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Health and nursing system in France

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Abstract *This paper concerns the French Health Care System that revolutionized the rationale of the existing social protection. It emphasizes that, in this country, it is essential to train professionals integrated into a "know-how", and also prepared for the current and future changes in the nursing profession. A literature review was carried out based on the classification and analysis of the texts and documents researched, and we tried to understand the French Health and Nursing System. This allowed the construction of two thematic categories. The first one is the "Health Service" that addresses health training courses for prevention, while the second one deals with Nursing Education, which is a competency-based framework. The demography of nurses in France is also discussed, which highlights the increased number of nurses from 2010 to 2018.*

Key words *Nursing, Professional training, Labor market*

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Introduction

France, like other European countries, has a universal health system, primarily financed by the state through a national health insurance system. In the 2000 Global Health Systems Assessment, the World Health Organization concluded that France provided "the best comprehensive health care" in the world[1].

The French public health system integrates comprehensive social security systems, set up to guarantee access to rights considered fundamental by the entire population, such as health, social welfare, health care, and labor law. Based on principles of equity in funding coverage and solidarity, this system has revolutionized the logic of existing social protection. In the health sector, it relied on nonprofit and individual contributory insurance programs limited to only a portion of the population (particularly workers and their dependents). Despite these similarities, these systems have different ways of consolidating and articulating with the private sector[2].

The revelation of documents on the history of nursing in different parts of the world has proven to be a practice of care knowledge, since the relationship of the nursing profession to society is full of concepts that have been established in the historical path of the profession and influence the conception of its meaning as a health profession[3].

The Brazilian nurse profession does not differ much from the French reality. Padilha and Borenstein describe how nursing in France has been marked by a history of struggle for the recognition, appreciation, and development of the profession, resulting in achievements that provide the profession with new and decisive directions. Knowledge of the socioeconomic, cultural, and political currents that influence and have influenced the course of the nursing profession history helps to clarify the context of changes in practice[4].

According to Courtois et al.[5], the professionalization of nursing care in France coincided with the establishment of the Third Republic (1870-1940), a period that led to progressive secularism of institutions Sisters of Charity who worked in hospitals.

In this context, two nursing training projects have emerged: the republican model of public assistance schools in Paris and the nightingale model distributed by the province of France. The first emphasizes the need of the nurse to serve the patient and the Anglo-Saxon model, based on a collective and structured organization, with tools such as the record of care, the development of diagnoses, the flexible positioning between the nurse and the patient, the pursuit of autonomy and technical competency[5].

France is becoming increasingly concerned with training professionals who are part of a "know-how" and prepared for current and future changes of the profession. This is reflected in the historical moment of nursing and in the recent formation of the National Nurse Association Council, an official body that has been representing the nursing profession in this country[6] since January 2009.

Thus, from the classification and analysis of the texts and documents searched, we aimed to interpret the French health care and nursing system, which allowed us to build three thematic categories: – *The Health Service*: Health Training at the Service of Prevention. – *Nurse Training in France*: A competency-based baseline. – *The Nurse Demography in France*.

The Health Service: Health Training at the Service of Prevention

"We must conduct a profound reform in order to ensure that, as often as possible, French women and men, throughout their lives, can have at school, the workplace, and even more so than others in less-favored areas or certain medical deserts, access to health and care. What I can do to achieve this is to create a three-month health service for health students (...). We must lead a decompartmentalization, a cultural revolution. According to Emmanuel Macron, President of the Republic, this health service will be integrated into educational models, and will eventually affect more than 40,000 students yearly" (Emmanuel Macron, speech at Nevers, on January 6, 2017).

Commitment of the President of the Republic, the Health Service reflects the will of the Government to place prevention at the heart of its action, with a twofold objective: to initiate future health professionals into primary prevention and allow them to intervene in the field, with the population, especially young people, to reduce the social and territorial inequalities of health.

