WHITE PAPER A FOR FUTURE-PROOF CARE

Impetus for a master plan for nursing care in Germany

The situation in the nursing profession demands action - and it needs to happen now!

In our country there is an urgent need for a national Master Plan for nursing care.

„Estimates suggest that there is already a shortage of 100,000 nursing professionals in Germany“

Initial situation

The Covid 19 pandemic made all citizens aware of how important caregivers are ...

... and how much this profession is defined on the one hand by empathy with people in need of help and on the other hand by a commitment to the limit. But it was not only during the pandemic that it became known that, due to the increase in older people and people in need of care in our society, there is already a serious gap between the growing need and the number of people who are willing to make a nursing profession their professional life.

Estimates currently suggest that Germany already has a shortage of 100,000 nursing professionals and that this deficit will almost double in the next five years. This development is leading to a dangerous downward spiral that has the potential to contribute to further division in our society. Therefore, a process must now be set in motion with urgency that consolidates the situation in the short term while defining medium- and long-term goals and measures capable of averting further deterioration of the situation.

What are the reasons for the shortage of nurses?

» The reasons are manifold and include developments in society as a whole, economic pressure and hierarchical structures in the health care system, the neglect of further development, education and training in the nursing profession, and the inadequate remuneration of many nurses.

Reasons 1 | societal

Overall societal factors contributing to the shortage of nurses

Not only in the healthcare sector, but also in other areas of our society, we are registering a development characterized by a strong focus on personal well-being and self-optimization, which only takes the common good into consideration in times of crisis and then only temporarily. This is why there is a shortage of skilled workers not only in the nursing professions, but also in other health professions, among educators, among teachers and in social work.

It is noteworthy that these professions have so far been performed predominantly by women. Thus, the current situation is also an expression of the insufficient equality of women in Germany for decades compared to other countries, e.g. Scandinavia. The attitude in our society that care and education are primarily private and at best charitable tasks has led to a dead end, even though there are numerous regulations in Germany that guarantee basic access to the services of the health and education system regardless of individual monetary possibilities or level of education.

Until now, it has not been a political priority to ensure this in terms of quantity and quality. In fact, the lack of qualified staff and the resulting workload have also led to a creeping quality deficit. Opening up nursing care to less qualified staff in order to be able to continue to provide services is worsening quality and contributing to the frustration of well-trained professionals who feel responsible for providing high quality. People who can afford it are therefore increasingly taking the initiative and organizing their own care or that of family members outside the healthcare system, in some cases at considerable financial expense.

Similarly, in education, there is a trend toward private sponsors of daycare centers, schools and universities. However, since education and health are supporting pillars of our prosperity, these areas must be given much greater attention to enable general prosperity. It must become clear to citizens that prosperity with the collateral damage of a lack of care and education is not prosperity for many and causes society to drift further apart.

Reasons 2 | economic

Economic pressure in the healthcare sector

During the pandemic, the German healthcare system proved to be fundamentally efficient in terms of the infrastructure provided in the area of acute and intensive care. However, existing deficiencies became more than apparent in the areas of human resources for care, digital infrastructure and public health.

In all three areas, the necessary financial resources had not been provided in previous years, and there had even been a reduction in resources. The reason is the existing underfunding of the health care system in many areas. A decades-long lack of sufficient investment by the states and municipalities in the structural, medical technology and digital infrastructure of clinics in the so-called „dual" financing system, the fundamental effectiveness of which must be questioned, has led to the carriers making extensive savings in the area of personnel costs.

Planning that is not in line with demand and an uneven distribution of resources ultimately led to the fact that existing capacities, especially intensive care capacities, cannot be fully utilized to this day. A large number of hospitals does not result in any improvement in mortality and morbidity compared to other countries, so that a different structuring of inpatient care seems sensible. In addition, there have been false incentives in the range of services, resulting in the promotion of services that allow a high contribution margin to be achieved.

