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Nursing shortages in Norway and England:

Status quo, implications and policy interventions

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Abstract

Nursing shortage or the shortage of nurse workforce is a global public health crisis affecting both the developed and developing countries alike. Because nurses are the frontline in most health systems, the lack of them thereof, is a hindrance in delivering effective health care service to the world population. The critical demand of nurses is severe in the Sub-Saharan region and East Asia that are still suffering from the double burden of diseases, i.e. AIDS/HIV, and infectious diseases such as malaria. An estimation of 600 000 nurses, for instance, are needed in Sub-Saharan region to meet the United Nation's (UN) Millennium Goals (MDG).

The developed countries of Norway and England may not face the same health problems that come with the double burden of diseases and nursing shortages. However, challenges, such as, global financial crisis, cost containment, a 'double whammy', low inflow and high outflow of nurses from the workforce are some of the many factors that affect the need for more nurses. The underlying multiple factors of burdensome workloads and poor working conditions are increasing job-related burnout and dissatisfaction. Consequently, these further generate a vicious cycle of turnover and outflow of nurses from the workforce.

The content analysis approach of international and national policy frameworks, recent media attention and published studies on the subject of nursing shortages in England and in Norway, are the primary sources for analyzing the status quo, implications and policy interventions of nursing shortages in both countries. In addition, this thesis is aiming to attempt to uncover the possible short-term and long-term solutions in light of national and international policy frameworks on recruitment and retention of nurse workforce.

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Abbreviation

DoH	Department of Health
GP	General Practitioner
ICN	International Council for Nurses
MDG	Millennium Development Goals
MoH	Ministries of Health and Education
OECD	Organization for Economic Cooperation and Development
NHS	National Health Services
NMC	Nursing and Midwifery Council (UK)
NSF	Norsk Sykepleierforbund (Norwegian Nursing Union/Association)
WHO	World Health Organization

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Chapter 1: Introduction

A global overview of nursing shortage

Nursing shortages or shortages in the nurse workforce are a global public health crisis affecting both developed and developing countries. The role of nurses in health is vital, as nurses are the frontline in most healthcare systems. Their expertise and the skilled care they provide to people around the world play a key role in delivering successful healthcare. The lack of nurses, therefore, is one of the main hindrances in operating effective healthcare services. Consequently, failure in dealing with the lack of nurses, whether it be local, regional, national or global, will lead to failure in maintaining or improving health care (Büscher, Sivertsen, and White 2009, 9; Buchan and Aiken 2008, 4; Buchan and Calman 2005)

Today's collective global health burden has altered the role of nursing. It has become more advanced and complex. Thus, an increase in the inflow of nurses is needed to provide adequate care for the world's population. However, the declining number of nurses is leading to a vicious and dangerous cycle of increased understaffing, resulting in critically negative health outcomes in both rich and poor countries alike. The critical demand for nurses as human resources is severe in developing countries, especially in East Asia and sub-Saharan Africa. These regions have the lowest average nurse-to-patient ratios, on top of already suffering from the heaviest burden of infectious diseases such as HIV/AIDS and malaria. The World Health Organization (WHO) reported that 57 countries were experiencing critical shortages, which is equivalent to a global deficit of 2.4 million doctors, nurses and midwives. The International Council of Nurses (ICN) also reported that more than 600,000 nurses are needed in sub-Saharan Africa to meet the United Nations (UN) Millennium Development Goals (MDGs)¹ (Buchan and Aiken 2008, 2).

¹ Millennium Development Goals (MDGs): 1. Eradicate Extreme Poverty and Hunger. 2. Achieve Universal Primary Education. 3. Promote Gender Equality and Empower Women. 4. Reduce Child Mortality. 5. Improve Maternal Health. 6. Combat HIV/AIDS, Malaria and Other Diseases. 7. Ensure Environmental Sustainability. 8. Global Partnership for Development (United Nations Millennium Declaration),

Nursing shortage and consequences for patient safety

The role of nurses, in terms of nursing care, is particularly important in the early detection of illnesses with sometimes vague or late symptoms such as infection, dehydration, deterioration, and many more. Because nurses are often near the patient, they are able to pick up early signs of illnesses and intervene in a timely manner. This prevents further health deterioration of patients, which saves lives. The effectiveness of nurses for round-the-clock surveillance is dependent on and influenced by the number of available nurses (L. Aiken and Clarke 2002).

Studies show that shortages of nurses are ranked as one of the greatest threats to patient safety. Multiple studies suggest that there is a link between low nurse staffing and a range of negative and even critical health consequences for patients, such as the increased spread of infection to patients and staff and increased high risk of errors and malpractice (Buchan and Aiken 2008; L. Aiken et al. 2003). Evidence from a study in US and English hospitals shows that lower numbers of nurses and doctors increase mortality rates and are associated with higher failure-to-rescue rates² among surgical patients. Mortality is regarded as the most severe effect of low staffing (L. Aiken and Clarke 2002; Griffiths, Jones, and Bottle 2013; RCN 2013a, 6).

Conversely, a higher nurse-to-patient ratio is associated with a 3–12% reduction of negative health outcomes, such as nosocomial (hospital-acquired) infections including urinary tract infection and pneumonia. Similarly, many international studies have found a positive relationship between higher nursing staffing levels and reduced patient-risk adjusted mortality, a lower risk of medical complications, a higher nurse-assessed quality of care, improved health of nurses through a lower risk of work-related injuries and lower absenteeism. In short, a higher number of nurses is associated with better health outcomes, better quality of care and more satisfied nurses. Also, a higher educational levels of nurses is also associated with better patient outcomes (Simoens, Villeneuve, and Hurst 2005, para. 21; L. Aiken and Clarke 2002; L. Aiken et al. 2003, 1623).

² Failure to rescue: death after a treatable complication (Griffith et al. 2013); or death in patients with serious complications (Aiken et al. 2003, 16, 18).

Contributing factors to nursing shortages

Low inflow and high outflow

The contributing factors to nursing shortages are multi-faceted (Buchan and Aiken 2008). The major contributors in developed societies are predominantly due to the low inflows of entrants into the profession and the high outflow of people leaving the workforce. The low inflow is due to the fact that there are fewer entrants of younger generations into the nursing profession, especially now that wider professional opportunities are available for young people. The negative perceptions of the working conditions and the low social value afforded to nursing also have a negative effect on recruitment (Simoens, Villeneuve, and Hurst 2005). The outflow of nurses from the profession is mainly caused by high turnover rates, which are primarily due to the higher percentage of retiring nurses in the workforce; nurses leave the job before retirement age because of the current challenging working conditions (Zurn, Dolea, and Stilwell 2005, 10–11).

Impact on nurse workforce

The nursing shortage and low staffing levels are linked to burdensome nurse workloads, higher levels of job-related burnout and job dissatisfaction, leading to the intention to leave current jobs (L. Aiken and Clarke 2002). Among European nurses, including those in Norway and England, the intention to leave is rated between 19 and 49% (Aiken et al. 2012, 142–146). The poor *working conditions* of nursing jobs are often related to poor nurse-to-patient ratios or low staffing levels, long working hours, schedule changes, work overloads, shift work, lack of appreciation from superiors and colleagues, not being included in policymaking and inadequate pay (Buchan and Aiken 2008; Buchan and Calman 2005; Simoens, Villeneuve, and Hurst 2005). Many nurses report that pressure to accomplish work is high, taking mandatory overtime, skipping meals and breaks frequently and doing too many non-clinical jobs and spending too little time with patients as a result. The poor working conditions and job dissatisfaction result in burnout, absenteeism and turnover, especially among newly qualified nurses. Absenteeism and turnover are generating a vicious cycle of negative effects of shortages, and they are costly for healthcare systems around the world (Buchan and Aiken 2008; Jones 2005; Goodin and Heather 2003).

Moreover, high job turnover rates will likely lead to higher costs for health providers due to recruitment, the training of new staff, increased overtime and the use of temporary agency staff to fill in the gaps. Other costs of turnover include reduced job efficiency of new staff, decreased staff morale and decreased group productivity (Zurn, Dolea, and Stilwell 2005, 3).

Policy Frameworks: recruitment and retention

The issues of nursing shortages are complex. There is no single ‘magic bullet’ policy or action that will resolve the nursing crisis. Multi-faceted solutions are therefore imperative (ICN 2006, 6; Buchan and Aiken 2008, 5). Various policy framework interventions have addressed the problem of nursing shortages; among the common goals and aims are the improvement of recruitment and retention by getting (increasing the inflow of nurses), keeping (keeping the remaining nurses in their current workplace) and keeping in touch with those who have left the workforce. Conversely, nursing shortages, according to the ICN and the WHO, are a symptom of inadequate policy for recruiting and retaining a nurse workforce and are considered a serious problem (Zurn, Dolea, and Stilwell 2005, 3–8).

The problem of nursing shortages has been also highlighted on international agendas, as well as at the regional and national levels. A variety of international literature and research studies on this problem are available to serve as tools for policymakers. Furthermore, there is an abundance of proposed policy interventions and strategies to serve as helpful tools for policymakers, including those initiated by the WHO, WHO Europe, the ICN and the Organization for Economic Co-operation and Development (OECD). These existing policy intervention initiatives can be utilised to combat nursing shortages globally, regionally or nationally. They also offer strategies to tackle the nursing shortages in failed states. However, this paper will look only at the nursing shortages in the two developed countries of Norway and England. Therefore, this paper will only briefly mention but not apply all the policies provided by the institutions mentioned above. It will focus only on two policy interventions to narrow down the subject and discuss it thoroughly within the limited scope of this paper.

Main objectives and Research questions

The main objective is to examine comparatively the status quo of nursing shortages in Norway and England. This paper will describe, analyse and evaluate the measures with which these countries address the problem nationally and internationally. Furthermore, this paper will attempt to demonstrate how these countries can learn from each other.

Research questions

What is the status quo of nursing shortages in Norway and England, respectively?

How are these two developed countries addressing the current national problem of nurse shortages?

The structure of the thesis will start with relevant terms and a short introduction to both countries' healthcare systems and nurse labour markets to provide a bigger picture of the study. Then, it will proceed to answer the research questions chronologically. In addition to answering the research questions listed above, recommendations for both countries are provided in the discussion section. They will be based on the relevant policy interventions proposed by the international organisations of the WHO, the ICN and the OECD.

Personal experience

The reason for choosing Norway and England stems primarily from my own personal experience working as a registered general nurse in these two countries. As a result of working in different locations (various types of wards and hospitals and various health institutions), I was able to witness how vastly wards can vary from one another in terms of understaffing. Observing these differences strengthened my curiosity to understand why some workplaces are struggling with understaffing, whilst others do not have the same challenge. During this master programme, I encountered the topic of nursing shortages that eventually led to this quest for knowledge regarding the causes and solutions of nursing shortages in these two countries.

Clarifications

The main objective of this paper is to examine and analyse the problem of “nursing shortages” or shortages of nurses, which means shortages of professional nurses or registered general nurses, RNs, as defined below. The purpose of such specification is to narrow down the topic to a group of health professional workers to study it in isolation. It will not be confused, used interchangeably, or be synonymous with other healthcare workers giving nursing care, e.g. unlicensed or unqualified healthcare assistants (HCA)³ or skilled, licenced or trained HCAs,⁴ although they will be addressed and included in the paper, as their contributions play a significant role in both countries’ healthcare systems. When the term ‘healthcare systems’⁵ is used, it usually refers to all types of health care provisions and institutions. Other concepts will be defined throughout the paper and therefore will not be presented or repeated in this section.

Moreover, England is the main focus in this study, although the United Kingdom (UK) is often referred to because the literature used in this paper may refer to the United Kingdom when National Health Services (NHS) is addressed. In addition, it is due to the fundamental similarities in HR policy and the fact that all NHS professionals are still registered at the United Kingdom level. This author is also aware that there may be variations in the management of NHS and the delivery of healthcare services in different countries of the Kingdom, especially since its devolution in 1998 (Buchan and Maynard 2006, 129; Buchan 2007).

Terminology

Global perspective of nursing and nurses: The term ‘nursing’ can be difficult to define. The ICN definition of nursing⁶ indicates that nursing is an independent profession that involves working collaboratively with other health experts to provide holistic care to people of all ages, families, groups and communities in all settings, whether they are sick or well. The nursing profession includes health promotion, prevention of illness and care for ill, disabled and dying people. As the Royal College of Nursing (RCN) puts it, the main focus of nursing should be on health, not merely

³ ‘Ufaglært’ in Norwegian.

