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The free movement of nurses:



Paul De Raeve

A win-win situation if based on ethical recruitment guidelines

Within the liberalisation process of the Single European Market, the cross border movement of goods, services, professionals and patients is a priority for the European Commission and Member States. The proposal for a Directive on the Mutual Recognition of Professional Qualifications COM (2002) 119 Final 2002/0061 (COD), discussed in the Legal Affairs and Internal Market Committee of the European Parliament, will shape the future mobility of health professionals within Europe. The seven professions, each covered by a Sectoral Directive, emphasise the importance of a clear separation between the sectoral and the general regimes, a better protection of public interest and public health in the free provision of services and legal certainty for the direct input of the professions within the future consultation mechanism. While this political discussion is still going on, the health professions, in specific the national nursing organisations, face significant challenges:

The increase in unemployment within the EU is the main source of poverty and social exclusion, and has an impact on the health of European citizens. Nurses have a pivotal role to play in identifying those vulnerable groups and implementing policies to prevent poverty and social exclusion.

The increased cross border movement of health professionals leads to regional shortages of nurses. A European platform to facilitate cooperation for the better use of health resources within the EU is urgently needed. The nurses from the 52 Member States of the WHO European region are regarded as a 'supplementary' source of health care staff leading to a "skill and brain drain". The most qualified nurses will be the first to migrate, while the European region is still facing enormous differences in health status, life expectancy, social inequalities and poverty. The issue of

enlargement and how this process will impact on health demands across the EU needs to be visualised together with recognition of qualifications for health professionals because there is already free movement within the general system.

The reform of health care systems should be based on the achievements of the Member States and the exchange of information between the European health professions, patients and policy makers. Policy development and implementation necessitates a 'bottom-up' approach in order to reconcile national health policies of Member States with European obligations and to facilitate access to medical and nursing care in the EU.

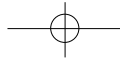
These challenges deserve detailed analysis especially given that health is an important economic and social factor in an enlarged Europe. Nurses provide around 80% of direct patient care and it is essential, when designing new policy in the social and health area, to include nurses and nursing to obtain a full picture of care.

The PCN strategy

Although there is already free movement for generalist nurses across Member States, we are still struggling with different levels of basic education, different programmes and different outcomes. Comparable data about nurses and nursing is required at a European level to inform health policy, to study and improve the quality/effectiveness of patient care, and to manage nursing resources. The single most common reason in all countries in relation to the current labour crisis in all health professional groups is a lack of information in respect of the number of health service employees, the healthcare needs and the delivery of services. Systematic information is needed about nursing practice, which is featured by a diversity of patient population (age, demographic features, pathology, and patient's need of care) and variation between care (different nursing care, medical treatment).

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Assessing a surplus or shortage of nurses necessitates the development of benchmarks in Europe to fit nursing resource requirements with health service demands. Systematic information should enhance the quality of decisions, financial performance and obtained results. A real human resources policy can only be made when there are comparable data available.

Therefore the Standing Committee of Nurses of the EU (PCN) has called on European stakeholders and institutions to:

Set up a European Workforce Monitoring Forum capturing information about health professionals and their services in order to make predictions on future trends and support workforce and health service planning. By doing this, we prevent substitution of 'expensive' nurses for 'cheaper' care assistants or aides.^{1,2}

Concentrate on problems in relation to recruitment and retention of an ageing nursing workforce in Europe. Political objectives regarding human resources in the health sector are needed. The nursing profession and career end need to be more attractive.

Develop further the implemented ethical and practical recruitment guidelines for nurses at a European level for all health professions. All European stakeholders play a significant role in helping to promote these ethical guidelines. Aggressive recruitment practices are not the answer and will lead to under-resourced and disrupted health services affecting further reforms of Member States health care systems.³

Development of educational standards and accredited programmes at a European level for the better protection of public interest and public health in the free provision of health services. There is ample evidence that a higher educational level will lead to high quality of care and patient satisfaction.⁴

Members States should be assisted and encouraged to *collate accurate and comparable quantity and quality data*. The nursing workforce, competences and mobility is essential within a single market but needs to be related to the quality of care and safety of patients.

Good practice with ethical standards

PCN members have concrete examples of partnership projects on developing a framework for mobility. This involves assessing contribution to provision of health care in

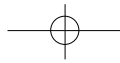
the host country, development of competencies, and facilitating nurses' re-entry for added value to the country of origin. This win-win situation is obtained using guidelines for the ethical recruitment of nurses, and setting out standards for employers and agencies to follow.

