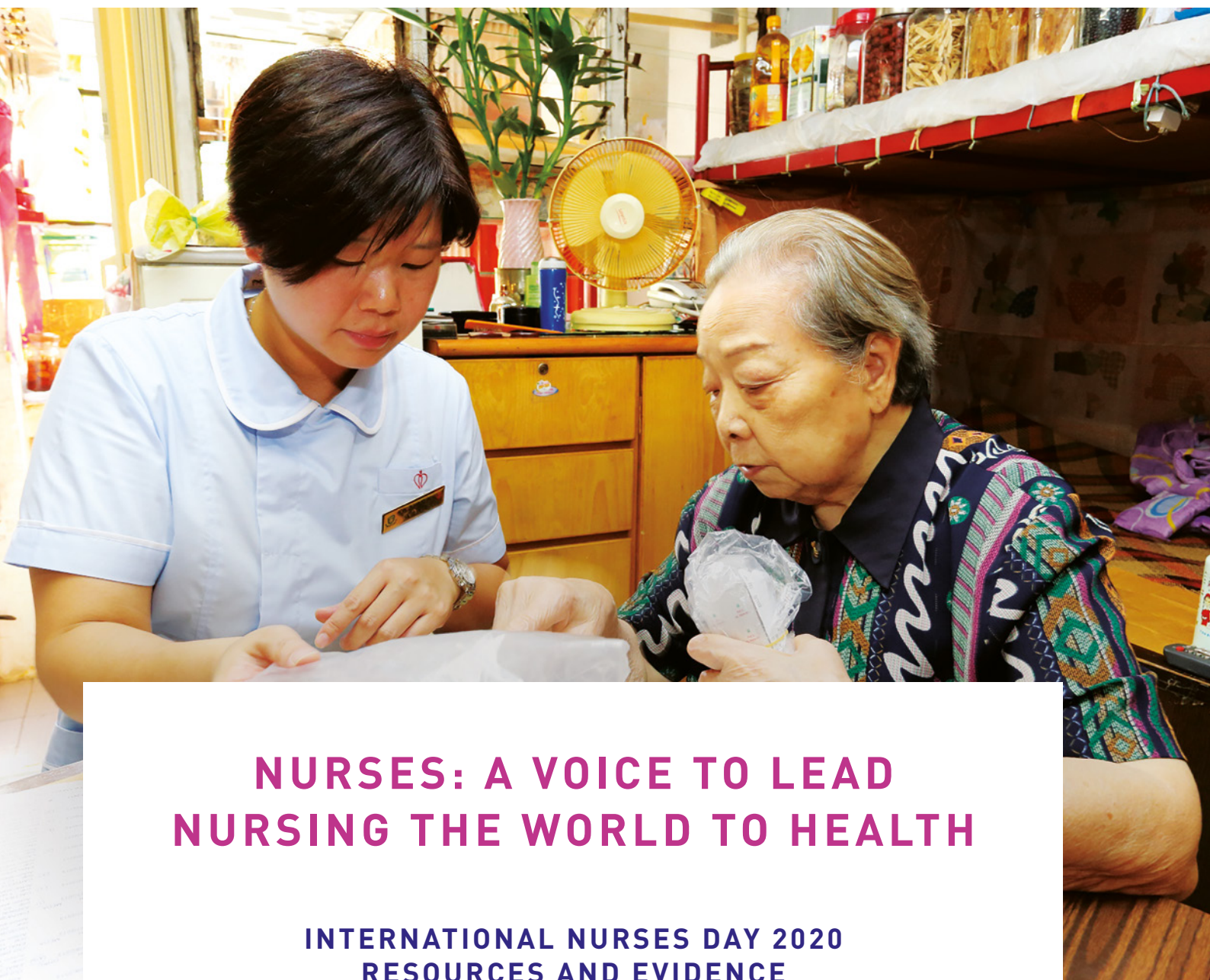


NURSES

A VOICE TO LEAD
NURSING THE WORLD
TO HEALTH



2020
INTERNATIONAL YEAR
OF THE NURSE AND
THE MIDWIFE



NURSES: A VOICE TO LEAD NURSING THE WORLD TO HEALTH

INTERNATIONAL NURSES DAY 2020
RESOURCES AND EVIDENCE

INTERNATIONAL COUNCIL OF NURSES





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INTRODUCTION

By Annette Kennedy, ICN President

Nursing the World to Health

There are more than 20 million nurses across the world and each one of them has a story. They know about hope and courage, joy and despair, pain and suffering, and life and death. As an ever-present force for good, nurses hear the first cries of newborn babies and witness the last breaths of the dying. They are present at some of life's most precious moments, and at some of its most tragic. Nurses serve humanity and, by their actions, they protect the health and wellbeing of individuals, communities and nations.

Around the world, people routinely recognise nursing as the most honest and ethical of the professions: people instinctively trust and respect nurses and the work that they do. But public understanding of nursing varies widely and is often distorted. Images of nurses as angels of mercy are common, but they go hand in hand with perverse sexual stereotypes. And the old-fashioned idea that nurses are somehow subordinate to doctors is pervasive. The fact is that very few people understand the breadth of roles and responsibilities of modern nurses, and that means they do not truly appreciate the outstanding value of nursing to every person on the planet.

The International Council of Nurses (ICN) believes that it is vitally important to show the world who nurses are and what they do—especially this year: The International Year of the Nurse and Midwife. ICN wants the voice of nursing to be heard around the globe, to spread the word about our great profession and how it contributes to the wellbeing of the world. As carers, healers, educators, leaders and advocates, nurses are fundamental in the provision of safe, accessible and affordable care. Through this International Nurses Day report, we use the authentic voices of the world's nurses to give the world a glimpse into this wonderful, innovative and vital profession.

“...there are no national boundaries in the service of society, but that the fundamental needs of people are the same the world over - health of mind, body and spirit - if he/she is to do their work in the world.”

Nina Gage

ICN President, 1925



ICN: Solidarity and unity from the past...

The creation of ICN occurred at a time when the telephone had only just been invented and the main form of transport between continents was by arduous and lengthy sea voyages. Despite these communication and distance challenges, ICN managed to bring together the global nursing community from all parts of the world.

Even in the midst of great world conflict, ICN continued to bring the global nursing community together. At the time of ICN's centenary in 1999, Lynaugh and Brush¹ reflected on its travails in the first half of the 20th Century and attempted to view them through a modern lens:

'Despite wars, political and economic chaos and racial and religious strife the International Council of Nurses has been held together for 100 years by a 'special glue' concocted by dedicated nurses. Its ingredients: friendship, collegial support and enthusiasm. Today ICN is still thriving, leading and representing nurses from all over the world.'

ICN existed for almost 50 years before the creation of the United Nations and World Health Organization and foreshadowed what they could achieve. Despite the enormity of differences, confusion or strife within and between countries, the nursing profession consistently worked together, stood together, and came together in unity to bring about positive change for a healthier world. ICN has provided leadership and collaboration to develop the profession through its influence on health policy and planning, many guidelines and positions statements, its influence on nursing leadership, and the many opportunities for learning and discourse that have allowed the highest attainable standards of health become a reality in many places, and a viable prospect in others.

...and into the future

In 2017, when I was elected President of ICN, I chose the word 'Together' as my presidential watchword.* There could be no more appropriate watchword than this in these times of great division. 'Together' signifies the collective potential and intention of the global nursing community to improve the health and wellbeing of individuals, communities and countries, whatever their allegiances.

The World Health Assembly's designation of 2020 as the *International Year of the Nurse and the Midwife* is an exciting opportunity to promote nursing across the world. We finally have a global spotlight on nursing, and we want health professionals, politicians, policy officials, health systems and the public to celebrate, be inspired by and informed about nursing. 2020 provides the opportunity for a unique insight into the largest healthcare profession on the planet, but it is just the beginning. 2020 is a catalyst to jump-start a new way of looking at nursing so that, in the future, nurses will be seen for the unique contribution they bring to the wellbeing of all the peoples of the world.



* 'Watchwords' have been chosen by ICN Presidents since the very beginning of the organisations history in 1900. They outline the overarching principle for the president's term of office.

PART ONE WHAT IS NURSING?

2020 is an opportunity for nurses to better explain what we do, to break the myths around nursing and to advocate for investment in the profession. In order to explain what nursing is, we need to look back at how nursing started, what we have learned from the founders of modern nursing, and what the key attributes of nursing are that make it stand out from other healthcare professions

As we celebrate the 200th anniversary of the birth of Florence Nightingale and the 120th anniversary of the International Council of Nurses, we take a look at the impact of Florence Nightingale, Ethel Gordon Fenwick, and the founders of ICN and how compassion, trust, person-centred care work alongside evidence, statistics and leadership to create the modern nurse.

It is by looking back at our past, that the theme for International Nurses Day 2020 was chosen. In World War II, nursing had borne witness to the greatest divisions and suffering the world had ever seen. Despite this, the profession provided care and hope during the war and afterwards. In response to the sacrifice that nurses had made to protect health, United States (US) President Harry Truman wrote movingly to the then ICN President Effie J. Taylor²:

‘Nurses ... worked unstintingly in the service of their country during the war in providing care for the disabled. They shared the hardships of combat, asking no reward except the knowledge that their sacrifices enabled others to live. Today the need for nurses is no less than during the war years. Shattered bodies and minds lie in the wake of the most destructive war in history. The sick must be nursed back to health.’

President Truman recognised that, in the aftermath of the war, the struggles of health and wellbeing would continue and be a challenge for many generations to come. His call to action, which is as relevant today as it ever was, can be described in the phrase *Nursing the World to Health*.

As the largest group of frontline health professionals caring for the health needs of individuals and communities, nurses have powerful stories to tell that can help to bring about positive change. A supported and empowered nursing workforce is an effective solution to the problem of improving health outcomes. Nursing is at the core of enabling health systems across the entire world to achieve high quality, accessible and affordable healthcare. Through sheer weight of numbers, our scientific reasoning and our proximity to the patient, we are *Nursing the World to Health*.

2020 is an important time for nursing. It provides the opportunity to clearly demonstrate to policy makers, health professionals and the public about the enormous contribution of nurses to health and wellbeing; the roles and responsibilities of this vital profession; and to shatter the perpetuated myths and stereotypes that have afflicted the profession for far too long. This is our moment. Let us seize this time not just for the sake of nursing, but for the benefit to health of our world.

“History cannot give us a program for the future, but it can give us a fuller understanding of ourselves, and of our common humanity, so that we can better face the future.”

Robert Penn Warren
Poet³

Is Florence Nightingale still relevant today?

By Professor Anne Marie Rafferty, Professor of Nursing Policy, Florence Nightingale Faculty of Nursing and Midwifery, King's College, London & Christophe Debout, General Secretary, European Federation of Nursing Educators (FINE)

Florence Nightingale was a complex character. Born to a life of privilege, she benefitted from the liberal, free thinking values of her parents, and a family tradition of campaigning for humanitarian causes. She was educated by her father who exerted a profound influence on her intellectual and moral development. Her polymathic gifts meant she could access data and works of reformers from a range of European sources. She was also blessed by her family's support of women's education, which enabled her to network with the intellectual and political elite, using them as an audience for her reforms. Leading thinkers passed through the Nightingale household and it was here that the young Florence was introduced to some of the best minds of the Victorian era. It was partly through such networks, that Nightingale was able to visit the hospital in Kaiserwerth, Germany, which spurred her decision to enter nursing, an unusual decision for a woman of her birth and standing.

The interdependence of her theological and scientific thinking led her to regard statistics as key to understanding the 'laws of nature'. This was all important in the context of the social upheaval, urbanisation and industrialisation of Victorian Britain where randomness seemed to rule the human condition. Statistics became a vehicle for targeting intervention, reducing risk and combatting poverty and deprivation. Her quest to do something practical was not only driven by her empathy for the human condition and a moral compulsion to act, but also by frustration with the role of women. Nightingale railed against gender as a barrier to participating in public life. Her mode of nursing relied upon working to the authority of one female leader in an institution as well as affording the opportunity to women of earning their living and forging independent careers.

200 years later, does Florence Nightingale speak to us today?

Nightingale's nursing intersected with a broader set of interests in public health, advancement of medicine, hygiene, epidemiology, statistics and military health. In that sense, her vision was thoroughly modern: intersectoral, interdisciplinary and global. Her understanding of the physical and psychological environment of the hospital and home reveal not only a deep scientific understanding of hygiene, but health and healing, details of care that added to comfort as well as nourishment of the human spirit.

Nightingale's statistical and analytical skills formed the bedrock of her international and comparative statistics, anticipating the development of International Classification of Disease (ICD) codes today. Her research on hospital outcomes finds echoes in the work on staffing by Aiken et al.⁴ She was, above all, a brilliant communicator both visually, through data, and verbally, through the power and epigrammatic prose style. She was adept at presenting data in a graphic form to dramatize her message and move her audience to action. She understood the power of statistics to change minds and encourage politicians to implement reform.

Her clear, persuasive style and proactive approach to policy-making made her a skilled policy entrepreneur—putting the evidence in the hands of policy makers via her networks; communicating it in an easily digestible format, then lobbying her case with every tool she had at her disposal. The rise of random controlled studies and evidence-based practice is now common currency in nursing and healthcare practice. Indeed, Nightingale's very definition of nursing, both sick and health nursing, resonate with our approaches today: *"What is nursing? Both kinds of nursing are to put us in the best possible conditions for nature to restore or preserve health—to prevent or to cure disease or injury."*^{5, p.187}

Her teaching on hygiene remains exemplary as we battle with sepsis, excess mortality attributable to hospital acquired infections: MRSA and *C. difficile*. Added to that, antimicrobial resistance (AMR) is poised to be one of the leading causes of mortality by 2050, in which handwashing and hygiene may be some of the most potent defences against transmission. AMR forces us to fall back on practices of the pre-antibiotic period.⁶

Hospital scandals are not a thing of the past and recent experience in the US, UK and elsewhere demonstrate many of the underlying causes are staffing shortages and the want of good quality nursing.⁷ Her support for nursing as a secular occupation; a means to enable women to be trained, educated and pursue an independent living has amplified the impact of education on the health of the population, both indirectly and indirectly. Evidence demonstrates that investing in the education of nurses delivers a health dividend for the community in terms of its health literacy.⁸

Nightingale would undoubtedly be shocked by the scale of global health inequalities today; the nursing shortage; the threat of AMR, resurgence of infectious disease such as tuberculosis and emergence of new threats such as HIV, Ebola, cholera, to our health security.

She would put her righteous indignation to work, call time on the nursing shortage and escalate it up the international political agenda by declaring it an international emergency. She would rally support for a global nursing summit at the 2020 World Health Assembly; marshal all her networks and political resources to lobby governments and non-governmental organisations to commit to a treaty compelling governments to take action by putting a legal framework in place to ensure sufficient supply of nurses to speed up progress on the SDGs and UHC for underserved populations.

She would convene a follow-up summit with finance ministers at the World Economic Forum meeting in Davos to create a new global Nightingale Fund to deliver the biggest ever investment in nursing and midwifery in history.

She would call on all nurses to take leadership of hygiene and antibiotic stewardship. *Notes on Nursing* would be relaunched as an online platform to empower patients and their families in the 21st Century in how to keep healthy and look after themselves, targeting those with chronic disease and mental health problems in the first instance.

She would train a new breed of digital nurse designers to produce solutions for care delivery and patient safety systems as well as engage with innovations such as blockchain.

She would remind us that globalisation is an opportunity to connect with our values, each other and set out a bold manifesto for change. This would require a power shift from 'old' to 'new power'⁹ and new ways of collaborative working. Nursing associations would need to adapt and work together to form a super collaborative to use their collective organising power to mobilise on a scale as never before, working closely with the public, patients and families.

Finally, she would urge an intergenerational approach, with young and older leaders trained together in organising methods and political influencing skills. Together, they would act as the new generation Nightingales who would lead the charge and create nursing as a global social movement for social good.



Miss Nightingale with her tame owl Athena, circa 1850
After a drawing by Parthenope Lady Verney

Creating the Foundations for the Nursing Profession

In focus

Florence Nightingale was an inspiration to the founders of the International Council of Nurses in 1899. Ethel Gordon Fenwick, Lavinia Dock, Agnes Karll and others who founded ICN championed the need for professional self-regulation and campaigned on the important social issues of her time, including the emancipation of women.

The idea of those pioneering nurses was to bring together professional fellowship, a world-wide vision of nursing, and improve nurse education. In 1899, Ethel Gordon Fenwick stated:

'The nursing profession, above all things at present, requires organisation: nurses, above all other things at present, require to be united. The value of their work to the sick is acknowledged at the present day by the Government of this and all other civilised countries but it depends upon nurses individually and collectively to make their work of the utmost possible usefulness to the sick, and this can only be accomplished if their education is based on such broad lines that the term a trained nurse shall be equivalent to that of a person who has received such an efficient training and has proved to be also so trustworthy that the responsible duties which she must undertake may be performed to the utmost benefit of those entrusted to her charge. To secure these results two things are essential: that there should be recognised systems of nursing education and of control over the nursing profession. The experience of the past has proved that these results can never be obtained by any profession unless it is united in its demands for the necessary reform, and by union alone can the necessary strength be obtained.'^{10, p.7}



Mrs Ethel Gordon Bedford Fenwick, United Kingdom, President, International Council of Nurses, 1900 - 1904

Gordon Fenwick realised the importance of international cooperation and collaboration in ICN's bid to regulate nursing around the world and apply universal standards about what it meant to be a nurse. Her ground-breaking work, and that of countless other nurses over the years, created the foundations on which modern nursing stands.

ICN has continued to build on those foundations and nursing today is just as relevant and essential as it was 120 years ago. International collaboration and sharing amongst National Nursing Associations (NNAs) is as important now (or arguably more so) than it was 120 years ago. There can be no doubt that Florence Nightingale, along with the Founders of ICN would support ICN's work today and encourage national nursing associations to become members of ICN in order to work together on a global scale to advance the profession and advocate for health for all. That was their hope, their vision and their legacy for the future.