⁴ ‘Helsefagarbeidere in Norwegian.

⁵ Healthcare system: hospitals, nursing homes, community healthcare services, rehabilitation centres, etc. Community healthcare services means nursing homes and home-based healthcare services.

⁶ ICN definition of ‘nursing’: <http://www.icn.ch/about-icn/icn-definition-of-nursing/>

treating illnesses. The ICN further elaborates that the key roles of nursing should include the following ‘advocacy, promotion of safe environment, research, participation in shaping health policy, patient health systems management and education’ (ICN 2014; RCN 2012).

Defining the term ‘nurse’ is also difficult, as there is no clear and single universal definition of what a ‘nurse’ is (Buchan and Aiken 2008, 3). Different countries have used different typologies of ‘nurse’ depending on the educational level, the qualifications required and the scope of training. The two most common typologies of nurses are ‘nurses’ ‘registered nurses’, in England and Norway. According to the OECD, the term ‘nurses’ refers to people who are registered or certified and actively practicing in public and private hospitals, clinics and other healthcare facilities. This also includes self-employed nurses. However, nurses working in administration, research and industry positions are excluded from this typology (Simoens, Villeneuve, and Hurst 2005, 23–24). The definition of ‘registered nurse’ (RN) or ‘registered general nurse’ (RGN) refers to nurses who have completed and acquired skills at the post-secondary or university degree level during their training and have passed a licensing examination to earn the right to legally use the title ‘registered nurse’. According to the International Standard Classification of Occupation (ISCO), the category of nurses is referred to by the ISCO-88 code and is classified as ‘Nursing and Midwife Professionals’ (Simoens, Villeneuve, and Hurst 2005).

Nursing shortage definition: According to ICN (2004), there is no universal definition of ‘nursing shortage’, but there is empirical evidence of imbalances between the demand and supply of registered nurses in the market conditions or according to the current needs (Buchan and Aiken 2008; Simoens, Villeneuve, and Hurst 2005). From an *economic perspective*, the demand for nurses is likely to increase when there is an economic expansion, population growth, an increasing ageing population, medical technology progression and higher patient expectations. The increase in health expenditures as a portion of the gross domestic product (GDP) is evidence of the strong growth in demand. The supply of nurses can be expected to fall or grow slowly as the results of trends in societies toward reduced work hours, an ageing workforce and the reduction of the size of the nurse workforce (Simoens, Villeneuve, and Hurst 2005, para. 12). The ‘shortage’ is not just about numbers and economic models. It does not necessarily mean that there is a lack of individual

qualified nurses; rather, there is an abundance of nurses who are unwilling to work in the current nursing conditions (Buchan and Aiken 2008). As previously mentioned, the nursing shortage is a symptom of inadequate policy for recruitment and retention of the nurse workforce (Zurn, Dolea, and Stilwell 2005).

Country-level policy perspective: From a country-level perspective, a nursing shortage is defined and measured according to the country's own historical staffing levels, resources and estimates for demand for healthcare services. It is the 'gap' between the current availability of nurses and the aspiration for higher-level healthcare provision. Therefore, it is not too easy to quantify or define a nursing shortage, as the definition can be used differently by different stakeholders, even in the same country (Buchan and Aiken 2008, 5).

Indicators of Nursing Shortages: To assess the magnitude and scope of nursing shortages, various indicators have been used. These include absenteeism rates, retention rates, vacancy rates (the number of unfilled posts at particular time) and turnover rates (that is, the labour force that is lost each year through retirement, death or international migration in moving to another sector of the economy) (Zurn, Dolea, and Stilwell 2005, 8–10). Other indicators that have been used by some articles and studies have included 'job dissatisfaction' and 'intention to leave', as these indicators are regarded as potential causes that are linked to absenteeism and turnover (Zurn, Dolea, and Stilwell 2005, 11; Aiken et al. 2012).

Chapter 2: Methods

A qualitative approach

This chapter describes the methodological approach of this thesis, the process of searching and selecting literature and texts on the topic and the analysis of them. The thesis has a qualitative approach: it focuses on meaning and context for the selected texts rather than numbers or other quantifiable phenomenon (Chambliss and Schutt 2009, 250)

Norway and England are the units of the thesis' analysis. The thesis is based on secondary data and uses qualitative content analysis. Once the theme, subject matter,

policy framework, research questions and the choice of cases was established, the basis of the research material had to be collected, described and classified.

Using documents/text alone as primary sources was a conscious choice because of limited time. The documents used had to be in sufficient quantity and of the necessary quality. The research material and data in this study were based first on a review of scientific and scholarly literature and the content analysis of those strategically selected documents from various sources to define and answer the research questions. These diverse texts and documents included academic journals, research articles, official public and governmental documents, various nursing organisational articles and news media headlines and articles on the relevant topics of nursing shortages and the policy interventions addressing recruitment and retention. These various secondary sources were systematically classified according to genre and then linked to the cases of Norway and England (Shank 2006, 151).

Content analysis was the approach used in this thesis. It is “a research method for systematically analysing and making inferences from text” (Chambliss and Schutt 2009, 85). The text surveyed here ranged from academic articles, newspapers and governmental documents (ibid). As a way of processing various data from different outlets, one could code articles by using key words on the subject matter. The key words used in this paper were, e.g. *nurse shortage*, *turnover*, *absenteeism* and *job dissatisfaction*.

Comparative analysis

The other distinctive features of content analysis are ‘comparison, contrasting and categorizing’ of the collected data ‘to test the hypothesis’ (Schwandt 2007, 41), which in this study, is the hypothesis of the (degree) of nursing shortage and the effects of policy interventions. The comparative method is used to examine patterns of similarities and differences across cases, as with the two countries, aimed at uncovering similarities and differences between them. For comparative projects, Kasza (2002) suggests that the most promising avenue is to give attention to policy-specific areas—in this case, the nursing shortages and the policies implemented to meet the challenges.

The premise of the research paper was to study the issue of nursing shortages in two nation-states. A cross-case display analysis will provide a multifaceted perspective of the particular and historical character of the issue. The grounds for comparison of the choice of the countries, Norway and England, were due to the similarities in healthcare systems, delivery and some degree nurse labour market organisation, as well as their differences in policy interventions implemented to address the problems of nursing shortages. In comparing these two nations, both the nature of nursing shortages and new solutions for shortages were discovered as well (Ragin 1987, 14; Heidenheimer, Hecllo, and Adams 1990, 1; Shank 2006, 154).

Data sources

The main sources used in this study were secondary literature addressing both quantitative and qualitative studies. Most of the literature was accessed online via Oslo University College's database and the Google search engine. A variety of search engines were used, such as PubMed, Cochrane, SvedMed+ and Google Scholar, especially in searching for academic journals. The literature used included journal articles, official, governmental reports, research articles and media news. Official documents, i.e. white paper articles and other governmental reports, were obtained from the university library as hard copies (Norway) or searched directly from parliamentary sites: www.regjering.no (Norway) and www.dh.gov.uk (United Kingdom). Organizational documents (WHO, OECD), statistical reports from SSB (Norwegian Statistics), nursing organisational reports and magazines from the ICN, *Sykepleien* from NSF (Norsk Sykepleierforbundet) and the Royal College of Nursing (RCN) were the other literature on the subject, acquired directly from their respective websites. News media headlines and articles were searched either via the school database or from various websites, e.g. www.vg.no and www.dagensmedisin.no for Norway and national nursing and online websites such as www.nursingtimes.net, www.dailymail.co.uk and RCN's website for England/the UK.

The broad and specific terms that were used to search were as follows: *nurse shortage*, *nursing shortage*, *nurse recruitment* and *nurse retention*. This yielded fruitful international scientific reports and journals at the British and international levels. However, 'nursing shortage', or *sykepleiermangel* in Norwegian, yielded very few results. Other words that further enhanced the search methods were *nursing workforce*,

nurse labour market, nursing fatigue and nursing burnout and absenteeism. The search for geographical locations specific to selected countries was not limited to Norway or England, as part of the aim of the study was to look at the topic of the situation and compare it to the global level as well.

Limitations

Language was a limitation throughout the data collection process. Most of the literature on the case of Norway was written in Norwegian. These documents had to be translated. There was some literature on the subject matter that lacked significant data and lacked consistency in the indicators (turnover rates, absenteeism rates) over time, which made it more difficult to compare the outcomes of the chosen cases accurately (Norway and England). Some of the literature suffered from significant inadequacy, as it tended to focus on the problem of the topic and suggest interventions but lacked an analysis of the progress and results of previously implemented policies. This made it more difficult to examine the problem and evaluate the effectiveness of the policies. The case of nursing shortages in Norway was an example of this difficulty due to the few scientific papers available on the subject. The relevant documents found were recent research studies on just one part of the healthcare system and not the whole. For instance, there were multiple research, governmental plan and evaluation reports addressing merely the general shortages of healthcare workers in the municipal healthcare sectors, excluding hospitals. The problems and implications of nursing shortages in hospitals in Norway have received considerable attention in the media. In some ways, the media coverage fills the gap caused by the lack of literature on the subject, as the media has illustrated the importance of the subject matter.

To confirm or deny the presumption of the lack of literature in Norway, two NSF representatives and Dag Hofoss, one of the researchers who conducted the last isolated study solely on Norwegian nursing shortages, '*Sykepleiermangelen*' (Hofoss and Buxrud 1987), were contacted. The NSF representatives' responses confirmed that the literature was indeed limited. Hofoss' reply was that he did not have any more knowledge on the topic since the publication of his work in 1987. In England and the United Kingdom, the nursing media are commonly used, to spread their message across a wider audience and to influence policy by 'going public'. The RCN in Wales,

for example, has a regular column in the national newspaper to raise and discuss nursing-related issues (Büscher, Sivertsen, and White 2009, 59), which was helpful in the study of the English case of nursing shortages. Thereby, the use of the media outlet is emphasized, since the media indicates the severity of the subject matter, which is in this case, the problem of nursing shortages.

Source credibility

During the course of the data collection, it was important to check whether the data was consistent and cohesive rather than scattered and contradictory. Credibility could be proved if multiple data sources could confirm the same thing. In addition, if the data turned out to be inconclusive, it would affect the outcome of the content analysis. It was also important to consult literature based on both qualitative and quantitative data to understand the magnitude of the issue at hand. Once the relevant data was collected, it was also necessary to examine the source critically to analyse its degree of objectivity.

Overall, the corpus of the wide range of literature presented in this study included reliable, credible and authentic published material. For example, the published academic journals have been, in principle, subjected to peer-review; therefore, they are regarded as valid and honest (Ó Dochartaigh 2002, 56). Nevertheless, awareness and scepticism was considered for all the literature used in this study, as there might be “*a degree of unsubstantiated generalization, political and ethical bias*” (Hart 2005, 71), e.g. governmental documents, organisational articles and media news. For instance, it should be kept in mind that, since the nursing shortage is on the political agenda, different institutions and spokespersons may have biased interests in emphasising different aspects or different research results or even asking for different types of studies. In this case, the texts from the media are an example of sources where spokespersons with agendas are given a voice.

Chapter 3: Tackling Nursing Shortages: Policy Frameworks

The policy frameworks on recruitment and retention strategies were specifically chosen from the reports listed below. These reports specifically target nurse recruitment and retention and nursing shortages in developed countries such as Norway and England.

(1) “Nurse Retention and Recruitment: Developing a Motivated Workforce”, by Zurn, Dolea and Stilwell (2005), from the ICN and the WHO.

(2) “Tackling Nurse Shortages in OECD Countries,” by Simoens, Villeneuve and Hurst (2005), from the OECD.

