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ARTICLE

'Nurses are seen as general cargo, not the smart TVs you ship carefully': the politics of nurse staffing in England, Spain, Sweden, and the Netherlands

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Abstract

Nurse workforce shortages put healthcare systems under pressure, moving the nursing profession into the core of healthcare policymaking. In this paper, we shift the focus from workforce policy to workforce *politics* and highlight the political role of nurses in healthcare systems in England, Spain, Sweden, and the Netherlands. Using a comparative discursive institutionalist approach, we study how nurses are organised and represented in these four countries. We show how nurse politics plays out at the levels of representation, working conditions, career building, and by breaking with the public healthcare system. Although there are differences between the countries – with nurses in England and Spain under more pressure than in the Netherlands and Sweden – nurses are often *not* represented in policy discourses; not just because of institutional ignorance but also because of fragmentation of the profession itself. This institutional ignorance and lack of collective representation, we argue, requires attention to foster the role and position of nurses in contemporary healthcare systems.

1. Introduction

Shortages of nurses put healthcare systems under pressure, as governments are confronted with a mounting backlog of non-COVID care and rising care demands due to demographic transition. The COVID-pandemic has put nurses in the spotlight, and, especially in the first months, made nurses into a celebrated profession (Croft and Chauhan, 2021; Mohammed *et al.*, 2021; Kuijper *et al.*, 2022). The COVID-pandemic also elucidated the looming crisis of nurse workforce shortage, accelerated further by the pandemic. The high care load faced by nurses has caused extraordinary sick leave rates in most countries as well as a need for time to recover, both physically and mentally (Oliver, 2023). In various European countries, waiting lists are growing and hospital wards are forced to close due to lack of nurses, while community nurses struggle to find time to cater to their growing list of patients (Torrente *et al.*, 2021). Nurses are increasingly leaving the profession for jobs in other sectors, through early retirement or self-employment, inducing an 'exit spiral' as increased demands and stress are directed towards those nurses who remain in the healthcare system (Yu *et al.*, 2019; van Schothorst *et al.*, 2020; Rada, 2022) while inadequate staffing has

consequences for the accessibility and quality of patient care (Jones *et al.*, 2015; Griffiths *et al.*, 2018). At the same time, as we will argue in this paper, the government understanding of nursing and hence the ability to find feasible solutions to foster the position of nurses is generally poor.

Current workforce problems should not come as a surprise. Policy reports produced in the past two decades have warned about the consequences of demographic change, as well as a growing gap between existing work and education systems and changing healthcare innovation and care demands (European Observatory, 2006; OECD, 2008; Campbell *et al.*, 2013; European Commission, 2021). Policy recommendations have been consistent over time, calling for better education, higher salaries, skill mix change, technological innovation, and enhanced workforce planning. The recently established State of Health in the EU Companion Report (2021), for instance, proclaims that more reliable health data and analysis are needed to facilitate (policy) decision-making, putting great belief in 'governing by numbers' (Porter, 1995) to tackle nurse workforce issues, without making any concrete suggestions how this will impact on the role and position of nurses, or how it will make their work more attractive. In fact, data-driven policy thinking reflects the dominant instrumental and universal policy strategy to combat nurse workforce shortage which tends to overlook the institutional legacies of healthcare systems, as well as the more specific national, organisational, and professional policies and practices that impact the position of nurses in contemporary healthcare systems (Kuhlmann *et al.*, 2013; de Bont *et al.*, 2016).

We focus on nurse workforce *politics* to better understand how the role of nurses is framed in contemporary healthcare systems and to what extent nurses can represent the voice of the nursing profession in the policy debate. As such, we shift focus from policymaking to combat workforce shortages as is often applied in policy and health services literatures (eg. Kuhlmann *et al.*, 2015), and discussions on professionalisation that is targeted in literatures on professions and organisations (eg. van Wieringen *et al.*, 2017; Ernst, 2020), to healthcare politics. We apply Laswell's (1936) classic political question 'who gets what, when, and how' to the nursing workforce, examining how and to what extent nurses play a role in healthcare systems in England, Spain, Sweden, and the Netherlands. The four countries face the consequences of a nurse workforce crisis, yet in different ways and with varying implications for the position of nurses. We conduct an institutional discourse analysis (Schmidt, 2008, 2010) to consider how existing institutional arrangements, organisational strategies and stakeholder relations impact on the role and position of nurses in healthcare systems and policymaking. Noticeably, this paper does not aim to provide a comprehensive overview of the politics of nursing in the selected countries. Yet by conducting comparative research, we aim to encourage a scholarly debate in the field of healthcare policy and politics on the role of nurses in contemporary healthcare system reform. The following question guides our research: *How are nurses organised and represented in contemporary healthcare systems, and with what consequences for their position in healthcare policymaking?*