The UK has currently 42,000 internationally recruited nurses (7.5 % of all UK-based nurses) of which 4053 (0.7%) are from EU and EEA countries.⁵ With these numbers it clearly is not exaggerating to state that some health care organisations would cease to function without international nurses. Although language, differences in clinical and technical skills, racism in the workplace, and the reaction of patients are the main challenges, the process of recruitment has become more systematic, planned and strategic in recent years. Whilst the contribution of internationally recruited nurses should be welcomed and valued, the UK Royal College of Nursing (RCN) has recommended that the main focus of the UK's recruitment activity should now be to grow nursing capacity from within the UK.

The UK code of conduct on international recruitment states that "NHS employers should not target developing countries for recruitment of health care personnel unless the government of the country formally agrees via the Department of Health". Although there are still problems with the code's implementation, the RCN has also issued good practice guidance to health care employers on the recruitment, induction and retention of internationally recruited nurses. The majority these nurses come from outside Europe (the top three countries are The Philippines, South Africa and Australia) but there are also examples of successful recruitment from Eastern Europe, for example from Bulgaria, a future accession country.

Three years ago 33 Bulgarian nurses, from across the whole country and not just one hospital/city, were recruited to a hospital in Nottingham, England. The hospital used a planned recruitment approach with proper induction, not just in relation to work and clinical issues, but also in respect of the challenge of settling in England, for instance, assessing services in Nottingham where they were living, etc. After induction there were monthly 'recall' days organised to pick up any other issues, such as language ability, cultural differences in handling/dealing with patients and difficulties in getting used to working in a multi-disciplinary environment, with primary care,





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social services, etc. These differences have to be recognised but they are not insurmountable problems. Development opportunities were given to these Bulgarian nurses along with other staff and most of them have advanced their careers in three years to a higher grade and the retention rate is very high.

Less than 100 Polish nurses have been recruited to Norway since the end of 2001, as part of a formal agreement with the Polish government. The recruitment has taken place among those few who completed a three year programme in line with the Sectoral Directive in the mid-1990s and among those who have a masters degree. As Poland has changed its three year programme, recruitment is now limited to those with a masters degree (5% of Polish nurses). Polish nurses recruited are all given 16 weeks of language training (full time) prior to their departure for Norway, but additional courses are given after arrival. A temporary license for up to two years, successful completion of a three week course on Norwegian legislation and additional training in the care of older people are requirements for authorisation.

If migration is only temporary, qualifications acquired abroad may intensify the international exchange of experience and result in raising the quality of care if migrants return to their home countries. Currently, though we do not have any information on how many nurses have returned or will return to Poland, but recruitment only occurred recently in late 2001. This government programme ends in 2003, and the same goes for government recruitment of nurses from Germany and Finland. No official reason so far has been given, but it could prove to be too expensive, given the extensive need for language training.

Considering that the Netherlands has a significant shortage of nursing and caring personnel, and in Poland a 'growing number of nurses are unemployed', the Polish and Dutch Governments agreed to facilitate the temporary employment of Polish nurses in the Netherlands. The objective is to pave the way for mutual recognition by bridging the gap in the level of competencies. Two year employment contracts, additional in-service education provided by employers and meeting minimal European requirements are key criteria to participate in the project. Within the context of this pilot project, the competence of the Polish nurses will be monitored in order to assess the

actual qualification level of the Polish education system for nurses in comparison with the Dutch education system for nurses (BIG-register). The Polish government will then ensure that these nurses on their return are given an equivalent job in the health care sector.

These concrete examples show that exporting 'redundant' health care staff may result in a win-win situation for both countries. If migration is only temporary, qualifications acquired abroad may intensify the international exchange of experience and result in raising the quality of care standards if migrants return to their home countries. Ethical recruitment is about how staff can be recruited abroad without endangering nursing care in the countries of origin and how to overcome difficulties when only a small number of nurses have qualifications which meet the criteria for EU free movement.⁶ Therefore the EU has a particular role to play in helping to promote ethical guidelines within Member States governments and health care organisations.

Conclusion

Through twinning projects, PCN members have gained important experience on the exchange of information, building excellence, and providing input to policy development on the mutual recognition of professional qualifications as well as implementing ethical guidelines for the recruitment of nurses.

For the nursing workforce competence and mobility is essential within a single market and needs to be related to the quality of care and safety of patients. Countries are currently competing in the recruitment stakes and it becomes clear that recruitment from other countries is not the answer. We are "robbing Peter to pay Paul", taking the more experienced professionals from countries that have a surplus, but these most experienced nurses are needed to develop their own national and local health service.

Due to the fact that aggressive recruitment practices lead to under-resourced and disrupted health services, European stakeholders working on health and social policy need to endorse ethical guidelines and standards in the recruitment for all health professionals and develop a European labour market with better workforce planning and monitoring based on comparable data. By doing this, the free movement of health professionals and patients can be a win-win situation for all.

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