In a 2017 survey, 12% of 17-year-olds reported drinking alcohol several times a day, and 25% smoked daily. Pediatric obesity affected 3.5% of children and was 4.5 times more common among workers' children than executives' children. Finally, 80% of adults were sedentary. This worrying finding showed the high frequency of

risky behavior in France and, more particularly, among young people and socially more vulnerable populations. An information and prevention policy was, therefore, necessary.

Thus, on March 26, 2018, Prime Minister Edouard Philippe and Health Minister Agnès Buzyn presented the 25 flagship measures of the National Health Prevention Plan. Among them, the creation of the health service was announced. The health service is a set of preventive actions carried out by the students of the health sectors in order to promote the behaviors favorable to Health and will be deployed across the territory to any public and, more particularly, the most vulnerable.

Run jointly by the Ministry of Solidarity and Health and the Ministry of Higher Education, Research and Innovation, the Health Service is set up for the start of September 2018 for all students in Health. Initially, the courses covered are medicine, dentistry, midwifery, pharmacy, physiotherapy, and nursing, i.e., 47,000 students per year. For the school start of September 2019, the Health Service will be extended to all Health sectors, which will bring the total to 50,000 students per year.

Prevention includes the promotion of health-promoting behaviors whose impact on the quality of life, morbidity, and mortality is shown. Today, differences in life expectancy, and more generally, social inequalities in health, are essential and often linked to unequal access to desirable behaviors. Thus, the competence to carry out health prevention and promotion actions is essential and must be imperatively shared by all health professionals. As part of a 6-week educational module integrated into the training, the health service will be shaped as mostly group prevention interventions on priority Public Health themes.

Prevention as an issue…

Designed to overcome the severe lack of prevention training during studies, the Health Service aims to introduce future health professionals to the organization of preventive workshops related to a specific theme.

The Health Service aims to train and familiarize students with the issues of primary prevention but also to enable them to work together around the same theme in the context of their schooling.

Thanks to partnerships, students will be able to discover, in a multidisciplinary or non-multidisciplinary team, other facets of their medical disciplines in structures where health is not necessarily a priority such as colleges, high schools but also businesses and prison environments. The focus will be on sensitive environments and areas, where the trend towards giving up care is the most important. To do this, a specific first stage of training allows students to acquire the knowledge and skills required to intervene with target audiences.

Based on Professor Vaillant's report, mandated by the Ministers of Solidarities and Health, and of Higher Education, Research and Innovation, the prevention themes selected are: food (lifelong nutrition), physical activity, addictions (alcohol, tobacco, cannabis and other illicit drugs), emotional and sexual life (sexuality education integrating prevention of infections and sexually transmitted diseases, as well as contraception). These themes were chosen for their impact on health according to the national priorities of public health and regional policies in particular to match the supply of health services and places of intervention.

Student's interventions occur in primary, secondary and higher education establishments, military training centers, health and medico-social facilities (accommodation establishments for the older adults and dependent people, health homes and centers), social support structures (nursery, maternal and child protection centers, shelters and social reintegration centers), associative structures, companies, administrations, Ministry of Defense bodies, places of care and deprivation of liberty.

Such interventions have a wide outreach and vary. This allows one to reach a larger audience, especially in Priority Education Zones and rural areas. Thus, the health service has several objectives and challenges.

A pedagogical objective

Indeed, before carrying out its preventive action, the student must acquire the necessary knowledge: in public health (policy, organization, promotion), communication by targeted audience, to be able to identify the places likely to host the health action, in order to make the best use of qualitative and quantitative methods of analysis, sources of data and information, to evaluate the impact of the actions carried out during the course.

These actions will be purely civic and solidary because remuneration is not envisaged for this

new module. However, the state will cover travel expenses. Students will not be paid for their interventions that will come at no cost to them and will be adapted to their training time without increasing their workload.

At the end of the health service and the implementation of the preventive action, a time of debriefing and evaluation allows exchanging views with the referents of the program. Self-evaluation is, therefore, essential.