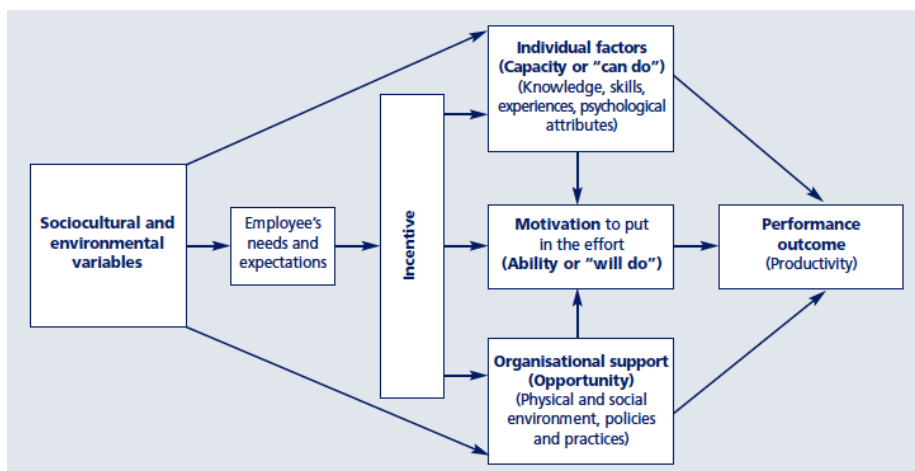
Recruitment Policy Intervention

To affect the inflow of nurses into the profession, policies are needed to improve domestic training and education, nurse re-entry and nurse migration. There are three approaches to achieve this: a) increase the input or increase the entrants, e.g. increase the number of students; b) decrease the attrition rate by improving the retention of students, improving the retention of existing nursing staff and c) attract nurses back into the workforce, e.g. nurses who have retired, left or come from other countries through migration (Zurn, Dolea, and Stilwell 2005, 4; Simoens, Villeneuve, and Hurst 2005).

Retention Policy Interventions

Reductions in the number of nurses occur when there is an outflow of nurses from the profession, caused by turnover rates from emigration, retirement or career change. Therefore, policies should be designed to target the factors that can improve nurse retention and affect turnover, such as workplace strategies; minimum nurse-to-patient ratios; education levels, continuing education and career advancement; pay levels; and violence and harassment (Simoens, Villeneuve, and Hurst 2005).

Figure 1: Relationship between incentives, motivation and performance of health workers



Source: Adapted from Kanungo and Mendonca (1994) in Zurn et al. (2005)

Motivation and performance

Aside from the factors mentioned above that involve the whole structure of the health system (macro level), the ICN and WHO recruitment and retention strategies also pay attention to the micro level of the health system by addressing the individual nurses' *motivation and performance*. It is believed that these two micro-level factors have an impact on the whole structure of healthcare systems, especially on the outcomes of patient care and safety. *Motivation* is believed to be a key factor in the performance of staff and organisations. It also serves as a predictor of staff intention to quit the workplace. Performance depends on whether the staffs perceive themselves as being "able to do things", "willing to do things", and whether means are available and facilitated, in order for them to perform nursing tasks appropriately and accordingly. In this context, it is imperative to link incentives and performance, as incentives affect performance (Zurn, Dolea, and Stilwell 2005).

Targeting personal characteristics: It is to recognise the personal characteristics of nurses related to age, sex and education, especially among young and well-educated nurses. The young and well-educated nurses are likely to develop their careers and change employers and professions. Incentives to prevent turnover should include offering professional development opportunities and career and pay enhancement. For the older nurse workforce that is likely to be more stable, policies should focus on keeping them from leaving and attracting them back to work through retention programs, flexible shifts or child care facilities (Zurn, Dolea, and Stilwell 2005).

Monetary incentives: Remuneration and monetary incentives are both indirect and indirect payment, e.g. wages, salary bonuses, pension, insurance, allowances, fellowships, loans and tuition reimbursement (Zurn, Dolea, and Stilwell 2005).

Non-monetary incentives: This is defined as work autonomy, career development and shift work. Work autonomy is when an individual has freedom/a feeling of control over his/her own work is regarded to be the key variable explaining job satisfaction. Evidence suggests that career development encourages retention. It is especially important when the nursing profession is characterised by the growth of knowledge related to medical health and medical technological advancements.

Frequent use of overtime, mandatory overtime, and the challenges of mandatory part-time work, full-time work and mandatory overtime, are key areas of job dissatisfaction. Therefore, working time and shifts should be adapted according to nurses' needs, with more flexibility and choice of shifts (Zurn, Dolea, and Stilwell 2005).

Reducing workplace violence: Violent acts are committed by patients, patients' relatives, other nurses and other professionals in the form of bullying, physical violence and assaults, increases the use of sick leave and burnout. Reducing violence in the workplace is likely to reduce attrition (Zurn, Dolea, and Stilwell 2005).

Leadership: Evidence from international studies shows that leadership has a positive impact on nurses' job dissatisfaction and their commitment to institutional goals (Zurn, Dolea, and Stilwell 2005).

Chapter 4: Healthcare system and workforce organisation

This section presents the Norwegian and English healthcare systems. It provides an overview of the healthcare organisations in terms of responsibilities, coordination, management, financing, health access, provision monitoring, nursing education and the nurse labour market.

The Norwegian healthcare system

Norway has approximately 5,077,798 inhabitants in the third quarter of 2013.⁷ The Norwegian health care system is organised at two levels: the national and local (municipal) levels. All specialised healthcare services and public hospitals are owned and run by the state, divided into four regional authorities (RHAs) (Lindahl and Squires 2011, 92). At the local level, the 430 municipalities in all 19 counties are responsible for the funding and delivery of primary health care services, i.e. general medical services, including a regular general practitioner (GP) scheme, emergency care, treatment, rehabilitation and all types of long-term care services such as community nursing and nursing home services. Private specialists and consultations for elective operations are also available in Norway. However, these are still contracted through the same RHA. Similarly, private nursing homes and private

⁷ <http://ssb.no/befolkning/statistikker/folkendrkv/kvartal>

mental health services are mainly provided through contracts with the municipalities (Lindahl and Squires 2011, 93–94).

The financing of the Norwegian healthcare system is predominantly funded through taxes. Some funding is through block grants, state grant supplements, earmarked means and some patient charges or co-payments (Johnsen and Bankauskaite 2006, xiii–xv; Lindahl and Squires 2011, 92). Healthcare coverage is universal. This means that provision is open to all regardless of social status, income or geographical localities, similar to the rest of the Nordic countries and the United Kingdom, although there are no defined benefits as to what it is included in the healthcare coverage package. Private/voluntary health insurance (VHI) does not play a significant role but rather has a supplementary function, such as offering shorter waiting times for elective operations and specialist consultations. About five per cent of the residents have VHI but still use a mixture of publicly provided services and VHI-covered services because acute specialised care is almost all provided publicly. Norway had the second highest spending on healthcare among OECD countries, with the government health expenditures of 9.6% of GDP,⁸ in 2009 (Lindahl and Squires 2011, 93).

Healthcare Organization: The Ministry of Health and Care (2006) has the overall responsibility for government policy in all health sectors. Within the ministry, the Directorate of Health and Social Affairs (Helsedirektoratet) carries out the practical work of organising and implementing health programs, while the Board of Health (Helsetilsynet) is responsible for ensuring that the healthcare sectors comply with the national quality standards. The Norwegian Institute of Public Health is responsible for public health surveillance and spreading health knowledge to the population (Brenne 2006, 71). Norsk sykepleierforbundet [NSF or the Norwegian Nursing Organisation (NNO)] is both the national professional organisation and the trade union for Norwegian authorised nurses and midwives. The NSF is not associated with any political party (NSF 2008; Kyrkjebø, Mekki, and Hanestad 2002, 297).

⁸ GDP: gross domestic product

The English healthcare system

England is the largest country in the United Kingdom, which also includes North Ireland, Scotland and Wales. In March 2011,⁹ the resident population of England and Wales was 56.1 million (White 2012). England's health expenditures were 10% of its GDP in 2009. The National Health Services (NHS) is England's national provider and funder of all types of healthcare services.¹⁰ It works jointly with local authorities, private, public and third party organisations at both the national and local levels. The English healthcare system includes primary care and specialist care, and hospital care is universal and is mainly free of charge at the point of use for all residents and non-residents. However, for non-residents such as visitors and illegal immigrants, the only treatment is given in an admission and emergency department (A&E) or for certain infectious diseases that treated are free of charge (Harrison et al. 2011). Around 75% of the NHS funding is supplied through national taxation, while 20% is from national insurance with a little cost-sharing payment income, and the rest comes from other sources. Other additional income comes from charges for drug prescriptions, dentistry services, fees and charges from patients who use NHS services, which are privately funded. Approximately 12% of the population is enrolled in voluntary private health insurance (VHI). Most private hospitals provide services largely for elective conditions and are financed through voluntary private health insurance (Harrison et al. 2011, 38–39). Other private healthcare organisations mainly provide nursing or residential home services, which are still largely funded publicly (Buchan and Maynard 2006, 130).

Healthcare Organization

The Parliament and the Department of Health (DoH) are responsible for health legislation and general policy. Currently, the Care Quality Commission (CQC) ensures that all social and healthcare sectors in England adhere to the national set of quality standards through a registration system and the monitoring of performance. All services, whether private or publicly provided, must be registered by the CQC,

⁹ No population data are available yet for 2012 and 2013 for England (<http://worldpopulationreview.com/countries/england-population/>)

¹⁰ England: All types of healthcare services includes screening, immunization and vaccination programs (preventative); inpatient and outpatient (ambulatory); hospital care (specialist); physical services (GPs); inpatient and outpatient drugs; dental care; some eye care; mental health care, including care for those with learning disabilities; palliative care; some long long-term care; and rehabilitation (Harrison et al. 2011, 38).

which regulates, assesses, investigates and even closes down services that exhibit poor performance (Harrison et al. 2011, 40).

Norwegian Nursing Education and Nursing Labour Market

Nursing Education

All higher education in Norway, including nursing education, is free of charge, although the students have to provide their own books (Kyrkjebø, Mekki, and Hanestad 2002, 300). Although the Norwegian MoH regulates nursing education through framework plans containing the curricula, teaching, assessment and practice methods (Brenne 2006, 77), domestic nursing education in Norway is decentralized. This means that each nursing school determines its own number of students according to the needs of the labour market (Simoens, Villeneuve, and Hurst 2005, para. 46). Nursing education has undergone many reforms; among them is the *Competence Reform 2000*, with the aim of improving quality and research on education and improving internationalization of education in higher education, including nursing. As the result of this reform, nurse education developed into nursing science as an academic discipline and could lead to a master's degree and specialised nurses (e.g. intensive, operation, psychiatric and midwifery) and PhD programs (NSF 2005, 6–7; Brenne 2006, 77). Nurses in Norway can be categorised under the typology of RN or RGN and those with specialisations. To become an RN, one must first complete three years of general nursing education leading to a bachelor's degree in nursing and nurses with specialisations (NSF 2005, 6–7). Norwegian nursing license registration is authorised by *Statens autorisasjonskontor for helsepersonell* (SAFH) only once and is valid until the holder is 75 years of age (Berge et al. 2011, 34–35).

Nurse Labour Market

In 2010, there were 104,000 registered nurses, with 73% actively working. Ten per cent were men, and 37% was 50 years old or above. Thirty-eight per cent of the active working nurses were working in the specialist care sector (hospitals), whereas 14% were in the teaching and public administrative sectors (Roksvaag and Texmon 2012, 52). Around 60% of Norwegian nurses have a specialisation; 21% have more than one specialisation, and 76% of these are in the age group of 50–59 years (Dæhlen and Seip 2009). Statistics Norway has developed a framework, HELSEMOD, for

estimating the future supply and demand for health personnel, including nurses, and workforce supply planning is based upon this calculation. Accordingly, the educational capacity planning, funding and competence building are adjusted based on the same calculation. The Directorate for Health and Social Affairs in collaboration with Statistics Norway is in charge of estimating future supply and demand for health personnel (Brenne 2006, 72).

English Nursing Education and Nursing Labour Market

Nursing Education

Nursing education in England, as the in the rest of the UK, is divided into the following four fields, which are used to categorise nurses according to their qualifications and training: adult nurse, mental health nurse, learning disabilities nurse and paediatric nurse. These are called pre-registration-level nursing programmes. The training lasts for three years and leads to a diploma certificate. Beginning in 2013, nursing education or the pre-registration program is moving toward the degree or bachelor level (NMC 2009, 6–9). The nurse education and training program is centralised and influenced by the government. The number of nursing students and the training capacity is determined between the DoH and local Workforce Development Confederations, which identify the local needs. The DoH provides the funding and ensures that local plans collectively meet the national needs. The government does not fund the higher education (master's degree or PhD programs). Students who wish to study further must fund their own courses (Simoens, Villeneuve, and Hurst 2005, para. 46; Buchan and Maynard 2006). The Nursing Midwifery Council (NMC) authorises all nursing registration. For non-EU/EEA ¹¹citizens, a list of requirements is prerequisites prior to application, such as one-year minimum nursing practice post-graduation, a registration fee and language exam, International Testing System (IELTS) (NMC 2010).