Case Study

MSF – Removing barriers to care for the most vulnerable

Contributor: Nada Kazoun, Médecins Sans Frontières

Bar Elias, a town in Lebanon around 10 km from the Lebanese/Syrian border, is where Médecins Sans Frontières (MSF)—Doctors Without Borders—has established a hospital. The hospital serves all patients, irrespective of their race, religion, gender, or political convictions; a value that is deeply rooted in MSF. The medical team provides surgical services and takes care of poorly healing wounds, including burns.

Prior to the Syrian crisis, services for wound care were not available in the region and were limited to secondary healthcare centres and private clinics. These services were neither accessible nor affordable to most patients, who they were forced to pay out-of-pocket for treatment, medication and transport.

With the important influx of Syrian refugees in Lebanon, and the increase in the number of patients suffering from complicated wounds and burn sequelae, this lack of services was further highlighted. It was evident that there was a need for guidelines for wound care, as well as qualified and competent healthcare professionals. Thus, MSF designed and introduced a new nurse-led wound care protocol, aimed at removing barriers related to accessibility, high cost and quality of care, and rendering the services available to the community.

Consequently, MSF Bar Elias hospital began offering care services for wound management, including burns, based on evidence-based research and delivered by trained and qualified healthcare professionals.

From January to August 2019, 99 patients were admitted for wound care, and almost 1,400 wound care procedures were carried out. During the same period 89 exited the programme, with 59 healed, five referred, seven moved-away and 18 lost to follow-up.

One example, ‘Abdul’ aged 15, had untreated epilepsy and untreated seven-year-old burns with large wounds on both legs. Because of a lack of space in the family’s tent, Abdul crawls on the ground, which aggravates his condition and does not allow his wounds to heal.

A multidisciplinary team consisting of three nurses, a social worker, a health promoter and a mental health specialist, used the MSF wound care protocol alongside educational sessions and counselling for his caregivers. After two months of treatment, Abdul’s wounds had healed completely and closed over.

This sort of intervention gives patients a second chance at life. We, as nurses are motivated by the impact of our work with these patients. We feel we can now be advocates and work hand in hand with our patients and their families to achieve the best outcome possible.

Moreover, we are witnessing the outcome of our dedication to treating patients as a whole, and not merely as a disease. Nurses are at the heart of the programme, with their knowledge, technical expertise, judgement, and interpersonal relationships with the patients and families. These are the milestones for the success of the wound care programme at our hospital.

A Nurse provides wound care at Bar Elias Hospital, Lebanon



Whole person and people-centred care

By Kyung Rim Shin, President, Korean Nurses Association

In celebration of the 200th anniversary of the birth of Florence Nightingale, 2020 has been designated by the World Health Organization (WHO) as The International Year of the Nurse and Midwife. More than ever, nurses and midwives will be at the centre of global health policies in 2020 and will have an unprecedented window of opportunity to elevate our status. In order for us to make use of this special year as a stepping-stone to reach a higher level, we will need to look back at the great nurses in history and reaffirm the genuine values of nursing with a reflection on how nursing practice has evolved over the years. We will then be able to use that reflection as a compass to guide us moving forward.

Florence Nightingale was the founder of modern nursing, a statistician and an able public administrator who defined concepts of public health. She collected vast statistics from her service in field hospitals during the war and was an activist for reform in public health systems and patient care. Her work transformed the social recognition of nursing into a profession based on beliefs in human dignity and scientific knowledge. She laid the groundwork for people-centred care.

People-centred care refers to planning and implementing public health and nursing services focusing on recipient requirements. Patients are viewed not as passive recipients of care but as active participants in interactions with health workers. Nursing starts with an understanding of the patient and how he/she has lived. Key values are human dignity, compassion and respect where the dignity of patient and family is espoused, nursing care is provided with compassion and patient opinions and life choices are respected.¹¹

Two patients suffering from the same condition will come from different backgrounds and have different life stories. Their response to care, their needs, attitudes and symptoms will be different and therefore individualised nursing care is needed. Unfortunately, patients' dignity is sometimes undermined due to structural inadequacies in social systems and the prevalent practice of disease-centred patient care.

Such an example was witnessed in 1916 in Korea, when as many as 6,254 Hansen's disease (HD or leprosy) sufferers were confined to a remote island named Sorok-do to face force labour, forced sterilisation and many other human rights abuses. Many HD patients found the mistreatment unbearable and

committed suicide. Then in the 1960s, two Austrian nurses, Marianne and Margaritha came to Sorok-do to care for those patients. It was a time when prejudices about the disease were at the peak and even medical staff could not bring themselves to touch patients' bodies without double gloves on. The two dedicated nurses had received training on Hansen's disease in India prior to coming to Korea and had known that possibilities of transmission by contact were extremely low. They touched patients with their bare hands, put their noses to their wounds, ran day care for their children and became friends as well as caregivers without receiving payment.

They demonstrated true volunteer spirit and love as they provided rehabilitation, education and vocational training as well as medical supplies, facilities and relief support for leprosy patients. Patients were treated with dignity and respect. As a result, they found reasons to live and strived for hope in their lives.

In people-centred care, patient dignity is fully respected, and trust is built with interactions imbued with understanding and affection. Individualised care is given in consideration of patient perspectives, values, beliefs and cultural background. At an appropriate time, appropriate care is offered with appropriate information given to patients so that they can make decisions on the treatment and care they would receive. Eventually, this brings about a better disease management, quality of life and patient outcome. As the quality of nursing services improve, self-confidence and job satisfaction of health workers in the nursing profession is elevated.

Even with AI automating many spheres of life now and in the future, human beings capable of empathising with others will have valued qualities. Nursing differs from medicine in that it is based on those intrinsic nursing values centred on human understanding and caring for patients with a holistic view that cannot be substituted by machines.

Nursing professionals of the next generation should therefore develop deep understanding of individual human needs and receive continuous training with a focus on the whole person as well as holistic approaches to problem-solving.

Case Study

Japan – Responding to the health needs of individuals and communities during and following disasters

Contributor: Japanese Nursing Association

Japan's geographical conditions and climate mean it is frequently affected by natural disasters, including typhoons, torrential rains and earthquakes. In 2018, for example, there were 29 typhoons and more than 90 significant earthquakes.

Following the Great Hanshin-Awaji Earthquake in 1995, the Japanese Nursing Association established a disaster relief network system in cooperation with local nursing associations. This system dispatches disaster relief nurses to affected areas following large-scale natural disasters, enabling them to provide support flexibly in response to local needs. In the numerous disasters since 1995, almost 9,000 disaster relief nurses have been called into action.

Japan currently has 9,822 disaster relief nurses who are trained and registered as such with their local prefectural nursing associations. Once a disaster occurs, they participate on a voluntary basis as members of nursing professional associations.

Disaster relief nurses work in affected healthcare institutions, social welfare facilities, and evacuation centres for between three days and one month after a disaster. This means they work in the subacute post-disaster and chronic phases, helping with continuing nursing care, rather than in the acute phase, where rescue operations are required.

Disaster relief nurses who are dispatched to healthcare institutions help to receive patients from other affected facilities, respond to increased healthcare needs at emergency units, and take over care to enable local nurses to have a rest.

In evacuation centres they advise on physical exercise, provide personalised care to people requiring assistance, including older people, and provide consultation and guidance on taking medicine, treat wounds of the injured and undertake infection control measures.

At an evacuation centre that housed evacuees with infectious gastroenteritis caused by norovirus, disaster relief nurses noticed that the residents washed their hands

with pooled water and took action to prevent that method of spreading infection. This was in an area where the local people habitually used pooled water and believed it to be clean and healthy.

The nurses provided detailed explanation to each evacuee concerning how to maintain hand hygiene in an environment with an unrestored water supply, which resulted in a decrease in the number of infected persons.

One disaster relief nurse spotted an evacuee holding his chest. The man said he had a history of angina, but although he had not brought his drugs to the evacuation centre, he had not contacted the medical team on their rounds. The disaster relief nurse called an ambulance and the man was admitted to hospital.

These cases highlight the characteristics of nursing practice that respect people's values and beliefs. Disaster relief nurses practice core elements of nursing by providing support to people, securing their lives and living with them by their side.



Compassion as the 'true North' of the nursing moral compass

By Professor Jill White, Professor Emerita of the Faculty of Nursing and Midwifery at the University of Sydney & the Faculty of Health University of Technology & **Dr Amelia Afuha'amango Tuipulotu**, Minister for Health, Tonga

If we look at our history, we are able to gain some understanding of the social contract through which our profession emerged, that which was asked of the nurse by society. The earliest nursing grew from a feeling of concern for the suffering of others and a desire to act to lessen that suffering, a feeling named 'compassion'. The earliest evidence of nursing comes from the 7th Century when Islamic nurses brought the tradition to Southern Europe where it was adopted by Catholic churches as a vocation for nuns given the strong philosophical fit of service to others through compassion. The religious heritage of nursing continued to spread throughout Europe and into Canada in the 1600s. With the break of the Protestants from the Catholic church and the subsequent closing of monasteries and convents, the organised system of education of nuns/nurses diminished and, through the 1600s-1800s, there was little organised system of training those who sought to help others in sickness.

Florence Nightingale's legacy needs no retelling here, except for emphasising her utter commitment to the nurse being of the right temperament, character and education. It is in the Nightingale legacy we get the coming together of the values of compassion and discipline and the personal values of Nightingale of speaking up, speaking out, collecting data for policy and for political influence, and of the vital importance of education. The interplay of these three influences forms the modern history of our profession.

Every society has a developed understanding of the concepts of right and wrong; each individual develops what is commonly referred to as a personal 'moral compass', with the 'true North' telling if you are on course or veering away from the chosen direction. As a member of a profession, the moral compass includes the expectations of a good person working as a professional within an agreed social contract. In nursing, this social contract is usually enunciated in the form of a code of ethics and standards for professional practice.

The first formal code of ethics was developed by the American Nurses Association in 1950 describing the non-negotiable responsibilities of a nurse. ICN then provided its first global template code of ethics in 1953. ICN is currently revising the 2012 code of ethics to expand its emphasis on broad social justice responsibilities, however, it remains the document which is "*a guide to action based on social values and needs*".¹² Whilst some elements of ethical behaviour will be common to all countries, there will be subtle culturally specific nuances that differ, as the code reflects a society and its values. In the ICN 2012 version, the code speaks of confidentiality, respect for human rights and sensitivity to values, customs and beliefs.

It speaks of maintenance of environmental safety, of competence and education, collaboration, and advocacy for equity and social justice. It speaks of the demonstration of professional values of respectfulness, responsiveness, compassion, trustworthiness and integrity.¹²

Of these characteristics one could see respectfulness, respect for human life, cultural sensitivity, trustworthiness and integrity as the inner moral compass of the lay person. The professional moral compass, the practice of compassionate care, encompasses responsiveness, collaboration, confidentiality, safety, competence, advocacy and education—the touchstone of professional nursing.

In nursing, the expectation is for the adherence to both moral (lay) and ethical (professional) sensitivity as part of the development of a professional moral compass. The professional moral compass brings us to the contemporary touchstone of nursing: compassionate care—that fundamental or quintessential quality; the test of the genuineness of nursing. It is the capacity to decide with intelligence and compassion, given uncertainty in a care situation, drawing as needed on a critical understanding of codes for ethical conduct, clinical experience, academic learning and self-knowledge, with an additional ability to anticipate consequences and the courage to act.¹³

Compassion is not cost neutral. It requires emotional and practical resources, and a culture that facilitates and values the components of compassionate care: ongoing education, speaking up, taking calculated risks, a culture that is non-punitive and which fosters norms of ethical practice and role models the courage to act. Liaschenko¹⁴ names this courage 'moral agency' and urges nurses to collectively work to provide a moral community and to provide counter stories of our work as powerful, ethical and intelligent.

Forming moral communities provides support for the growth of moral agency: the ability to say "*I am holding you morally accountable to take my concerns seriously because my part in the care of this patient is just as important as your part*".¹⁴ This strength will enable our professional moral compass to follow its 'true North' and provide compassionate care which is our social mandate and has been since the 7th Century and before.

We as nurses need to do our bit—understand and continually refine our professional moral compass, and policymakers and governments must heed the public demand for compassionate care. Collectively, we must grow an environment and culture that fosters such care.

Case Study

USA - Providing compassionate care to Veterans

Contributor: Cathy M. St Pierre, USA

The Veteran's Health Administration (VHA) is the largest integrated healthcare system in the US with more than 322,000 full-time healthcare professionals and support staff. It serves military veterans and their families in an extensive range of medical centres and outpatient clinics, providing comprehensive inpatient, outpatient and specialty health care to more than 9 million veterans annually, including women's health, mental health and rehabilitation care services. In addition, several VHAs provide long-term care for ageing veterans with complex physical and mental health needs.

Cathy St Pierre is one of 500 Nurse Practitioners in the VHA who provides direct healthcare to veterans. She currently works in four hospital departments: chronic pain management, environmental health exposures, homelessness and research, with 50% of her time spent working with homeless and formerly homeless veterans.

In the US, approximately 11% of homeless people are veterans, with 37,000 veterans experiencing homelessness on any given night in 2018. Many factors contribute to veterans' homelessness, including the lack of affordable housing, unemployment and mental health conditions, including post-traumatic stress disorder (PTSD) and substance use disorder. Six in ten homeless veterans are over 51 and the proportion of older homeless veterans (over 62), most of whom have complex medical and psychiatric needs, is expected to rise.

To reduce homelessness among veterans the VHA joined forces with the US Department of Housing and Urban Development (HUD) and created the Veterans' Affairs Supportive Housing (VASH), which has rehoused more than 85,000 veterans in the past decade.

At the Veteran's Administration Hospital in Bedford, Massachusetts, Dr St Pierre provides direct healthcare and consultation to veterans enrolled in the VASH programme. She collaborates with the programme's social workers to help them understand the medical and mental health needs of the veterans they work with. She also provides direct health assessments and management of acute and chronic diseases of veterans, and provides support to the hospital's complex of 69 one-bedroom veterans' apartments.

Many of the veterans in the HUD-VASH programme also have significant mental health disorders, including PTSD and substance use disorder, putting them at risk of suicide. The HUD-VASH programme's team monitors at-risk veterans and provides a safety net to help veterans to access immediate care to prevent suicide. This type of on-site care can prevent more serious medical and mental health sequelae in a population who, in the past have not sought out medical care in a timely manner.

Cathy St Pierre (left) and a colleague with a US army veteran



Leveraging trust in nursing: professionalism, possibilities and pitfalls

By Dr Marla Salmon, Professor of Nursing and Global Health & Adjunct Professor of Public Policy & Governance, University of Washington, USA



***“Please know me,
be there for me,
and truly care.”***

I was at the beginning of my career in our local hospital; she was a long-stay patient. Her innate grace and the fancy bed jacket that she wore over her hospital gown appeared to be her last weapons against the loss of control and dignity that she was suffering. I quickly learned that she insisted on doing her own personal care. While it was fine for me to help her wash above the waist, she was adamant that she should be the only person to clean below her waist and above her knees. We negotiated some modified approaches over time—but, with averted eyes on my part, whenever possible.

One evening, she looked at me with a probing gaze as if pondering an important decision. Finally, she spoke in a quiet, confidential tone. *“Honey, would you like to see something?”* Slowly, she pulled aside the covers and directed my gaze to that part of her body that she had worked so hard to keep hidden. There, high up on her inner thigh, was a small tattooed heart. She said nothing, but smiled at me knowingly as I realised that she was more than that proper lady in the bed jacket. She was a person who had lived another life, who had once loved and been loved. In that one simple act, she said to me: *“Please know who I am and truly be there for me...in these final days.”*

She died a few days later. I gave her a final bed bath, observing those modesty protections that we’d negotiated, then carefully dressed her in a clean gown and tucked her in for her final sleep. I felt her presence with me during this final act of caring. I left her room saddened by her death, but also feeling the privilege and gift of having been trusted to truly care.

After these many decades of my career, I have forgotten her name but, she remains with me and has had a profound impact on my life and career as a nurse.

The gift that she gave to me is the knowledge that trust is the heart of caring and its reward. To know who our patients are, and to truly be there for them is the essence of nursing.

* * * * *

The professionalisation of nursing around the world has impacted the health of individuals and resulted in significant changes in both the status and reputation of its members. In many countries in which nursing is highly professionalised, it is also ranked as the most, or among the most, trusted profession. The trust rankings of nurses align very closely with those attributes that are the hallmarks of professions, and those expectations of the public that are fundamental to their social contract. While all occupations engage in work in exchange for some form of compensation, professions are granted special status based on their ‘contract’ with society requiring adherence to certain standards of conduct and expertise. Autonomy and self-regulation are crucial conditions of this contract, and reflect the trust and expectation that members of the profession are educated and socialised in ways that ensure their appropriate expertise, sound judgement, integrity and ethics, commitment to the client’s wellbeing, and selflessness and altruism to their work. In exchange, society grants the privileges of special status in society, including autonomy, self-regulation, special relationships with institutions, and government.

There are two kinds of trust from which nursing benefits: trust in individual nurses, and the public’s collective trust in the profession. Individual trust accrues when a nurse builds positive relationships with clients and families, earning the nurse permission to do things in that relationship that others would not be allowed to do. Abiding trust for the nurse is based on the capacity to relate to the patient and family in ways that assure them that their best interest and wellbeing are being placed at the forefront.

Trust for the profession is rooted in that social contract in which the nurse’s behaviour is governed by and reflective of codified expectations and standards. This social contract, while reflected in laws, regulations, training, and institutional expectations, is fundamentally rooted in the ongoing experiences of patients and their families. In other words, what individual nurses do has significant impact on the public’s view of the profession. Misconduct of individual nurses has potential for erosion of the social contract with, and trust of, all members of the profession.

Of all of the forms of misconduct, self-dealing—serving one’s own interests before those of patients and families—is among the least palatable for the public. The loss of the public’s trust that nurses are their advocates and put their interests first, places both the profession’s social contract with the public, and individual nurse’s relationships with their patients at significant risk.

The most trust-earning transaction is that in which the public is the beneficiary without any apparent benefit to the profession. A transaction that has significant benefit to the public, while also advancing the interests of nursing, could create public debate about the motive. (This is sometimes the case when arguing for expansion of roles that compete with those of physicians or other health workers—especially if there is apparent financial benefit involved). Those transactions that benefit the profession without apparent benefit to the public are likely the least palatable beneficiary arrangements when leveraging trust. So, the ‘optics’ of these kinds of transactions are very important.

