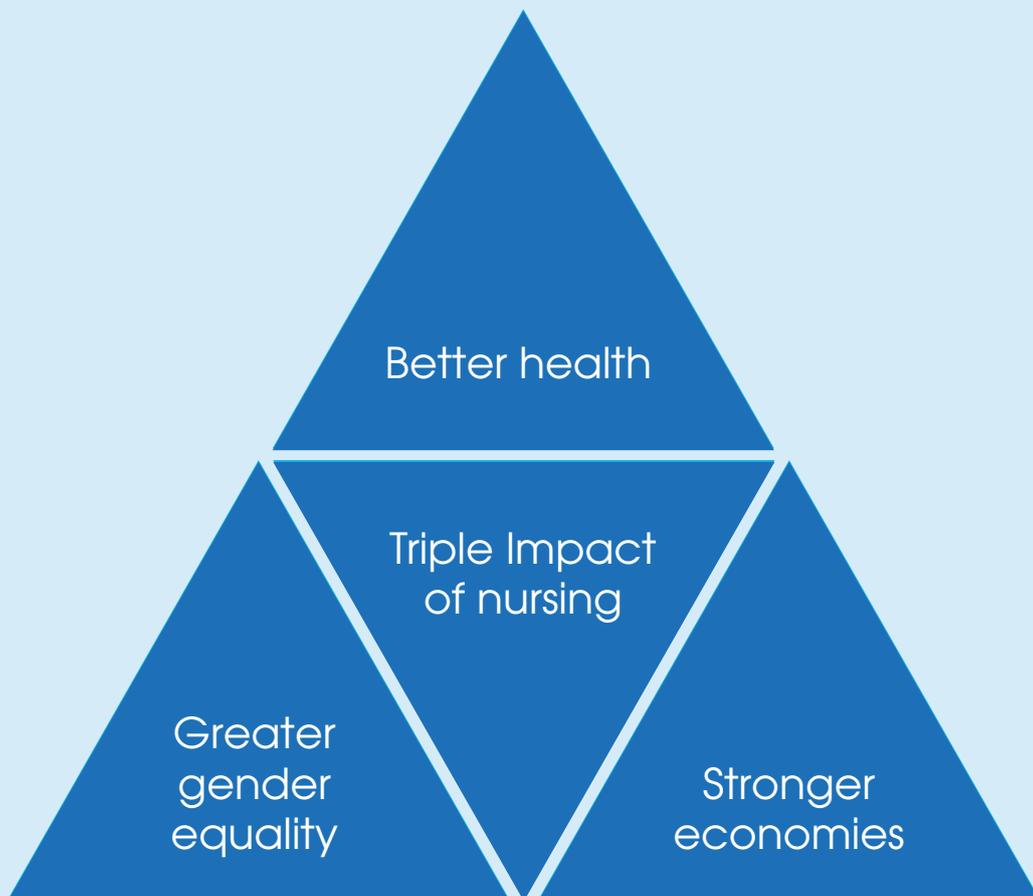




A Report by the All-Party Parliamentary Group on Global Health

Triple Impact

How developing nursing will improve health, promote gender equality and support economic growth.



Acronyms used

APPG	All-Party Parliamentary Group on Global Health
DFID	Department for International Development
EU	European Union
HEE	Health Education England
ICCHNR	International Collaboration for Community Health Nursing Research
ICN	International Council of Nurses
NGO	Non-governmental organisation
NHS	National Health Service
NMC	Nursing and Midwifery Council
NP	Nurse practitioner
QNI	Queen's Nursing Institute
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RN	Registered nurse
SDGs	Sustainable Development Goals
THET	Tropical Health and Education Trust
UHC	Universal health coverage
VSO	Voluntary Service Overseas
WHO	World Health Organization
ZUNO	Zambia Union of Nurses Organisation

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All-Party Parliamentary Group on Global Health: Triple Impact – how developing nursing will improve health, promote gender equality and support economic growth; London, 17 October 2016; <http://www.appg.globalhealth.org.uk/>

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Preface

In September 2015 the nations of the world signed up to the ambitious goal of ensuring that everyone in the world should have access to health care – universal health coverage – and that *nobody should be left behind*.