2. Theoretical framework: discursive institutionalism

We turn to nurse workforce policies and politics in England, Spain, Sweden, and the Netherlands by 'diving into' these countries' institutional nurse workforce discourses. We examine how workforce policies are presented, brought into practice, with what results, and how nurses experience them. The approach can be labelled as discursive institutionalism, which has been coined by Schmidt as a 'fourth new institutionalism', in addition to rational choice, historical, and sociological institutionalism. These theoretical institutional fields share a common interest in how social processes evolve through historical and social-technical governance arrangements that cause a path-dependent evolvement of society, and how institutional transitions and reforms can be explained. Discursive institutionalism is 'an umbrella concept for the vast range of works in political science that takes account of the substantive content of ideas and the interaction process by which ideas are converged and exchanged through discourse' (Schmidt, 2010: 3). It aims to explain the actual preferences, ideas, beliefs, actions, and normative

orientations of actors articulated in, among others, policies, programmes, strategies, and philosophies (Schmidt, 2008, 2010). Discursive institutionalism shows how institutions are shaped by discourse and simultaneously have the capacity to create and impose discourses, constructing or fostering certain values, meanings, and positions (Foucault, 1972), both to maintain institutional arrangements ('institutional stability') and to enforce transition ('institutional change'). Institutions can promote and legitimise a certain discourse as they emphasise certain ideas and explanations over others, using specific forms of knowledge selection, exclusion, and domination (Foucault, 1972). Discourses are performative; they are 'world producing' and shape social reality, creating patterns of understanding and doing which people apply in social practice (Dahler-Larsen, 2013; Wallenburg *et al.*, 2019). Schmidt stresses the ability of discursive institutionalism to provide insight into the dynamics of institutional change by explaining the actual preferences, strategies, and normative orientations of actors (Schmidt, 2010).

Of particular interest is the notion of institutional ignorance, which points out the processes by which institutions build or obscure knowledge (Gross, 2016; Paul *et al.*, 2022). Institutions draw attention to certain practices and knowledges whereas others are silenced or ignored. This can be both intentional and strategic, and unintentional. The concept of institutional ignorance draws attention to the silencing of certain social actors or practices – taking away or denying power and influence –, but also to the protection of certain actors or practices from public scrutiny (Gross and McGoey, 2015; Owens, 2022). Scholars in the field of professions and organisations have for instance pointed at the invisibility of nursing work, which fosters their lack of power in healthcare organisations and the health system more generally (Allen, 2015; van Schothorst *et al.*, 2020; Kuijper *et al.*, 2022).

The discursive institutionalism approach is relevant for this paper as we aim to explain how nurse workforce policies are constituted and played out in different institutional settings. It draws attention not only to such issues as capacity planning and salaries, but also towards the shaping of (collective) nurse identities and issues of representation (Currie *et al.*, 2010). Moreover, it raises awareness of the work that is conducted to create a collective voice for nurses vis-à-vis policy actors as well as other healthcare professions (eg. Rafferty and Holloway, 2022) to strengthen (or downplay) the role of nurses in healthcare systems.

3. Methods

In this paper, comparing nurse workforce politics in England, Spain, Sweden, and the Netherlands, we followed a qualitative approach combining desk research and interviews with representatives of nurses in each country. These countries are selected based on their different institutionalised healthcare systems (ie. the Netherlands has a social insurance system with market-based governance arrangements, the other three countries have tax-funded healthcare systems but with either national- or regional-based governance infrastructures) as well as differences in their history of nursing politics. For example, in England, quality of nursing care has been subject to public debate in the past decade after the Francis Inquiry in the early 2010s (Singleton and Mee, 2017). In the Netherlands, nurses have fiercely resisted reforms of their profession in the past decades (Felder *et al.*, 2022). In Sweden, nurse associations and unions have gained influence at the national policy level; whereas, in Spain, nurses have great difficulties in getting themselves heard by policymakers and politicians. More institutional features of the four countries are presented in Figure 1. In this paper, we elucidate and compare the four different discursive institutional practices to learn more about nurse workforce politics.

3.1. Research approach

In all four countries, we reconstructed the institutional discourse on the national nurse workforce and related policy debate(s) by collecting documents such as white papers, analysing 'micro

England
Taxed-funded, National Health Service (NHS) in which residents have access to healthcare based on clinical need instead of ability to pay. Department of Health & Social Care governs the overall policy for the NHS and social care workforces. NHS England and NHS Improvement support and oversee the performance of NHS trusts, including workforce related issues like nurse retainment. Local NHS trusts, foundation trusts and General Practitioners employ nursing staff, are responsible for their recruitment, retention, and day-to-day management. Nurses require completion of a three-year university-level education (undergraduate). Registration at the Nursing and Midwifery Council is mandatory, with nurses being represented by the Royal Colleges of Nurses, which acts as both a professional body and a union.

Spain
Tax-funded, NHS. Health workforce is governed at various levels: the national government decides on the legislation; regionally operating Autonomous Communities oversee the provision, management, implementation, and financing of nursing workforce. Nurse wages follows the civil servants' national regulation but are determined by each Autonomous Community separately. Nurses are trained at various levels: degree, specialization, master, and PhD. Education is determined by the Ministry of Education and Vocational Training and the Departments of Education of the Autonomous Community. The nurse workforce is represented by several nurse associations and unions at the national level and regional level.