As Head Teacher of College Eric Wolf points out, the advantage of this type of action is that "it is about students and, therefore, young people who speak to other young people. The fact that students speak and use the same words allows students to be less complex when talking about certain practices, such as homosexuality, and the like. These are complicated topics to discuss with adults".

The Health Service must, therefore, make prevention accessible to all by different educational means. By choosing prevention through the Health Service, the government also wants to combat the costs of avoidable morbidity.

The social cost of licit or illicit drugs in France was around €250 billion per year, estimates economist Pierre KOPP in a study published in 2015 for the French Observatory of Drugs and Drug Addiction (OFDT). Net state drug expenditure was €22 billion, of which nearly €5 billion for alcohol, nearly €15 billion for tobacco and over €2.3 billion for illicit drugs, or 5.8% of public spending, almost a third of the budget deficit.

It is also more than 800,000 years of life that have been lost due to the pathologies associated with alcohol consumption, over 680,000 because of tobacco use, and more than 40,000 because of the use of illicit drugs.

Work on information and prevention is therefore essential. The challenge of the health service, notwithstanding its primary role of prevention, is ultimately a long-term transformation of the action of health professionals, modernizing the curriculum and adapting to France's prevention needs. It is about introducing all future health professionals to the issues of primary prevention and health promotion, developing their skills to take action with the general audience, fighting against territorial and social inequalities in health through interventions with the most vulnerable public, combating preventable morbidity, promoting the autonomy of the students within the framework of a pedagogy by project and reinforcing the sense of their engagement in their studies, and favoring the inter-professionalism and interdisciplinarity of health students by carrying out projects common to several training programs.

The implementation of a public health service policy at the national level is unprecedented in Europe. Moreover, as Professor VAILLANT points out in his report to the government, "the establishment of a health service for all health students is an ambitious reform that contributes to the preventive change advocated by the High Council of Public Health and is a priority axis of the 2018-2022 national health strategy. The success of the health service that initiates a cultural change putting prevention at the center of the practices of future health professionals presupposes a real accompaniment of change. National stakeholders and actors in the field have a major role to play here. Universities, schools, and institutes for training health students, Regional Health Agencies, rectorates, prevention professionals, associations working in these areas will have to be fully involved to allow the health service to express itself in all its dimensions. The dimension of reduced territorial and social inequalities in health, particularly with actions carried out for people in disadvantaged situations, seems essential, but the implementation of this type of action will probably require a little more time".

In the long run, the health service should allow guaranteeing the competence of all health professionals to carry out prevention and health promotion actions for all the public and to fight against the territorial inequalities of access to health care by developing collaborations with several professionals related to the health sector or not.

Nurse Training in France, a competence-based baseline

The modernization of the French health system, as a whole, affects all the health professions and leads to a necessary evolution of the healthcare professions and, thus, the training of these future professionals.

The current context of hospital care is through a coordinated set of care actors and medical devices, techniques, standardized procedures, and care protocols. The goal is to make patient care more efficient through the use of ever-changing knowledge, leading to a reorganization of care structures, care practices, and learning.

Thus, the training of health professionals encompasses the development and updating of knowledge, specific skills, initial and continuing

training. In this context of massive development of medical and scientific techniques, the training of future health professionals requires the opening and reorganization of training standards. Therefore, the transition from qualification to competence has required the revision of training programs for paramedical professions.

In 2009, the Ministry of Health renovated the nursing diploma, under a model allowing its registration in the academic structure of the Bologna process and assigning to it a European certification by obtaining a bachelor's degree. The reform of the 2009 State Registered Nurses of 2009 (DEI) training (decree of July 31, 2009 concerning the DEI), allows the incorporation of this profession into the framework of the system Bachelor's Degree-Master-Doctorate (LMD) and obtaining the bachelor's degree to the State Nursing diploma, which allows, hence, to continue a master and doctorate course.

The nursing student requires three years of training divided into six semesters (equivalent to 4,200 hours) to acquire the skills necessary to practice the profession. The selection of candidates for nurse training occurs after obtaining the baccalaureate. The training system builds on a competency framework based on the activity guide from the job description of the civil service trade directory.