Nurse Labour Market

In March 2012, there were around 669,953 qualified nurses, midwives and health visitors registered with the Nursing and Midwifery Council (NMC) in the United Kingdom, and there has been an increase of 9,000 nurses since March 2011. For the

¹¹ Non-EU (Non-European). EEA (European Economic Association)

last 10 years, there has been a 20% increase in the number of nurses in England, from 256,218 in 2001 to 306,346 in 2011. The overall numbers of registrants have fluctuated in recent years, with no clear trend (Buchan and Seccombe 2012, 7–8). The Workforce Development Confederations are key bodies responsible for workforce planning in the England NHS, collaborating with NHS and non-NHS employers in planning and developing the health sector workforce and making decisions on funding allocation for training and education (Buchan and Maynard 2006, 130).

Chapter 5: Status quo of Nursing Shortages in Norway and England

To answer the first research question, the status quo or the current state of nurse understaffing will first be described. It will be followed by the presentation of the impact of the nursing shortages on the countries' healthcare systems and the delivery of patient care. The two countries of the study will be presented separately, followed by a summary and comparison.

Norway

Gap competence in the municipal health sectors

A report from the Health Directorate for Health and Social Affairs (Helsedirektoratet 2007, 11) states that Norway has succeeded in training sufficient numbers of healthcare workers in most of its professional groups. Similarly, in a white paper report presented to the Norwegian Parliament (St.mld nr.13(2011-2012), 2.3.1), *Education for Welfare: Interaction as Key*, it is cited that, currently, the balance of demand and supply for working in the municipal healthcare sectors, i.e. nursing homes and community-based health services, is relatively good. However, the report proceeds to state that there is a gap between the competence levels in these health sectors, and simultaneously, there is a growing need for knowledge and competence (ibid). The big difference in the competence and skills is evident when unskilled HCAs (health care assistants) account for 38% of the total health and care workforce,

trained HCAs comprise approximately 32% and registered nurses make up only 16% of the workforce (¹²Stortingsmelding nr. 13 (2011-2012), 3.2.3).

In 2003, the OECD reported that there was an estimated shortage of 3,300 full-time equivalents (FTE), or about 5.4% of practicing registered nurses (Simoens, Villeneuve, and Hurst 2005, para. 24–27). Former NSF leader Bente Slaatten, in a news article in *Dagbladet* (02.04.2007), summed up the nurse workforce situation, stating that the number of nurses in the Norwegian healthcare services was too small and that there was a vast need to raise the quality of care to live up to what is defined as ‘good practice’. She acknowledged that there was no documentation on the number of workers needed to meet the demand. An illustrative example she drew to illustrate that ‘need’ was the high job vacancy level. For example, for the 1,700 registered vacancies, there were only 200 job applicants (Slaatten 2007).

Geographical imbalance

With a population a little above five million¹³ and thinly scattered around the nation, this also contributes to the geographical imbalance in the number of health workers across the country. The rural areas and the northern parts of the country are more vulnerable to shortages, as healthcare workers are largely clustered around the big cities and neighbouring towns (Rechel, Dubois, and McKee 2006, 7).

Impact of nursing shortages

A few recent research articles suggest that the country is suffering from general understaffing and report on the constant difficulties in filling the gaps and holes in the schedule rotas throughout the healthcare system. The problem of nursing shortages normally escalates during the summer and holiday periods due to short- and long-term leaves, and there is a constant need to fill in the weekend rotas. The difficulty of filling the rotas seems evident in the use of mandatory overtime and the constant use of foreign nurses from agencies as substitutes or the direct hiring of overseas nurses (Berge et al. 2011, 5–8, 33; Gautun 2012).

Vacancy levels

¹² White paper (Stortingsmeldinger) definition from <http://www.regjeringen.no/en/doc/propositions-and-reports-/white-papers-.html?id=1754>

¹³ <http://ssb.no/befolkning/statistikker/folkendrkv/kvartal>

Too few vacant posts advertised and problematic recruitment into those advertised vacant posts are the two main problems that have been persistent, contributing to widespread and long-term nurse understaffing (Berge et al. 2011, 33). Additionally, according to this report, the problem of nursing shortages is an important explanation for why both hospitals and municipal healthcare sectors report widespread violations of rules and regulations concerning working hours. Therefore, the changing in working hours raises the question of how it affects patient care (Berge et al. 2011, 11). In hospitals, the shortages are predominantly of nurses with specialisations, e.g. intensive and psychiatric nurses (Berge et al. 2011) and theatre (surgical) nurses. For example, in the Oslo regional hospitals (Oslo Universistets sykehus, OUS), 30 theatre nurse posts out of 400 are vacant, and 1/5 of the theatre nurses are over 60 years old (Fonn 2013). The community healthcare sectors (nursing homes and home-based nursing services), are reported to be severely subjected to understaffing of regular nurses. In some counties, the reported nurse vacancy rates in home-based sectors are up to 60%, replaced by unskilled or unlicensed HCAs. Sometimes, there is no one to fill the enormous gap (Østby 2013).

Media coverage on the impact of nursing shortages on hospitals

In Aftenposten news online (30.06 2012) reported that, when the hospital in Stavanger SUS, was lacking up to 1,200 nurses for the 2011 summer holiday period, the hospital had to look for nurses in neighbouring countries such as Sweden and Denmark without any luck, and the managers were worried that it would take a toll on the patients' safety. Hence, to remedy the foreseen understaffing of nurses during holiday seasons, the remaining nurses were ordered to take extra (mandatory overtime). It has also become a yearly routine to reduce the number of available hospital beds to alleviate the pressure of shortages, among other strategies employed by one hospital in the country (Olsen 2012).

A-hus hospital scandal: One of the most striking examples of media coverage on the consequences of the lack of nurses alongside other healthcare workers in the hospitals was the heated scandal of the newly opened hospital, Ahus. It was opened in 2008 and was not properly equipped with enough labour to receive new patients. The hospital was often heavily criticised in the media, especially in 2012, for the many reported cases of malpractices and possible unnatural deaths due to labour shortages, which

was backed up by the county governor's report that malpractice in the hospital was indeed associated with understaffing, as reported by Lisbeth Nilsen on 21.09.2012 in the online medical news outlet *Dagens Medisin* (Nilsen 2012). At the pinnacle of the scandal, the coverage resulted in the replacement of the Health Minister in 2012 due to the allegations that she was responsible for the vacancy posts being stopped.

One of the news items on the case above from *NRK (national television broadcasting)* news online (24.06. 2011) reported that approximately 20 patients had to be accommodated in the corridors every day since the hospital's opening in January 2011 due to a lack of nurses. These patients added to the remaining healthcare workers' everyday workloads and discontent. Other reported reasons for discontentment included having little time allocated to each patient and being unable to give the quality of care they wished to provide (Gimmingsrud and Sund 2011).

Equal access to basic care

Another problem with nurse understaffing in patient care is that patients are not getting all their basic care due to the time pressure on the remaining staff. There are too many patients to handle with too little time. Healthcare workers report being unable to provide satisfactory care like they wish they could give due to the lack of time allocated per patient. Medical and physiological needs are commonly prioritised, but other care, such as psychological or social needs, which are also considered 'basic needs' of the patients, are reportedly not being met (Slettebø et al. 2010, 536). Hence, the ethical implication concerning the right to access basic care becomes an important issue as well.

Use of temporary nurses

Since early 2000, there has been an increasing use of temporary nurses, predominantly consisting of overseas nurses. The temporary nurses are usually hired from health recruitment agencies, consisting largely of Swedish nurses. The others are directly hired abroad from other European countries and the Philippines (Berge et al. 2011, 33–97). In 2009, there were around 7,600 migrant nurses working in Norway. The number of health recruitment agencies increased from 67 in 2004 to 137 in 2009, along with the number of nurses working for them. There was an increase in the number of agency nurses from 568 to 3,313 in the same period, making up 4% of the

total employed nurse workforce. About 84% of the nurses working for the agencies are recruited from abroad, with Swedish nurses comprising 80% of them, working predominantly in hospitals together with other Scandinavian recruited nurses. Non-Nordic recruited nurses work in the community healthcare sectors, mainly in nursing homes (Berge et al. 2011, 9–10).

The health sectors' general impression of nurses working from health recruitment agencies is relatively good. This is especially of Swedish agency nurses because of the similarity in nursing education, practice and language (Berge et al. 2011, 74–75). However, problems still occur for all parties involved. One of the problems that healthcare sectors encounter with foreign agency nurses is that some of them lack competence or do not have the competence that the institutions need (ibid.125). The surveys done by the same research article shows that 25% of institutional representatives perceive the foreign agency nurses as having little or no knowledge of Norwegian healthcare rules and regulations, including what standard 'good practice' involves. Another concern voiced by many representatives is that many foreign agency nurses have poorer supervised adaptation training needed, in which the increase use of agency nurses with poorer nursing knowledge can put patient care at risk (ibid.95).

Adecco-scandal: The biggest health recruitment agency in Norway was brought to the public attention for systematically breaching rules and regulations under working environmental laws and 'social dumping' of overseas nurses. 'Social dumping' is term used of foreign labour subjected to poor working conditions which migrant nurses have been associated with lately. Overseas nurses have been known to be exploited through poor working conditions, such as more working hours than allowed, receiving lower wages, and poor housing conditions for short-term agency nurses. Some non-Nordic foreign agency nurses were even driven into debt by their non-serious agencies (Berge et al. 2011, 95, 126). The Norwegian language is also a challenge for many non-Nordic nurses (ibid. 114, 126).

Reasons for shortages

Demographic changes

The demographic changes in Norway is said to affect the need for more health personnel. The growing elderly population to care for, with multiple and more complicated illnesses, especially beginning in 2020, when the number of those 80 years old and above is predicted to increase significantly. The number of people age 67 years and above will double in the next 50 years, contributing to fewer hands to take care of the sick and elderly population (Helsedirektoratet 2009, 2; Gautun 2012, 15–16). The increasing elderly population is due to the high rate of births after World War II (the baby boomer generation), as well as the increasing life expectancy (Midsundstad and Bogen 2011, 8). Furthermore, the baby boomer generation is approaching retirement age and requires replacement when they retire. One-fifth of the health and social workforce is age 56 and above and will retire early, before reaching the pensionable age (Helsedirektoratet 2007, 16). Aside from demographic changes, younger consumers (under 67 years of age) of healthcare, especially in community primary care, is on the rise and catching up as well, which is another reason for the increase in demand for an inflow of nurses and healthcare workers in the healthcare system, especially in the home-based healthcare sector (Gautun 2012, 16).

Limited domestic recruitment

The number of nursing students has increased by 70% since 1990. Despite the increase, there has also been a trend of fewer applicants for nursing education, dropping from 9,019 applicants in 2005 to 7,514 applicants in 2008 (Helsedirektoratet 2009, 56–59). According to the table below, the estimated number of domestic nurse registrants has been stable for the last ten years. In 2010, 3,483 licences were granted, compared to 3,473 licences in 2000. The migrant registrants make up a large portion of the total registration (Berge et al. 2011, 36).

Figure 2: Estimated number of registered licences from 2000–2010 by nationality (Norway, Sweden, Denmark, Finland, Iceland and other countries)

Land	Estimate										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Norway	3473	3473	3324	3542	3664	3680	3627	3676	3424	3475	3483
Sweden	865	590	660	769	595	1205	1430	1621	2023	1973	1686
Denmark	418	310	305	355	229	172	156	165	136	150	158
Finland	212	201	156	126	56	63	74	58	76	73	60
Iceland	3	11	9	6	7	6	4	2	6	39	76
Others	101	195	290	413	317	208	210	322	443	559	558
Total	5072	4780	4744	5193	4868	5334	5501	5844	6108	6269	6021

Source: SAFH in Berge et al. (2011, 36)

Absenteeism

Problems with turnover due to retirement and early retirement, absenteeism (long-term sick leave), leaving on social benefits and job turnover into other professions are also contributory factors affecting the current shortages. The absenteeism rate is high among healthcare workers, around 30% higher in comparison with the rest in the country. Absenteeism among healthcare workers is also relatively higher in Norway compared to other European countries in the same job. The reported high rate of absenteeism can be explained by the high rate of women in labour market participation, as women are the ones taking care of sick children and old parents and taking maternity leave. Women have 60% higher absenteeism than men in the same healthcare sectors, but men working in the healthcare sectors also have a higher rate of absenteeism compared to other working men in general (Midtsundstad and Bogen 2011, 8; Gautun 2012, 42).