Sweden
Tax-funded, NHS. Health workforce is governed at the national, regional, and local level. The national government decides on the legislation and is responsible for ensuring that the healthcare system is efficient and keeps up with its overall objectives. Almost all of Sweden's healthcare is administrated and financed locally through 21 regional councils. Regions decide on the allocation of resources and are responsible for the overall planning of health and social services, as well as workforce capacity planning. They have the power to levy income taxes; the regional taxes pay for around 70 percent of healthcare costs; the rest is governmental grants and patient fees. Nurse education is funded and supplied by the national government. Most of the registered nurses are educated at colleges and universities. A lower number are educated at private foundations. Nurse licences are issued by the National Board of Health and Welfare. Nurses are represented by the Swedish Association of Health Professionals (*Vårdförbundet*), which is a trade union with a membership of 114,000 representing nurses, midwives, biomedical scientists and radiographers.

Netherlands
Social insurance-funded system with regulated competition. Nurses are particularly governed at the local level; through nurse education (vocational schools and applied science universities) and through healthcare organizations that set work requirements and govern and finance skills training and nurse specialization programs (often in close relation with training institutes, both public and private). Government bodies influence the development of the nurse workforce only indirectly, through research and project funding. Yet, they play a central role in professional registration and quality regulation through the Dutch Healthcare Inspectorate. Nurses are represented by various unions and the nurse association, *Verpleegkundigen en Verzorgenden Nederland (V&VN)*.

Figure 1. Institutional characteristics of the four health systems.

stories' in social media, newspapers, and other grey literatures. We constructed a template to collect central characteristics of the healthcare systems as well as the institutional role and position of nurses in the four countries. Based on these findings, the literature, and our own expertise in the field, we constructed a topic list for the interviews. Interviews were semi-structured, meaning that we used a topic list and asked follow-up questions and encouraged interviewees to bring in the topics important to them. Topics that we addressed included the reasons for workforce shortages among nurses; targeted national policies and their successes/failures; policy trends; representation of nurses at the policy and organisational level; and lessons learned. In each of the four countries, we conducted interviews with a representative of the nursing association and the nurse union(s), the Ministry of Health (in Sweden: SALAR, the representative for local and regional government), a nurse expert, and a representative from the field of nurse education (5 interviews per country, $N = 20$ in total). Most interviews were conducted digitally. Interviews lasted between 30 and 90 min. With permission of the interviewees, interviews were recorded and transcribed verbatim. Interviews were conducted in the national language. Transcripts were anonymised. During data collection, we organised online reflexive meetings (2) to share and compare preliminary findings among the authors to sharpen our analysis.

3.2. Data-analysis

Based on the results of the country-tables, document study, and interviews, we wrote country case reports (all in English) in which we described a country's main problems and challenges regarding the nurse workforce, (policy) ideas, and nurse profession's strategies to dealing with those issues. In these country case reports, we used (translated) quotes from the interviews to illustrate findings.

In the analysis, we paid specific attention to the impact of the national institutional context on nurse workforce development. The country case reports were analysed and compared by the first author in close collaboration with the last author. We used an abductive analysis approach, meaning that empirical findings and theoretical insights and concepts were used 'in tandem' to deepen the insights (Tavory and Timmermans, 2013). Emerging central themes were checked and

discussed in-depth with the other authors during the second reflexive session. Out of this iterative process, four themes emerged (ie. nurse representation, work conditions, career building, and breaking with the public healthcare system) that we use in presenting our comparative analysis below.

In the following, we will explore the differences between the four countries – and their explanations. To illustrate our findings, we use interview quotes (in case of the Swedish, Dutch, and Spanish cases, quotes have been translated into English by the authors). We refer to our anonymised respondents like 'RS1', in which 'R' refers to Respondent, the second capital refers to the country (in this case 'S': Spain; Sweden is indicated with 'Sw'), and the number to one of the country-respondents (which we numbered from 1 to 5 for each country).

4. Results

4.1. Nurse staff politics: from poor representation to 'breaking out' the public system

In this section, we present the four themes that stood out in the comparative analysis: the (political) representation of nurses, working conditions of nurses, lack of adequate career opportunities, and surviving the system – which sometimes means breaking with the public healthcare system to obtain better working conditions. We highlight interesting similarities and differences that emerged from the analysis and that reflect contemporary issues in nurse politics. The findings are heavily influenced by national characteristics of healthcare systems and the nursing profession. More detailed information about the institutional characteristics of the four national healthcare systems can be found in Figure 1. Table 1 displays the key characteristics of the position of nurses within the four countries.