Individual nurses leverage trust every day as they ask their patients to rely on their judgement and believe that the nurse will act in their best interest. It is expected that when nurses act within the framework of professional ethics and legal scope of practice, patients can depend on them. However, leveraging trust by the profession on a larger scale is a more complex question and has a profound impact on all of its members. Failure to fulfil what the public sees as its contract with nursing can have significant impact on nursing’s status as a profession and the wellbeing of its members.

Trust is a reflection of the relationship with the public; of how nursing conducts itself on the one hand, and how it is perceived on the other. Nurturing a positive relationship with the public means both meeting and helping to shape expectations. This is about building common ground in which

nursing and the public work together to achieve benefit to society and its members, while respecting and supporting nurses to do their work. This connection between nursing and the public must be nurtured in the collective, as well as through every individual interaction between nurses and those they serve. It also means that nursing governs itself in wise and prudent manners, putting the interests of the public first in how nurses are trained and regulated.

This ongoing accountability is a crucial form of assurance to the public that nursing is trustworthy.

Trading trust for professional benefit may have one-time benefit and longer-term negative consequences. A strong, informed, ongoing relationship in which nurses earn their reputation as compassionate, expert professionals who advocate the public’s good hold far greater promise for ongoing shared benefit than one based on occasional transactions.

In summary, trust is the underpinning for nursing’s status as a profession and the relationships that individual nurses have with their patients, families and the public at large. The social contract that frames nursing status as a profession frames the ways in which we can practice, our ability to utilize our expertise and judgement, how we are prepared, who judges our conduct, and even influences our work conditions and compensation. The relationships between the profession and the public are dynamic and reflect the ongoing engagement of nurses as individuals and members of groups and professional organizations. Leveraging trust for the benefit of individual patients, families and the public at large is key to maintaining and building trust. When considering leveraging trust, the fundamental question should be: “What will this transaction do to the special, trusting relationship that nursing has with the public?”



Case Study

UK - Making healthcare information accessible and understandable

Contributor: Parveen Ali, United Kingdom

Two nurses, Parveen Ali and Nisar Ahmad Gilal present a weekly radio programme in Urdu/Hindi for South Asian communities in Sheffield, England, which provides information about health conditions using easy to understand and jargon-free language for members of the community who have limited proficiency in English.

Nearly 10% of Sheffield's population is of South Asian origin, including people who come from or whose ancestors are from Pakistan, India and Bangladesh. Urdu/Hindi is the national language of Pakistan and is understood by many individuals from South Asia whose mother tongue may be Punjabi, Hindi, Potohari, Sindhi or Balochi.

The health profile of this community is worse than that of the rest of the population in England, with many people living with diabetes, heart conditions and stroke. Health literacy in this population is a cause of concern. Ethnic communities whose members have limited proficiency in the mainstream language tend to have low health screening rates, for example, in cervical screening and routine health checks, late presentation of serious illnesses, low uptake of services for mental health conditions and poor management of long-term conditions, such as diabetes.

The Health Show with Parveen Ali aims to provide simple, jargon-free information about health conditions, increase awareness about public health issues and dispel any health myths by ensuring that information is provided by registered nurses and specialist healthcare professionals.

The programme, which is also broadcast live on Facebook, has been running for more than a year and feedback suggests that people find the information useful and trustworthy, feel better able to understand their health conditions, and can access health services more readily.

Designing and delivering this programme has helped improve the image of nurses in the eyes of the public and especially in South Asian communities, where relatively few individuals choose nursing as a profession. The programme demonstrates that nurses can use their knowledge and skills innovatively and contribute to health promotion, disease prevention and dissemination of information. By doing so, they have fulfilled their duties as healthcare professionals, shown that nurses are leaders and provided a positive portrayal of the profession.

Nurses Parveen Ali and Nisar Ahmad Gilal present their health information radio programme for South Asian communities in Sheffield, England.



Changing the narrative of nursing

By Dr Barbara Stilwell, Executive Director, Nursing Now Global Campaign

Over the decades, nurses have sought to explain exactly what nursing is. Bio-psycho-social in its approaches, it relies too on a relationship with the client or patient that acknowledges individuality and develops trust, honesty and joint problem solving. Emotional intelligence is key to this relationship and at the heart of care. However, a recent international systematic review of public perceptions of nursing found role incongruity among the public: they trusted nurses but did not necessarily respect them and did not understand their work.¹⁵ Is 2020 an opportunity for nurses to do better at explaining what they do, why they do it and how it can change health outcomes?

An early American nurse theorist, Hildegard Peplau, developed a model of nursing that remains an implicit basis for all nursing practice. Her deceptively simple idea was that at the heart of all nursing interventions lies the relationship between the nurse and the patient. Peplau also surmised that the relationship between nurse and client could be therapeutic, in itself. Not surprisingly Peplau's work has been applied to and inspired mental health nursing.

If the *foundation* of nursing work is the nurses' ability to build enabling relationships with each of their patients or clients as an individual, then all that follows is designed to respond to what the patient or client reveals about what they need, taking into account the context—family, background, education,

economic status, their present health issues—that the patient or client brings to the consultation today and their future health goals. Building a relationship with the patient enables the nurse to explore each dimension of health and to discover which is the most important for the patient and their health to inform the nursing care to be given.

The unique expertise of nursing is to identify the issues to be addressed during each encounter and to explore them with the patient through their therapeutic relationship. This is the added value the nurse brings to the procedure and what distinguishes nursing practice from medical practice. This is true person-centred care and, if practiced well, then nursing becomes *in itself* a therapy that includes management of illnesses, education for wellness, and support for physical, mental and emotional resilience.

Many technical procedures can be performed competently by several members of the healthcare team and indeed task sharing is common in many clinical areas. But it is not the tasks that give richness and therapy to what nurses do—it is the focus on the whole person and on the many dimensions of that person.

The *art* of nursing is to establish a relationship with the patient that allows full exploration of their situation or context to identify priorities and determine a rational course of action.



The science of nursing lies in the clinical abilities of the nurse to carry out physical assessments, prescribe and carry out treatments, refer appropriately to other team members and manage cases for a healthy outcome.

The following are but a few examples demonstrating the value to health outcomes that can be achieved by nurses:

1. Patients with lung cancer live longer, avoid unnecessary hospital admissions and cope better with treatment when cared for by specialist nurses.¹⁶
2. The delivery of primary healthcare services by nurses instead of doctors probably leads to similar or better patient health and higher patient satisfaction.¹⁷
3. In high income countries, adequate numbers of well-educated nurses working in acute care areas can reduce the risk of patient mortality.¹⁸
4. Nurse-led care may be more effective than medical care in promoting patient adherence to treatment and patient satisfaction.¹⁸
5. Shifting specific tasks to nurses to scale up the care of poor, rural dwelling Africans with HIV/AIDS, hypertension and diabetes had a positive impact on physicians' workload and resulted in better disease management for more people.¹⁹
6. A failure to match staffing with patient needs is associated with increases in patient mortality.¹⁹

As a profession, nurses must engage with data—what is collected, what is measured and how the findings are used—to demonstrate the value of their work and especially of whole person care on health outcomes. Nurses also need to get the news out about their potential impact. This is important information for patients to have—they should be demanding and expecting nursing care just as they demand medical care.

Together we need to find a strategic solution to engage the public in advocating for nurses because of the life enhancing value that nursing care has. We need to push for linking nursing care to health outcomes and to better data collection. Nurses should be lobbying for better ways to capture workforce data that will adequately measure nursing inputs. As a nursing community we can reflect on the adequacy of existing models of care to capture nursing for the next century. 2020 is a chance to change the narrative about nursing.



Case Study

Barbados - Empowering those with mental illness

Contributor: Barbados Nurses Association

The Community Mental Health Nursing Service (CMHNS) aims to provide the highest level of mental health care to meet the biopsychosocial needs of individuals, families and groups, to reduce the incidence of mental illness and hospitalisation. Its health promotion model and comprehensive, holistic and evidence-based approach aims to empower people to take charge of their health and to make informed decisions.

The CMHNS originated in September of 1971 thanks to the pioneering work of Monica Jordan, a nurse who set up the service to address the problems of increased defaults from follow-up care and a high rate of readmissions to the psychiatric hospital.

By the early 2000s the service had grown, and the nurses were exposed to specialised community mental health training, enabling them to deliver health promotion and illness prevention activities.

Today, the CMHNS is facilitated by a large multidisciplinary team, and it also provides a Child Guidance clinic within the

polyclinic setting, bi-weekly prison clinics, court assessments on demand, and a 24-hour public access service. It has overseen a noticeable decrease in readmissions to hospital and most persons in the community with mental health concerns seek help from the community service, rather than the hospital, which still has a stigma attached.

The CMHNS has a dedicated team of specialist nurses who provide a level of care and an approach that empowers this population to maintain mental wellness in line with Sustainable Development Goal #3 for people to have good health and wellbeing.

The nurses who work for the service have a tremendous sense of achievement in enabling clients with mental illness to stay in their communities, manage their mental health problems and remain productive citizens.

As the stigma associated with admission to a psychiatric hospital continues, empowering and enabling these citizens to lead normal lives without having to be admitted to hospital is a major achievement of the CMHNS.



PART TWO THE CHALLENGES TO NURSING THE WORLD TO HEALTH

As seismic demographic and economic shifts take place across the world, health and healthcare are increasingly becoming a central issue. There is continued pressure on healthcare financing through increasing health demands, technological and scientific advances and consumer expectations. These forces when combined create hurdles that sometimes appear insurmountable. However, as evidence is emerging, effective and efficient healthcare brings improved health outcomes, more prosperous and cohesive societies.

Fundamentally, while health is considered a national asset, there are many different health priorities across different regions. These range from inadequate health facilities and access of care, through to caring for the elderly, conditions of lifestyle and choice, or lack of appropriate education and skilled workforce.

In this section, we look at some of the challenges that must be addressed as we nurse the world to health, and the ways in which health systems must change and adapt to meet these challenges. These include: ensuring high performing health systems; addressing inequality and the social determinants of health; providing cost-effective quality care throughout the lifespan; and addressing shortages of health professionals through high value healthcare services.

Wounded in the heart, mind and body

By Kim Ryan, Adjunct Associate Professor Sydney University, Credentialed Mental Health Nurse

Globally, it is estimated roughly one billion people suffer from anxiety and a third of these will also suffer depression. Sixty million people suffer bi-polar disorder, 21 million have schizophrenia or other psychotic disorders, and every 40 seconds a person commits suicide. The World Economic Forum in 2019 predicted by 2030 the global primary cause of ill health will be depression, with the estimate cost of 16 trillion dollars a year. The current cost of lost productivity due to mental ill health is predicted to be 2.5 trillion dollars. While these figures are staggering, we know mental ill health and mental distress are vastly under reported so if we could be looking at a much greater impact due to mental health problems in the future.²⁰

However, it is not only the mental health problems which need to be addressed, it is also the physical health of people with mental illness. People with severe mental disorders have, on average, a life expectancy of 10-25 years less than

the general population.²¹ The vast majority of these deaths are due to chronic physical medical conditions such as cardiovascular, respiratory and infectious diseases, diabetes and hypertension. People with severe mental illness tend to smoke more, have less physical exercise, poor diet, impacted on by side effects of medication.

Following a heart attack, those living with a mental illness are about 60 times more likely to commit suicide than people who did not experience mental illness.²² Even for people with no history of mental illness, the risk for suicide is tripled in the month after a heart attack—and the risk remains elevated for at least five years. Living with a chronic condition like diabetes, endometriosis, respiratory or neurological conditions can also increase your risk of depression and anxiety. Two hundred million women suffer from endometriosis, and high rates of depression and anxiety can amplify pelvic pain.²³

To support people to achieve full health and live a full life we need to enable them to seek help, receive help and support their best health and well-being. WHO continues to remind us there is no health without mental health, but to truly achieve this we need to address stigma and discrimination.

Stigma and discrimination are evident in all countries in relation to mental ill health in varying degrees.

New Zealand announced in 2019 its first mental health and wellbeing budget: a progressive step and significant investment bringing mental ill health out of the shadows. But sadly, we know there are countries where people are still shackled to beds, cement blocks, or in animal pens. As nurses we have a role and responsibility to break down these barriers and support the advancement of mental health care to all people.

As nurses, we work across all clinical and service care settings, with people from all cultural backgrounds, across the entire life span, and addressing the spectrum of healthcare needs. Nurses and midwives account for nearly 50% of the health workforce, with over 20 million nurses globally, a powerful force for change. The number of mental health/psychiatric nurses vastly outweighs that of psychiatrists. It seems abundantly clear that the way to address the mental health needs of our global communities is through nursing.²⁴

All nurses need to be more aware and capable to address the mental health needs of the people with whom they are working. The person suffering with endometriosis is likely to see a reproductive nurse, but unlikely to see a mental health nurse until they are experiencing a mental health

problem; the person who has experienced a heart attack will likely see the general nurse or cardiac nurse, and these nurses need to be able to explain the incidence of mental health problems and support the person through their journey.

At the same time, it is critical we continue to build and support the mental health/psychiatric nursing workforce who have the skills, knowledge and experience required to be a part of the solution of the growing mental health needs of the global community. Mental health/psychiatric nurses are well placed to support all nurses and midwives to better recognise mental health problems, and provide general mental health support and care. Mental health education in all nursing and midwifery education programmes needs to be strengthened to ensure the nursing and midwifery workforce are skilled and confident to deal with mental health problems and know when to refer to a mental health/psychiatric nurse.

Focusing on the medicalisation of mental health does not acknowledge the necessary focus and required investment in addressing the social determinates of health, without good mental health cannot be achieved. The circumstances under which we live, work and play affect our health and mental health, we cannot hope to achieve optimum wellbeing if we don't have access to education, housing, employment, safe food and water and a sense of safety.

To drive change, we need to address the mental health needs of the global community. Mental health/psychiatric nurses need to have an equal place on all decision-making bodies, and be enabled to contribute their unique knowledge, skills and insights to improve the mental health and wellbeing being of all.



Case Study

Australia - Leading primary care for people living with a mental illness

Contributor: Associate Professor Karen Heslop, Australia

Cockburn Wellbeing is a free, Nurse Practitioner (NP) led primary care service for people living with a mental illness who do not regularly access health care. The service aims to reduce the physical health disparities in this client group when compared to the general population.

It is estimated that 40% of people who have a mental illness also have a chronic physical illness, such as obesity, cardiac disease, hypertension, respiratory disease, metabolic syndrome, diabetes and cancer. Lifestyle factors such as a poor diet, smoking, alcohol and substance abuse and inactivity all contribute to poor health outcomes and people in this group are more likely to die at a younger age than the general population.

Using an integrated model of care, NPs provide a full range of services, including screening, detection and management of common chronic diseases, alcohol and other drug interventions, oral and sexual healthcare, education on lifestyle and health literacy, medication management, and counselling and psycho-social support.

NPs are particularly important in the primary care setting as people with mental illness do not always have the capacity to navigate the healthcare system effectively. NPs provide effective care that is holistic and complimentary to services provided by general practitioners (GPs), and systematic reviews on their efficacy consistently report high consumer satisfaction with care and the cost effectiveness they provide.

The NPs at Cockburn Wellbeing provide services within the City of Cockburn region in Western Australia, where 9.4% of the Cockburn population suffer high to very high psychological distress.

The Cockburn Wellbeing service provides low cost, integrated, effective and engaging primary care services for people who historically do not engage with health care on discharge from specialist mental health services.

Cockburn Wellbeing is an important service as health disparities are increasing in this client group, despite the fact that community awareness of the issues is high. When people are discharged from hospital, they often

do not access healthcare until they are extremely unwell, and pressure is inevitably then placed on emergency services. Cockburn Wellbeing aims to keep these clients well in their local community through regular engagement using an integrated model of care.

Patient Story

When client X, who has schizophrenia was referred to Cockburn Wellbeing after discharge from hospital, he was socially isolated, overweight, a heavy smoker and had been unemployed for several years. After assessment, a major focus of the NPs care was on lifestyle management and supporting him to integrate more within his community. This included regular monitoring and screening procedures in relation to physical health risks and his medication. Health education about his mental illness was provided as well as his need to make lifestyle changes. After 12 months contact, Client X had stopped smoking, his body mass index had reduced, and he had obtained a permanent part-time job. He remains engaged with NPs at Cockburn Wellbeing and recommends the service to other people.



Health systems capable of meeting the needs of individuals and communities

By David Stewart, Consultant, International Council of Nurses

Sometimes numbers do not convey the real horror of news that is presented. In 2018, the Lancet²⁵ published a study that showed that there were 8.6 million excess deaths in low/middle income countries (LMIC) that were amenable to healthcare. Five million of these were the result of poor-quality care and 3.6 million were due to the non-utilisation of healthcare. This loss of life is estimated to cost \$6 trillion to local economies. This issue is not isolated to LMIC; in the USA, for example, medical errors are the third-leading cause of death after heart disease and cancer.²⁶

A health system is meant to restore health and alleviate suffering. What can we do when the system is to blame? The cause may be related to inadequately skilled staff, errors in judgement or care, or a defect with systems such as a computer malfunction, medication errors, surgical mistakes or conditions that go undiagnosed. However, when the system works well, the world has never had such a sophisticated arsenal of interventions and technologies for curing disease and prolonging life. Much of the suffering in the world caused by illness and disease is needless as there are effective and affordable interventions for prevention, treatment and rehabilitation. So, moving forward, how do we achieve health systems that are responsive to the needs of individuals and communities?

Health systems are highly contextual to the region. However, there are global similarities in actions that can be done to support the strengthening of high performing health systems.

A high performing health system is one that has a philosophical shift in focus away from just curing the sick to one that supports wellbeing, prevention and early intervention. This system works with other sectors like education, employment, information and technology, housing and transportation to address the social determinants of health. It has a holistic understanding of people's needs and ultimately works with consumers that are informed and empowered. A system organised like this is important for improving health and reducing longstanding disparities that are often concentrated in social and economic disadvantages. Most importantly, it is accessible and safe so that millions of people no longer die needlessly due to poor care and unavailability of health services.