The care of patients with a high demand for personnel without correspondingly lucrative, apparatus or medical services were shifted from the acute medicine of the clinics to the rehabilitation or nursing home sector. On the other hand, the need for medical and nursing care increased, since the achievements of modern medicine mean that very old patients in particular are increasingly surviving acute illnesses but have a greater need for medical and nursing care on a permanent basis.

These new needs have arisen without sufficient time to provide appropriate training and development for caregivers in rehabilitation and nursing facilities and to adjust staffing ratios to the increased workload.

THIS HAS EXACERBATED THE SITUATION FOR NURSES IN TWO WAYS:

1. *In the clinics, the work of nursing has been condensed by the increasing medical and apparatus interventions even on the so-called „normal wards". At the same time, there is a high documentation effort due to a deficient digital infrastructure. These developments cause nurses to leave their profession prematurely, as there is no time for the original nursing activities for the patients and it is not possible to ensure quality, which can even endanger human lives.*

2. *In the rehabilitation and nursing home sector, the lack of qualifications for the tasks at hand and the lack of junior staff are leading to considerable quantitative and qualitative gaps. In an increasingly commercialized sector, the strain is becoming so great that nurses are giving up their professions here, too.*

Reasons 3 | structural

Hierarchical structures in the health care system

The culture in the German healthcare system, especially in the inpatient sector, continues to be characterized by very strongly hierarchical structures between and within the occupational groups. The nursing profession is largely perceived as subordinate by the medical profession, but also by funding agencies, which can also be seen in the governance of hospitals. For example, in university medicine, although nursing is represented on the board of directors at most sites by a director of nursing - more rarely by a director of nursing - this is still not the case on some boards.

Historically, the concept was utilized for a very long time that the doctors decided on personnel matters over the nursing staff and also on their professional tasks. The self-image of nursing was also shaped by this for a very long time. Although this has changed in the last 20 years, and the self-image and self-confidence of nurses are different today, it has not yet been translated into structures and also not yet into lived practice in many places. Large hospitals now rightly have a qualified personnel board, as broad expertise is required for the complex tasks of personnel management and development among the many different professional groups. Nevertheless, nursing management must also be represented on the board so that the quality of nursing care, which is a key factor in the success of patient treatment, is adequately represented in professional terms.

The sluggish introduction of professional representation by nursing chambers or their withdrawal also shows that it is not taken for granted that nursing will look after its own interests. In terms of content, it is absolutely necessary for teams of different occupational groups to act on an „equal footing“ on a multi-professional basis. This is particularly pronounced in acute and intensive care medicine but is also becoming increasingly important in primary care.

It would significantly improve the attractiveness of the nursing profession if a culture of teamwork were more clearly and factually practiced and this culture were also given greater visibility in its external presentation. It is therefore to be welcomed that interprofessional training is addressed as a component in the amendment to the licensing regulations for physicians.

Another serious problem is the fact that in the nursing profession, more than 80 percent of employees are women, while the management level in the medical profession remains predominantly male. The principle of „unconscious bias“ is a decisive factor here. It has the effect that women are not trusted with these management positions and are assigned subordinate roles.

However, today‘s generations of women in the professional world are increasingly withdrawing from „serving“ work, which is demanded as a quasi-natural role and which therefore does not receive adequate appreciation and respect. This view also fails to recognize that the „emotional“ part of nursing work requires adequate education and ongoing appropriate professional staff development. In addition, due to this situation, there are also multi-layered dependency relationships that contribute to the fact that the nursing profession is not seen as attractive and stressful.

Reasons 4 | Education

Neglecting the improvement of education and training

The Nursing Profession Reform Act (PflBG) was passed in 2017 after lengthy debate and came into force on Jan. 1, 2020. It includes the continuation of vocational nursing training with five equivalent in-depth assignments in practical training and does not provide for basic academic training. Initial academic training is only made possible as a parallel training approach.

The legislation pursued the goal of creating international connectivity and conformity with EU law. In the current discussion, the so-called „generalist" training is apparently also seen as an important instrument for coping with the shortage of nurses, as it opens up more career opportunities for trainees by qualifying them primarily for nursing as a whole rather than exclusively for the care of children or the elderly.