Five competences underlie the "core business":

To evaluate a clinical situation and establish a diagnosis in the nursing field;

To design and conduct a nursing project;

To accompany a person in carrying out his/her daily care;

To implement diagnostic and therapeutic actions;

To initiate and implement educational and preventive care.

Five "cross-sectional" competences common to certain paramedical professions:

To communicate and lead a relationship in a care setting;

To analyze the quality of care and improve professional practice;

To research and process professional and scientific data;

To organize and coordinate care interventions;

To inform and train professionals and trainees.

In France, nurse training is an alternating training consisting equally of clinical training in a professional environment and theoretical training.

- The theoretical training of 2,100 hours, in the form of lectures, guided personal work and directed work and practice of care through simulation.

- The 2,100-hour Clinical training, in professional health-and-care-related environments. "These periods alternate with periodic theoretical teaching in training institutes. During these internship periods, the student is confronted with the nursing practice with the patients"[7].

The idea of competence is essential and must be clearly defined in this training repository. Thus, in this new device, developing skills is not accumulating knowledge, gestural, organizational, technical skills, and abilities; instead, it is to be able to combine all this in a situation and also to transfer it.

So what are we talking about when we talk about competence?

"The competence of a professional is recognized by his ability to manage a set of professional situations effectively. To this end, he/she will have to combine and mobilize several skills or resources"[8]. Competence is recognized and would be the result of mobilized transferable resources in different real situations.

It is the mobilization of several resources, different knowledge, "theoretical knowledge (knowing how to understand and interpret), procedural knowledge (knowing how to proceed), procedural know-how (knowing how to proceed and to operate), experiential know -how (knowing and doing), social know-how (knowing how to behave), cognitive know-how (knowing how to deal with information, to reason, name what one does, and to learn)"[9]. It is then a matter of being able to arrange these resources in a situation adequately and efficiently.

Thus, we can consider that competence is achieved over the knowledge acquired and mobilized in previous experiences, from situations of care experienced with the patient. This transferable knowledge allows managing new situations for which we do not have an established benchmark or reference. Therefore, we can say that competence is built.

At the same time, the first meaning of competence stems from the legal vocabulary, as an aptitude legally recognized by a public authority to act under specific conditions, from which the idea of aptitude, skill recognized by someone because of his knowledge and experience derives, and this recognition gives him/her the right to judge or decide.

In this context, competence is the ability of a person to make a value judgment in a field of which he/she has a thorough knowledge, which is what is called professional competence[10]. The power to act and decide appropriately must be recognized by others for competence to exist.

On the other hand, "competence is not characterized by the achievement of an objective set in advance, achieving the best possible results; what characterizes it is the relevance, that is to say, the fact of exactly agreeing to the object in question"[11]. What is emphasized here is that the competence of the nurse and caregiver is characterized by the relevance of the care he lavishes upon a patient during a singular conference and not the theoretical, virtual validity of standardized, non-singular care that does not allow staging the singular conference.

So what are we talking about when we talk about improving competences?

Nursing care is very diverse and involves many technical, organizational, scientific, and, in any case, relational aspects that require specific competencies.

We can distinguish three types of competences, namely, "conceptual competences (analyzing, understanding, acting systemically), technical competences (methods, processes, procedures, techniques of a specialty), human competences (in intra and interpersonal relationships)"[12]. This more traditional structuring is a benchmark that seems well suited to the field of nursing and breaks down competences into knowledge, know -how, and soft skills.

Exploring the different ways of approaching competence shows two opposing conceptions. One that is behaviorist, knowledge-centered, and the other, learner-centered and the development of one's inner potentialities.

The behaviorist conception emphasizes the learning of "conduct behaviors structured according to a goal, an action, a specific task, observable and based more on knowledge and program content"[13]. This design seems adapted to the learning of procedures and protocols. Classically, competence is considered as the fruit of great learning, resulting from experience, seniority recognized to people. This conception gives here primacy to the image of the "mold", which imprints its form on the individual, almost despite himself, the idea that competence has become incorporated into man as second nature.