This report makes the very simple point that universal health coverage cannot possibly be achieved without strengthening nursing globally. This is partly about increasing the number of nurses, but also crucially about making sure their contribution is properly understood and enabling them to work to their full potential.

The report goes on to argue that strengthening nursing will have the *triple impact* of improving health, promoting gender equality and supporting economic growth.

Much of what is said here will be familiar to nursing leaders, but they alone cannot bring about the changes that are needed. Politicians, non-nursing health leaders and others must work with them to create radical changes in how nurses are perceived and in what they are permitted and enabled to do.

We urge the UK government to work with the Commonwealth, Europe, the World Health Organization and others to take a leading role in raising awareness of the opportunities and potential of nursing, creating political commitment, and establishing a process for supporting the development of nursing globally.

Change will take years but a start can be made. The UK government – with its proud record of international cooperation, development and support for gender equality – has the opportunity to set the direction and lead.

Nursing and midwifery

This report does not cover the separate profession of midwifery except in as much as many nurses worldwide are also midwives. We recognise, however, the central importance of midwifery to achieving universal health coverage and the need for it too to be strengthened. The full potential of midwifery needs to be understood more widely and midwives also need to be able to work to the full extent of their knowledge and skills.

Acknowledgements

We are very grateful to the many people who met us, responded to our call for evidence and offered advice. There is a full list of acknowledgements at the end. We particularly note here our gratitude to those who attended our witness sessions; the Royal College of Nursing, which assisted us with the whole review, particularly Susan Williams, Senior International Adviser; the International Council of Nurses, which provided advice and support; and the Commonwealth Nurses and Midwives Federation, which helped arrange many interviews.

Above all we are indebted to Johanna Riha, who led and undertook most of the research for the report; Emily McMullen, who continued the work; and Hanadi Katerji and Tajel Mehta, who supported them both. We are particularly grateful to Jane Salvage, who has been our invaluable adviser and guide on nursing throughout the whole review and report writing process.

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Key points and recommendations

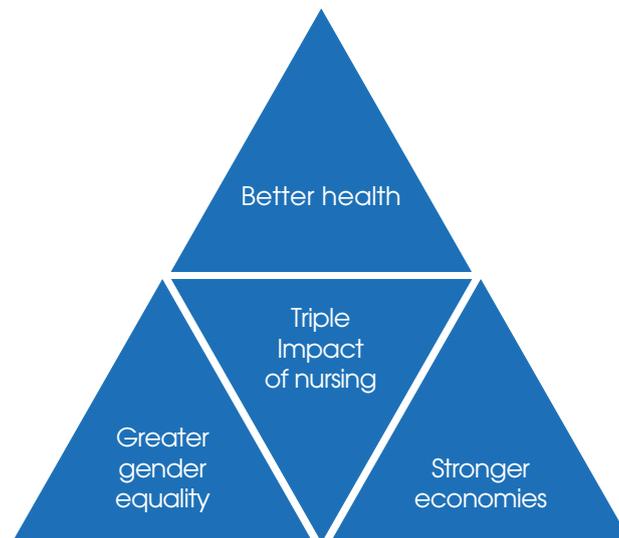
Triple impact

Nurses are by far the largest part of the professional health workforce and achieving universal health coverage globally will depend on them being able to use their knowledge and skills to the full. Yet they are too often undervalued and their contribution underestimated.

There is enormous innovation and creativity in nursing – with, for example, nurse-owned clinics in Africa, village ‘wise women’ in Central Asia and nurse specialists in the UK – and the potential for much more. These sorts of development are needed if countries throughout the world are to ensure that all their citizens have access to health care.

Increasing the number of nurses, and developing nursing so that nurses can achieve their potential, will also have the wider *triple impact* of improving health, promoting gender equality and supporting economic growth.

Figure 1 The triple impact of nursing: better health, greater gender equality and stronger economies



The unique contribution of nurses

Nurses undertake different roles in different circumstances, but they all share in the combination of knowledge, practical skills and values that makes them particularly well placed to meet the needs of the future as well as those of today. While other professions share some or all of these features, the nursing contribution is unique because of its scale and the range of roles nurses play.