An evaluation of the effects of the Nursing Profession Reform Act is planned for 2025, possibly at a later date due to the pandemic. If the legislation does not lead to the desired goal, does not improve the attractiveness of the nursing profession and at the same time does not provide sufficient further training in functional nursing, the situation will become even worse.

The ratio of female to male nursing professionals is 80 to 20 percent. After three years of training as a nurse and subsequent initial professional experience in full-time work, the start of in-service training often coincides with a period in which decisions are already being made about starting a family. Even if in-service training is successfully completed after two to three years, starting a family of their own can mean that nurses are unable to make full use of the skills they have acquired.

It is undisputed that comprehensive basic training is necessary in the nursing professions. Specialization at too early a stage due to the shortage of skilled workers (e.g. OTA, ATA) works against a solid professional basis for the nursing profession. On the other hand, due to the increase in knowledge, required content of the various disciplines must also be taught to a greater extent in initial training. As with medical training, this requires completely new formats that reduce unnecessary factual knowledge and promote intrinsic motivation for lifelong learning.

It is also undisputed that a larger proportion of training should be academicized. Compared to other countries, the academization of the nursing profession in Germany is still in its infancy. For an incomprehensibly long period of time, the necessity of academic training for nurses has been questioned. This is still held to some extent today by opinion leaders, mostly female physicians and business economists.

Since the mostly part-time courses of study in nursing sciences, nursing pedagogy and nursing management have so far trained nurses who primarily do not take on patient-related tasks, there are fears that academization could exacerbate the shortage of nursing care for patients. This argument ignores the fact that this is not the case in other countries despite basic academic training.

In Scandinavia, the first degree programs in nursing were introduced as early as the 1980s. In Sweden and Great Britain, all nurses have academic degrees. In the Netherlands, the figure is 45 percent, combined with a significantly higher standing for nurses and correspondingly higher remuneration. In these countries, there is also greater interprofessional collaboration, with nursing also taking on activities that in Germany are still assigned exclusively to physicians.

The professional profiles that have long been established in other countries, for example those of the Advanced Nurse Practitioner range of courses, are necessary in order to implement medical and nursing expertise on patients in a more quality-assured manner. In the important area of primary care with

preventive and outreach services, community health nurses will be needed to make the health care system economically viable through sustainable prevention strategies.

The examples from other countries show that it is possible and necessary to use academic training to establish teamwork on an equal footing with physicians. It is unlikely that the attractiveness of the nursing professions can be significantly improved without greater academization, as almost half of school leavers in Germany now have the right to access a university or acquire it while working.

However, academization alone will not solve the shortage. This was not the case in Scandinavia, the Netherlands, the USA, Australia and the UK either, which is not surprising, because the overall social conditions are comparable and support the thesis that the problem cannot be solved by better remuneration alone. Rather, what is needed is a change in the culture and appreciation in society with regard to the professions of so-called „care work".

Reasons 5 | Remuneration

Compensation in the nursing professions

Even before the pandemic, collective bargaining in the nursing professions made it clear how the shortage of nurses was already putting such a strain on individuals that the focus was not on compensation issues but on working conditions.

However, it has not become clear enough to the public that this is not just about the physical and psychological stresses. What it means to live as a caregiver on almost constant call, that even planned vacations have to be postponed, that maintaining social contacts is almost impossible and that it is not possible to adequately fulfill the care tasks in one's own family, can hardly be grasped and understood by many citizens who pursue regular working hours in office environments.

Fortunately, the days when nurses lived in nurses' homes right next to hospitals are long gone. But because of the high rents in metropolitan areas, many employees have to add considerable commuting time to their working hours. Another burdening factor is the rising cost of commuting to work.

The sensible introduction of lower staffing limits to improve working conditions will not change the situation in the short term. On the other hand, however, this is a suitable means of ensuring nursing quality and increasing the attractiveness of the nursing profession in the medium and long term. The presence of a defined number of nurses is essential in order to be able to bill health insurers for services in the interests of improved patient safety.