4.2. Representation of nurses in healthcare policy

A striking difference between Sweden and the Netherlands on the one hand, and Spain and England on the other emerged from the data. In Spain and England, nurses lack adequate representation at all levels, including the unions. In England, the nursing profession has been troubled for some time, particularly in the aftermath of the Mid Staffs scandal and the subsequent Francis Inquiry that uncovered severe lack of quality of nursing care (Francis, 2010), leading to a public outcry for more compassionate care (Singleton and Mee, 2017). The scandal and subsequent debates, that were widely covered in the media, impacted English nurses' reputation severely. The profession has not recovered since. Moreover, it has harmed the position of the Royal College of Nursing, the nurse formal representative at the national level. The Royal College of Nursing acts as both a union and a professional association, yet respondents state that it has insufficient formal and informal power to negotiate better salaries and working conditions. Negotiations are entangled with the interests of other healthcare workers, and nurses do not have a special position to discuss and negotiate their interests and professional needs like (for example) medical doctors. Similarly, in Spain, nurses have a compulsory college membership but they raise concerns about lacking political will from the college ('Consejo General de Enfermeria') or the union/association to represent their interests properly: 'It is always the same people talking to the government, they don't do anything for us' (RS1). Also, nurses do not possess higher management positions, which renders them invisible at organisational and political levels and makes it difficult to put forward nursing needs in those contexts. The slogan of one of the leading Spanish nurse associations '*Una enfermera en la Moncloa*' ('a nurse at nr. 10') has become key. It calls to have a nurse 'in power' to have a say in national healthcare policymaking, and to render legislation more in favour of the nurse profession.

In the Netherlands and Sweden, nurses have gained more influence in national policies and at the organisational level in the past few years. In Sweden, the Association of Health Professionals,

Table 1. Characteristics nurse workforce

	England	Sweden	Spain	Netherlands
Number of nurses per 1000 citizens *Includes part-time and full-time contracts*	7.9[1]	10.8[2]	6.1[3]	13[4]
Nurse average salary per year, compared and average national salary	€41,054 Average salary: €43,700[5]	€43,000[6] Average salary: € 38,000[7]	€28,500 Average salary: € 24,555[8]	€37,500[9] Average salary: €45,600[10]
Nurse vacancies	39,652[11]	Not available	Not available	16,700[12]
Sickness rates	4.1%[13]	Not available	7.8%[14]	10%[15]

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6880250/
[2] https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/statistik/2022-9-8093.pdf
[3] https://data.oecd.org/healthres/nurses.htm
[4] https://www.statista.com/statistics/544144/number-of-nurses-employed-in-the-care-sector-in-the-netherlands/
[5] https://www.nuffieldtrust.org.uk/resource/nursing-strikes-facts-and-figures-on-uk-nursing-staff
[6] https://www.scb.se/lonestatistik/Sjukskoterska/
[7] https://www.scb.se/hitta-statistik/sverige-i-siffror/utbildning-jobb-och-pengar/medelloner-i-sverige/
[8] https://es.talent.com/salary?job=enfermera
[9] https://www.nationaleberoepengids.nl/salaris/verpleegkundige
[10] https://www.werkzoeken.nl/salaris/
[11] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---december-2021-experimental-statistics
[12] https://azwstatline.cbs.nl/#/AZW/nl/dataset/24136NED/table?ts=1679829787821
[13] https://www.kingsfund.org.uk/blog/2019/10/nhs-sickness-absence
[14] https://www.adeccoinstitute.es/wp-content/uploads/2022/04/I-informe-trimestral-absentismo-y-siniestralidad-laboral-Abril2022-final.pdf.
[15] https://puc.overheid.nl/nza/doc/PUC_703808_22/1/

Areas particularly affected	Adult and social care[16]	Anaesthesia, intensive care, surgical care, elder care[17]	In all areas, but mainly in social care, older population, and intensive care[18]	Older person care, youth care, mental care[19]
Differences between regions	No substantive differences between regions, yet shortage rates for London are higher (vacancy rate of 13.5% in 2019, no post-COVID numbers available)[20]	All regions have reported a shortage of nurses as well as specialist nurses. As for the municipalities, 67% of these report a shortage of nurses and 79% a shortage of specialist nurses[21]	In general, a gap between north and south Spain is observed, with most regions of the north having a ratio of nurses per 100,000 inhabitants over the country mean (except for Galicia). Regarding the islands, Balearic Islands show a ratio below the country mean, while the Canary Islands show a ratio above the mean[22]	In nursing homes, most vacancies are in non-urban areas, while specialised hospital care (like intensive care treatment) seems most problematic in the bigger cities[23,24]

[16]https://committees.parliament.uk/publications/6158/documents/68766/default/
[17]https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2022-2-7759.pdf
[18]https://diarioenfermero.es/alerta-roja-ante-la-falta-de-enfermeras/
[19]https://puc.overheid.nl/nza/doc/PUC_703808_22/1/
[20]https://researchbriefings.files.parliament.uk/documents/CDP-2020-0037/CDP-2020-0037.pdf
[21]https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2023-2-8352.pdf
[22]https://www.consejogeneralenfermeria.org/component/jdownloads/send/69-otros-documentos/2340-informe-de-ratios-por-comunidades-autonomas-y-provincias-2021
[23]https://puc.overheid.nl/nza/doc/PUC_636235_22/1/
[24]https://puc.overheid.nl/nza/doc/PUC_703808_22/1/

