualifications and Occupations), led by the European Commission's DG Employment, which seeks to identify and categorise qualifications, skills and competences using common terminology in all EU languages. It is within this policy context that the four categories of the EFN Nursing Care Continuum (health care assistant, general care nurse, specialist nurse and advanced nurse practitioner) were designed to: (i) define categories which make sense in relation to the minimum requirements of EU legislation; (ii) clarify the competencies of the four categories; (iii) assist policy-makers to advance the mind-set on how to collect comparable data for planning and forecasting, which is currently highly political; (iv) assist in curriculum design, negotiating skill mix and skill needs to respond to societal challenges; and finally (v) guide the formulation and revision of competencies at national jurisdiction level to guarantee compliance with the modernised PQD Directive. As one of the fundamental pillars to maintain sustainable health care systems and implement high quality and safe care is to have a highly educated, dedicated and skilled workforce, the collected data needs to be comparable within the EU and methods used for planning and forecasting have to incorporate criteria and logarithms that are nursing sensitive.[5]

The EFN Nursing Care Continuum Qualification Categories

A clearer understanding of the different roles between the four categories in nursing care and comparable numbers of the entire nursing care continuum will lead to valid and reliable data upon which good nursing workforce policies can be developed at regional and national level.

Since the EFN members agreed on the EFN Nursing Care Continuum (October 2012),[4] they have engaged in collecting data, country by country, on the entry-level education, qualification and competences for each category to have a more accurate understanding of the four categories in the 28 EU Member States. The analysis highlights some key findings discussed in turn below.

Health Care Assistant

The health care assistant (HCA) is 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.[6]

With regard to HCAs, there are differences in terms of regulation and education across Member States but they are all present in the nursing care continuum supporting nursing activities under the supervision of a general care nurse. Their education starts after 8 (Croatia), 10 (Netherlands) or 13 (Ireland) years of general education, it lasts from 9 months (Bulgaria) to 3 years (Denmark), and is situated at the upper secondary school level. The competencies differ slightly but are all related to providing basic nursing care (such as hygiene, mobilisation and feeding). Additionally, in some Member States the role of HCA is not formalised, resulting in different nominations of the title "nurse", (i.e. practical nurse), a situation which creates confusion among patients. For instance in Finland, the title 'nurse' include professionals whose education has started before the minimum ten years of general education and consequently do not comply with the minimum requirements established for a general care nurse as set out in the PQD Directive. Therefore, this role falls better into the category of HCA as the role and responsibilities undertaken correspond more closely. The same example holds for Italy where there is a group of health care workers who call themselves nurses, but do not comply with the minimum requirements of the PQD Directive relating to the entry level, duration, and balance between theory and practice.

> coherent approach to workforce planning and forecasting

The EFN supported the DG SANCO study "Contec" whose objective was to map the current situation of HCAs in each participating Member State and to discuss the comparability of their qualifications, with particular emphasis on cross-border mobility. These designs cannot be created in isolation from the existing EU legislation. The Contec study results were therefore helpful to create a clearer and more detailed framework for the employment and duties of HCAs, next to the scope of the skills and competences required, benchmarked with that of the general care nurse.

General Care Nurse

A general care nurse is a self-regulated health care professional who works autonomously and in collaboration with others and 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).[6]

This second category is legally set by EU law, the PQD Directive and Chapter 3 of the *Acquis Communautaire*. It applies to students fulfilling educational programmes totalling at least three years

of study, consisting of at least 4,600 hours, of which one third is theoretical and one half (2,300 hours) clinical training. The PQD Directive includes a list of measurable learning outcomes and competencies, highlighting the independence of the nursing profession.

Specialist Nurse
A specialist nurse is a nurse prepared beyond the level of a general care nurse and authorised to practice as a specialist with specific expertise in a branch of the nursing field.[6]

For this third category of the EFN nursing care continuum, there are different specialities and lengths of education across Member States but the common trend is that the specialist nursing education starts after achieving the qualification of a general care nurse, through postgraduate studies. In some cases, in addition to an existing qualification as a general care nurse, nurses are requested to prove professional experience of two years before entering specialisation studies. Most specialist nurses are disease-specific (oncology nurse, diabetes nurse, etc.), life cycle-specific (paediatric nurse, geriatric nurse, etc.) or sector-specific (community care nurse, operating room nurse, intensive care nurse, etc.).