The main common reasons for the high rate of absenteeism are due to illnesses in the healthcare sectors such as musculoskeletal disorders (MSDs) and psychological disorders, accounting for 60% of sick leaves in the general population. These disorders are common among unskilled and low-skilled workers. Unskilled healthcare workers along with cleaners are more subject to MSDs due to the nature of their physically difficult jobs. Pregnancy and maternity leaves are a logical explanation for the high rate of absenteeism among women, but women are also reported to have higher sick leaves at all ages, even if the factors of pregnancy, number of children, wages, education and profession are controlled (Midtsundstad and Bogen 2011, 8). Eight per cent of nurses leave the profession and receive rehabilitation or disability benefits, and 21% of unskilled and skilled healthcare workers leave their jobs due to mental and physical exhaustion (Helsedirektoratet 2007).

The underlying cause of physical and mental exhaustion (burnout) among healthcare workers in general, leading to the main reasons for the high absenteeism rate, is the difficult physical and mental workload of healthcare jobs, especially at the community level. Insufficient support from managers, time pressure and little or no control over their own job situation also contribute to exhaustion and absenteeism. Conversely, recent research studies show that job flexibility and supportive managers

have a positive effect on the ability to cope with physical and mental exhaustion, thus contributing to lower absenteeism (Midsundstad and Bogen 2011, 8). Many younger people leave their nursing and midwifery jobs and switch to other careers. The main reasons reported for turnover are heavy workloads, feeling unappreciated, inconvenient working hours and lack of opportunities for advancement, career development and further professional development (Helsedirektoratet 2007).

Involuntary part-time nurses as labour force reserve

Norway has a high percentage of part-time workers, and this is associated with the high participation of women in the labour market. In 2007, 43% of women were working part-time, while 11% of men worked part-time. Part-time contract systems are normal in the healthcare and social sectors due to the need to staff continuing 24-hour shifts (evenings, weekends and night shifts). As a result, obtaining a full-time permanent position that is equivalent to 37.5 hours per week is a problem in the healthcare system. Many employers are contracted only for a fraction, as low as 17% positions. To earn a wage that is equivalent to a full-time position, workers have to work more than one part-time job (involuntarily) (Helsedirektoratet 2009, 18; Helsedirektoratet 2007, 17). An analysis by SSB shows that, among the nurse workforce, only 55% were granted full-time positions. 35% are engaging in longer involuntary part-time work, and 10% are working short part-time work (1–19 hours/week). 12–20% of involuntary part-time workers wish to have longer working hours; six per cent wish to have shorter working hours, while the rest are happy with their contracted working hours (Nergaard 2010, 27–31); 10.6 per cent are defined as ‘underemployed’¹⁴ (Helsedirektoratet 2009, 18). In other words, there is an unutilised ‘nurse labour reserve’ among nurses who are already in the workforce (Berge et al. 2011, 15, 137).

This is another reason for the limited recruitment and why the nursing career is unpopular among younger generations, as well as why many leave the profession after a short time due to the unlikelihood of obtaining a full-time position. This could also be the reason behind the reputation of the nursing profession as a poorly paid job. Incomes become low due to the lower contracted hours as a consequence of part-time

¹⁴ Underemployment is defined as voluntary part-time workers having attempted to acquire longer working hours than contracted through public (pool) employment, advertising themselves or contacting their current employers (Helsedirektoratet 2009, 18).

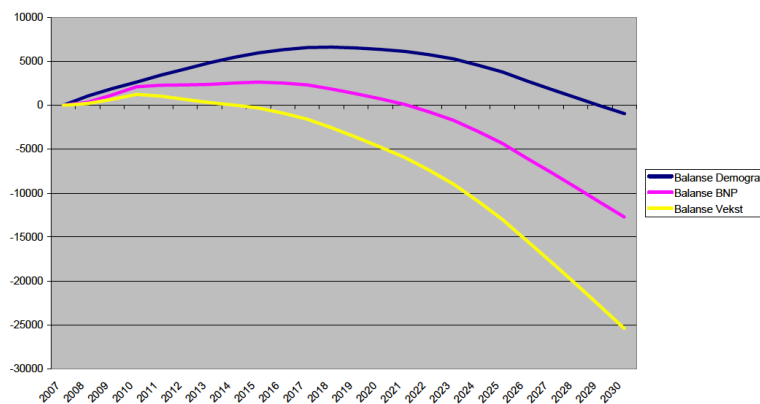
contracts. The reason may not necessarily be due to the lower annual wages in comparison to other professions (Helsedirektoratet 2007).

Other reported reasons are tight financial constraints affecting general recruitment, as well as the insufficient reporting system between local administrators, mediators (higher administrators) and local governments that may be under-communicating the local needs (Gautun 2012)

Future projections

There are various calculations concerning the future of the nurse labour market from Statistics Norway (SSB). One calculation for 2030 predicts understaffing by approximately 13,000 nurses (Helsedirektoratet 2009, 54), whereas a calculation for 2035 predicts understaffing by 28,000 nurses. This number accounts for 68% of the total predicted shortage of healthcare personnel of around 76,000 by 2035 (Roksvaag and Texmon 2012).¹⁵ What is common with all the calculations is declining the considerable declining trend of undersupply of nurses in the future.

Figure 3: The balance of the nurse labour market by 2030 through various calculations of demand



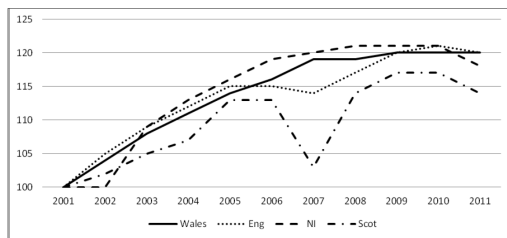
Source: SSB/Helsedirektoratet (2009)

¹⁵ The future prediction of demand and supply of healthcare workers is calculated by Statistics Norway (SSB) using the HELSEMOD planning tool under the commission of the Directorate of Health and Social Affairs.

England

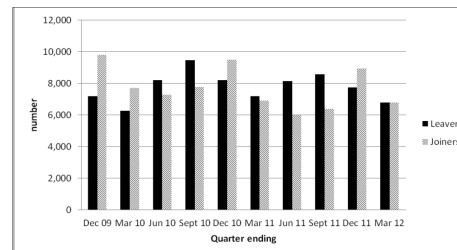
In the United Kingdom's 2012 nurse labour market review (LMR), Buchan and Seccombe outline the current status of the nursing workforce and highlight the three main causal factors in the declining numbers of nurses: the decreasing numbers enrolling in domestic nurse education, decreasing international recruitment and the outmigration of UK nurses. The RCN and the LMR 2011 reports show that decreasing numbers of student places and the increasing numbers of staff members leaving the workforce could result in a loss of 99,000 nurses over a ten-year period (RCN 2013a, 10; Buchan and Seccombe 2011).

Figure 5: Annual trend in NHS qualified nursing workforce in the four UK countries



Source: Buchan and Seccombe (2012,9)

Figure 4: Quarterly turnover of nurses in NHS in England, 2009–2012



Source: NHS in Buchan and Seccombe (2012,11)

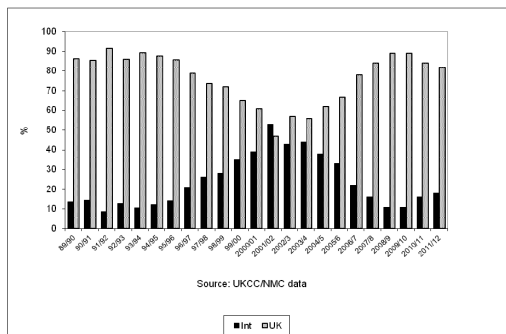
The figures above show a seasonal fluctuation in the inflow and outflow of nurses in England (and the UK) over a decade, as well as the latest data for NHS in England. Figure 6 shows that England has been struggling to keep up with the inflow of nurse supply in comparison to the rest of the UK, with an enormous drop in numbers in 2006–2007 and a declining trend beginning in 2010. The latest data for NHS in this same report show a reduction of 5,780 staff members and around 3,700 FTEs between May 2010 and June 2012 (Buchan and Seccombe 2012, 9). Figure 2 illustrates a fluctuating close match in the amount of inflow and turnover. In March 2012, for example, there were as many 'joiners' as 'leavers' in the NHS in England (Buchan and Seccombe 2012, 9–13).

Nurse inflow

According to Figure 7, domestic nurse education (pre-registration) is the major source for the nurse supply in the UK, and international recruitment at some points was a major contributor to the increases size of the workforce. The decline is the result of

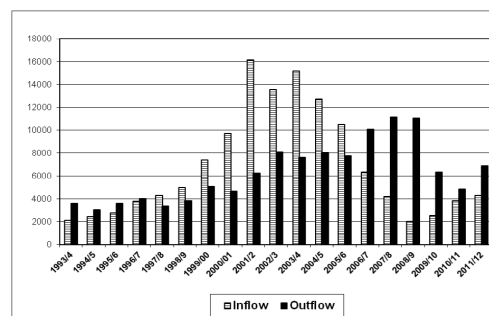
restricted student places, even though there has been an increase in the number of applicants. The LMR 2011 reports about a 25% increase in the number of applications in England, though only 60% of the applicants were successful (22,755 out of 48,076 applicants) (Buchan and Seccombe 2011, 23). The decline in international recruitment was the result of tougher policy, changes in the NMC entry requirements and changes in the immigration system (Buchan and 2012, 2).

Figure 6: International and UK sources as % of total new admissions to the UK nursing register, 1989–2012



Source: NMC Buchan and Seccombe (2012)

Figure 8: Inflow and outflow of nurses from the UK, 1993–2012



Source: NMC/Buchan and Seccombe

Nurse outflow

In recent years, the UK has seen a trend of outmigration among its nurses as they move abroad to Australia, Canada, New Zealand and the USA. The outflow of nurses is rising more than the net inflow (Buchan and Seccombe 2012, 2) and is also driven by push and pull factors of labour migration. The developed Anglo-Saxon countries that still rely on active international recruitment to remedy their massive nursing shortages are expressing interest in the UK as a source of nurses. There have been recruitment strategies to attract UK nurses in, for example, advertisements in UK nursing journals or deliberately targeting some areas where there have been broadcasted job cuts and recruitment freezes (Buchan and Seccombe 2012, 19–23).

Financial pressures and future projections

The LMR 2012 sheds light on the effect of financial pressures on the current and future NHS nursing workforce. Cost containment is leading to a reduction in commissioned training and education and to reductions in staff size (vacancies post-freeze), pay freezes and reduced training budgets for the nursing workforce. All these

factors have an obvious effect on the size and shape of the nurse workforce (Buchan and Seccombe 2012, 2). WHO Europe (2013) has reported an estimated shortage of 40,000 nurses in the United Kingdom in 2012. The Centre for Workforce Intelligence (CfWI) reports a ‘most likely scenario’ in England of 47,500 fewer nurses by 2016 (Lintern 2013b).

Impact of nursing shortages

The NHS has been known to be struggling to attract and keep nurses and midwives in the workforce. These problems are regarded as serious, and they are most crucial in the inner cities, i.e. London, and teaching trusts. The turnover rates, particularly in London, range from 11 to 38%; 34% of new graduates are not registering to practice (Finlayson et al. 2002b), and recent reported vacancy rates range from 6–16%, equivalent to 20,000 FTEs or 34,000 individuals (RCN 2013b, 3). The ageing nurse workforce is contributing to the increasing turnover rate. In 2001, in England, 19% of its nurse workforce was 50 years of age and older, and this increased to 26% in 2010 (Buchan and Seccombe 2011, 19). The problems of recruitment and retention of key workers are considered to be ‘severely hampering’ NHS healthcare delivery and putting the government’s plan of modernising¹⁶ it at ‘risk’, thereby having serious implications for patient care and safety. The report published by Francis (2013) on the scandal at Stafford Hospital, discovered that the hospital care was worsening and that hundreds of excess of death were partly caused by dilution of nursing skill mix, a decrease of nurse staff and more on unqualified HCA (health care assistants) (RCN 2013b, 2, 6). This report of incidents serves as a stark warning of the serious consequences of low staffing levels on patient safety. *Daily Mail* online news (22.01.2013) has revealed that 28,000 patients die every year as a result of complications (e.g. pneumonia, blood clots) that could have been treated had they been detected early but were not due to a lack of trained medical staff (Borland 2013).

Other underlying causes and reasons

With the high rates of turnover and nurses not registering to practice, Finlayson et al (2002b) have found other causes and reasons that nurses leave or do not join the

¹⁶ NHS Plan Summary:

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/Browsable/DH_4933598

profession, and they have categorised these under four headings: pay and cost of living, the changing nature of the job and the staff not feeling valued (Finlayson et al. 2002b). Although these journal articles are from 2002, the same problems persist today as illustrated with recent examples below.