The opportunities to shape this future are promising and possible. But it takes participation and collaboration between policy makers, health professionals and ultimately consumers. Maintaining high-quality care requires a focus on human resources for health with particular emphasis on nursing as the largest provider of front-line health services in the world.

Characteristics of a high performing health system

- All people, regardless of age, sex, religious belief or any other factor have access to quality, safe and affordable care
- Strong leadership and governance are in place for effective oversight, system responsiveness and accountability
- Appropriate prevention, promotion and treatments are delivered at the appropriate time, in the appropriate place, for the appropriate patient and consumer
- Clinicians use technology to more accurately diagnose and treat illness and deliver care
- All care delivery stakeholders across the ecosystem effectively and efficiently communicate and use information with the consumers best interest in mind
- A high performing health workforce resourced and empowered (i.e. sufficient staff, fairly distributed, competent, responsive and productive).
- Patients are informed and actively involved in their treatment plan
- New, cost-effective delivery models bring healthcare to places and people that don't have it
- Health services are delivered safely, effectively and efficiently with a minimum waste of resources.²⁷



Divided communities, unequal world

By Dr Susan B. Hassmiller, Senior adviser for nursing, Robert Wood Johnson Foundation

Far too many people in our world experience health inequities, power imbalances and injustices from their first breath until their last. A wide chasm exists between the wealthy and the poor, the healthy and unhealthy, and the educated and uneducated. According to the World Bank, in 2015, more than 700 million people—or 10% of the world's population—lived on less than US\$1.90 a day.²⁸ These people struggle to fulfil the most basic needs, such as healthcare, education, clean water and sanitation. Even within wealthier nations, the poor face significant obstacles: lack of access to good jobs with fair pay, quality education and housing, safe environments, healthy food and clean water, and healthcare.

To ameliorate this divide, the 191 UN member states committed in 2015 to achieving the SDGs by 2030. The goals address poverty, hunger, inequality, climate change, prosperity, peace, and justice both between nations and within nations. They imagine a world far better than the one we inhabit today—a world where everyone has access to healthcare, enough to eat, and an opportunity to thrive. Although only one of the SDGs specifically addresses health, advancing the SDGs will drastically improve the world's health. That is because the social determinants of health—the complex social and environmental factors such as where we are born and live, the strength of our families and communities, and the quality of our education—shape our health over our lifetimes. The inequitable way that people experience the social determinants of health are largely responsible for health inequities, the unfair and avoidable differences in health status seen within and between countries.²⁹

Nurses are well-equipped to play a role in achieving the SDGs. The nursing profession is rooted in a fundamental concern for the social, emotional, and physical needs of the disadvantaged.³⁰ Nurses are trained to understand the factors shaping a person's life—whether that person lives in poverty, lacks access to safe housing, or struggles with addiction, for example—and how they affect that person's health. Nurses also know how to adapt care to best suit these circumstances to provide people their best possible opportunity for health.³¹ We need nurses' expertise in addressing the social determinants of health to tackle our world's most devastating health crises, which are often interwoven with factors such as discrimination, homelessness, and violence.

For example, consider climate change (SDG #13), which affects every country on earth, but will disproportionately affect the poorest among us. If drastic action is not taken, a UN report warns that food shortages will rapidly increase due to land degradation, which makes less land available for farming. According to some of the report's authors, food shortages are more likely to affect poorer regions than wealthier ones, causing an increase in migration to North America and Europe.³² WHO also estimates that between 2020 and 2050, climate change is expected to cause roughly 250,000 additional deaths per year from malnutrition, malaria, diarrhoea and heat stress.³³

Nurses, as the largest component of the healthcare workforce throughout the world, can partner and lead efforts to help health systems become more sustainable, as well as make more sustainable choices in their own households and partner with others at the local, national, and international levels to reduce the impact of climate change.³⁴ They can raise awareness of the health implications of climate change and advocate for policy changes. As disasters increase in intensity due to climate change, nursing's existing collaborations and partnerships with humanitarian organisations will become more important in disaster risk reduction, response and recovery.³⁵

Nurses must serve as partners and leaders in addressing the social determinants of health. That is why the US National Academy of Medicine and the Robert Wood Johnson Foundation are collaborating on a second report on the future of nursing, which will be released at the end of 2020. This report will guide nurses and institutions in working together to better understand the social determinants of health, the unmet needs of individuals and communities, and nurses' role in addressing them. Nurses, policymakers, other health professionals, and elected officials throughout the world will be able to use the report as a blueprint for how the nursing profession can address the social determinants of health to create a more just and equitable world. (*More information about the report can be found at: <https://nam.edu/publications/the-future-of-nursing-2020-2030/>.*)

Case Study

Canada - Supporting survivors of human trafficking

Contributor: Asmaa Mabrouk, Canada

Human trafficking and exploitation affect a wide range of people, from affluent teenage girls living in suburban homes, to adult men living on the streets. Any situation that involves the recruitment, harbouring or transportation of people into a situation of exploitation, through the use of deception, coercion or violence, is human trafficking. Exploitation is a situation in which a person's vulnerabilities are used against them to coerce sexual interaction

For those experiencing human trafficking, traditional health care services can be stressful and inappropriate because of busyness, long waiting times and difficulties navigating the system.

To counteract these difficulties, experienced PHC Nurse Practitioner Tara Leach created the Health Care, Education, Advocacy, Linkage for Trauma Informed Healing (H.E.A.L.T.H) clinic, a clinic that is tailor-made for survivors of human trafficking.

She practices holistic care that acknowledges how trauma, such as sexual violence, exploitation, and childhood adversity, can affect a person's life. As a Nurse Practitioner, her appointments are not time-limited, and patients are not required to provide ID or proof of insurance.

The philosophy of the clinic is to provide judgement-free, trauma-informed care within a patient-centred framework.

The clinic's clientele is expanding as many people do not identify themselves as having been trafficked, despite their histories of coercion, exploitation, and sexual violence.

The H.E.A.L.T.H. clinic has had a positive impact on our clients' lives. Many of them had never been followed up by a healthcare provider and are now finally able to adjust medications, deal with ongoing health issues and learn more about their mental health diagnoses. The clinic has also referred many clients to substance abuse programmes to help them manage their addictions so that they can re-integrate into society in a safe and productive way.

In addition to sexual health services, a large portion of our work is dedicated to treating, managing and diagnosing mental health issues. Many patients come to us with undiagnosed conditions, including post-traumatic stress disorder, anxiety, depression and attention deficit hyperactivity disorder, and they need help finding the right medication and coping mechanisms. Many have long histories of abuse and neglect, which means they require a lot of care and support. The clinic is now recruiting a psychologist to improve the care of patients who have more complex needs.

The clinic's most important provision is compassionate, non-judgemental, trauma-informed care. It does not penalise people for missed appointments, it doesn't force clients into treatment, and it tries to help them on their terms. The best care starts from a place of compassion, trauma-informed understanding, and kindness, regardless of the patient's past.

Hope at the end of life: The essential role of nurses

By Professor Patsy Yates, President, International Society of Nurses in Cancer Care, Distinguished Professor, Queensland University of Technology

Dying is a universal human experience, but how we experience dying is shaped by a range of personal and sociocultural influences as well as by availability of social and community support and access to quality healthcare systems of which nursing services are an essential component. Nurses have long played a critical role in the way people experience dying, bringing comfort, hope and dignity, including to those who are marginalised. The role of nurses in the provision of care at the end of life and nurses' everyday work to promote comfort and dignity and to advocate for universal access to palliative care bring hope for people who are dying.

Palliative care as a basic human right

In her early writings, Dame Cicely Saunders, acknowledged as founder of the modern hospice movement, articulated the relationship between physical and mental suffering *"with each form of suffering capable of affecting the other"*.³⁶ Saunders' idea of total pain included physical symptoms, mental distress, social problems and emotional difficulties. Care of people who are dying therefore needed to be based on the whole person.

Today, WHO acknowledges that access to palliative care is a human right and should be provided through person-centred and integrated health services that pay special attention to the specific needs and preferences of individuals.³⁷ Despite almost universal agreement about the importance of palliative care, significant challenges exist to providing such services, several of which have been highlighted by WHO in its statement entitled *Key Facts about Palliative Care*.³⁸ Nurses play a vital role in overcoming every one of the challenges included in this list.

- Palliative care improves the quality of life of patients and their families who are facing problems associated with life-threatening illness, whether physical, psychosocial or spiritual.
- Each year, an estimated 40 million people are in need of palliative care, 78% of them live in low- and middle-income countries.
- Worldwide, only about 14% of people who need palliative care currently receive it.

- Overly restrictive regulations for morphine and other essential controlled palliative medicines deny access to adequate pain relief and palliative care.
- Lack of training and awareness of palliative care among health professionals is a major barrier to improving access.
- The global need for palliative care will continue to grow as a result of the rising burden of noncommunicable diseases (NCDs) and ageing populations.
- Early palliative care reduces unnecessary hospital admissions and the use of health services.

The role of nurses in ensuring access to palliative care as a human right

As the largest workforce in global healthcare, nurses are in a strategic position to influence the quality of palliative care delivery across the illness trajectory.³⁹ Fundamentally, nurses play a central role in the care of the dying because the very foundation of nursing, which lies in its holistic focus and emphasis on respect for the person's dignity, provides enormous untapped potential for addressing what is most important to people at the end of life. A 2016 systematic review of palliative care health services found more support for the role of nurses than any other discipline.⁴⁰ Working with their communities and as part of an interdisciplinary team, nurses deliver quality end of life care services for communities and health systems, providing hope for people to live well for as long as possible, hope for universal access to palliative care, and hope to achieve a thriving, comprehensive, integrated system of care.



Kastelo is the first paediatric palliative care unit on the Iberian Peninsula. A team of nurses and paediatricians provide care to up to 30 children with chronic illnesses.

Hope to live well for as long as possible

Hope means different things to different people living with life-limiting conditions. For some, hope is linked to a desire to prolong life or for a medical cure, but this may not be clinically possible. For others, hope means having positive personal relationships, good quality of life and the ability to set and achieve goals. Hope can also lie in one's spiritual or religious beliefs. Nursing interventions which are directed at achieving these hope-sustaining goals can play a critical role in enabling people to live well for as long as possible. Hope, when conceptualised in this way, places more emphasis on the person's active engagement in life and focuses on identifying what is good and positive for the individual, enabling them to connect to others.⁴¹ This holistic, person-centred understanding of hope, one which focuses on living well with a life-limiting condition for as long as possible, aligns well with nursing philosophy and practice.

Hope for universal access to quality palliative care

Sociologist Alan Kellehear states that *"it is not cancer, heart disease or medical science that present modern dying with its greatest moral tests but rather it is poverty, ageing and social exclusion"*.⁴² Nursing has great potential to address the challenges associated with social disadvantage through our compassion and reach into communities in need. However, one recent multi-country study highlighted that significant barriers exist to providing home care at the end of life across all countries.⁴³ These barriers included personnel shortages, lack of funding and policies, poor access to end-of-life

or hospice services, and decreased community awareness of services provided. These issues must be addressed as we build capacity in nursing services to provide palliative care, since nursing services will continue to be key to our hope for achieving universal access to quality palliative care, no matter what one's social circumstances.

Hope for a thriving, comprehensive, integrated system of care

One of the paradoxes of care for people as they near the end of life, even in countries where resources and evidence for palliative care exist, is that such services remain underutilised. Some writers⁴⁴ have argued that, in well-resourced countries in particular, the domination of biomedical processes places palliative care at risk of becoming over-medicalised thereby losing its essential holistic base. Nurses have an important advocacy role in preventing such trends and ensuring that advances in the science underpinning palliative interventions continue to be based on the needs and wishes of the person, their family and community. Nurses can ensure that the individual and community voice is heard in the care process and can advocate sufficient resources to ensure the human aspects of care are not neglected. By contributing this holistic perspective to care at the end of life across all communities and settings, nurses provide hope that a comprehensive, integrated system of care will continue to thrive as our knowledge of palliative care advances and as we face the inevitable growing demand for palliative care services across the world.



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Case Study

Taiwan – Caring for bereaved parents

Contributor: Yuling Wang, Taiwan

Death has always been a difficult topic to discuss in East Asian cultures, but it is even harder for those who have lost a baby in pregnancy to let go of their inner grief and get back to normal life.

In Taiwan, foetal congenital anomaly has been the leading cause of newborn deaths for decades. The grief of pregnancy loss is distinct, and its influences result in traumatic life experiences for the women and their family. However traditional Taiwanese cultural beliefs about death can impede the parent's grieving process and lead to disenfranchised grief, so it is essential to provide professional support for these families.

In 2018, the National Taiwan University Children's Hospital initiated the Children Friendly Medical Service Project to strengthen the core value of holistic care. It is dedicated to building up a comprehensively healthy environment for children from foetus to adulthood.

Led by Head Nurse Pi-Lan Chang in the obstetrics ward in National Taiwan University Hospital and supervised by Professor Shao-Yu Tsai from National Taiwan University, research nurse Yuling Wang conducted participant observation research into the needs, coping strategies and resources of families who experienced loss during their pregnancy. We provided bereavement support from hospitalisation until two months after discharge.

For each unique family, we established nurse-family partnerships to foster a positive and trusting relationship. The research nurse provided care that was compassionate and focused on emotional support. We took the first step to uncover the parents' neonatal death plans. Parents who were concerned about death taboo and afraid to express their feelings after a stillbirth were guided to release their emotions through therapeutic communications. In addition, we cooperated with clergy and family members to provide spiritual support as a way to relieve concealed grief.

Twenty-eight families were included in this research, with 19 of them joining a retrospective interview when they revisited our clinic. After applying the practice of life narratives to bond the families and their babies, families who saw their babies and those who did not felt empowered to follow their own paths in coping with their grief.

We found families were able to recognise their inner strength and resilience and redefine the meanings of the stillbirth. One parent shared, *"It was a gift from God. Our baby came for some reasons. He brought us a strengthened mind and solid love."*

The uncertainty, lack of pre-induction information, and being judged by society are major stressors for these families and parents expressed a desire for professional support: *"We need a specialist such as you who can offer non-judgmental advice, and be a guide during this painful journey."*

Through this pilot research, our team first investigated the needs of the bereaved, then helped unearth their deep grief, while seeking a way to cope with it together.

It is important for health professionals to perform culturally sensitive bereavement support. With the concept of holistic care, our team successfully rebuilt the bonding between families and stillborn babies. Consequently, bridging the gap between life and death.



Are we doing the right things to meet the health needs of the people we are serving?

By **Michael J. Villeneuve**, Chief Executive Officer, Canadian Nurses Association & **Claire Betker**, President, Canadian Nurses Association

“Every country’s journey towards universal health coverage is unique. But in all countries, the key is primary care that delivers the services that people say they need, rather than the services someone else decides they should have.”

Dr. Tedros Ghebreyesus
Director-General, WHO⁴⁵

From health and wellness promotion to end-of-life care, healthcare is delivered in myriad settings around the globe. How we decide what services are needed, and what setting makes the best match to deliver it, is not always clear or consistent. Decisions may be informed by ideology, economics, political timing, or any number of forces that may have little to do with hard evidence. As leaders around the world grapple with demands to deliver more and better health services, faster and more affordably, it is important to ask whether we are providing the right sorts of services, in the right places and the right ways. Are they appropriate? Accessible? Safe? Clinically effective? Satisfying to the people using services and those delivering them?

Health systems have started to look at this in the form of ‘valued based healthcare’: delivering outcomes that matter to patients, individuals and communities and the costs to achieve those outcomes. To achieve this, we need to ask the *Five Rights*: Are we delivering the Right Care, by the Right Provider, at the Right Time, in the Right Place, and at the Right Cost?

The rise of acute care and costs

The balance between social and health spending contributes more to health outcomes than the absolute amount spent on just healthcare.⁴⁶ However, hospitals are much more visible, action-oriented and exciting to most members of the public than highly effective public health programmes. While hospitals may deliver sudden and dramatic improvements in individual health, their impact on broader population health is less certain; but belief that treatment and improved health are linked has led to what some have called the *seduction of the acute*, i.e. getting to better health means more acute care, doctors, drugs and buildings.

A compelling example of this phenomenon is the North American health systems of Canada and the USA. Decision makers in these two countries have been unable to break the pattern of funneling funding to acute care despite a compelling body of evidence showing that the health of a population can be attributed mostly to factors that have nothing to do with formal healthcare. The USA spends more on healthcare than any other nation—\$10,739 per person in 2017, or 17.9% of gross domestic product (GDP).⁴⁷ Canada spent about \$6,839 per person in 2018 for its UHC programme—11.3% of GDP.⁴⁸ These levels of spending might be tolerable if the promises of the other four of the *Five Rights* were being delivered, but the evidence that this is so is scant.

Concerns about the rising costs of our current health systems and their questionable safety records *have* drawn attention and forced hard conversations about whether we are doing the right things to deliver on the promise of better population health. Successive reports of the Commonwealth Fund have called into question the efficacy, equity, safety and health outcomes of healthcare systems in Canada and the USA, typically placing the neighbours at the bottom of the rankings of similarly wealthy OECD nations.⁴⁹ Despite years of focus on quality and safety in Canada, a 2017 study concluded that, left unchecked, there could be some 400,000 annual patient safety incidents in acute and home care settings over the coming three decades, adding \$2.75 billion in treatment costs per year.⁵⁰ Mortality related to these incidents ranks only behind cancer and heart disease. Globally, WHO has stated that 1 in 10 patients is harmed while in hospital, and counts patient harm as one of the top ten causes of death and disability.⁵¹

Nursing can be deployed to help drive better outcomes

The active participation of nurses is essential to transform health systems and improve access to care. Speaking at the ICN Congress in Singapore in 2019, WHO’s Dr. Tedros Ghebreyesus said, “*We simply cannot achieve universal health coverage and the health-related targets in the SDGs unless we empower and equip nurses and midwives, and harness their power.*” Nurses have solutions and can be utilised more effectively to help resolve the big challenges in health systems, however we must educate, regulate, deploy, support and reward them to lead that change. And we in nursing must step up forcefully and do the work.