On the other hand, the classical conception of competence is deconstructed in the face of the conception, which approaches competence as a developing potential recognized by results, and which gives a pre-eminence to the developing knowledge; its recognition is conditioned by results.

However, what about the learning of the adaptation of these procedures and protocols to the patient's singularity?

In the field of care, competence allows taking care of the patient in his/her singularity and the specificity of circumstances and events. It allows acting in the right way at the right moment to seize the *kairos*.

When we consider competence as "an invisible, internal potentiality, a generative capacity capable of generating an infinity of conducts adequate to an infinity of new situations"[13]; we consider competence more as a translation of the cognitive functioning of the learner, the subject, than as a manifestation of knowledge.

Also, during the production of competence[14], a change in the relationship to things occurs and affects both the knowledge mobilized and the individual developing it. This transformation is considered as an impression on the material, in the mold's fashion, and also as developing potentialities.

Contrary to the long experience, the conception of the short time of competence is conceived "as mobilization of various capacities in an integrated way in the wake of the triptych of knowledge, know-how, and soft skills"[15]. Thus, exiting the behaviorist conception, and the mold's metaphor, we go towards competence as a process allowing one to reach a new, singular result. Moreover, this is the type of competence that the nurse must adapt to the particularity of the patient, the context, and technical and scientific advances. Thus, competence as a process is established from the mobilization of different resources, initial potentialities, which by "capillarity" lead to transformations to achieve a remarkable result.

Active pedagogies, such as training in simulation and analysis of practices, allow the development of this process because the issue is the construction of knowledge by the learner himself instead of the transmission of knowledge.

The matter now is about the nature of the resources to mobilize in order to adapt the result and whether these resources are mobilizable during simulated learning.

Care is based on the mobilization of multiple knowledge that is not only cognitive, but also

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procedural and emotional. While the conditions of the adequate management of its resources in situation can remain somewhat mysterious, we understand quickly that if being competent it being able to act, to decide efficiently and to be recognized for that, the use of teaching techniques such as simulated learning is well suited to the necessary development of logical and rational intelligence, which is required to ensure a methodical, planned, orderly and safe work. Moreover, the observation of professional nurses in professional situations coupled with rational knowledge, by inductive reasoning, also allows us to look for data relating to the patient's experience. Selecting and linking this data allows us to solve problems and plan appropriate, well-targeted care.

Our human relationships with patients are complex and demanding to grasp their reality, a set of reasoning and perceptions, and, therefore, emotions, emotions experienced during the meeting. This emotional intelligence also ensures the effectiveness of our actions and our relationships.

Learning to practice is one of the critical pillars of nursing education. The changing health needs of populations, and the technical and scientific upheaval of medical care, confront the caregiver with complex care situations, besides the increased demand for quality and efficiency.

The nurse training program aims to build a future autonomous and reflective professional who must be able to self-evaluate their practices, learn in and through the situation.

In the face of a continually evolving field like health, health professionals must know how to call into question self-evaluating their practices and knowledge. It is the analysis of practices that allows this work; it is realized in a real situation with the patient during internships, but also in simulated situations, and a simulation laboratory. The idea is to promote learning through activity so that students can build, integrate, and transfer new knowledge.

In nursing training institutes, simulation learning, promoted by H.A.S[16] as a priority method for the initial and continuous training of health professionals, may concern many activities integrating a clinical simulation context, and resorts to more or less elaborate technical simulators for the repetition of technical gestures and role-plays.

However, if we want to allow the student to develop competences, we cannot stop at the repeated gestures consistent with the protocol, a behavioral pattern of reproduction, primarily when we evaluate in simulated situation the preparation of an injection, performing a transfusion, injection on an implantable injection port[7].