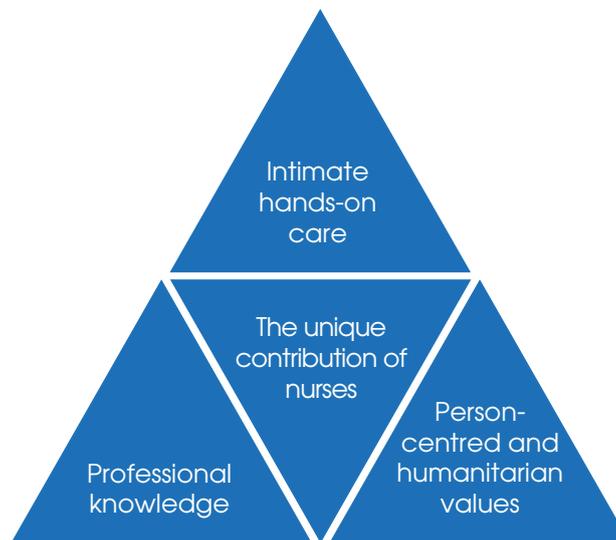
Nurses have many roles: they can provide and manage personal care and treatment, work with families and communities, and play a central part in public health and controlling disease and infection. Whatever their particular role, they can be guided throughout by their professional education and knowledge and their person-centred and humanitarian values.

Nurses are often the first and sometimes the only health professional that people see and the quality of their initial assessment, care and treatment is vital. They are also part of their local community – sharing its culture, strengths and vulnerabilities – and can shape and deliver effective interventions to meet the needs of patients, families and communities.

Nurses around the world, however, have shared concerns about staffing problems, poor facilities and inadequate education, training and support. This can result in poor quality care. Moreover, nurses report that they are frequently not permitted to practise to the full extent of their competence; are unable to share their learning; and have too few opportunities to develop leadership, occupy leadership roles and influence wider policy.

Different areas of the world have different needs. Africa, for example, where nurses provide care to a very wide range of people, often with little support or resources, needs hundreds of thousands more nurses with good generalist skills – effectively specialists in general nursing – as well as tens of thousands of speciality-based nurses. The specific needs vary from place to place but the combination of knowledge, skills and values that nurses offer is needed everywhere, and needs to be developed to its full.

Figure 2 The unique contribution of nurses



The UK contribution

The UK can play a leading role in developing nursing globally by working with its partners in the Commonwealth, Europe and elsewhere as well as with international agencies including the World Health Organization and the World Bank. It has enormous influence globally through the work of the Department for International Development; the NHS; and the UK's universities, non-governmental organisations, and health and life sciences industries – as well as through the great tradition of nursing, education and research fostered by the NHS, universities, nursing organisations and national agencies.

The vote to leave the European Union has, however, created a significant risk that the UK will lose many of the European nationals employed in its health and care system and will be unable to recruit more. The APPG believes that the UK needs both to find methods for securing the continuing employment of EU citizens in the health and care system, and to reassess and increase levels of nurse education to meet its own needs. It needs also to maintain its commitment not to recruit health workers from countries with major shortages.

Recommendations

This report argues that there is an urgent need globally to raise the profile of nursing and enable nurses to work to their full potential if countries are to achieve universal health coverage. Nursing can and must take the lead on these issues but cannot achieve them without the support of politicians, policy-makers and non-nursing health leaders.

The APPG recommends that the UK government, together with the Commonwealth Secretariat, the European Union, the World Health Organization and other international agencies, works to:

1. **Raise the profile of nursing and make it central to health policy.** Nurses have an enormous part to play in achieving universal health coverage, and nursing should be central to global policy and plans.

- a. Convene a high-level global summit on nursing, aimed particularly at political and health leaders outside nursing, to raise awareness of the opportunities and potential of nursing, create political commitment, and establish a process for supporting development.

This should be part of a longer-term initiative that will embrace all the following recommendations.

2. **Support plans to increase the number of nurses being educated and employed globally.** The World Health Organization global strategy on human resources for health, *Workforce 2030*, adopted by member states in 2016, proposes a framework for making the most effective use of health workers and developing country-specific investment plans to address workforce shortages.