The pandemic has not only made the situation more difficult, but also more public. As an ad hoc recognition measure, the payment of one-time bonuses to nurses was promised. However, the positive effect in the perception of caregivers has failed to materialize because the distribution of bonuses raises questions of fairness. In addition, there is growing concern in the nursing community that necessary measures and sustainable changes and increases in compensation will not be seriously addressed in the aftermath of the pandemic.

However, these are urgently needed, as Germany is slightly above the OECD average in terms of remuneration, but many comparable European countries are significantly (50-80 percent) above German remuneration. It is therefore generally accepted that the level of remuneration for the nursing professions in Germany must rise. However, given the complex causes of the nursing shortage, this can only be one of many measures to sustainably reduce the nursing shortage.

What needs to change?

» ***In our country, there is an urgent need for a national master plan for care. The various competencies and responsibilities of a master plan are briefly outlined in the following table.*** *Urgency is required, as the situation could escalate very soon due to demographic trends. The recruitment of foreign nursing professionals, which cannot be dispensed with, will not solve the problems in the medium and long term.*

Similarly, structural reform of hospitals and cross-sectoral care will not achieve improved availability of nurses in the short term. Whether this „results“ in a redistribution in the long term will depend on whether new health care structures emerge regionally, such as primary care centers with convalescent beds and attractive fields of activity for nursing professionals. This is because the professional orientation of nursing professionals - often women with family responsibilities - is often very tied to the region, which is not surprising given the challenging activities in terms of time and content.

FIELD OF ACTION	MEASURES IN THE SHORT TERM
Society as a whole Framework	› Measures of knowledge transfer and communication to convey a positive image of the system relevance of nursing (and other care professions). This should already start in school › Translation of "New Work" into the nursing profession through digital transformation in clinics and homes, flexible working time models, working time accounts, and interprofessional teams. › Provide for number of people in care also more as "provision" in terms of continuity management and contingency plan
Economic pressure in the healthcare sector	› Controlling or monitoring processes that ensure that the financial resources for care actually reach the care.
Hierarchical structures in healthcare	› Cascade models for governance in all areas of health care that take into account the real ratios of female to male nurses and ensure representation of nurses on boards › Early warning systems for inadequate leadership behavior and abuse of power
Education and training	› In principle: promotion of the professionalism of nursing (access requirements, quality of education, differentiation of educational levels, etc.). › Ensure practical assignments and instruction in the various training areas and train more teaching staff › Securing and expanding primary qualifying courses of study with suitable incentives/framework conditions (offer for high school graduates) › Securing and expanding higher education structures for enough teaching staff in training and at universities
Operational organization and care management	› Controlling the quality of care › Organizational changes such as closing stations on weekends. › Various measures for workplace health promotion, from massages to relaxation courses, etc. › Measures against emotional burn-out / support for relationship work
Compensation and other forms of appreciation	› Increase in collectively agreed remuneration › Eligibility of allowances for retirement pension › Working time accounts with the possibility of time off for care work in the own family › Additional days off for shifts taken from free time

any:

MEASURES IN THE MEDIUM AND LONG TERM	RESPONSIBILITY
› Development towards a stronger attitude of care and solidarity in society › Recognize the importance of the common good and health for prosperity and satisfaction, as well as for the functioning of all other sectors, and position themselves accordingly › Health care must be clearly and explicitly part of services of general interest	Schools, universities, academies, politics, media Hospital and nursing home operators Municipalities and local authorities
› Ecalculation of the necessary financing for nursing care in inpatient and outpatient areas according to modeling in different scenarios › Calculate economic cost models to evaluate and balance business effects (more health promotion and prevention, and time allotments for specialty care that promotes self-management and prevents complications)	Politics, payers, science
› Master Plan for Equality and Valuing Diversity in the Health Professions. › Reform of self-governance and adaptation to current understanding of health care	Care, Politics, Academies
› Full connection to the EU directives on nursing professions › Expanding nursing professional roles in clinical settings as well as in public health. › Implementation of a coherent, permeable, and nationally uniform education model for the nursing professions (from nursing assistant to master's degree/promotion) › Promote discipline formation in nursing science	Politics, care, universities
› Introduction of skill-mixed teams with mandatory inclusion of academically qualified nursing professionals in all areas - Adaptation of organizational structures	Care management, cost unit
› Innovative working time models for nursing with temporary reduction or increase of hours › Further training offers › More vacation days in career progression	Human resources departments of hospitals and nursing management, self-government, collective bargaining partners, federal ministries