The road towards competence requires us to leave this metaphorical idea of the mold to reach a competence as an adaptation to the singularity of the context, environment, and patient through a process of transduction of knowledge, which, in stepwise fashion, allows to achieve a remarkable result adapted to each patient.

Finally, what matters to develop competences and professionalize is reflexive analysis, where the simulated situation is only its support and pretext. The reflective analysis of the different activities carried out allows the development of competences and the structuring of professional identity.

When learning in a clinical environment, the practicing nurse shows, does with the trainee student, allows him/her to act under his/her watchful eyes, explains the reasons for his/her choices and strategies; what we call the invisible face of care questions the student to identify what he has understood, and realizes with him/her a reflection.

Asking questions as Aristotle and his *maieutics*, "giving birth" to the spirits, allows us to express hidden knowledge, which we do not know we know. Thus, the quality of learning in the care environment allows the student to transcend mimicry, reproducing what he sees, highlighting the invisible process that is the clinical reasoning leading to care.

Moreover, the development of emotional intelligence is essential for the caring relationship because it humanizes care[17]. This form of intelligence is complementary to logical reasoning and must also be worked upon from the initial training. Besides the qualities of rational intelligence, essential to ensure coordinated and safe care, the contribution of emotions during interactions gives meaning to the relationship, and humanize care. Relationships with patients are complex and demanding to grasp their reality, to bring into play a set of perceptions and emotions that will guide us in our interactions. This set involves other forms of intelligence, emotional intelligence, and social intelligence that allow us to understand our environment, to adapt, and to achieve what the other lives.

Learning to take care

It is not necessary to have a diploma[18] in order to provide care daily. Parents take care of

their children; we take care of the people who are dear to us, and even objects, when they have an emotional value. Taking care of something, of someone is caring, it is the expression of particular attention, of the importance that we give to the other.

Training future health professionals is also making them aware, developing in them this willingness to provide care. While caring is not enough to be a caregiver, one still has to know how to care, and to do so, must have a diploma and be trained. Thus, the trainer, the teacher, must be creative, possess educational ingenuity to combine the care techniques while providing care. Training health professionals is taking care of educating to care, the linking of knowledge to the service of others, and of a practice, which is not only the application of knowledge.

Although simulation as a pedagogical technique is a useful tool when it allows to put the learner in realistic situations before practicing on the patients and allows the development of the critical spirit, it is limited all too often to safety objectives, learning technical protocols in the evidence-based teaching mode as compared to evidence based-nursing.

Providing care does not only require being a good technician but also emotional intelligence. Nurses are men and women driven by the feeling of belonging to a caring culture where human know-how that is attentive to the other is inspired by how the other, the body, and the environment are viewed, with mutual respect between human beings.

Just as caring, educating is an art, touching know-how, beyond learning, a man-on-man action. This aspect of *tèchnè*, the art of knowing in education and care, suggests that training and education are care professions, a form of attention to the other that marks our dependence and vulnerability.

Plato often refers to medicine as a model for politics, and Aristotle believes medicine is a mine of practice and knowledge. He affirms it is the art of care that illustrates the "middle ground", and medicine, since education is not only knowledge but also the practice of a singular activity, which aims to train, to relieve to heal, and not knowledge in itself. A *tèchnè* that is built by the experience and generates the *poietic* adapted to the singular case: in a nutshell, an art.

Thus, we give the actors who train the health professionals, the care to educate to care, two terms which rest on the linkage of a shortage with competence in the service of others, the linkage of knowledge and practice where the practice is not just the application of knowledge.

Training and to be trained is giving meaning and feeling emotions. Giving meaning is a term that may seem overused, paved with good intentions. We will then say that training to the care is attempting to seize the essence of care, to give consistency to the action to care and feel emotions.

The Demography of Nurses in France

The number of nurses in France stands at 638,248 (versus 616,573 in 2014), as per the report "The Demography of Other Health Professions (RPPS and Adeli)" published by the Research, Study, Evaluation and Statistics Direction (DREES) on April 8, 2015. Thus, they would be 109,925 to practice in a liberal regimen, and 528,323 to be employees.