- a. Work with low and middle-income countries to develop and support their workforce plans through funding and partnership schemes.
- b. Reaffirm support for the WHO *Global Code of Practice on the International Recruitment of Health Personnel*, publish a report on UK progress in implementation since 2010, and provide support for education and employment of health workers in their own countries.
- c. Assess the impact of leaving the European Union on staffing in the UK health and care system, and take mitigating action including finding methods for securing the continuing employment of EU citizens in the health and care system and reviewing and increasing the number of nurses being educated in the UK to meet its needs.

3. **Develop nurse leaders and nurse leadership.** Experienced nurse leaders are needed in the right places to help nursing deliver its potential and ensure that the distinctive nursing perspective is included in policy-making and decision-making.

- a. Establish a large-scale new programme globally to develop nurse leaders that will enable them to engage more effectively in policy-making and decision-making. The International Council of Nurses has plans for developing such a programme that could provide a template.
- b. Ensure all countries have appropriate nurse leadership posts throughout all their structures and organisations.

4. **Enable nurses to work to their full potential.** Nurses are too often not permitted or enabled to fulfil their true potential. Cultural, regulatory and legislative enablers and barriers need to be identified and removed and good practice shared and acted on.
 - a. Develop new ways of sharing good practice – drawing on existing work by nursing organisations, the Commonwealth Health Hub and others – to create more coordinated and effective ways of identifying and sharing good practice globally, and ensure they are brought to the attention of policy-makers and other health leaders.

5. **Collect and disseminate evidence of the impact of nursing on access, quality and costs, and ensure it is incorporated in policy and acted upon.** There are many small-scale studies of the impact of nursing. These need to be brought together with new evaluation and research to demonstrate impact at scale.
 - a. Commission research to bring together existing evidence and initiate new studies on how and where nursing improves access, quality and costs and what contribution nursing can make to universal health coverage.
 - b. Ensure that existing and future research findings are widely disseminated and understood in order to influence both practice and policy.

6. **Develop nursing to have a *triple impact* on health, gender equality and economies.** Developing and investing in nurses – the vast majority of whom are women – will help empower them economically and as community leaders. Improving health and empowering women will in turn strengthen local economies.
 - a. Adapt development policy to bring together programmes and funding to address simultaneously the three Sustainable Development Goals focusing on health, gender equality, and inclusive and sustainable economic growth (numbers 3, 5 and 8) and work with partners throughout the world to develop nursing strategies that work towards achieving all three goals.¹

7. **Promote partnership and mutual learning between the UK and other countries.** There are many partnerships between British organisations and their counterparts abroad that bring mutual benefit and shared learning.
 - a. Expand the DFID Health Partnership Scheme and redesign it so as to engage as many nurses as possible and promote mutual learning and support between UK nurses, their organisations and their counterparts abroad; and support UK agencies including Health Education England, Wales for Africa, and the Scottish government’s international development programme to promote the engagement of NHS and other health and care organisations in global partnerships that bring mutual benefits.

1. Nurses and nursing globally

This chapter describes the purpose and scope of this review and provides an overview of the main issues.

It describes the wide variety of roles played by nurses globally and the many different contexts in which they work. It points to the common themes and the similar roles they play, as well as the differences between them.

The chapter goes on to discuss the rapidly changing environment in which nurses work, and recent policy responses. It concludes with some examples of innovation and enterprise from around the world.

The purpose and scope of the review

The ambition to achieve universal health coverage (UHC) globally, as part of the agreement of the Sustainable Development Goals (SDGs) in 2015, means that there will be even greater demand for health workers.¹ This will put particular pressure on nurses, as they are the largest group of professional health workers globally and carry out most direct patient care.

The All-Party Parliamentary Group on Global Health (APPG) therefore decided to undertake a review, with the support of the Royal College of Nursing (RCN), of how nursing needs to develop globally to cope with this and other challenges. The APPG has not attempted to cover this very broad area in detail, but has concentrated on identifying major trends and development needs, considering in particular what the UK can do to support the development of nursing globally.