SAHP (*Vårdförbundet*), represents the nursing profession at national, regional, and local levels. As a trade union, SAHP has substantial coverage among nurses (with more than 80 per cent of the workforce belonging to the union). SAHP is active in the public debate and acts as a strong lobbyist in Swedish health policy, particularly at the national level. The organisation influences public opinion through its media presence, its frequent appearance in referral committees, and when its expertise is drawn upon in formal government investigations. While SAHP holds an established role in policy formation, our respondents argue for greater visibility of nurses in ongoing public debate at national and regional levels. Also, in Sweden, nurses often lack formal management positions in addition to the SAHP, such as being members of hospital boards. Dutch nurses face similar challenges. Here, nurses are represented at the policy level by the *Verpleegkundigen & Verzorgenden Nederland (V&VN),* an association for nurses and nurse-associates. V&VN has moved into the inner circle of the Dutch corporatist tradition of healthcare policymaking in the past few years, now being one of the main actors next to (among others) insurers, medical, and hospital associations. This more central and political position was strengthened during the COVID-crisis, when both the nursing profession and the government realised that nurses should be at the forefront of policy decision-making to have a direct influence on the political decisions that impact nursing work and well-being and to gain support for urgent measures like upsurging care. However, a board member of the V&VN explained in the interview how they struggle with their newly acquired role, both with respect to positioning themselves between already institutionalised interest groups that have strong ties with the Ministry of Health and other regulatory bodies, and how to represent their highly varied rank-and-file that have various interests:

> 'I always have to mention the remuneration issue. When I give a presentation or an interview, and I don't say how important nurses are and that they deserve a decent salary, I certainly get comments and complains. That I don't think enough about the nurses at the work floor'. (RN1)

The difficulty of representing a big and varied group of nurses and nurse-associates with different concerns was mentioned in all country case studies. Nurse associations must learn to play the political game and represent nurses with various backgrounds and professional aims at the same time. This can cause friction. In the Netherlands, for example, an announced law to provide bachelor-trained nurses with more authority was disrupted (and then withdrawn) due to fierce resistance among vocationally trained nurses that felt degraded, blaming the nursing association to represent only one subgroup (Felder *et al.*, 2022). Hence, representation can be troubled by conflicting inter-professional interests that force nursing associations to act carefully. Also, nurse associations experience a big gap with the working field as only a (very) limited number of nurses have a position in a management board or at the Ministry, which makes it difficult to build a nursing coalition and having more influence at the organisational level as well as at the sharp end of healthcare delivery.

4.3. Working conditions

All four countries have introduced targeted policies to attract more nurse students and/or retain nurses already employed. In England, for instance, national targets are implemented to attract 50,000 full-time equivalent (FTE) registered nurses by the end of 2024, aiming to employ at least 350,904 FTE nurses across the NHS. In Sweden, where workforce policies are primarily regulated at the regional and municipality levels, the national government has initiated several funds to stimulate nurse education. In Spain, a visibility campaign has been launched to both attract new students and to present a more favourable picture of nurses and nursing work to the public, showing the importance of nurses and care. In the Netherlands, in contrast, the national government has stated that training and attracting more nurses will harm other sectors'

workforce needs and will render healthcare unaffordable in the future (WRR, 2021). Instead, the Dutch government wants to invest more in health technology and in fostering the position of nurses in the healthcare system to enhance nurse retainment.

Poor working conditions, however, stood out in all interviews at all levels – yet, interestingly, not so much in official policy documents and reports. Nurses and nurse representatives raise concerns about the workload, high sick leave rates and low salaries as well as a lack of public appreciation, something that was very present in the early phase of the pandemic (Mohammed *et al.*, 2021). While COVID-19 has shown a shift in appreciation for the work of nurses in the general population, with a positive effect on initial student recruitment, there is a discrepancy between the appreciation of people when they engage with nurses, including their busy work lives, and the political reality that sees a lack of willingness to provide adequate salaries and career development plans. Working conditions are particularly problematic in Spain and England. In England, where the Francis committee revealed serious shortcomings in nursing in the late 2010s, respondents argued that things had only gotten worse:

'Work conditions are not sustainable. We are killing our nurses with workload and very poor working conditions'. Due to low staff rates, 'nurses are firefighting throughout their shifts, a kind of merry go round worker who can be redeployed to fill gaps'. The constant pressure 'is psychologically exhausting and wears people out'. (RE1)

In England, nurses sometimes must work long shifts (over 12 hours), and high work pressure results in medical errors which, respondents stated, are not adequately dealt with and both patients and nurses suffer from it:

'Medical errors are being made and reported, with evaluations of reporting systems highlighting the scaring, guilt, and isolation'. 'There is no support in the system to help nurses dealing with traumatic incidents, leaving them with carrying shame, internalizing blame and given them a lot of psychological pain, which strongly contributes to nurses leaving the workforce'. (RE1)

Also in Spain, nurses experience great difficulties in their work, and lack of nurse capacity make that patient needs remain unfulfilled:

'There are not enough nurses and there are always some tasks unfinished. As a result, shifts tend to exceed the working day hours. Patients have more needs (as they are older and more dependent) and there is not enough time to do prevention and promotion'. (RS2)

The troubled position of both patients and nurses in daily practice is further problematised by precarious employability rights. In Spain, it is difficult to obtain a permanent contract (sometimes one-day contracts are offered) and salaries are low. Payment rates are subject to a longstanding and unresolved issue about the classification of nurses as civil servants of an 'A2-category' profession instead of 'A1' (A1-category civil servants bear more responsibilities and earn significantly higher than professional groups in the A2-category). This categorisation is decided upon by the Spanish Ministry of Health. Dissatisfaction here also concerns lacking recognition of nurses' clinical authority and competencies. Speciality training is insufficiently recognised; only six nurse specialities have yet been formally recognised and accommodated. Attempts to provide nurses with the authority to prescribe medicine have had only limited results as these newly obtained professional rights are very restricted in practice.

Although working conditions seem to be poorest in England and Spain, also in Sweden and the Netherlands, nurses raise issues about their position and increasing work pressure. Lack of nurse staffing impact on future nursing; in all countries, there is a lack of training opportunities,

especially an adequate system of internships to train a new generation of nurses is missing. In Sweden, a national coordinator has been appointed to support universities, principals, and care providers in their effort to increase the availability of places for training and to analyse possible obstacles. In the Netherlands, the government has provided extra funding to vocational-schools and healthcare organisations to create more internships. This money was not ear-marked, however. One respondent recalled how the money became part of broader negotiations between educational and healthcare organisations and was finally used to fill other budget gaps, also illustrating the difficulty of the government to pursue changes in nurse education, as well as the great dependency of nurses on other stakeholders in healthcare (interview RN5). Nurses lack the professional and legitimate authority to make decisions and therefore have great difficulties in getting themselves heard:

> 'We nurses are not seen as a specific resource but as general cargo; something you put in a container and ship from Hong Kong to Rotterdam. We are put in a container with as many as possible; we are not the smart TVs that are handled carefully. (…) A hospital executive knows exactly how many medical specialists there are, but only has a general clue about the number of nurses'. (RN1)

As this respondent points out, nurses are seen as 'a general good' instead of individual professionals with specific competencies and authority. In Sweden, England, and Spain, we also observed this focus on nurses as a vocation and as a group instead of professionals. A respondent from England argued that '[u]nlike doctors who have a clear career progression from junior doctor to consultant, the system only plans for nurses coming into the system without planning across the different structures of seniority and types of nurses' (RE3). Such capacity planning systems are also missing in the Netherlands, Sweden, and Spain: nurses are not considered individual career-makers that require specific career pathways, but they are 'workforce' that must keep the system going. In the next section, we explore this issue more in depth.

4.4. Building a nursing career

Policymakers tend to consider nurses as one, clearly bounded and defined profession. In practice, this is less clear, however. The profession includes different categories of nurses such as registered nurses, specialised nurses, nurse-associates, and nurse-assistants. Nurses are trained at various levels, ranging from practice-based ('vocational') to university level. They bear different (legal) responsibilities that also vary between countries (van Kraaij *et al.*, 2023). To complexify even further, different terms and competence frameworks are used across countries.

In all four countries, a growing group of nurses demand better career options. However, in all these countries, it is difficult to make a career in nursing. Nurses often 'opt out the profession' and hence move away from 'bedside nursing' to make a career, for instance by becoming a healthcare manager or teacher. There appear limited opportunities to negotiate a higher payment as this is regulated by collective labour agreements. A respondent from England remarked: 'Some nurses remain on the same pay band for over a decade' (RE3). In Sweden, nurses are sometimes offered an additional fee and/or an adjusted work schedules (so-called wish schedules) to make the work more attractive. Yet, also here managers are reluctant to make such exceptions as 'it becomes too expensive'. At the same time, attempts are made to create new career opportunities in which nurses are provided with a more diverse and challenging role. In the Netherlands, a growing group of (master-level trained) nurse practitioners work at the crossroad of medical and nursing work, for instance in long-term care. In Spain, nurses do not have an established career progression. However, in Catalonia (one of the Spanish Autonomous Communities), a parallel system for advanced practice is being created in which nurses can obtain certificates that are attached to salary increase and promotion.