Pay and cost of living: Although the government has increased the wages for both junior nurses and senior nurses, the nurses' basic wage still remains low in comparison with those of other careers, e.g. teachers and policemen (Finlayson et al. 2002a, 542). In an RCN (2007) report, nurses are said to be the worst paid professional group in the public sector. Nurses earned 20% less than primary teachers and 24% less than secondary teachers. Nurses with managerial responsibilities earned 14% less than police officers without the same managerial responsibilities. 68% of nurses reported having taken temporary work to supplement their incomes. The LMR 2011 and the *Daily Mail*, on March 21, 2011, reported that nurses' wage above 21,000 GBP would be frozen for two years for 2011–2012. This news was a 'bitter blow' for the nurses and other medical staff members who were already paying more in pension contributions and simultaneously receiving low wages (Daily Mail Reporter 2013; Buchan and Seccombe 2011, 5).

Nurses living in London have received an allowance increase of 3.7% and a living supplement worth up to 1,000 GBP. In addition, nurses living in high-cost areas outside London have received up to 600 GBP as a cost of living allowance. The NHS plan promised cost of living allowances and residential units, especially for nurses living in high-cost areas, such as, London. New scheme was announced to be set up to help nurses and other public sector workers buy their first homes. However, living costs, particularly in London, remain a concern because of the high average house prices and the high mortgage requirements. A nurse has to earn three times her regular monthly salary in order to afford to buy a house in London (Finlayson et al. 2002a, 542–543).

Changing nature of job: The increasing burden of bureaucracy and a lack of appropriate support are changing the nature of nursing today. In recent years, nurses have experienced increasing amounts of paperwork and less time with patients. The paperwork overload is partly due to regular auditing and clinical governance activities. Today's nurses are being drowned with too much paperwork, such as 'lengthy

admission forms, patient care plans, complex discharge planning documents and an abundant of risk assessments'. There have also been complaints about not getting appropriate help with administrative (paperwork) support, resulting in overtime (Finlayson et al. 2002a, 542). An RCN survey in 2008 reported that more than 1,700 nurses were spending more than a million hours a week on paperwork and clerical tasks. In the same year, an analysis done by the University of Leeds reported that 25% of nurses' time is spent on patient administration (Lomas 2012). The problem of increasing paperwork is just one of the many tasks of nurses' workload on a daily basis. On top of this, nurses are complaining about spending time performing functions and roles that are not related to their professional skills, such as cleaning rooms or 'deep cleaning' beds or removing trays, as reported by *NursingTime.net* on August 21st, 2012 (Calkin 2012). The high levels of vacancies and turnover rates are increasing workloads and pressure on the existing staff. It is resulting in nurses having to care for more acutely ill patients with fewer staff members while also supervising agency staff who are unfamiliar with the routines in the wards, which is another burden (Finlayson et al. 2002a, 542).

Feeling valued: Many new initiatives have been recognised to help make nurses feel more valued in their work, such as flexible and family-friendly work arrangements, as outlined in a 1998 government white paper and reiterated in the NHS Plan. The government has also added a 'zero-tolerance' policy against violence towards NHS staff. The commitment includes eradicating harassment and discrimination. This can be found in the Department of Health's Improving Working Lives Standards. However, there is ambivalence in the politicians' public portrayal of nurses, sending out mixed messages. On one hand, nurses are cheered as champions, with recognition and awards. On the other hand, the 'government rhetoric of the public service workers can be negative' (Finlayson et al. 2002a, 543). For instance, the NHS has a managing performance and target culture that involves rewards and sanctions when targets are met. Such a target could, for example, be a reduction of patient waiting time. When targets are met, the rewards given could include bonuses, awards and public 'star ratings', or there could be 'naming and shaming' in the public for poor NHS performance (Bevan and Hood 2006; Hood 2006).

Summary of the countries' status quo

There are common characteristics in the status quo of nursing shortages in England and Norway, such as the implications and consequences of understaffing and contributing underlying reasons. Both countries are facing a 'double whammy', a demographic dilemma of increasingly elderly populations and ageing nurse workforces, limited recruitment and high predictions of nursing undersupply in the future. Common symptoms and indicators of the nursing shortage in both countries are high levels of vacancies, absenteeism and turnover and the increasing use of temporary agency nurses and international recruitment. The impact of nursing shortages on the healthcare system and healthcare delivery are also similar, such as the reported alarming hospital scandals involving critical patient outcomes and even reported unnatural deaths due to understaffing. The fact that patients are not getting their psychological and social needs properly taken care of due to limited time allocation per patient and time pressure, with prioritising of medical and physiological needs, is having ethical implications for patients' right to have their basic needs covered. Similarly, little time spent on patients and the inability to provide satisfactory patient care have contributed to staff job dissatisfaction. In attempting to remedy the shortages, both countries are challenged by the use of mandatory overtime, filling nursing vacancies with less qualified staff and the use international recruitment through direct hiring and the use temporary agency nurses. In Norway, there seems like an under-communication on the shortage of nurse workforce. Although the understaffing of the healthcare workforce in general is acknowledged and reflected in government reports, the challenges solely associated with nursing shortages and its effects, are highlighted by the media. In England and the UK, the nurse labour market review (LMR) gives an annual overview of the status and the key challenges of the NHS nursing workforce. For the 2012 review reports highlights that the nursing workforce is being over-stretched and under-resourced as a consequence of financial pressures and cost containment, leading to budget cuts for the nursing workforce and a reduction in the number of education places.

Chapter 6: National Recruitment and Retention Policies

In this chapter, the second research question will be answered:

How are these two developed countries addressing the current national problem of nursing shortages?

How Norway and England address the current national problems of nursing shortages has been broad, diffuse and complex. This section will present some key government policies and the evaluation of effective short-term and long-term strategies.

Norway

The shortage of the general healthcare workforce is a problem acknowledged by the Norwegian government, with special emphasis on reducing the number of unskilled healthcare workers and reducing the competence gap in municipal health care services (nursing homes and home-based care). This problem and recommended solutions are reflected in various governmental white papers,¹⁷ action plans and reports to map out and assess today's needs as well as those of the future. The key governmental papers relevant to this paper are 'Utdanne og utnytte godt' (2009), 'Recruitment of Health Workers: Towards Global Solidarity' (2007), and the 'Competence Boost 2015' implementation plan from the white paper (St.mld nr. 25 (2005-2006) 2012) '*Mestring, muligheter og mening*'.

According to the governmental papers, it is of great importance to take responsibility through an ethical health workforce policy that is based on sustaining its own workforce and its national future needs. To accomplish this, the Norwegian government has taken the responsibility to abide by an international agreed-upon framework of obligations and/or the WHO's codes of practice. The Norwegian recruitment and retention policies focus on solving its own healthcare workforce problem nationally by being self-sufficient. In addition, the Norwegian government has committed to global solidarity with less economically developed countries. This includes assisting and strengthening capacity building, reducing migration driving factors and ensuring responsible foreign recruitment (Helsedirektoratet 2007, 5–6; Helsedirektoratet 2009, 10).

Self-sufficiency Strategies

¹⁷ Selected governmental documents: (1) St.meld. nr. 25 (2005-2006) *Mestring, muligheter og mening (Omsorgsmelding)*. (2) St.prp.nr.1 (2006-2007), *Nasjonal helseplan (2007-2010)*. (3) St.meld.nr.18 (2007-2008) *Arbeidsinnvandring*. (4) NOU 2008:14 '*Samstemt for utvikling*', in (Helsedirektoratet 2009, 10).

The ‘Recruitment of Health Workers: Towards Global Solidarity’,¹⁸ (Helsedirektoratet 2007) and ‘*Utdanne nok og utnytte godt*’ (Helsedirektoratet 2009) governmental reports are national recruitment and retention policy frameworks, in collaboration with other multi-level sectors, with recommendations and on-going implementation policies on how to be self-sufficient in solving the national problems of health personnel shortages. In these papers, the government indicates that the health workforce shortage is complex, and various strategies are recommended. The common key strategies in these papers are: (1) better utilisation of labour of those already in the workforce by reducing involuntary part-time work; reducing early retirement; performing better distribution of tasks, ‘task-shifting’ between different workers to provide the best quality of patient care; and acquiring more knowledge on how to use the various health workers; and (2) increased education capacity for nurses and an increased competence level among unskilled HCAs through economic incentives and adequate access to training (Helsedirektoratet 2009, 2).

Recruitment and retention schemes

One of the many effective strategies in improving recruitment and retention is reducing involuntary part-time work means increasing the number of full-time equivalent positions. A couple of municipalities have implemented a 3+3 rotation scheme, which means three working days and three days off. This scheme was reported to have yielded positive, concrete results, with more working hours among involuntary part-time workers, a more stable staff environment, a better working environment, increased care quality and increased efficiency, achieved goal in reducing absenteeism, reduction of mandatory overtime and use of bank staff, improvement in full-time position recruitment and increased job satisfaction among the staff, are the positive results of this scheme (Helsedirektoratet 2009, 27). Although, this also means that staff will have to work more weekends. This, in turn, breaches the traditional ‘every third weekend’ scheme, which is the main reason that there are involuntary part-time arrangements in the first place: to fill in the gaps for unpleasant

¹⁸ This report is a collaborative work by a working group consisting of representatives from the Ministry of Labour and Social Inclusion, the Ministry of Education and Research, the Norwegian Association of Local Authorities (KS), the Norwegian Agency for Development Cooperation (Norad), the Directorate of Integration and Diversity, Statistics Norway, the Norwegian Council for Higher Education, the Norwegian Nurses’ Association, the Norwegian Knowledge Centre for the Health Services and the Directorate for Health and Social Affairs (Helsedirektoratet 2007).

shifts such as weekend shifts, as Norwegian employees highly value having days off on the weekends. 'Working rotation shifts' scheme, a rotation working shifts which involve weekend, evening and night shifts, and is regarded as 'unpleasant shifts' (Helsedirektoratet 2009, 28–29). Other strategies that have been effective in filling in gaps of shortages in Norway are on-call-schemes, substitute/ temporary pool/bank, student arrangements, financial compensation, increase of working hours among involuntary part-time workers, facilitating and organizing work situations for employers. Increasing the staffing level (nurse: patient ratio) has proven to have an effective improvement in the municipal health care sectors. However, increasing the nurse: patient ratio is dependent on political will and priorities (Berge et al. 2011, 11).

For the elderly workforce, pension reform and facilitating working conditions have been an essential policy in reducing absenteeism and early retirement. The most frequently used approach was reducing night shifts and working hours. Similarly, various programs have been implemented and, monetary and non-monetary compensation and incentives have been provided to reduce absenteeism and sick-leaves, and recruitment of those who have been on sick leave. 'God vakt' is for the hospital staff, one of the many on going initiatives. This includes better leadership and improving staff's satisfaction. Some of the programs are specifically targeting the female as they make up the high absenteeism rate. Most of these strategies are still on-going and their effectiveness are yet to be assessed and evaluated (Helsedirektoratet 2009, 28–29, 30–38).

Domestic nurse education

There seems to be ambivalence and contradiction in the Norwegian governmental approach to higher education. On one hand, the second recommendation is to increase the national nursing education capacity. The governmental report suggests that, if the education capacity increases by 10%, the future predicted shortages of 13,000 of nurses by 2030 could be turned around into a surplus (Helsedirektoratet 2009, 54). Another study suggests an annual increase of 20% or 800 students (Berge et al. 2011, 15). On the other hand, another Helsedirektoratet (2007, 18) report suggests, for the time being, higher education will not be given the necessary recruitment measures to increase or maintain the level of admissions, due to a large youth population, until 2015. Nevertheless, the Directorate for Health and Social affairs has recommended an

assessment of the annual budget plan to ensure that the education capacity will be reflected in central planning and rearrangement in bursaries as financial incentives to recruit more entrants (Helsedirektoratet 2009, 60).