Advanced Nurse Practitioner
The advanced nurse practitioner (ANP) is 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 s/he is credentialed to practice.[6]

The fourth category of the EFN nursing care continuum is a general care nurse in compliance with the PQD Directive who has acquired advanced knowledge and expertise on clinical judgment, skilled and self-initiated care, and research inquiry. Many EU countries already have regulations on ANP in place (Finland, Iceland, Ireland, the Netherlands, Norway and Slovenia), whereas others have officially started the legislative process (Denmark, Lithuania, Poland and Sweden). From the data analysis, it becomes clear that the ANP profile has become prominent, especially in chronic disease management, where it has proven to be successful in delivering sustainable and cost-effective care.[7] The EFN welcomed the study conducted by the OECD in 2010, providing an overview of advanced nursing practice.[8] To further develop and implement the ANP in EU health care systems, the EFN started an EU thematic network (co-ordinated by DG Connect) with specific focus on the design of EU guidelines for the development of ANPs in clinical settings.

Qualification versus occupation

Health policy experts and researchers have long argued that current data tend to be fragmented, inconsistent, and not comparable nationally or internationally.[9] [10] [11] Questionnaires for data collection, mainly designed from the ISCO-08 code, are mixing qualifications with occupations, leading to confusion and political discussions that do not benefit professional development in the EU and Europe. The questionnaires used by Eurostat, OECD, WHO and ILO lead to inappropriate comparison of the nursing workforce and, as such, to unrealistic planning for the future. With the data collected through the WHO-Eurostat-OECD Joint Questionnaire that is based on an occupational approach, it becomes challenging to build confidence within the profession as the numbers provide space for ambiguous interpretations.[12] Therefore, if we really want to look into gaps in the data analysis, we should focus on using the four categories of the EFN nursing care continuum, as these are clear in definition, non-biased in numbers, and simple to use. Even more important for the EU health workforce, these categories start from the legal basis of the PQD Directive which does not describe where a nurse needs to work – hospital or not – but explains who is a nurse and who is not.

Due to the clear structure from a lower to a higher qualification level, the four categories of the EFN nursing care continuum are more suitable for use by statisticians and health economists to collect data and conduct research that is trustworthy for the design of evidence-based policies.

Challenges

The main challenge in redesigning measurement scales and methods to plan and forecast the nursing workforce is the mind-set of European policy-makers and international institutions responsible for data collection. In the last few decades, systems have been developed without engaging the professions substantially, which explains the existence of titles falling in between categories of the nursing care continuum and creating disruption in the comparability of data. The leaders of the nursing profession therefore feel an urgent need for more dialogue with policy-makers and politicians to better understand, from a professional perspective, the rationale for change. Building trust systems and mechanisms for the collection of EU-wide data is key to making sense out of planning and forecasting. Claiming more nurses and health professionals for health systems implies a robust stakeholder engagement approach to deliver successful policy outcomes.[13]

> “data tend to be fragmented, inconsistent, and not comparable

Going beyond definitions and glossaries is key to making change possible. Implementing new knowledge into practice goes beyond mapping exercises, literature reviews, and developing ‘cookbooks of best practices’. Nurses struggle daily to survive in a complex working environment, where they waste their time in collecting data that do not serve their needs, but that leads to recommendations which will never be implemented. We need to go beyond recommendations; we need to implement findings into practice. Although there is a tendency to make the analysis of policies and health processes very complex, the health and nursing workforce is not demanding this complexity. Instead,

data collection needs to be "simple" and "digital" in order for nurses to free up time for the benefit of direct patient care.

Finally, speaking with one voice is key for change. The nursing leaders from the professional associations, the regulatory bodies, the nursing unions and the governmental chief nurses should strengthen each other to build nursing further as a profession within the EU.[13] The nursing community leaders need to jointly advocate datasets and methodologies for planning and forecasting which support the professional bodies, the regulators, the unions and the Chief Nursing Officers. Speaking with one voice for nurses and nursing is key to success.

Conclusions

Based on the statistical and economic shortfalls in using the ISCO-08 code in the WHO-Eurostat-OECD Joint Questionnaire, the EFN argues professionally and politically that politicians, policy-makers, researchers and nursing leaders should deploy the four categories of the EFN Nursing Care Continuum to collect comparable data and use it to plan and forecast the nursing workforce. The EFN is also of the opinion that the ISCO-08 code creates confusion on terminology and leads to unreliable data collection. The EFN advocates for the replacement of the ISCO-08-based categories with the four categories of the EFN Nursing Care Continuum, in order to collect reliable data. Only by using a terminology that can be understood at EU level by health policy opinion formers and researchers, will it be possible to plan and forecast the future nursing workforce adequately and to deliver safe and high-quality health services in continuously reforming health systems.

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