Better matching of providers with population health needs can benefit from a human-resources planning model like the Service Based Planning Framework derived by Tomblin-Murphy et al.⁵² which sets out the health needs of any population, the competencies required to meet them, and the competencies available within any given team of providers. Looking at the resulting demand/supply competency gap, *“it quickly becomes clear that a range of providers can safely deliver any given competency, in satisfying ways to patients and at costs they can bear”*.⁵³ But that assertion demands uncoupling long-held beliefs that certain competencies—diagnosis, for example—belong exclusively to any one provider. It demands that we reframe one of our key challenges not as a *shortage of family doctors*, for example, but a *shortage of access to primary care*—and then ask who has (or could be taught) the requisite competencies to safely close that gap at costs taxpayers can bear.

Nurses have solutions that we know work well and can be delivered largely within the existing scope of nursing practice. A substantial body of evidence links well-educated nurses deployed in the right numbers and mix of nursing categories to positive health outcomes across many settings, including a generation of compelling science linking hospital nurse staffing with morbidity and mortality outcomes. Nurse-led models of care have proven their clinical efficacy, satisfaction to the public, and cost-effectiveness when compared to traditional models. For example, Browne, et al.⁴⁶ concluded that *“models of proactive, targeted nurse-led care that focus on preventive patient self-management for people with chronic disease are either more effective and equally or less costly, or are equally effective and less costly than the usual model of care.”* Reporting on nurse prescribing in the UK, the Royal College of Nursing⁵⁴ found improvements in patient care such as timelier access to medicines and treatment, increased flexibility for patients who would otherwise have had to see a doctor, improved service efficiency that allows physicians to care for complex patients, diversion of avoidable emergency and hospital admissions, and better access to more streamlined and patient-centred care. Graham-Clarke, et al.⁵⁵ noted that *“patients are expected to be cared for, and treated by, the most appropriate healthcare professional”* thereby reducing medical workload and *“enabling the more complex cases to still be treated by medical practitioners despite a reduction in their numbers. Costs are reduced by streamlining care through reducing multiple appointments with different healthcare professionals, and by using the most appropriately qualified professional”*.

Most public health is planned and delivered by nurses and a 2017 systematic review in the UK *“demonstrated a median return on investment of public health interventions of about 14:1. Thus, for every £1 invested in public health, £14 will subsequently be returned to the wider health and social care economy”*.⁵⁶

Basu, et al. argued that *“a lot of the pressure on acute care hospitals caused by overstay could be reduced ... through a proper expansion of home care, complex continuing care, nursing homes, and disease specific care facilities”*.⁵⁷

All of that care is nursing care and nurses' leadership should be prominent in implementing the solutions.⁵⁸

Going forward

In repeated polls in Canada and the USA over the past 20 years, nurses nearly always come out on top of the list of professionals most trusted by the public. That outcome is the result of decades of hard work by professional associations, development of standards of practice, strong nursing education including a baccalaureate as minimum entry to practice for registered nurses and master's preparation for advanced practice nurses, and strong nursing regulation including a history of common examinations across all jurisdictions in the federation. That top-ranking public trust is a tremendous resource for nursing that is the envy of every other professional and it puts us in a position of significant power.

The public expects nurses to work with partners to transform healthcare so that we are more effectively delivering the range of health services they need. It is in this work that strong professional nursing and policy organisations, like the Canadian and American Nurses Associations and the American Academy of Nursing, can exert an important public policy impact on behalf of nurses.

Nurses globally may take some lessons from the strength of Canada's professional nursing workforce, while noting our caution that the way forward should place higher priority on public health, health promotion and wellness, and the prevention of illnesses and injuries. We want to preserve the best of the acute services that work well for people while at the same time toppling outdated traditions in favour of structures that allow nurses to much more effectively help deliver the right care in the right place and right time at reasonable costs.

Case Study

Lebanon - Improving access and uptake of immunisation

Contributor: Rana Hassoun, Lebanon

In 2017, the Accelerated Immunisation Activities was launched by the Lebanese Ministry of Public Health in coordination with UNICEF and WHO. Its aim is to keep Lebanon polio free, enhance coverage for Inactivated Polio Vaccine and Measles Mumps and Rubella vaccines, and strengthen routine immunisation. The objective was to screen all children between 0 and 15 years to identify those who have dropped out of the system and not received their vaccinations.

Community health workers identified these children and referred them to a nurse-led primary health care (PHC) centre. Nurses at the centre check the child vaccination card, administer the missing vaccines according to the national calendar and book an appointment for any subsequent follow ups or immunisations. Children who did not respond to the invitation to be immunised were followed up by the community health workers.

There are a number of reasons why children were not up to date with their required vaccinations, including PHC Centre staff being fatigued and overwhelmed by dramatic population increases; limited human resources capacity/lack of registered nurses; ignorance about how to access PHC services; and reduced confidence in PHC as compared with private clinics, emergency rooms, and hospitals.

Other barriers to implementation included long waiting times and transport problems; low levels of community involvement; missed appointments; missing vaccination documents and personal identification papers; distrust of PHC staff; and commonly held myths and misconceptions about immunisation and economic barriers, even though vaccines are provided free of charge.

To improve uptake of vaccinations, the nursing leadership identified a number of important actions to take, including increase in registered nurses and other staff; effective communication to increase the trust in nurses and effective supervision of community health workers;

increase in medical supplies and better use of resources; better awareness and educational sessions; improved facilities in clinics and waiting areas; and reliable transport.

As a result of this service and the changes made by nurses, up to 10,000 people a year from underserved and poor communities are receiving vaccinations, a 400% increase on previous years.

Improving immunization coverage in Lebanon



Nurses, the costs of healthcare, and the pursuit of value in healthcare

By Dr Jack Needleman, Department of Health Policy and Management, Fielding School of Public Health, University of California, Los Angeles

The proportion of national wealth directed to healthcare is evidence of the value given to it. Across the world, health spending is a substantial share of GDP and, as the wealth of a country increases, the percentage of national wealth increases. WHO reports that health spending as a percentage of GDP is approximately 7% in low-income countries, 6% in middle-income countries and 10% in high-income countries. Still another measure of the desire for healthcare is the willingness of individuals without access to public or private health financing to pay out of pocket for care: in high-income countries this accounts for approximately 20% of health spending, over 30% in middle-income countries, and nearly 40% in low-income countries. Even while healthcare is valued, there is continued pressure to push the costs of health services as low as possible while making care available.

For low-income countries, key challenges are utilising the current workforce as efficiently as possible, and expanding healthcare services to provide high value care as quickly as possible. Nurses have been and can be a critical component to addressing care needs in a highly resource-constrained environment.

Overall in low- and middle-income countries (LMIC), nurses are the largest health profession. However, across LMIC, there are substantial shortages of nurses and physicians, and the nurse-to-physician ratio varies. In Sub-Saharan Africa, while the ratio of both physicians and nurses to the population is low, there are five times as many nurses as physicians. In India, by contrast, the overall ratio of physicians and nurses to population is low in comparison to many other LMIC, but there are only 1.5 nurses for each physician. In China, the ratio is 1:1. These differences clearly reflect variations in how care is organised and delivered, the relative role of physicians and nurses, and perhaps the relative cost of, or historic capacity for, educating physicians versus nurses. Countries with low nurse-to-physician ratios may be missing opportunities to expand access and services faster and at lower cost.

Coping with shortages of physicians has led to widespread task-shifting, often to nurses, of specific tasks usually carried out by physicians. There is a growing literature that suggests that task-shifting can be effective, increasing effective capacity within constrained budgets, and WHO has promulgated a set of recommendations to assure effective and safe delivery of care that is shifted to nurses and other non-physician staff. Central to these recommendations is the recognition that effective task-shifting to nurses cannot be done in an ad hoc manner but needs to be planned and managed so that policy and organisation are in place to support it. The fact that task-shifting, when well implemented, has been found to be an effective and safe means of coping with workforce and resource shortfalls suggests that embracing expanded scopes of work for nurses and building this scope into the education of nurses in LMIC may offer lower cost strategies for expanded access to healthcare services.

Cost issues are different for higher income countries, which have developed comprehensive healthcare systems able to provide most services for most of the population, and who often have developed an insurance or financing system that provides broad coverage for the population shielding them from having to make hard decisions about which services to obtain. For these countries, maintaining access is critical, but so is containing costs.

Labour is typically the largest cost item of spending in hospitals, and nursing the largest share of labour. As a result, cost containment in hospitals has often been about reducing labour costs, by constraining wages, trying to reduce the role of professional nurses by relying more on nonprofessional nursing staff, or reducing or restricting hours of nurses and increasing nurses' workloads. However, extensive research on staffing levels, mix and work environment, conducted across health systems in high- and middle-income countries concludes that professional nurses bring training and expertise to the bedside that is critical to care, and that, when the nursing staff does not have the training, time available for work, and work environment to support their work, time in the hospital, costs, deaths and other adverse events increase.

Some of the research has looked at the cost of a higher skill mix or more hours, and the extent to which the higher cost of more professional nurses would be offset by lower costs due to fewer adverse events, shorter hospitalisations or fewer readmissions. Across multiple studies, the results are consistent. In hospitals with a lower percentage of professional nurses on the nursing staff, the costs of longer length of stay and higher rates of adverse events exceed the costs the hospital would spend to increase the proportion of staff that are professional nurses. Efforts to de-skill the nursing workforce result in higher, not lower, costs. Increasing the hours of nursing reduces costs associated with longer lengths of stay and adverse events, but the net costs are low relative to total hospital costs. Furthermore, if these costs are divided by the number of avoided deaths associated with higher staffing levels, the cost per avoided death is within the range typically considered effective. In summary, the costs for adequate nurse staffing in high income countries are justified by cost savings and the net cost of lives saved.

Looking beyond inpatient care, there has been an increased recognition in higher income countries that professional nurses can be more effectively used in outpatient care and in coordinating care across settings. These include taking histories and physicals and providing counselling and advising on how to effectively initiate and sustain prescribed treatments. This allows physicians to focus on assessment, diagnosis and prescribing care, while the expertise of nurses in physical assessment, interviewing and patient education is more fully utilised. Outpatient settings find the additional cost of nurses is often offset by the increased volume of patients that can be accommodated and greater productivity of physicians. There has also been more extensive use of nurses as care coordinators and educators for patients with multiple chronic illnesses and patients about to be

discharged from hospitals to reduce the likelihood of a hospital admission or readmission. Careful targeting of these nurses to patients at highest risk of complications or hospital admission is being found to save money even as it improves the patient experience.

Finally, in both low- and high-income countries, there has been increasing efforts to educate nurses for advanced practice in which nurses assume responsibility for assessment, diagnosis and prescription of treatments that they or others will implement. Studies have routinely found that when advanced practice nurses (APNs) practice within their scope of training and education, making appropriate referrals to specialty physicians for more complex or diagnostically difficult patients, the quality of care is equivalent to care provided by physicians, and patient satisfaction is often higher. The education of these providers is more limited in duration, reducing its cost and shortening the time to entry into practice, justifying somewhat lower salaries than those demanded by physicians. For healthcare systems dealing with shortages of physicians or seeking to reduce the costs of medical services, increased use of APNs can be a cost saving means to achieving these goals.

Low-, middle- and high-income countries all strive to deliver high value health services at the lowest possible cost. Nurses are essential for the efficient expansion of high value care in low- and middle- income countries. In high-income countries, where constraining costs becomes an important adjunct goal to service expansion, there is a critical need to assure adequate funding to maintain inpatient nursing levels that can deliver safe and reliable care, and to expand the role of professional nurses and APNs in outpatient settings for patient education and care coordination that can lower the costs of patients with multiple or complex chronic illnesses.



Case Study

Russia – Improving treatment compliance through video-observed TB treatment

Contributor: Tatiana Fedotkina, Russia Nurses Association

Long-lasting TB therapy requires high levels of patient compliance, which can be problematic in countries experiencing a high burden of Tuberculosis (TB). In Russia, TB therapy is mandatory because of its infectious nature, potential social impact and mode of transmission.

However, travelling to hospital for observed daily treatment can be difficult for patients because of their poor health and low energy, and the fact that it is costly and time-consuming. The public health system in Russia provides several models of TB treatment and care designed to make treatment compliance easy, but despite this, treatment compliance rates are nowhere near 100%.

Many of the patients have drug resistant TB in multiple sites, and have co-morbidities including HIV and diabetes. For these people, the main health need is to recover from TB staying in the most comfortable circumstances possible.

In the Tomsk region of Russia, we are using video-observed therapy to enable patients to stay in their own homes and still get the essential treatment they need. More than 50 specially trained and equipped nurses are involved in the project, which is delivered using Skype software.

The patients also receive training on how to register and use Skype, and they give their consent to join the scheme.

The programme started small, with just six patients in Tomsk, but now 130 patients are on the scheme, including 30 children. Across Russia, more than 500 patients are receiving video-observed TB treatment.

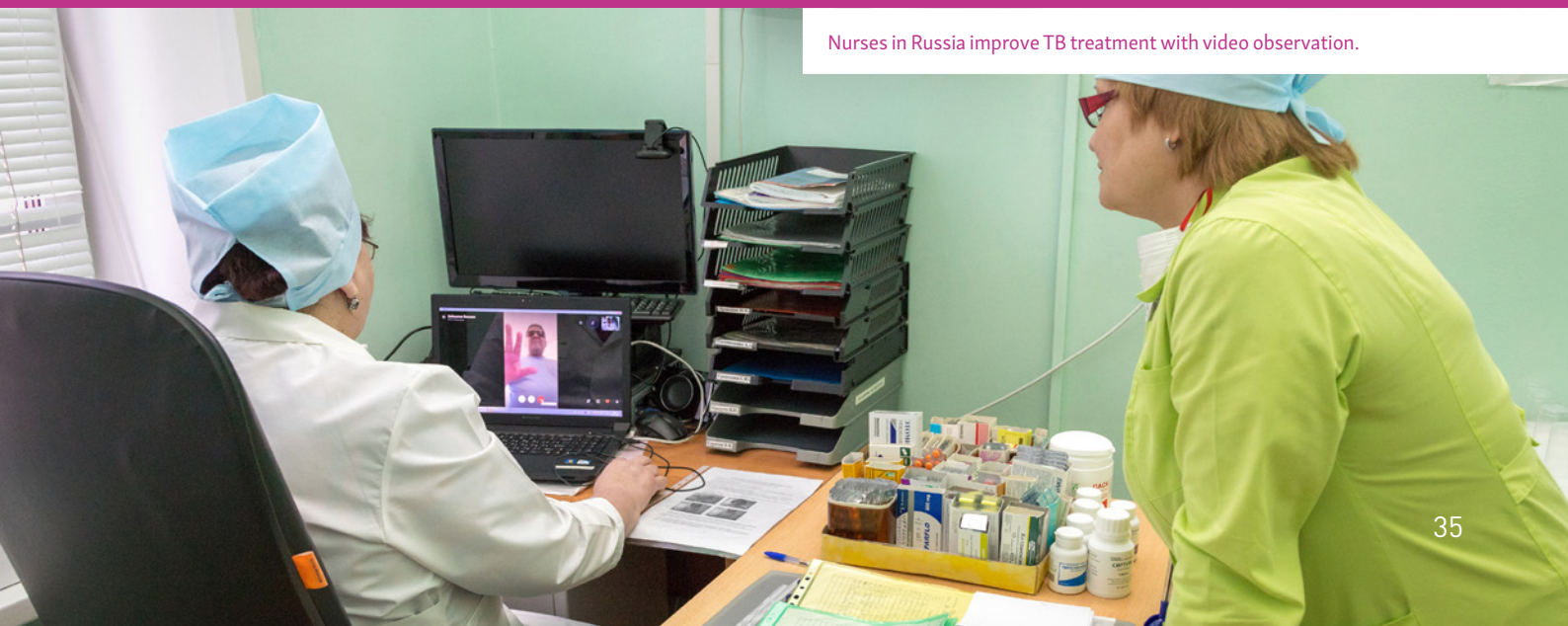
The treatment is highly popular with the patients as they recognise the benefits of not having to travel to receive their treatment – no patients have left the scheme, and other patients who are not receiving video-observed treatment are making efforts so show they are complying with the existing regime in the hope of being able to join the programme.

TB video-observed treatment provides regular therapy and supports high rates of compliance to treatment—100% so far—decreasing the risks of TB relapses and the development of drug-resistant forms of TB. It also enhances infection control measures as patients do not have to travel on public transport every day to receive their treatment in the clinic.

Benefits to patients include decreased time spent getting treatment, being able to stay at home, and cost savings related to transport to and from the clinic for treatment. Those on the project do still visit the clinic, but only once every seven to ten days.

All the patients are positive about this model of care: it is easier for them and they still get the valuable attention of experienced nurses, allowing them to ask questions and share any concerns related to their health. For the patients the routine daily intake of their medication has been transformed into a positive and fruitful collaboration with a nurse, who supports and encourages them on their way towards healing.

Nurses in Russia improve TB treatment with video observation.





PART THREE HARNESSING THE POTENTIAL OF NURSING THE WORLD TO HEALTH

“Whether people know it or not, they come into hospitals for nursing care.”

Terry Fulmer

President of the John A. Hartford Foundation

Nursing is one of the most trusted professions in the world. Yet, when asked, the majority of people cannot adequately describe the roles and responsibilities of nursing. Much of the work of this profession goes unexplored and unpublicised, and yet, nurses continue to be at the forefront of patient care delivery at every step of the way across all of life’s continuum. More than likely, nurses will be a deciding factor in the health outcomes of patients and consumers.

This section aims to clearly articulate how to best harness the potential of nursing and build the workforce for today and tomorrow. We address how stronger nursing leadership might help to improve health; explore good practice in advanced practice and nursing innovation; and look at nursing programme development and the importance of labour market analysis in nursing workforce planning. We also discuss the importance of good care environments and how they are associated with better patient and nurse outcomes; along with the need to transform nursing education to improve practice and promote lifelong learning. The impact of safe staffing on patient outcomes is addressed, and how we can retain nurses through recognition and rewards. Finally, we look four aspects of workforce planning that must be in place to effectively address nursing shortages and ensure nursing workforce sustainability.