In total, 87% are women in this profession (84% in the liberal environment and 88% of employees). Specialized nurses represent 52,463 professionals, including:

- 19,074 childcare nurses;
- 9,709 anesthetist nurses;
- 7,225 operating theater nurses;
- 9,307 health managers;
- 423 public health executive nurses;
- 5,995 nursing staff;
- 730 psychiatric nursing staff.

Nearly half of nurses (322,996) practice in public hospitals, followed by for-profit private health institutions (69,438) and individual practices (61,768).

The areas of activity with most nurses are around the primary French cities, namely, Paris, Lyon, and Marseille. The regions with the least number of nurses are Corsica (3,368), Limousin (9,733), and Franche-Comté (11,909), except the DOM-COMs.

The demographic statistics of the health professions published by the DREES refer to professionals registered in the Adeli directory or the Shared Directory of Health Professionals (RPPS) as being active and working on 1 January.

As a reminder, the Directorate of Research, Study, Evaluation, and Statistics (DREES) lists, for 2017, 10,311 IADE, of which 69% are women and 31% men. According to the results of the SNIA survey, 40-44 years is the most represented age range (23.25%), followed by 35-39 years (18.09%) and 49-47 years (17.97%). There is also a significant overrepresentation of men aged 40-44 (+13 points) and under-representation of professionals over 60 years.

The distribution of the panel by functions performed is as follows: IADE (93.06%), Health Managers (5.63%), IADE Senior Health Executives (1.20%), IADE Care Directors (0.11 %).

This statistic[19] indicates the number of nurses practicing in France between 2010 and 2018 (Chart 1). We note that the number of nurses has increased during this period, exceeding 600,000 nurses in 2014.

Collaborations

C Guesdon-Caltero: concept, design and drafting. N Cherchem: concept, design and drafting. MA Frota: drafting and critical review. KMC Rolim: approval of the version to be published.

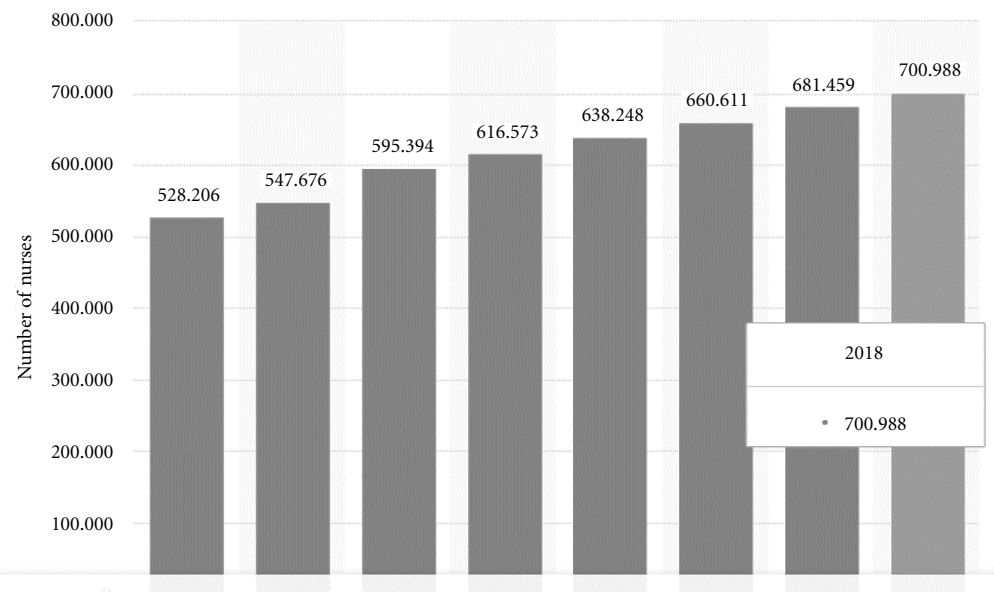

Chart 1. Number of practicing nurses in France from 2010 to 2018.

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