Care in Germany – personal experience reports of a caring relative

MEDICAL HISTORY OF THE PERSON IN NEED OF CARE:

» 2005 Breast cancer

» 2015 Metastasis in the stomach, surgical removal of the stomach and creation of an artificial bowel outlet (stoma).

» In 2015-17, a total of 41x in the OR (mostly VAC change).

» Field report of a family caregiver, part 1 - REHA clinic (April - July 2015)

„A REHA stay occurred immediately after hospitalization. My mother was on a full diet in the hospital after her surgery. After losing weight due to the many surgeries, she gained it back slightly.

However, the rehab clinic felt they had to put my mother on a diet, and she lost 20kg in a matter of weeks.

The nursing staff at the REHA clinic was not able to take sufficient care of my mother. Thus, I was forced to travel to the REHA clinic (about 170 km from my home) several times a week to have repeated conversations with the nursing staff. Unfortunately, since there was neither insight nor changes in care, I was forced to deal with the attending physician (surgeon at the hospital) and the health insurance company. Finally, my mother was transferred from the rehab clinic back to the hospital.“

» Field report of a family caregiver, part 2 - nursing home (September 2015 until death in May 2019)

„The nursing home was recommended to us, and so my bedridden mother moved in there in August 2015 with care level 3. It was known to the nursing staff that my mother had a small bowel stoma and therefore required special nutrition. She was supposed to eat a few snacks every few hours.

My mother often called me and asked for help, because dinner was served in the nursing home at 5:30 p.m. and breakfast often after 10 a.m.. The nursing home was not able to adapt the care and supply or nutrition to my mother‘s illness.

Several times I also received calls from the nursing home. I was told that many of the nursing staff were ill and that I should please take care of my mother‘s needs. The nursing staff knew that I could take care of the

ostomy care as well as everything that belonged to the care because I am fit in the matter. So I was able to position my mother according to the rules, etc., but I lacked the strength to shower her, for example, because I myself had cancer.

Due to time constraints, I was asked by the nursing staff to apply for all necessary aids for my mother at the health insurance. So I contacted the health insurance and was able to apply for e.g. an anti-decubitus mattress, a special wheelchair with anti-decubitus cushion, a stable rollator etc. without any problems. I had a confirmation in my mailbox within 2 days. I also had to take care of an optimal stoma care. I received an introduction to complete stoma care in the hospital. Then I applied to my mother's health insurance company for a new, skin-friendly stoma system for her."

» Field report of a family caregiver, part 3 - personal balance sheet

„Providing care both in a rehab clinic and in a nursing home took an immense toll on me as a family member. I made sure my mother was properly fed, properly bedded, that a wheelchair was available, that my mother received parenteral nutrition due to weight loss, and that she received the best possible care for her ostomy.

In this regard, I must mention that the hospital was constantly at my side as a contact person during this strength-sapping and very difficult time and gave me many helpful tips on nutrition or stoma care for my mother.

Unfortunately, from my point of view, the nursing home did not provide the services for which it was paid. It was due to the lack of staff. It was assumed that the relatives would take over some services as a matter of course.

I can still remember that the nursing home called me several times and asked for help in caring for my mother. In addition, I must emphasize that I lived 30 km away from the nursing home. I was often with my mother at the nursing home for 8 hours at a stretch and came home exhausted. As soon as I arrived, I received a call from the nursing home and had to make the trip again.

I would have loved to take care of my mother at home, but I was unable to care for her around the clock for health reasons."

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