Nursing the World to Health through leadership

By Professor Jill White, Professor Emerita of the Faculty of Nursing and Midwifery at the University of Sydney & the Faculty of Health University of Technology & Professor Jane Salvage, Director, ICN Global Nursing Leadership Institute

Health systems worldwide are long overdue for a revolutionary change of focus. For over 100 years, most countries have structured the leadership of health services predominantly from a biomedical perspective, usually led by physicians. This may no longer be appropriate or effective for today and the future. By focusing primarily on disease, we are viewing and managing health through the wrong lens.

Here we ask why it has taken so long to change this lens and discuss the barriers to moving to a non-pathologised system of healthcare and how to overcome them. Part of the solution, we argue, is greater nursing engagement in leadership and policy. We also consider what leadership through a nursing lens looks like, and how stronger nursing leadership might help to improve health of front-line health services in the world.

The current context of health leadership

The extent of male dominance in health leadership is well documented. Women make up 70% of the global health workforce but occupy only 25% of leadership roles. In global health organisations, women make up only 31% of executive directors; 20% of health board chairs; and 31% of ministers of health.⁵⁹ Even within the overwhelming female profession of nursing, men hold a disproportionate number of leadership positions; in Kenya, for example, 76% of nurses are women but men hold 62% of faculty posts. Research commissioned by the Nursing Now campaign highlights not only a 'glass ceiling' for women but a 'glass elevator' for men in nursing,⁶⁰ concluding that the main barriers to women include the dual work/family roles of women; the cost and low availability of child care; the high cost and low availability of education and mentoring; and the gendered nature of society.

The critical contribution of nursing to health

The *Triple Impact* report⁸ provided evidence of the critical contribution of nursing not only to achieving UHC, but also to gender equity and economic development. It recognised the imperative of including nurses in making health and social policy, and stressed the need for more leadership education and opportunities. The adoption of its recommendations and further action by the Nursing Now campaign has already changed the health conversation within nursing and more broadly. That conversation was further developed by the election of Dr Tedros Adhanom Ghebreyesus as WHO Director-General in 2018—a major shift in the global health environment. A public health specialist, the first African leader of WHO, and the first who is not a physician, his leadership of health system reform in Ethiopia gave him first-hand experience of the critical contribution of nursing to community health and well-being. One of his first actions at WHO was to appoint a chief nurse, Elizabeth Iro, to his top team. Subsequent actions included naming 2020 as the Year of the Nurse and Midwife and commissioning the first WHO *State of the World's Nursing report*. Governments are now being urged repeatedly to think more deeply about nursing, and how to tackle the projected global shortfall of nine million nurses by 2030.⁶¹ All this has helped to move nursing up the political and policy agenda.

Current global epidemiological and social changes—particularly NCDs, mental health and issues associated with ageing—will potentially respond well to nursing interventions. At a time of rising global nursing shortages, these challenges create ever greater imbalances between nursing workforce supply and demand: the opportunity for change is ripe. So how could nursing leadership differ from current health leadership, and how do we best prepare nurses to be ready to step up and out?

Leadership through a nursing lens

Nurses traditionally have had difficulty articulating their practice and the difference it makes in terms that are understood outside the profession. Today, however, we have gold-standard evidence on the importance of nurses' educational level and staffing ratios in the provision of cost-effective, safe care,⁶² and some very public statements of the valuing of nurses' compassionate care by WHO, ICN, Nursing Now and many others.

Nurses have also traditionally shied away from associating themselves with the word 'power'. Much needs to be done to help nurses feel comfortable with power and influence, and be competent to participate actively in policy-making and leadership in health beyond professional nursing practice. Policy leadership development programmes like the ICN's Global Nursing Leadership Institute (GNLI) and campaigns like Nursing Now are leading the way.

In this bicentenary year of the birth of Florence Nightingale, it is interesting to consider her as the first leader to articulate health through a nursing lens. Demonstrating authentic leadership, she simultaneously saw the big picture (macro) and the consequences at the human level (micro). Outstanding nurses in leadership roles have shown similar qualities over the last 200 years, but many others struggle to connect the macro and micro. It is hardly surprising as nursing is rooted in our individual practice with our patients and communities; but we ignore the macro at our peril. We experience daily the influence of policy and politics: in the funding of our health systems, the health challenges we tackle, the socioeconomic policies that affect the communities where we live and work, the widening inequalities within and between countries, and the failure to provide UHC.⁶³

The three important components of the essence of leadership through a nursing lens are: (1) a strong and consistent moral compass; (2) continuous education including both personal and interpersonal development (micro level) and organisational and political understanding (macro level); and (3) the ability to hold and move between all three aspects simultaneously.

The three leadership components need to be exercised together, despite sometimes feeling contradictory. The competences required for all three components are necessary for the 'right thing' to happen at micro or macro level: know the territory, know the stakeholders, argue from evidence and authority, understand others' perspectives, and move to consensus and action.

These components are rarely continuously developed and integrated in nursing education and development, and often provided—if at all—in one-off leadership programmes. Currently this type of professional development is only available to a select few nurses, usually at more senior levels. The lack of such opportunities helps to explain nurses' lack of readiness to step forward to lead in health. While personal and interpersonal development might predominate in early career, organisational and political understanding must also be fostered.

There are glimpses of change, some stimulated by the third wave of feminism and the MeToo movement.⁶⁴ For example, the prestigious *Lancet* journal now refuses to be represented on panels on where women are not included;⁶⁵ and gender equity is now part of the conversations of the G7. The discourse around gender equity, so long marginal in nursing despite its centrality to our concerns, is finally centre stage. Nursing leadership and health policy should be everybody's business.⁶⁶ We must push the changes and be ready to lead.



Case Study

Chile – reducing waiting time and improving patient experience

Contributor: Margarita Yercic, Chile

The Sotero del Rio Assistance Complex is a public hospital located in the south eastern area of Santiago, Chile. It has an assigned population of 1.6 million inhabitants who live in the most vulnerable communes in the country.

The complex has an ambulatory health service that sees 600 patients a day, and a hospital with approximately 800 beds and ten operating theatres.

The surgical service, and specifically the surgical wards, have a permanent list of 7,000 patients awaiting resolution of their health problems in different specialties. The average waiting time on the list varies from four weeks to eight years, depending on the type of surgery required.

After analysing the surgical pathway, the nursing leadership proposed the creation of pre-surgical units, led by nurses, which would centralise and optimise each of the stages of the surgical process.

Once the patient is informed that they need surgery, he or she is added to the hospital's surgical waiting list and to the national surgical waiting repository: at the same time, the data also appears in the records of the pre-surgical unit. This enables the nurse in charge to contact the patient to explain all the stages of the preparation process and answer any questions they might have about their surgery. In addition, the nurse coordinates all necessary examinations and consultations, and contacts other specialists and the surgical team to ensure the process is as fast as possible.

Finally, the nurse is actively involved with the team that controls and evaluates the theatre lists.

The pre-surgical units have led to the following benefits:

- A reduction in waiting list of patients in need of a surgery by 40%
- A reduction the preparation time for surgery from eight months to six days in all areas/specialties
- The delivery of comprehensive, continuous nursing care that responds to the individual needs of patients and their families
- Improvements in the health literacy of patients
- Optimisation of the efficient use of operating theatres
- Improvements in the efficiency of clinical support services, including laboratory, imaging and other specialties
- Improved patient satisfaction
- Improved coordination of care throughout the care continuum.

The pre-surgical units project has been recognised by the Chilean Ministry of Health and replicated in several public hospitals in the country, effectively addressing the needs of local populations.

Partnerships and collaboration, in and outside of healthcare: Moving from silos to interconnectedness in nursing leadership

By Bongzi Sibanda, Educator, healthcare consultant & Advanced Nurse Practitioner & Professor Khama Rogo, Lead Health Sector Specialist with the World Bank and Head of the World Bank Group's Health in Africa Initiative

*The Global Strategy on Human Resources for Health: Workforce 2030*⁶¹ highlights Interprofessional Education and Collaborative Practice (IPECP) as essential in addressing healthcare workforce challenges globally. This implies that workforce training should be 'genuinely multi-professional', promoting teamwork, partnership and collaboration amongst disciplines, industries and patients. Nurses, as frontline health leaders, must identify current and future opportunities for collaboration, partnerships and engagement in leadership, scholarship, policy and practice to improve healthcare outcomes for communities.

Literature highlights optimising IPECP as one of the key methods for improving health outcomes globally.^{67, 68} International recommendations that all health professionals should be trained to deliver patient-centred care as members of the interprofessional team over the last decade has resulted in integration of IPECP in academia and clinical practice globally.⁶⁹ But there is still more work to be done. The anticipated updated WHO *Framework of Action on Interprofessional Education and Collaborative Practice*⁷⁰ and the *Sydney Interprofessional Declaration*⁷¹ due for publication in 2020 will be fundamental in advancing the IPECP agenda across the globe.

Economics and trade

The three pillars of UHC (Access-Quality-Cost) call for innovation and radical rethinking in the way the health sector is run.⁷² Human resource is a fundamental input, without which neither access nor quality can be achieved. The nurse is a critical, most dependable member of the health management team. Not only is nursing an essential catalyst in the majority of clinical and nonclinical processes but is by far the most affordable. Nursing skill is needed at primary care level (prevention, immunisation and home-based care and outreaches), at secondary level (in patient, clinics and surgery), and in tertiary care (specialised care and NCDs).

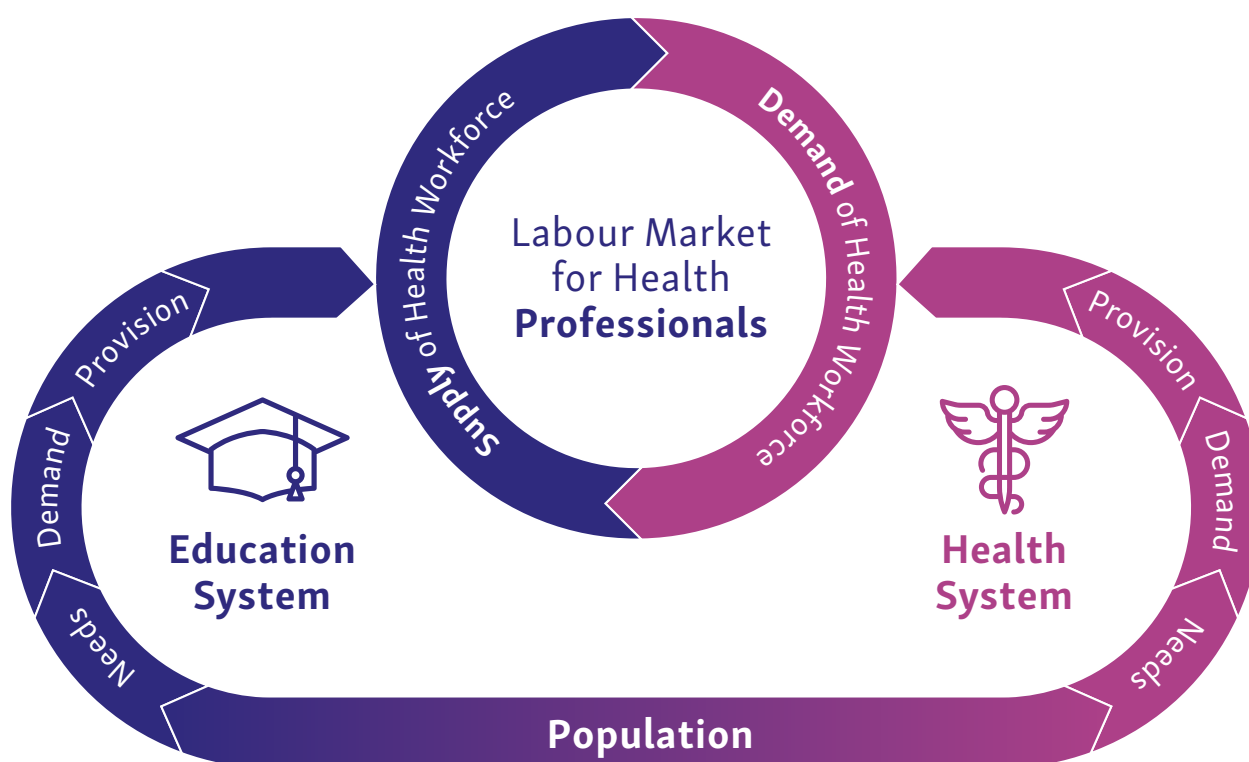
However, nursing is grossly undervalued globally⁸ and its production has never been subjected to labour market analysis. The *State of the World's Nursing Report* is a timely report to guide this dialogue.

Recommendations on nurse-to-population ratio are meaningless in a rapidly changing world. How many nurses are required and with what skill is too context-dependent to be defined by generic global ratios alone. In Africa, this approach has resulted in unquestioning continuation of nurse training curricula based more on colonial history than current national/regional needs;⁷³ introduction of new levels of pre-registration nurse training based on Western models; persistence with same duration of nurse training courses despite innovative learning approaches; limited access to specialised nurse training opportunities to cater for NCDs; lack of professional growth opportunities for general bedside nursing; innovation for frontline nurses often stifled; and uncompetitive remuneration and poor labour relations for a profession that invariably logs odd and longer hours.

More nursing schools were built in Africa in the last three decades, producing more nurses but of diminishing quality and relevance. Many qualify with no prospects for employment and the rate of unemployment of nurses has peaked in Africa.

The private sector is playing an increasing role in both production and employment of nurses in Africa, yet its regulation is still weak. To cater for the high number of high school graduates, more private nursing and medical schools are being set up today than public ones. The cost of private training is higher, making it harder for families to justify the expense if the return of investment is uncertain. This in turn, makes nursing a default choice, rather than the preferred one for most students. The effect of this on quality of nursing, professional commitment and brain drain cannot be overstated.

Figure 1: Intersection between education, labour markets and health sector



Implications for policy and practice /Call to action

Given current nursing workforce issues and developments in nursing education, collaboration and partnership working amongst stakeholders is essential to ensure curricula aligns with country contexts, population needs, service delivery and effective clinical supervision in practice. The need for greater synergy between practice and education while incorporating IPECP principles cannot be over-emphasised.

Nurse labour market studies are a must, to help us understand the needs of both the market and individual professionals and force dialogue between education and the health sector. It can no longer be taken for granted that we need more nurses and must train more to cover the WHO defined ratio.

It is important for nurse leaders to appreciate innovation and entrepreneurship development in academia and practice. This is essential if we are to attract and retain high calibre individuals within the profession and positively disrupt healthcare to improve patient outcomes.

Case Study

South Africa – Collaborating to address sexual violence Clinical Forensic Nursing

Contributor: Volene Joy Werely, South Africa

Clinical Forensic Nurses (CFNs) are first-line healthcare practitioners caring for the victims and perpetrators of sexual assault and domestic abuse. They are the lead voices for advocacy, prevention and education of communities and other health professionals. CFNs are nurses who are registered with the South African Nursing Council and trained in forensic clinical medicine and authorised to examine patients, take forensic evidence for an investigation, provide counselling and testing, and testify in court.

The scope of practice of the CFN indicates the distinct dual roles and responsibilities of a clinical nurse with responsibilities towards the judiciary.

In their clinical role, CFNs assess and examine the client, which includes history-taking, physical examination and psychological and emotional assessment.

The role also includes:

- diagnosis, including taking DNA samples and photo imaging
- provision of treatment, including post exposure prophylactics and others as needed
- referral to other health professionals and resources
- identification victims of human trafficking

In their judicial role, CFNs responsibilities are directed at:

- assisting the court in administering justice
- assessing fitness to give statements
- assessing fitness to stand trial and being cross examined
- ensuring the accuracy of the examinations

In their practice CFNs are faced with ethical and legal dilemmas - the reality that the most ethically defensible option may not be legal, and the legal options may not be the most ethically defensible.

CFNs, who serve both the victim and the perpetrators, can experience conflicting emotional and cognitive processing and ethical and rational decision making. The capacity to view issues from various perspectives, values and contexts is of critical importance to prevent bias and being judgemental.

The strengthening of a seamless inter-professional and inter-sectorial collaborative model among all the relevant stakeholders has been important in ensuring positive clinical outcomes and providing justice to victims.

Safe care environments: essential to patient safety and sustaining a qualified nurse workforce

By Dr Linda H Aiken, Director for the Center for Health Outcomes and Policy Research and the Claire M. Fagin Leadership Professor of Nursing Science and Professor of Sociology, University of Pennsylvania, USA & Dr Matthew McHugh Independence Chair for Nursing Education & Professor of Nursing at the University of Pennsylvania School of Nursing & Associate Director of the Center for Health Outcomes and Policy Research

Evidence suggests that medical errors are a leading cause of death and morbidity globally.⁷⁴ Care environments can be hazardous, both for patients⁷⁵ and for health professionals who are charged with the care and safety of patients.⁷⁶ Healthcare associated infections are a substantial problem and cause suffering and death.⁷⁷ Other harms to patients include the wrong medication or dose, falls and injuries while under care, or preventable skin pressure ulcers or bedsores. Research documents large variations in mortality across hospitals for common illnesses and surgical procedures that are not due to severity of illness of the patients but rather to unsafe care environments. Nurses are central to improving care environments but are under-resourced and lack authority to make the necessary changes in care environments that are required to keep patients safe.

The path-breaking patient safety report, *To Err Is Human*, made a very important contribution to our understanding of the importance of care environments by advocating a move away from blaming individual clinicians for their mistakes and instead defined safety as the responsibility of the hospital to redesign care environments and work places to keep patients safe. Transforming nurses' work environments was explicitly identified as a high priority to improve patient safety.⁷⁸ However, despite the identification of multiple clinical interventions to prevent harm to patients, concerns about patient safety persist. A recent study in US hospitals showed that over the past decade only 21% of hospitals improved care environments by as much as 10%; those that did improve care environments experienced the greatest improvements in patient safety.⁷⁵

What is a good care environment?

A good care environment is one in which evidence-based clinical practices are implemented with a high degree of reliability; is person-centred from the perspectives of patients and their families as well as clinical staff; where staff workloads are commensurate with their responsibilities; and where the organisation is continuously learning to be better.