An alternative track is combining positions, like patient care and teaching. This appears difficult, however, due to the shift-work routine: 'You aren't allowed to refuse the night shifts, but these are hard to combine with a part-time job in teaching' (RN4). Also, the strong appeal on nurses to be instantly available in case 'shifts must be filled' or 'more hands are needed' – expressions that in themselves demonstrate the view on nurses as 'workforce' instead of professionals – are a barrier to building a more varied nursing career. One of the Swedish respondents highlights that there is a lack of career development opportunities for nurses and that the career paths that exist primarily means leaving clinical work for an administrative role or managerial position or becoming a clinical researcher. The respondent calls for better structures for career development in the clinical work and expresses it as follows:

> 'But this very thing of having a career development and still being part of the clinical work and perhaps also working with quality improvement or research and integrating it, those structures do not generally exist today'. (RSw1)

Another nursing career route is through research; nursing research is growing in many countries as a result of the shift to evidence-based practice, as well as a growing awareness of the need to get more insight in nursing work to lever the profession (eg. Bridges *et al.*, 2013; Allen, 2018). In all four countries, possibilities to do research in nursing is limited however due to both time constraints ('the patient always comes first') and an underdeveloped research infrastructure. In the Netherlands, for example, nursing research has been slow to develop, partly because nursing schools are organised at the level of applied science rather than at university level. Chairs in nursing science were only established in the early 1980s and there are still only 13 appointed professors in nursing (and about 20 lecturers at universities of applied science). Although there are some programmes for nursing with ZonMw, the main funder of healthcare research in the Netherlands, these are sparse and lack size, especially in comparison to (bio)medical research. In Sweden, on the other hand, nursing research has grown remarkably during the last decades and there are now approximately 115 appointed professors in nursing at Swedish universities and colleges. In 2022, the National Research Council invested €17M for a new PhD programme for caring professionals, including nurses.

4.5. Breaking with the public healthcare system

Disappointment with the healthcare system pushes nurses out of the public system. They do so by moving from the public into the private sector, through self-employment, or through migration. A growing group of nurses is working self-employed or through private agencies. They work as entrepreneurs on an on-call or temporary basis or are employed by private independent staffing agencies. These so-called locum nurses or travel nurses are particularly present in the Netherlands and Sweden, but not in Spain. For England, there are no official statistics, yet the impression is that locum nurses are widely employed to fill in the gaps. Often, they set their own salary rate (which is higher than for employed nurses, also due to the social security premiums, a pension scheme, and insurance against clinical errors), or they work through private intermediary organisations that demand high fees for their service. Nurses are attracted to self-employed work because of the higher salaries and the possibility to choose their working hours. In recent years, costs for temporary personnel have substantially increased in Sweden and the Netherlands. In Sweden, the first half of 2022 alone witnessed a nearly 39 per cent increase in costs for locum nurses compared to the corresponding period in 2021 (SALAR, 2022). In the Netherlands, figures are blurred because nurses often work self-employed in addition to a (part-time) permanent contract. Yet it was recently estimated that 30,000 nurses are now working self-employed (of a total of 223.467 registered nurses) and that this number is growing by 10 per cent every year. Respondents were critical about the self-employment trend as it (allegedly) increases expenses, and extensive use of temporary staff can affect the continuity

and quality of care as well as the working environment for the regular staff. Most Swedish regions are currently trying to reduce their dependence on temporary staff. Some regions have decided not to use temporary nurses despite staffing difficulties. However, in regions with most staffing problems, dependency on self-employment has grown. Also in the Netherlands, policy-makers and healthcare organisations are critical on self-employment. It is considered 'unethical' in the light of increasing shortages and high work pressure. In a media interview, an executive stated:

> 'Locum nurses should think about their societal responsibility for the accessibility and affordability of healthcare: Don't they have any responsibility? Everybody bears social responsibility!' (Skipr, 2022)

This quote shows the moral appeal that is made on locum nurses to give up their independent position, which is considered unresponsible by this respondent. Also, directors of nursing schools are reluctant to offer courses on entrepreneurship as they 'don't want to stimulate self-employment' (RN4). This moral appeal is interesting in the light of the historical view on nurses as 'self-sacrificing for the needs of patients' instead of professionals searching for adequate payment and recognition (Mohammed *et al.*, 2021).

   Another way to break with the system is to leave the country altogether. This is particularly the case in Spain and England, and, to a lesser extent, Sweden. Spanish nurses are leaving to other countries such as Finland, Saudi Arabia, Sweden, New Zealand, Portugal, and the UK:

> 'During the last year, the number of nurses that asked the union for a leave certificate has multiplied by three. The reasons behind this decision are better working conditions in other countries, in terms of salaries, contracts, career progression and responsibilities'. (RS2)

To fill the void, healthcare systems adopt strategies to attract nurses from an international workforce market. For example, England is well known for its high inflow of foreign nurses. In England, 10 per cent of the nurses have an Asian background, and 6 per cent come from a European country (like Spain), as they are better off in England than in their home countries:

> 'There is a high demand for nurses from the Philippines, and other East Asian countries'. 'In our home countries, working conditions are characterised by low pay, and steep hierarchies, all conditions considered to be substantially better in the English NHS system'. 'Many migrant nurses appreciate the opportunity provided by the system, including opportunities to grow professionally through available training programmes. It appears that nurses from the Philippines, and other low- and middle-income country settings are highly resilient, and adaptable to the working conditions in England and show strong loyalty to the NHS system'. (RE2)

The examples in this section demonstrate that governments lack reflection on the reasons behind the choice of nurses to 'opt out' – whether through self-employment or by leaving the system. Governments are primarily focused on solving the consequences of these choices by restoring nurse workforce capacity instead of listening to the system's shortcomings and profession's concerns that make nurses break with the system.