Reduction the competence gap

The government's plan in reduction of the competence gap in the municipal health sectors, comprising predominantly of unskilled HCAs and trained HCAs, is to provide more national vocational training. In the white paper (St.mld nr. 25 (2005-2006) 2012) '*Mestring, muligheter og mening*' is the government's commitment policy framework to strengthen the recruitment and competence level in the municipal health care sectors. This plan is initially for the period of 2006–2015, but it is expandable to 2050. The initial goal was to recruit 10,000 people from 2004–2009. Nurses should make up one-third, another 1/3 should consist of trained healthcare assistants (HCAs) and the remaining 1/3 should include a mix of other skilled health professionals. The governmental recommendation suggests an annual increase of 4,300 nurses beginning in 2006 (St.mld nr. 25 (2005-2006) 2012, chap. 8). Similarly, the report from the Norwegian Helsedirektoratet (2009), the primary focus is general health care assistants (HCAs), with a special emphasis on municipal healthcare services. Based on the emphasis on these government plans and reports, the utilization of HCAs seems is much more highlighted in the recruitment agendas, of all types of applicants, particularly from secondary educational level. Suggestions have been raised if HCAs can take over the routine and traditional nursing tasks, as well as if nurses can take over doctors' task (ibid. 47).

Use of overseas nurses

However, according to the recent research report by Berge et al (2011), three strategies have been used to resolve the problem of nursing shortages in the municipal healthcare sectors and hospitals: (1) the use of external (foreign) nurses through direct international recruitment to remedy the problem of vacant full-time equivalent positions, (2) the use of agency nurses to remedy the short-term vacancies due to long-term absenteeism, various leaves and holidays and (3) the privatisation of some healthcare sectors so that the problem of recruitment is taken off the public's shoulders (ibid.10, 11, 17). In 2009, there was an increase of 10,500 nurses in municipal healthcare services. This is an achievement in the *Competence Boost 2015*

goal of the government's commitment to strengthening the municipal healthcare sectors. However, the increase of number nurse workforce indicates the huge impact of use overseas nurses in achieving that goal, for instance, 41% of licensure registrants came from international recruitment (ibid. 64, s36).

England

NHS Plan of 2000

The NHS Plan 2000 is the main driver of the government's commitment to increase the NHS workforce and modernise the NHS, to improve the former first NHS reform from 1948. Under the NHS Plan 2000, the government promised to recruit 20,000 nurses by 2004. These numbers would come from increasing the number of training places by 5,500 annually for nurses, midwives and health visitors, attracting back the 'leavers' and recruiting trained nurses from abroad (Finlayson et al. 2002a; Department of Health 2000). According to the 2012 annual review (LMR 2012), there was an increase in the number of nurses in the last decade in the UK and a 20% increase in England. This is a reflection of the government's policy response to the nursing shortages in the late 1990s. The policy was to invest in increased nurse education, to implement policies for recruitment and retention (flexible working hours) and to engage in active international recruitment until 2006 (Buchan and Seccombe 2012, 8). Although there was an increase in the number of nurses, it is not enough to meet the demand of the nursing shortage, especially in the future. As mentioned, domestic nurse education is the major source of nurses. Aside from the reported decline in pre-registration education, the major contributing determinant for the future nurse supply (Buchan and Seccombe 2012, 36), there has been a trend of a reduction in education capacity as a result of funding cuts.

Every year, there are more applicants for nurse education than there are funded training places. Since the UK government and policymakers determine the national capacity through the allocation of funding, their decisions have had a direct effect on the national recruitment of nurses through domestic education. In turn, this will have a direct effect on the individuals' choice of nursing as a career. The experiences of nursing shortages in the 1990s and the current declining number of nurses are regarded a self-imposed problem and not as uncontrolled events. It is a reflection of

the lack of potential recruits as a direct result of the government's decisions on funding allocation (Buchan and Seccombe 2012, 11–13).

Recruitment and Retention schemes

In the UK level, there have been a few recruitment programs to attract healthcare workers, such as 'Making a difference for nurses, midwives and health visitors', an education strategy to allow nurse education to be spread over more than three years. This strategy involves 'take-a-break period'-scheme, introduced new pathways into nursing via national vocational qualification (NVQ) programs and created new nurse consultant posts. Another program to attract mature students is 'Step-on, step-off' education, which means that one can take a leave of absence once a whole year is completed and then return to the same post later (Simoens, Villeneuve, and Hurst 2005, para. 55). The NHS Plan encouraged the re-entry of nurses by facilitating 'back-to-practice courses', increasing work-based learning and providing additional allowances for nursery costs, support and mentoring courses for the returnees. Additionally, financial rewards were given to those who completed a 'return to practice' course. 3,763 out of the 7,812 that the NHS contacted returned, and 1906 midwives have undertaken refresher education or been shortlisted since April 2001 (Simoens, Villeneuve, and Hurst 2005, para. 62).

International Recruitment

The United Kingdom has historically had an enormous inflow of migrant nurses due to active recruitment, peaking up to 40–50% in 2003–2004 (see Figure 3). The NHS Plan 2000 was also the main driver of the active recruitment and was successful in recruiting nurses. It was supposed to be only a short-term action to fill in the gap but has become an integral part of the recruitment strategies at the NHS. International nurses were predominantly recruited from India, the Philippines, Australia and South Africa. In order to manage the negative impact on labour migration and ensure ethical recruitment practice throughout the NHS, UK Code of Practice (CoP) for international recruitment was implemented, in accordance of the WHO code of practice. In the UK (CoP), developing countries will not be targeted for recruitment unless there is a bilateral agreement between governments. For instance, some developing countries are in the 'banned list' that will not be targeted for recruitment. Also, the Nursing and Midwifery Council (NMC) introduced a new English

proficiency and other revised entry requirements that may curb international nurse applications (Buchan and Seccombe 2012, 16; Buchan 2007; Department of Health 2004; Buchan and Maynard 2006, 133–134). The code does not ban international recruitment but rather moderates it. Private sectors, for example, are not required to adhere to the code, nor are individuals prevented from applying for employment. In 2004–2005, around 3,000 nurses from the ‘banned’ list were registered in the UK. Currently, the focus of international recruitment is to fill the ‘hard-to-fill’ vacancy posts (Buchan 2007; Department of Health 2004).

National Health Visitor Plan: This is an implementation document resulting from a collaboration of the Department of Health, NHS England, Public Health England and Health Education England. It is an implementation policy the government commitments, in 2010, to increase 4,200 health visitors¹⁹ (migrant nurses) by 2015 and beyond. The main purpose of recruiting health visitors is to increase the workforce in the primary local healthcare sectors. From 2011–2013, 1,000 new recruits have been recorded (Department of Health Public Health England 2013).

Workforce planning/Human resources issues

Workforce planning in NHS England is facing major data shortcomings and, especially concerning vacancy levels, which makes future planning difficult. The reason for this is that the new system is not yet fully defined or implemented and is a year behind schedule (Buchan and Seccombe 2012, 2). Historically, workforce planning and human resources was centralised. It was just in 2002 that the reorganisation of the NHS workforce planning system in England began (Buchan and Maynard 2006, 129–131). According to a recent government white paper, local employers will now be able to set the number of nurses (Buchan and Seccombe 2011, 12). The formation of Health Education England (HEE) will take a holistic approach to workforce planning, and the Royal College (RCN) will be monitoring the progress (RCN 2013b).

NHS temporary nurse staffing

¹⁹ A health visitor is a qualified nurse or midwife with post-registration experience who has undertaken further training and education in child health (<http://www.prospects.ac.uk>).

The employment of temporary bank nurse and agency nursing staff to meet short-term fluctuations in workforce demand has been regarded as an area of potential cost savings. In 2006, the National Audit Office identified poor procedures in many NHS trusts in terms of how workload assessments were used to project staffing requirements and to identify temporary staffing requirements. The expenditures on recruitment of temporary nurse staffing are lower than the cost of recruiting full-time nurses. The main policy response to that audit was the hiring of temporary staff aiming to reduce the dependence of the NHS on private-sector nursing agencies and to improve the quality of care. Whether these cost-containing measures are a 'flexible firm' model of employment or a failure to manage resources appropriately is yet to be seen (Buchan and Seccombe 2012, 24).

Summary

The aforementioned government policies in both England and Norway target nursing shortages from different angles. These policies have been newly implemented and are still on-going. In terms of recruitment in both countries, domestic education and increasing capacity remain essential strategies. In terms of recruitment and retention policy, Norway prioritises self-sufficiency and reducing involuntary part-time work. However, Norway is increasingly dependent on migrant nurses as a short-term and a long-term remedy. England, on the other hand, has been criticised for previously using active recruitment as a quick fix and a long-term strategy. Despite the policy on curtailment, England still relies on recruiting migrant nurses as one of its recruitment strategies to cover its nurse shortage. Insufficient data and a lack of thorough research on the subject matter create a gap in terms of predicting future nurse supply in both countries. Both countries use temporary agency nurses as a short-term solution to cover the nurse shortage, but the long-term solution is based on retention policies. Other long-term solutions include closer collaboration between regional and local health care services. Both countries have implemented a recruitment policy in accordance with the WHO policy framework for global solidarity. However, poor working conditions need to be improved in both England and Norway to keep the workforce in the profession and prevent nurse outflow. The increased use of unskilled and skilled HCAs has influenced policy, and both countries have been utilizing this skill-mix a solution and to fill in the gaps for nurses. Both countries want to attract

and keep staff into the profession using various methods. England has prioritised increasing educational capacity as their main means to attract students, whilst Norway includes rotating shifts and increasing the number of trained health care assistants. Financial budgets affect both countries, resulting in cost containment measures.

Chapter 7: Discussion of findings

The problem of the nurse workforce shortage is more complex than an imbalance in supply and demand of labour. International reports confess that there is no single 'magic bullet' to resolve it. It is therefore imperative that the solutions to tackle the problem be multi-faceted (ICN 2006, 6; Buchan and Aiken 2008, 5). In this chapter, the findings from chapters 5 and 6 will be discussed, aiming at providing suggestions for additional steps that the countries of the study can take to improve recruitment and retention strategies.

Recruitment strategies

The WHO, the ICN and the OECD suggest that, to improve recruitment, policies should be targeted at increasing the number of entrants into the nurse profession through domestic education, nurse re-entry and migration (Zurn, Dolea, and Stilwell 2005; Simoens, Villeneuve, and Hurst 2005). Both Norway and England have all three aspects in their recruitment agendas, with varying degrees of commitments to them. Despite some fluctuations, both countries have experienced an increase in the inflow of nurses as a result. At some points, the fluctuating trends were sensitive to the policies implemented. A common reason for the increase in the workforce is the contribution of overseas workers.

Domestic nurse education and training

Both Norwegian and English domestic nurse education statistics have been stable for the last decade, based upon entrance registrations, with some points of small fluctuations (Berge et al. 2011, 36; Buchan and Seccombe 2012, 11). Nurse education is challenged with both declining numbers of applicants and the fact that the number of student applicants is higher than the national education capacity. In England, the education capacity and the number of entrants are determined by governmental decisions through funding allocation. In that sense, the English government may

affect the individual choice to enter the nursing profession (Buchan and Seccombe 2012). For example, there was rise in the number of nurses as a result of the NHS Plan of 2000, when the number of student places was increased (Simoens, Villeneuve, and Hurst 2005, para. 52). The Norwegian nurse education is free of charge and is at the same level as other higher education in university. According to the government, governmental means have little effect on individual choices concerning higher education, and simultaneously, proposals for expanding the education capacity of professions predicted to be undersupplied in future have not yet been reflected in the Norwegian Ministry of Education's annual budget plan (Helsedirektoratet 2009, 60).

Nursing status and image

In order for nurses to work to their full potential, WHO Europe stresses that, the definition of the nurses' role in the society and their contribution to the healthcare systems and to existing public health challenges should depend on legislative frameworks. The role of nurses should be expressed formally in terms of requirements such as 'acceptance into educational program, successful completion of all requirements necessary to obtain a degree from a formal educational program' (Büscher, Sivertsen, and White 2009, 31–39). The Norwegian nurse education is a formal education on the university college level, with further possibilities for specialization, master degrees and PhD programs. Sixty per cent of Norwegian nurses have specialization. The looming problem that comes with this is 76% of highly qualified nurses are approaching pension age, replacing them in the future needs to be tackled as well (Brenne 2006; Dæhlen and Seip 2009). The English nurse education has moved in the same direction of upgrading professional profiles since 2013. Various pathways have also been launched to make nurse education flexible, in order to attract, retain and recruit again different types of applicants, such as, 'step-on-step-off' and 'take-a-break-period' scheme. Some of the reforms in England have indicated increase in the number of enrolments. However, literature implies that there is there no one best model of nurse education (Simoens, Villeneuve, and Hurst 2005). Strengthening the nursing profession and its visibility in the society may improve the status and attractiveness from a broad range of entrants, such as 'mature entrants, entrants from immigrant, and especially male entrants, which is a scarce in the workforce. For instance, male nurses account only around 10% in Norway (Buchan and Calman 2005, 10; Roksvaag and Texmon 2012, 52).