Good care environments and good work environments are basically the same concept. Research shows that hospitals in which nurses are dissatisfied with their jobs and experience

high burnout also have dissatisfied patients and clinical outcomes are worse.⁷⁵ Organisational features associated with good care and work environments include a flat organisational structure with few management levels between clinical care nurses and executive management; where authority, particularly around clinical care, is decentralised and entrusted to clinicians closest to the patient; and highly functioning interdisciplinary teams are expected and promoted. Evidence-based decision-making is expected for managers as well as clinicians, so that work environments and staffing levels are determined using best practices and evidence that is continuously re-evaluated. Finally, top management looks to internal expertise from nurses and other health professionals for suggested innovations and improvements in patient care rather than going to external sources and instituting top down organisational changes that do not have the full support of nurses and other caregivers.



Good care environments are associated with better patient and nurse outcomes

A robust base of evidence has confirmed that poor patient outcomes (including mortality, readmissions, length of stay, hospital-acquired infection, falls, decubitus ulcers) are much more likely in healthcare settings with poor work environments.⁷⁹ Even quality of end-of-life care is better in hospitals with good work and care environments.⁸⁰ A similarly large body of evidence shows that adverse outcomes for nurses (e.g. burnout, job dissatisfaction, intent to leave) are much more common in poor work environments.⁸¹

Researchers have shown that these relationships between work environments and patient and nurse outcomes are consistent around the world in differently organised, financed and resourced healthcare systems. Studies using similar protocols and measures implemented in over 30 countries demonstrate time and again the same relationship between good work environments and good outcomes.^{82, 83, 84} Such international studies make clear that having a good work environment is feasible regardless of any differences across countries in how healthcare is financed and managed —every country has examples of healthcare settings with good work environments. Work environments are important to nurse retention and good patient outcomes in all healthcare settings.^{85, 86, 87} Evidence derived from longitudinal studies shows that the observed relationships between a good work environment and good outcomes is likely causal because improvements in work environments are closely linked with improvements in outcomes.⁸⁸

Time to act on evidence to improve work environments

The challenge moving forward is translating what is known into action by implementing and testing real-world models of organisational reform to improve work environments. A promising case study of organisational reform is the Magnet hospital, a form of voluntary accreditation for care excellence that has operationalised these organisational features of good work environments. The concept of Magnet hospitals evolved from observations that those hospitals that were successful in attracting and retaining qualified nurses resembled the most highly ranked multinational corporations in having features of good work environments. Decades of research have subsequently shown that Magnet hospitals are not just better places to work from the perspectives of nurses, but they also produce better outcomes for patients.⁸⁹

The evidence is clear—outcomes for patients and for nurses are better in hospitals with good work environments. We now have testable models of organisational reform that offer promise as blueprints for the reform process. The challenge going forward is to test promising organisational reform innovations and champion the models that prove effective so that all nurses are able practice in good work environments and deliver the high quality of care that all patients deserve.



Education: preparing nurses for practice and lifelong learning

By Fadwa A Affara, International Consultant, Regulatory and Education Policy. Former Consultant, Nursing and Health Policy, International Council of Nurses & **Dr Fariba Al Darazi**, Nursing and Health Workforce Development Consultant. Former Regional Adviser for Nursing, Midwifery and Allied Health Personnel, WHO Regional Office for the Eastern Mediterranean

Changes in the epidemiological profile of populations served by nurses, technological advancements, knowledge proliferation and rapid changes in the health systems around the globe necessitate that the nursing education system respond to change in a timely and effective manner to enable graduates to function as safe and competent practitioners in meeting the health needs of their communities.

Role of scope of practice in providing a base for nursing education

The global conversation on human resources for health over the past two decades has focused on how to create a workforce capable of functioning in roles that address health promotion, disease prevention, and provide people-centred, community-based health services and personalised care throughout the lifespan. This examination has been, and continues to be, carried against a backdrop of concerns about the quality and relevance of education and a significant actual and projected shortage of healthcare workers.

Projections indicate an additional 40 million health worker jobs will be generated by 2030,⁹⁰ while at the same time anticipating an 18 million shortage of health workers, including a predicted shortfall of nine million nurses by that date.⁹¹ Thus, the challenge facing nursing in the field of education includes increasing both the quality and quantity of nurses; identifying and continuously updating the requisite body of competencies, skills and behaviours to perform to an agreed level of quality and appropriateness to current and future health contexts; and applying a transformative approach to education across its full spectrum.^{92, 93, 94}

One of the key tools to assist with identifying what you are educating for is having a defined scope of practice. Consequently, defining and maintaining the currency of scopes of practice is recognised as a key regulatory activity, and, whatever approach is used, ICN maintains that ... *articulating and disseminating clear definitions of the roles nurses engage in, and the profession's scope of practice is nursing's responsibility.*⁹⁵

Strategies supporting transformation of nursing education

It is of paramount importance to reform nursing education at the pre-service level to respond to the call for UHC and to meet the SDGs. The reform should focus on nursing education structure, processes and outcome. Using a systematic approach to develop a national education system that broadens the scope of the nursing role and enables graduates to think critically and respond to change in the healthcare system is key to transformation of nursing education.⁹⁶

The Institute of Medicine's report *The Future of Nursing: Leading Change, Advancing Health* key message is that nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.⁹⁷

The ICN/EMRO document, *Reducing the Gap and Improving the Interface between Education and Service: A Framework for Analysis and Solution Generation*,⁹⁸ identified strengthening collaboration between nursing education and nursing services as a key challenge facing nursing. In view of the changing nature of the healthcare scene, it is important to share and disseminate positive examples of how nurses have successfully demonstrated ways of bridging the education–service gap.⁹⁹

Strategies supporting transformation of nursing education

A major undertaking by countries should be a significant increase in nursing education investment at the pre-service, in-service and continuing education levels in order to prepare competent nurses in adequate numbers to meet national priority health needs and continue to maintain competence throughout their work life.

Continuing education contributes to maintaining competence and enhances nurses' professional development. Continuing education opportunities for nurses in developing countries is limited and needs to be increased and adequately funded. Systems for nurses' continuing professional development should be developed and should include training and education on leadership, advanced clinical practice, enhancement of research skills, application of evidence-informed practice and policy-making, and preceptorship and mentoring.

Interprofessional education and collaborative practice: the way forward

In his presentation during the first ICN Regional conference in Abu Dhabi, United Arab Emirates in 2018, Professor John Gilbert, stated that the intent of an interprofessional approach to health and well-being is to provide optimum client care, diminish duplication of services, address the gaps in service delivery, and overcome adverse consequences to patients.¹⁰⁰

WHO's *Framework for Action on Interprofessional Education and Collaborative Practice* emphasised the importance of interprofessional education for the development of a 'collaborative practice-ready' health workforce that is able to provide person-centred collaborative practice and is better prepared to respond to local health needs.¹⁰¹

Creating a culture that fosters interprofessional education and collaborative practice requires a change in health professions' education system and the health system that is developed strategically, sustained and agreed by all the stakeholders. Shaping the nursing profession to respond to the changing and complex environment where nurses provide care, necessitates transformation of nursing education, instilling the values of lifelong learning from early stages of nursing students' journey and making policy changes within the country's health system to promote lifelong learning, interprofessional education and collaborative practice to ensure patient/client safety and quality of care.



Case Study

Kenya - Improving access to safe surgery

Contributors: Mary Mungai, Hosea Kiptoo, Stephen Thuo, Mark Newton, Kenya

Kenya is a low to middle income country with a population of approximately 52 million people. It has a shortage of anaesthetists that is expected to take at least a decade to correct, so nurses are being trained to provide anaesthesia in areas where there are no anaesthetists, especially in rural parts of the country.

Since it started in 2006, the Kenya Registered Nurse Anaesthetist (KRNA) programme has trained more than 200 nurse anaesthetists, working in more than 60% of the counties in Kenya. The training programme provides anaesthetists for rural hospitals in a competency-based, context specific curriculum so that graduates are well prepared for their future scope of practice, which has been implemented within the government system. The obvious need and overwhelming success of this training programme has led to its expansion in other regions in Kenya to address similar deficits in the provision of anaesthesia.

An article in the *Anaesthesia & Analgesia* journal describes a study that compared hospitals where a KRNA was placed (intervention) with a hospital where there was no KRNA (control). None of the hospitals had anaesthetists. The intervention hospitals had a higher concentration of anaesthesia providers and a dramatic increase in the number of surgical operations.

The KRNAs involved said the education had provided them with sufficient training and leadership skills, including the confidence to care for very ill patients. The authors said the increase in surgical work was largely due to greater confidence in caring for surgical patients, specifically in improved obstetric surgical care.

The training of anaesthesia nurses at a high level can have a significant impact on the access to safe surgery in rural areas of Africa. Expanding this training programme to more sites outside of the urban areas of Kenya, and to other countries would increase the number of anaesthesia providers and increase surgical capacity.

This work is vital because it is a proven model that can be rolled out to other areas, demonstrates that well-trained graduates can be trained to become trainers, strengthens rural healthcare systems and could be repeated in other low to middle income countries where the anaesthesia deficits are a problem.

Nurse anaesthesia providers will increase access to surgery and possibly decrease morbidity and mortality due to surgical disease. The five billion people without access to safe surgery will only continue to grow in number unless we aggressively tackle the shortage of skilled anaesthesia providers in both urban and rural areas of low- and middle-income countries.

Trained nurse anaesthetists in Kenya increase access to safe surgery.



Safe staffing: A perennial challenge

By Dr Linda H Aiken, Director for the Center for Health Outcomes and Policy Research and the Claire M. Fagin Leadership Professor of Nursing Science and Professor of Sociology, University of Pennsylvania, USA & **Dr Matthew McHugh**, Independence Chair for Nursing Education & Professor of Nursing at the University of Pennsylvania School of Nursing & Associate Director of the Center for Health Outcomes and Policy Research

Despite extraordinary advances in technology in healthcare, the greatest global resource for health is human capital. Human capital in nursing means having an adequate number of nurses with the right mix of education, skill and experience to meet the ever-growing demands of complex patient care in all settings. In 2018, ICN¹⁰² formally recognised this in their position statement calling for evidence-based nurse staffing. One of the fundamental elements of safe staffing is simply having a sufficient number of nurses relative to patient care needs.

Developing the evidence base for safe staffing

Evidence suggests a clear picture that safe nurse staffing levels are necessary to ensuring high quality and safe patient care. The relationship between nurse staffing and outcomes has been found for virtually all major healthcare quality and safety outcomes including mortality, death from complications, healthcare-acquired infections, readmissions, and length of stay.^{62,103} The impact on outcomes has been found around the world regardless of healthcare system structure, governance or financing. For example, a seminal study from the US found that the odds of patient mortality increased by 7% for each additional patient per nurse.¹⁰⁴ A study of nine European countries and a separate study in South Korea found this identical effect.⁶² The benefits of good staffing are also not unique to hospital settings; they have been identified in different areas of hospitals as well as in other settings such as nursing homes.

Education as an element of staffing

The importance of investment in staffing is not limited to the number of nurses; the composition of nurses is critical as well. Each 10% increase in the proportion of nurses at the hospital bedside is associated with a 7% decline in mortality.⁶² Many studies have shown that university education of nurses has been linked with better patient outcomes. Furthermore, having both better staffing levels overall and a higher percentage of BSN nurses translates into better outcomes than if only staffing or education alone were to be improved.¹⁰⁵ The European Parliament recently modernised its policy on nurse qualification for mobility in the EU formally recognising for the first time a university pathway for professional nurses. While not requiring a university qualification

for nurses across the EU, the new provision incentivises member countries to offer university education for nurses in every member country, and the net result has been the development of baccalaureate nursing programmes in countries like Germany where nursing education has historically been a vocational pathway.

The path ahead for staffing policy

The 2018 ICN nurse staffing policy statement¹⁰² is a call to action to implement the substantial evidence base to improve staffing levels. Although nurse staffing policies have been implemented and have demonstrated benefit for patients, there is a paucity of action initiatives to implement improved staffing levels. One constraint may be the narrow range of policies up for discussion around staffing, for example, most staffing ratio policies are structured to apply to all hospitals. There are, however, alternative policy designs that could be tried, such as exempting hospitals that already have acceptable staffing and outcomes while applying a nurse staffing mandate to those hospitals that have the worst staffing levels. There is evidence suggesting that it is these hospitals that need remediation and where the outcome benefits of mandated ratios are greatest.¹⁰⁶ A staffing mandate might also be linked with nursing workforce development programmes and targeted incentives for working in understaffed hospitals to ensure that there is an adequate labour supply to meet the policy objectives. In its policy statement, ICN recommends that national nursing organisations work with government to promote safe staffing policy implementation and research to evaluate these policies. Countries should consider taking an approach similar to that taken by Queensland, Australia, that incorporates empirical policy evaluation so that a clear understanding can be developed regarding the benefits and costs of different designs for the global community.

Conclusion

The evidence is clear—having enough nurses preferably with at least Bachelor's education and having the majority of care providers in hospitals be professional nurses matters for patient outcomes. Going forward, the challenge is to make the necessary investments in human capital for health and to implement and evaluate policy interventions to ensure that the benefits of the nursing workforce reach everyone.

Safe staffing – improving health outcomes and the working environment. An exemplar model in Queensland, Australia

Contributor: Office of the Chief Nursing and Midwifery Officer, Queensland

Queensland Health implemented a policy establishing minimum nurse-to-patient ratios in 27 public hospitals on 1 July 2016. The research conducted on this policy initiative found that increased nurse staffing was associated with improvements in outcomes for both patients and nurses in adult medical and surgical wards. The staff survey showed positive changes as a result of nurse-to-patient ratio policy, including: improved “time to complete necessary care” and “time to detect patient changes”; better job satisfaction and less burnout; less likely to give hospital a failing safety or infection prevention grade; and more likely to recommend hospital to family and friends. Data analysis estimates that the legislation resulted in 145 fewer deaths, 255 fewer readmissions, and 29,222 fewer hospital days.

While the outcomes of legislating minimum nurse-to-patient ratio are significant, in Queensland there are existing frameworks for determining appropriate nurse staffing levels based on patient acuity and clinical setting. Within Queensland Health, there is an existing industrially mandated workforce management tool, the Business Planning Framework: A tool for nursing and midwifery workload management, which was first introduced in 2001.



Harnessing the potential of technology to improve health outcomes

Adapted from a piece written by Professor Petrie F. Roodbol, Professor of Nursing Science, University Medical Centre & Hanze University of Applied Sciences Groningen, Netherlands

Technologies are increasingly showing potential to overcome existing problems and challenges in the health care sector. Digital health boosts the performance of health systems to be more adaptive, flexible and responsive to patients, staff and the community. It can also support a patient centric approach to health care that is 'wellness based'. Digital health is increasingly a fundamental component of a high performing health system.

Today, technology is being specially developed for nurses to relieve their daily tasks, such as videoing to observe patients, intelligent toilets for health monitoring, vein finding tools to assist IV cannulation, smart stethoscopes to capture and analyse heart sounds, 3D printing to develop new medical equipment such as casts, and electronic health records for the recording of patient information.

However while technology has the potential to improve care, it also introduces unintended side effects, opportunities for failures and other possible adverse events. As such it is not without risks. There are thousands of different types of medical devices used by health professionals around the world and this means that technology related problems are inevitable. Common examples of this include: the increasing complexity of devices increasing nursing

workload; the poor interface between devices leading to inability to access of information; reduced patient engagement and contact; and other patient safety and privacy issues.

The most common causes for the potential of technology not to be realized include: 1. Poor design that has not taken into consideration the human factor 2. Poor interface with the patient care environment 3. Inadequate planning in the introduction of new technology into practice, and 4. inadequate support and maintenance of technologies.¹⁰⁷ The simple takeaway message from this is the lack of engagement and involvement with frontline staff.

Many Digital health applications are not specially made for nurses and are not nurse-friendly. Medical dominance in the development of electronic patient records, for example, means that nurses must fill in their observations and findings in several different places, requiring a lot of time and advanced computer skills. The available time for direct care for patients, which is the power and value of nurses, decreases.

While technology offers many advancements to healthcare provision, the benefits are unlikely to be fully realized without the active involvement of frontline health workers. To this end, the WHO¹⁰⁸ recommends that:



1 Setting and evaluating policy related to technologies

2 Ensure that the technologies they use meet international standards

3 Ensure decisions are made with their own and critical stakeholders inputs

4 Be involved in their organisation's policies and processes related adverse events related to technology

- 1 Nurses providing direct patient care should be involved in setting and evaluating institutional, organisational, and public policy related to technologies.
- 2 Nurses providing direct patient care can ensure that the technologies they use meet international quality and safety standards and technical specifications needed to perform in the clinical environment in which they are used.
- 3 Nurses providing direct patient care can ensure that institutional decisions are made with their input and the input of other critical stakeholders.
- 4 Nurses providing direct patient care should be involved in their organisation's policies and processes related to maintenance, training, monitoring, and reporting adverse events related to technology.

As technology continues to redefine the way health care is delivered and the way nurses practice, nurses must be included and involved in the design, development, implementation, application and research of new technologies.

Case Study

USA – Using drones to reach the under-served

Contributors: Teresa Tyson and Paula Hill Collins, USA

The Health Wagon is a nurse managed clinic established in 1980, whose mission is to provide care to those uninsured or underinsured in the rural Appalachian Mountain region of Virginia. The Health Wagon is the oldest free mobile clinic in the nation, whose mission is to provide quality, compassionate health care to the medically underserved. The clinics serve some of the USA's poorest individuals and continue to make life saving differences daily, turning back the tide of ever-worsening health care disparities with grassroots organisation, galvanizing resources and using technology never been seen before in Central Appalachia.

The mountains and the rough terrain of this region make health care a challenge; so too does the poverty. The Health Wagon works to address barriers by meeting its patients where they live. More often than not, the team will drive their mobile clinics up to 150 miles daily to remote roadsides in order to care for patients who have limited or no means of transportation. The Nurse Practitioners treat up to 100 patients a day providing evaluation, management and treatment using essential physical examination skills and detailed histories. Most patients who come for the first visit have not seen a primary care provider in years.

Many have uncontrolled blood pressures and blood sugars, as well as mental health issues, due to chronic diseases.