5. Discussion

Nursing has turned into a political issue for healthcare sustainability; increasing staff shortages and worrying images of insufficient future care provision have moved the profession into the core of healthcare policymaking. At the same time, as this paper has shown, existing policy strategies are inadequate to lever nurses as a political actor and to make current problems sufficiently

heard and acted upon. Although there are substantial differences between countries, for instance regarding nurse staffing (ie. shortages are more severe in Spain and England, and this differs between regions within a country) and how nurses experience their working conditions, in all four countries nurses are inadequately represented at national and organisational levels and they lack adequate self-regulatory capacity to lever the profession.

Our comparative discursive institutional approach has shown how nurse politics plays out in different healthcare systems at the level of policymaking, in healthcare organisations and in everyday healthcare delivery. Nurses face representation problems at all levels. Unions that represent nurses, for instance, must often also protect other professional interests and, consequently, nursing aims (eg. moving from an 'A2' to an 'A1' occupational status in Spain to increase salaries) get blurred in a myriad of other (and often competing) professional goals and interests. Yet also in countries with a strong nursing lobby, nurses do not (yet) succeed in gaining substantial influence. In Sweden, a particular problem is that nurses often do not possess the higher management positions that are needed to institutionalise such a more prominent role.

These concerns are however rarely addressed in piling policy advisory reports on nurse workforce shortage. These reports, both written by international agencies and national advisory committees, tend to focus on capacity issues like workforce planning, education, and replacing nursing staff with technology. This dominant policy discourse articulates nurses as a collective group ('general cargo') of workers that carry out certain actions and services, instead of (individual) professional workers that possess intrinsic professional aims and values. This 'institutional ignorance' (Gross, 2016; Paul *et al.*, 2022) of the contemporary nurse workforce revolves around issues of representation, working conditions, career building, and leaving the public system. Although (international) policy reports have over the years paid attention to the lack of nurses and the need for training and higher salaries, such issues have been largely ignored by (national) policymakers. Signs of nurses leaving the workforce or becoming self-employed are taken up in a moral manner rather than as a reflection of failing policies and lacking adequate knowledge to better understand those issues. On the other hand, nurse representation often is very limited and/or fragmented, also due to inter-professional conflicts. While nurses in the aftermath of the COVID-pandemic have increased the call 'nothing about us, without us' – a slogan frequently used in the Netherlands to require the involvement of nurses in decision-making, from the board room to the beside – who this 'us' is remains underdeveloped. Diverging interests between the different kinds and 'levels' of nurses fosters institutional ignorance as it remains unclear what kind of knowledge infrastructures should prevail and hence be invested in.

The discursive institutionalism approach used in this paper allowed to shed light on the ideas, strategies, and normative orientations of actors that can initiate institutional change. Nurses may be a dispersed group, but contemporary urgency also forces them to unite and 'speak truth to power'. In England, at the time of writing, nurses are on strike and out in the streets to demand better working conditions – something unheard of in the past – with more industrial action about to come. In Sweden and the Netherlands, national governments invest in the building of scientific infrastructures to develop evidence-based nursing routines and professional development strategies, giving more space for the development of a professional nursing discourse.

With this paper, we make a plea for nurse politics as a new field of policy and political research; elucidating nurses' (lack of) representation and impact as a knowledge domain that until now has been underexplored – and hence underused in fostering nurses and nursing work. While our analysis has limitations as we have not been able to go in great depth for each of the countries, our approach tried to lay the foundation for further research into the politics of nursing and identify themes that are of relevance across countries. With nurses as being one of the backbones of contemporary and future healthcare systems, and with those systems increasingly under pressure, it is of crucial importance to invest in such research.

6. Conclusions

Whereas countries are facing a growing and increasingly severe shortage of nurses, healthcare policymakers tend to focus on instrumental staffing issues and policies to increase 'numbers' of nurses, rather than questioning the political position of nurses and their subservient role in contemporary healthcare systems. This paper shows that nurses lack political representation in national policymaking, in healthcare organisations and in defining daily nursing practice. The institutional ignorance of the position of nurses and the nursing profession blurs a clear vision on what nurses need, and how the profession can obtain a full-fledged political role in healthcare and policymaking. Nurses now use the 'exit' option instead of raising their voice (Hirschman, 1970). A focus on workforce politics, in addition to workforce policy, allows for a fresh policy *and* scholarly debate on the sustainability of healthcare systems.

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