Nurse re-entry

Various reports indicate that there are a significant numbers of qualified nurses who are not in the current workforce in both Norway and England, e.g. the ‘nurse labour reserve’, due to involuntary part time contracts, outmigration and absenteeism.

Absenteeism is a dominant cause in Norway, whereas in England both factors are prevalent (Finlayson et al. 2002b; Helsedirektoratet 2007; Buchan and Seccombe 2012). There is not much literature available on the nurse re-entry schemes in Norway or in England. Nevertheless, many initiatives have been implemented regarding prevention from turnover due to absenteeism. Various initiatives in the NHS have attracted back ‘leavers’ by directly contacting them and provision with both monetary and non-monetary incentives, such as ‘back-to-practice’ courses and nursery facilities for children. Reports from the Norwegian and NHS’ various schemes, such as return packages, i.e. pension reforms, preventative programs, increasing full time contracts, have shown reduction of absenteeism and improved working morale and stability in the workplace and among consumers in the municipal health sectors (Helsedirektoratet 2009; Simoens, Villeneuve, and Hurst 2005, para. 60–62; Gautun 2012, 42–43).

International recruitment

Global solidarity

In Norwegian and English governmental documents on workforce recruitment strategies, both countries have committed to the WHO’s ethical international policies toward global solidarity and reducing the negative effect of migration, such as reducing brain drain in developing countries by promoting recruitment via bilateral agreements between governments and no active recruitment from the ‘ban list’ (NHS Code of Practice) (EU 2008, 11).

Despite these countries’ commitment to managing international recruitment, Norway has committed to being self-sufficient through education and utilising the present health workforce well, while England has curtailed international recruitment. However, these two countries find themselves still reliant on international recruitment to remedy the need for nurses. Norway is reported to be increasingly dependent on the use of agency nurses (who are predominantly of overseas nurses) and direct

recruitment from abroad. In 2009, 41% of nurse registrants were migrant nurses (Berge et al. 2011, 9–10, 36). On one hand, the UK managed to curtail international recruitment by implementing tougher immigration control and stricter nurse entry requirements. On the other hand, due to globalisation, free labour movement within EU countries and the economic crisis in the Eurozone, the UK is facing an ‘unmanaged’ inflow of migrant nurses (Buchan and Seccombe 2012, 14–18).

Pull and push factors of labour migration

International literature has a positive outlook on the immigration of overseas nurses, as migrant nurses comprise a significant portion of the nurse workforce and helps offset the shortages, as illustrated in the cases of Norway and England. International flows of nurses in and out are influenced by a number of pull and push factors. Pull factors are driven by higher wages and better employment in the host country. Poorer living and working conditions can be push factors in migration to other countries (Simoens, Villeneuve, and Hurst 2005, para. 63–75). After all, moving from poor conditions to greener pastures is a basic human right, and it helps both sending and receiving countries in the fulfilment of social justice (Dwyer 2007). However, international nurse recruitment is a symptom of deep-seated problems in both sending and receiving countries that have failed to plan and retain nurses in sufficient numbers. The recruitment of migrant nurses from overseas causes a domino effect; instead of being part of the solution to shortages, overseas recruitment only redistributes the problems of nursing shortages to countries that are less equipped to deal with it. The underlying problems can be solved nationally only by improving the current status of nursing shortages, the planning of health services and management of the health workforce at the local, regional and national levels (Buchan and Sochalski 2004).

National solidarity towards overseas nurses

In Norway, a further review of the national recruitment and retention policy frameworks, including the migrant healthcare workforce living in the country, is suggested. Solidarity recruitment does not pertain to strengthening other countries’ healthcare workforce and preventing the negative impact of labour migration, such as brain drain in the developing world. Solidarity recruitment should also include overseas healthcare workers working in Norway. After all, labour migration is not always manageable through political or immigration control, with today’s

globalisation, internalisation, freedom of movement and financial crisis (Buchan and Sochalski 2004). Additionally, including migrant healthcare workers in the national policy framework provides protection for all parties involved, especially for migrant nurses who are already in vulnerable positions of exploitation. However, there are no legal obligations for private enterprises to have a transparency regarding rules and regulations for recruitment. For instance, in England, private enterprises are not obliged to adhere to the UK Code of Practice (Department of Health 2004). Hence, regular inspection control and monitoring is recommended to prevent exploitation of exploitation of overseas nurses and prevent ‘social dumping’ that may further affect the status weaken recruitment into nursing profession, e.g. Adecco scandal in Norway. Inspection control and monitoring should also include knowledge in Norwegian health legislation, adequate language competence and training (Berge et al. 2011, 141, 145).

Retention Strategies

WHO, ICN and OECD policy frameworks suggest that retention strategies ought to target the reasons that nurses leave the profession through emigration, retirement and career change. Additionally, the attractiveness of nursing as a profession and a career in comparison to other occupations will affect the inflow as well as the outflow of nurses in the workforce. Hence, it is crucial that combinations of monetary and non-monetary incentives that affect staff motivation and performance are in place to retain nurses and prevent exodus (Simoens, Villeneuve, and Hurst 2005; Zurn, Dolea, and Stilwell 2005).

Improving poor working conditions

The many initiatives implemented and tried out, such as reduction of involuntary part time contract, flexible working shifts, preventative programmes have shown to reduce absenteeism rates, which can continuously be utilized as strategies for further improvement of retention. However, the widespread and similar effects of nursing shortages on the nurse workforce of inter-related and inter-connected *poor working conditions* are still prevalent in Norway and England. Consequently, these factors have lead to absenteeism and turnover in both Norway, and outmigration as well, in the case of England. Common and widespread reasons of poor working conditions in both countries, are associated with low staffing levels, longer working hours, heavy

work overload, the pressure to accomplish work, taking mandatory overtime, doing too many clinical jobs not related to nursing and little time spent with patients due to time pressure. These factors are linked to resulting burnout, absenteeism, job-related dissatisfaction, intention to leave and turnover. Wages, educational opportunities and opportunities for advancement were also reported common reasons for dissatisfaction. Other reports such as nursing tasks were left undone and less time with patient, due to lack of time are common discontentment among nursing staff (Buchan and Aiken 2008; Finlayson et al. 2002a; Midtsundstad and Bogen 2011; L. H. Aiken et al. 2012; Helsedirektoratet 2007).

There still seems to be a gap in retention strategies in both countries and more focus on the recruitment efforts. International literature supports the fact that turnover of nurses is linked to poor working conditions and low incentives. This points to the urgent need for emphasis on the retention strategies along with recruitment strategies. International literature suggestions on preventing turnover is improving and the poor working conditions and providing monetary and non-monetary incentives. The personal characteristics of staff; monetary incentives (wages, salary bonuses, pension, insurance, tuition reimbursement); non-monetary incentives (work autonomy, career development and shift work); reducing violence in the workplace; and leadership are contributory factors associated with keeping nurses motivated and boosting their performance. In turn, these have a positive impact on job-related burnout, intention to leave, absenteeism, turnover, retention and recruitment of the existing staff (Zurn, Dolea, and Stilwell 2005; Helsedirektoratet 2009).

Skill mix, task shifting and utilization of HCA

Given that nurse recruitment and retention is a challenge, though quite recent, the utilisation of healthcare assistants (HCAs) in a skill-mix strategy has been a trend in addressing healthcare workforce shortages, and it is regarded as cost-effective. It has even gotten international recognition from the WHO and the OECD, and it has been further suggested as a strategy, especially for developed countries suffering from poor recruitment of skilled health care professionals. Questions have also been raised in Norway, regarding task shifting, such as HCAs taking over routine and traditional nursing tasks, as well as whether nurses can take on some doctor tasks (Helsedirektoratet 2009). With the studies have suggested, though, that level of

education is linked to patient care outcomes and mortality (L. Aiken et al. 2003). The recent scandal in Stafford Hospital in England is examples of care failing and unnatural deaths due to lower of staffing ratio of trained staff compared to unskilled staff (RCN 2013a; Lintern 2013a). Hence, with these patient outcomes, the importance and effectiveness of higher education cannot be more emphasised on patient care delivery. Literature suggests that it is the level of education, and not the average years of experiences, among healthcare personnel that demonstrates professional behaviours central in patient safe, such as, 'problem solving, performance of complex functions, and effective communication' (L. Aiken et al. 2003, 1618). If HCAs are to be filling in the gaps of nursing shortages, further training is, therefore, crucial and imperative to boost their competence and confidence in delivering safe patient care. Evidences from Norway show that the level of education has an effect in absenteeism and turnover. HCAs have the higher absenteeism than nurses due to the nature of heavy workloads (Gautun 2012, 42; Midsundstad and Bogen 2011, 8; Helsedirektoratet 2009, 34)

Workforce planning

Tackling nursing shortages is more than recruitment and retention efforts. It is an integration and coordination of policy framework of both recruitment and retention strategies, cautious utilization of skill-mix and workforce planning. To date, none of the forecasting methods has proven accurate for long-term forecasting. The literature seems to indicate that nurse workforce planning exercises are currently unable to provide accurate projections beyond a three- to five-year period. This means that nurse workforce planning exercises need to be updated regularly if they are to be of any use. However, ICN encourages to workforce planning as it assists policy makers and involved stakeholders, from local level to governmental level, to determine which intervention will be most effective (Simoens, Villeneuve, and Hurst 2005, para. 51; Buchan and Calman 2005, 8–9) Both Norway and England have suffered in the past due to untimely responses to future nurse labour demand and supply in Norway (Brenne 2006) and due to lack of important gaps in data, particularly on vacancy levels, for instance in England (Buchan and Seccombe 2012, 2). In Norway, more research and a review of the national nursing shortage might be needed. It is for the purpose of understanding its nature and complexity in a national context and perspective; in order to assess the today's needs as well as the future needs, similar to

the UK's Labour Market Review (LMR) annual review. The LMR gives an annual review of the labour market in England, and the UK, which can be a helpful tool for all stakeholders involved in workforce planning.

Financial constraints

Nursing shortages is not just about the lack of entrants into the workforce; it is also a consequence of financial constraints hampering recruitment. Although, both countries spends a considerable amount of its GDP²⁰ on healthcare, Norway 9.6% of its GDP and, England 10%, in 2009. In England, this is a great improvement of health expenditure, compared to 7.7% of GDP in 2002 (Lindahl and Squires 2011; Harrison et al. 2011; Buchan and Maynard 2006). Still, both countries' nurse workforce has suffered from budget cuts and cost containment through redundancies by vacant posts being stopped, hiring freezing, downsizing education and training capacities. Other budget cuts involves pay freezes such in England in 2011-2012, during economic downturns. During economic downturns and recession, nurses are highly prone to budget cuts, because they are the largest group in the health workforce. Literature suggests that recruitment and retention efforts should still be maintained, to avoid a backlash when the economy is up again (Aiken et al. 2012, 144; Buchan and Secombe 2012; Alameddine et al. 2012; Gautun 2012).

Chapter 8: Conclusion

The findings describe that both countries are faced with similar problems regarding current and projected undersupply of nurses. The underlying multiple contributory factors such as demographic changes, cost containment and persisting poor working conditions are leading to absenteeism and turnover, and in turn, creates a vicious cycle of further understaffing.

Recruitment and retention strategies of both countries have served both short-term and long-termed remedies and solutions. The most vital aspect of both countries policies highlights the importance of investing in domestic nurse education. All types of students are important determinants of the future nurse supply. Improving the poor working conditions that affect retentions and exodus from the nurse profession is an

²⁰ GDP: Gross Domestic Product

essential strategy. Strengthening the role of nurses in the society contributes to improving the image, status and attractiveness as a career and profession.

The issue of nurse migration and its association to brain drain in the sending countries and the exploitation that migrant nurses encounter in the host countries needs continuous attention in the outworking of national health care policy both in Norway and England. Tackling national nursing shortages show to be an integrative policy framework of recruitment, retention, workforce planning and cautious utilization of skill-mix.

Both countries governments from the top level down to local levels seem to be working together side by side, in order to tackle the shortages from all levels and sectors. These strategies illustrate the complexity of the matter and showcase the need for more sufficient data. Fluctuation in the nurse workforce can easily be remedied in the short term, but research has proven that these short-term solutions only serve as a quick fix to a larger issue that needs to be seen in light of integrated multi-level-sector policy frameworks nationally and internationally.

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