In 2015, the Health Wagon was an instrumental partner in the first Federal Aviation Administration-approved drone delivery in the US in partnership with Flirtey, NASA Langley and others. Medications are initially flown to the Lonesome Pine Airport in Wise, Virginia by a remotely operated NASA fixed-winged aircraft and then a six-rotor drone is used to deliver pharmaceuticals to patients. The use of drones for medication delivery provides a great opportunity to assist in getting medications to our patients. The territory the Health Wagon serves consists of winding roads with long distances to the nearest pharmacy or hospital and hours from the main stationary supply clinic, where necessary supplies are kept. This historic drone is scheduled to be inducted into the Smithsonian's National Air and Space Museum.

The Health Wagon remains at the forefront of healthcare innovation serving a significantly underserved area and continues to be successful because of the commitment, efforts and passion of two Advanced Practice Nurses: Dr. Teresa Tyson and Dr. Paula Hill Collins.

Recognition and reward: how the health system can prevent nurses from leaving the profession

By Dr Pilar Espinoza, San Sebastian University, Chile & Dr Marina Peduzzi, Sao Paulo University, Brazil

In many countries, nurses and midwives represent more than 50% of health workers, but a shortage of around nine million of these professionals by 2030 has been predicted, impacting patient safety and the quality of care.⁹⁴ Given the chronic nature of nursing shortages, there is a need to analyse the nursing workforce using new approaches and avoiding purely numerical considerations. We need to look closely at why nurses are leaving the profession, and what can be done to retain them in order to address these chronic shortages.

There are numerous reasons for nurses to consider leaving the profession. Common global factors include: trouble identifying with the stereotypes of the profession (caregiver, willingness to serve, altruistic, and medical assistant); the intense demands of the profession, both physical, emotional and psychological; lack of recognition of the profession;¹⁰⁹ poor working conditions related to both heavy workloads and culture; moral injury or the inability of nurses to act by their moral values, obligations and professional responsibilities due to internal and external constraints associated with a broken health system;¹¹⁰ and conflicting demands between work and family.

Both the literature and the experience of professionals in hospitals and other specialised services show that hierarchical relationships forcing nurses to be subordinate, without spaces for questioning, centralised and non-participative managerial and clinical decision-making, and restrictions on professional autonomy characterise a fragile and unsatisfactory practice environment, hampering personal engagement and staff retention.

However, there is good news. There are simple and effective strategies to overcome these issues and reduce the rate of nursing turnover. Studies carried out in different parts of the world showed that improving job satisfaction in nursing requires: effective identification with professional team members; trustful and supportive interpersonal relationships; high cohesion of nursing team members; effective communication; role clarity; shared objectives; and decision making especially in physician-nurse collaboration.^{111, 112} Early career preparation, support and provision of opportunities, flexibility in shift systems, the right endowment and having the time to complete their patient care activities also increase job satisfaction and decrease the desire to change or leave their role.

It is important to highlight that even within the nursing discipline, there may be differences in nursing needs regarding job satisfaction. For example, advanced practice nurses need to make sense of the work to be fulfilled; critical care nurses emphasise the need for shift flexibility and appropriate professional endowment. Different conditions for job satisfaction also exist between nurses from different generations, especially in their perception of stress, burnout and intention to quit their job.^{113, 114}



Rewards

A relevant element of the organisation's human resources strategy that can enhance nursing job satisfaction and promote job permanence has to do with the rewards—monetary and non-monetary—given to nursing professionals in response to their professional efforts.¹¹⁵

Monetary rewards include payments for specific competence or skills, extraordinary performance, and bonuses. Non-monetary rewards include new responsibilities, expressions of appreciation and recognition from a supervisor, work justice, higher status, timely feedback, job stability and support from leaders, among others.¹¹⁶

International literature positively relates non-monetary rewards with greater commitment and job satisfaction, as well as decreasing turnover and intention to leave work. Initiatives that contain experiences of recognition positively impact job satisfaction; and those with a more holistic and comprehensive component—such as rewards which facilitate professional autonomy, promote participation in decision-making, show respect and permanent support, facilitate professional development, or provide flexibility to make home and work compatible—could represent an innovative strategy when handling the organisation's rewards system.

There are proven programmes such as the Magnet recognition that promote high levels of job satisfaction, autonomy and professional respect for nurses within the health organisation.¹¹⁷ The DAISY Award is an international programme that recognises and celebrates the qualities of professional nursing practice that achieve a significant difference in the experience of patients and their families. The award promotes positive and healthy work environments, and more significant commitment to the discipline and the organisation.¹¹⁸

One of the challenges to address the shortage of nurses and nursing professionals resides in the need to promote a broader understanding of nursing work in order to increased visibility and recognition of the profession. This is only possible through the involvement of all social actors responsible for ensuring access and quality of health services—managers of health systems and organisations, service providers, health professionals, patients, families, and the community.

This background shows the need to build new possibilities for nursing practices. In the managerial and political dimension, we need to allow greater flexibility in contracts and work schedules and better working conditions. In the healthcare dimension, we need to enable nurses to work more closely with their patients, families and the community. The new framework should guide nurses' actions in an articulated manner towards health promotion, health risks prevention and health recovery. We should also enable nurses opportunities to be involved in building health systems focused on the health of people and the population. Promoting the integration of interprofessional actions and services may help overcome the prevailing deep fragmentation that hampers the quality of healthcare.



Building the workforce capacity

By Professor James Buchan, School of Nursing Midwifery and Health, University of Technology, Sydney, Australia
& **Professor Gilles Dussault**, IHMT, Universidade Novo de Lisboa, Portugal

The nursing profession is the largest single health profession in the world. Workforce planning is critical to ensure alignment of nursing supply with demand required by the health system to create a sustainable nursing workforce, but the limitations of workforce planning are often downplayed or ignored.

Nursing shortages cannot be solved in isolation from broader health system issues. Workforce planning can assist in making better use of the available nurses and can assess how many will be needed in the future. If properly resourced, and effectively directed, strategic workforce planning can be a powerful tool for improving availability, accessibility and quality of the workforce.¹¹⁹ This can take the form of anticipating future needs (workforce, competences, skills-mix, numbers) and analysing the implications of different plausible scenarios. Rational planning, based on valid and reliable data and information, is key to making informed decisions about the future nursing workforce. Effective planning is also needed to adapt and optimise the utilisation of the existing nursing workforce. In short, workforce planning is a means to the end of improving health services and population health by improving the availability of suitably skilled nurses now and in the future.

Beyond planning

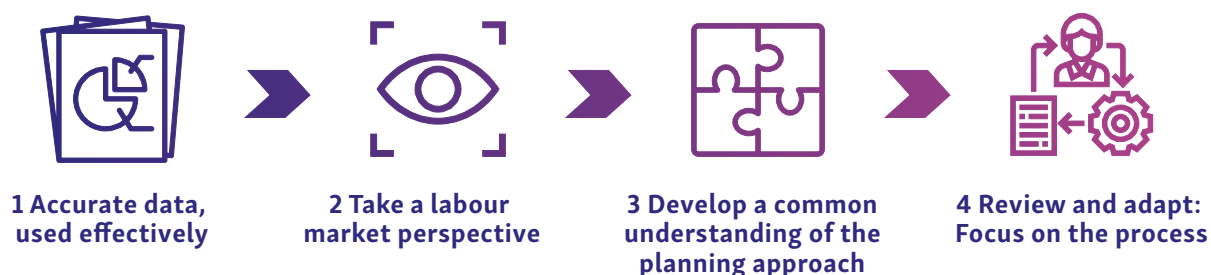
Can effective workforce planning 'stop' nursing shortages? Nursing shortages are often a symptom of deeper health system or societal ailments. Nursing, in many countries and health systems, continues to be undervalued as 'women's work', and nurses are given only limited access to resources to make them effective in their jobs and careers. An important objective is to improve day-to-day matching of nurse staffing with workload. As ICN highlights, *"Having insufficient or inappropriate nursing staff to meet patient needs also results in unsustainable workloads and has a negative impact on the health and wellbeing of staff.....Workforce planning systems that align patients' and communities' needs with nursing supply should be in place"*.¹⁰²

There must also be clarity of roles and a better balance of registered nurses, physicians, other health professionals, and support workers. The evidence base on nursing skill-mix is growing rapidly, and much of it stresses the positive effect of using a significant ratio of experienced graduate nurses, as well as nurse practitioners and other nurses in advanced roles.¹²¹

Effective workforce planning can mitigate some of the worst aspects of shortages, not forgetting that shortages are also a symptom of broader health system, funding and societal problems. Until this is understood, and we make better use of the available evidence to plan effectively, then the risk is that we repeat a cycle of inadequate, and often inappropriate, policy responses to shortages.



Figure 2: Four conditions for successful workforce planning



1 No country can aspire to having effective planning without a Human Resources Information System (HRIS) that enables policies to be shaped and tested and supports planners, educators and management to plan, recruit, pay, deploy, train and manage the nursing workforce. Data should normally include demographic, educational and employment indicators.¹²⁰ The starting point should be an audit of the current nursing workforce and related information.

2 Data is necessary but there is also a need to understand that the workforce is dynamic. At any time, there are nurses joining and leaving the workforce, moving between jobs, sectors, regions and countries. Capturing these labour market moves is essential to workforce planning. Examples of policies to combat nursing shortages are:¹¹⁹ scaling up the capacity of production of education institutions, linked to aligning curriculum with population health priorities; Implementing strategies to attract, recruit and retain qualified candidates to the nursing profession; broadening and increasing the scope of practice of nurses to make the profession more attractive and enhance effectiveness; retraining and upskilling, existing staff; and respecting the WHO Code on international recruitment in considering the options of international recruitment and bilateral flows of nurses .

3 The purpose of a national workforce strategic planning process should be to provide a commonly agreed, evidence-informed statement of intent and purpose about what will be done to manage the nursing workforce. This is not just a technical exercise, it is a process in securing engagement of stakeholders, identifying priorities and current constraints, profiling the current and anticipated future nurse workforce across short/medium/long timelines, and shaping policies. A recommended starting point is to convene a national stakeholder meeting.¹⁰² This would be an initial multistakeholder roundtable which would focus on identifying the key nursing workforce challenges and what can be done, by whom, to achieve improvements. Representatives of civil society, ministries, state agencies, health professions, regulators, employers, education sector, and NGOs should be involved to ensure a comprehensive focus.

4 To ensure that the development of the plan is sustainable and not regarded as a ‘one off’, it is necessary to establish a regular cycle of review and refinement of its content and implementation. The critical point here is that a sustainable approach requires an adaptive planning process, not a fixed point in time ‘plan’.

Case Study

Eswatini – Strengthening the capacity for Universal Health Coverage

Contributors: Colile P Dlamini, Bonsile Nsibandze, Tengetile R Mathunjwa-Dlamini, Elizabeth Macera, Eileen Stuart-Shor, Cynthia H Dlamini, Eswatini (formerly Swaziland)

The Kingdom of Eswatini is a small, landlocked country in southern Africa with approximately 1.3 million people, 80% of whom live in rural areas. The country is short of health workers and suffers from a high burden of communicable, maternal, perinatal, and non-communicable diseases and nutritional conditions. Despite impressive gains in reducing the incidence of HIV/AIDS since 2011, Eswatini continues to bear the world's highest burden of HIV/AIDS, with 26% of the population currently living with HIV infection. Eswatini also ranks third among African countries for deaths due to NCDs.

With the majority of the population living in rural areas and limited human resources for health, strengthening primary health care became an imperative if the goal of UHC is to be realised.

Achieving UHC in Eswatini requires new ways of thinking and new ways of delivering care, focused on communities of need. There is abundant evidence that advanced practice nurses provide care that is both clinically and cost effective. Faced with a high burden of disease and the problems of meeting the needs of underserved sections of the population, the University of Eswatini established a graduate level nurse practitioner programme that focuses on the family.

The three-year part-time Family Nurse Practitioner (FNP) programme creates nurses who can provide better and quicker access to care, reduce referrals and complications resulting from delayed care, and provide cultural and linguistically appropriate services, especially in the community settings. FNPs also bridge the gap between registered nurses and physicians and liaise with other healthcare practitioners to provide comprehensive primary health care.

The students are registered nurses from all parts of Eswatini, many with extensive experience in nursing. The rigorous curriculum requires them to travel long distances to attend their practical attachments. The course is arduous, but the students persevere because they understand their role and anticipate the difference they will bring to the Eswatini healthcare system by reaching the underserved population with quality and safe primary care services.

To date, three cohorts of students have enrolled in the FNP programme and the first graduates are anticipated in October 2020.

The FNP programme is a solution to some of the numerous health system challenges that abound in Eswatini. This cadre of advanced practice nurses are positioned to provide access to quality, client-centred, affordable, culturally relevant and comprehensive healthcare to diverse and underserved populations, and will have a major impact on our ability to achieve UHC.



THE LEGACY OF THE YEAR OF THE NURSE

By Howard Catton, ICN CEO

International Nurses Day 2020 will be unlike any IND before. This year we are not just celebrating a day, or a week. In 2020, the whole year is ours! What will be the legacy of 2020 The International Year of the Nurse and the Midwife? How can we grasp this unique opportunity to jump-start a new way of looking at nursing so that, in the future, nurses will be seen for the unique contribution they bring to the wellbeing of all the peoples of the world?

There is no doubt that it is fantastic to have the recognition of nursing at a global level and we should celebrate the appreciation of what nursing does, how far we've come and how much we've achieved, but it is more important than that! We have to take this year as an opportunity to make a step change in how nursing is regarded and bring about the hard investment in nursing that we want to see. We need this recognition to result in the promotion of nursing in leadership positions and change the image of nursing as well. 2020 is not only a time to celebrate but also to bring about lasting change. And, so, we need to think about the building blocks that must be put in place for that to happen so that when the warm words have disappeared and the spotlight of global attention has moved on to something else, we are left with the infrastructure to deliver.

What changes we want to see?

First, we must address the nursing shortage as several authors of this report have referenced. That means looking at both recruiting more nurses into the profession and retaining the nurses that we already have. How do we do this? We improve working conditions, salaries, respect, value, rewards. And all of that requires investment. As Dr Tedros said in his speech to the ICN Congress in 2019, *"We simply cannot achieve universal health coverage and the health-related targets in the Sustainable Development Goals unless we empower and equip nurses and midwives, and harness their power."*¹²² When we talk about improving access to healthcare, what that really means is being able to see a healthcare professional. There is no health without a health workforce!¹²³

Second, we must unleash the potential of advanced practice nurses and extend nursing roles as these are key to dealing with the global health agenda, new models of care, chronic diseases, etc. We do this by getting rid of regulatory barriers to support advanced practice; presenting the evidence and using it to build new services and influence policy; and, really importantly, getting more nurses in senior leadership positions to be the voice to lead: bringing nursing expertise, advice and evidence about what nursing can contribute to inform, develop and implement policy.

Third, when we address nursing, we address gender and inequalities. This goes hand in hand with addressing the image of our profession. It is time to break the myths surrounding nursing, just as the idea of what it means to be a woman is breaking away from the old traditional stereotypes. In order to address inequality in the world, we must address the inequalities in our profession and raise the profile of nursing.



How can we make these changes?

In order to deliver these changes, we need stronger, more effective national nursing associations. NNAs provide the bedrock of nursing solidarity and nursing cohesion. We need to bring all the members of the nursing family together to promote and advance nursing in pursuit of improved and better patient health. As the most trusted and the largest health profession, nursing associations can be an immensely powerful force for change and improvement.

NNAs look at the reality of practice, and pull together what works, what doesn't work, what matters to patients and people and what changes health outcomes. This is rich, powerful evidence which associations can use as the golden thread that leads to policy making. The nursing association is a vehicle like no other, bringing the experience of the frontlines through to policy making tables, driven by the enormous strength and power of the credibility of the wide range of nurses from across different groups. NNAs are a force—not only for improvement for nursing and for healthcare—but a force for social change, for rights, for justice, for the individual, families and communities.

Our agenda goes beyond health. In this day and age, we cannot ignore issues such as human rights, justice and equality; and nurses have the right—the duty—to speak on behalf of those issues and on behalf of our patients. Nurses have very clear principles and values about people-centredness, equality, and upholding rights and that is what gives us the justification and the credibility to engage and act as advocates for those principles.

Reaching beyond our borders

National nursing associations are vital to drive change, but the challenges that countries are facing are not issues that they deal with in isolation. They are influenced and affected by what is happening in their neighbouring countries—issues such as migration, mobility and climate change. These are the big factors that nations are facing, that their neighbours are facing; and so, to address those problems, requires collaboration across and between countries.

The very international nature of healthcare and the big global forces that are shaping the world—these are reasons why we need international bodies collaborating and working together. And this is why we need to have an organisation like ICN. In fact, if Ethel Gordon Fenwick and her colleagues hadn't created ICN 120 years ago, we would have to create it now!

We need to do more to collaborate with our neighbours and within our regions. Every year, ICN brings a delegation of nurses to the World Health Assembly to make interventions on topics of importance to the profession, but nursing needs to be as present, as effective, as vocal, and as visible at the regional WHO decision-making bodies. We also need to work more closely with nurses who are in regulation, education, government, hospitals and clinics. Associations are ideally placed to develop these relationship regionally: to reach out and develop new partnerships, and bring all parts of the profession together. We need to make sure all the profession is talking together, but we cannot just talk to ourselves. As a profession, we must reach out to other professional bodies; these might be political groups, technology companies, people in sports, media or industry. Just think of some of the really effective social movements that we've seen from other groups. Because of the complexity and interrelatedness of our world, to get things done, to get the visibility we need, we must reach beyond our borders – our national borders and our professional borders.

The power of nursing

Don't underestimate the power that we have: the power in numbers, in associations, in the trust and the credibility of the extraordinary nature of the work we do. Yes, we've done so much, but there is more that we can do! The power and the potential for what we can do not just for ourselves but for the sake of the health of the planet is limitless! But we have to have organisation and cohesion. We already have the structures and we should build on that.

Just look at the phenomenal work that the Nursing Now campaign has achieved in so short a time! Launched in 2018, Nursing Now groups have been formed in more than 100 countries.

Our vision is to bring together the power and the potential of the newly formed Nursing Now groups with the strength and influence of the established National Nursing Associations to create a new force for change.

2020 is a start not the end; it is the opportunity to begin a new chapter but it is not our destination....we are an indispensable and unstoppable force and together we can, we will, *nurse the world to health!*



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