This report follows on from the APPG's recent mapping of *The UK's Contribution to Health Globally*², which identified the UK's enormous ability to help improve health globally, and its earlier report, *All the Talents*, on the development of new roles and better teamwork in health.³

The APPG decided to focus only on nursing. It decided not to include midwifery, although equally important for the achievement of UHC, because it is a separate profession with its own distinct scope of practice. Nevertheless, many of the challenges and issues described here also apply to midwives, who in many countries are also nurses.

This report is about the real lives of nurses, and concentrates on the experience and needs of low and middle-income countries. It draws on discussions with nurses from many countries, a call for evidence, a literature review, and meetings with policy-makers and other experts with experience from around the world. The APPG panel set up for this review (hereafter 'the Review Board') was particularly concerned to ensure that the report accurately reflects insights and experience from low and middle-income countries and that its findings are not dominated by Western views and concerns.

An enormous amount of change is happening in health and health care globally and it is impossible to be certain how this will affect nursing, although some clear trends are emerging. There is also a great deal of innovation under way in nursing, and each chapter contains examples of enterprise and innovation from different groups and countries that highlight aspects of how nursing is likely to develop in the next few years.

The real lives of nurses

There is enormous diversity in the education, experience and responsibilities of nurses globally:

- Nurses in parts of rural Africa and elsewhere may be the only health worker for miles around and provide a wide range of care and services for local people, often going beyond their formal training and outside their legal scope of practice.
- Other nurses, in particular those working in hospitals in low and middle-income countries, may not be allowed to utilise their training to the full but are essentially ‘handmaidens’ of doctors and have no scope for development.
- Nurses trained to degree level in Cuba and elsewhere work alongside doctors as equal partners and with equal status in looking after people in their neighbourhood.
- Many nurses in the UK, the US and some parts of Europe are nurse practitioners with very wide-ranging roles, able to diagnose, prescribe, undertake a range of procedures, and develop and lead whole services.
- Nurses throughout the world take on wider leadership positions in government, academia and health care organisations – leading, managing, teaching, researching and shaping policy – as well as bringing their knowledge and skills to bear in many settings including industry and humanitarian programmes.

These examples illustrate how difficult it is to generalise about nurses and nursing. There are many common issues and concerns facing nurses in all these situations, as this report shows, but also important differences in education, training and development needs in different environments.

These differences are reflected in how nurse leaders and policy-makers approach the development of nursing. At one end of the scale, in Africa – the continent with the lowest proportion of health workers to the population⁴ – there is a need to train thousands more nurses with practical skills and personal resilience to deal with as wide a range of issues as possible. They are effectively specialists in general nursing. Africa also needs speciality-based nurses but the focus is different from high-income countries like the US, which has the highest proportion of health workers and focuses more on developing specialisms and extending the role and scope of practice.

Similar concerns

Despite these differences, nurses from different countries told the APPG about very similar concerns – all constant themes throughout this report, discussed in chapters 2 and 3. They included:

- pressure caused by shortages of staff and poor or missing equipment;
- the ‘invisibility’ of nurses and underestimation of the nursing contribution;
- not being permitted and enabled to work up to the limit of their competence;
- migration of nurses from poorer to richer countries and, internally, from rural to urban areas and from government services to disease-specific ones, non-governmental organisations (NGOs) and private practice;
- lack of involvement in policy and planning; and
- inadequate training and development.

These issues were not confined to the poorest countries. The World Health Organization (WHO), for example, has cut its nursing activities in recent years, with reductions in posts and funding in its six regions and at its headquarters. Meanwhile Afaf Meleis, Dean of Nursing, University of Pennsylvania School of Nursing, United States (US), told the APPG that only 10 US states permitted nurses to work to the full scope described in the federal Nurse Practice Act.

Common features

There are also many common features in all the roles described here. In particular nurses:

- are frequently the first and in some cases the only healthcare professionals with whom patients come into contact;
- spend considerable amounts of time with their patients and, mostly, provide very personal and intimate care as well as continuity throughout a period of illness or treatment;
- work within a shared system of humanitarian and person-focused values; and
- are generally part of the local community and have a good understanding of local issues and culture, which also affect them and their families.

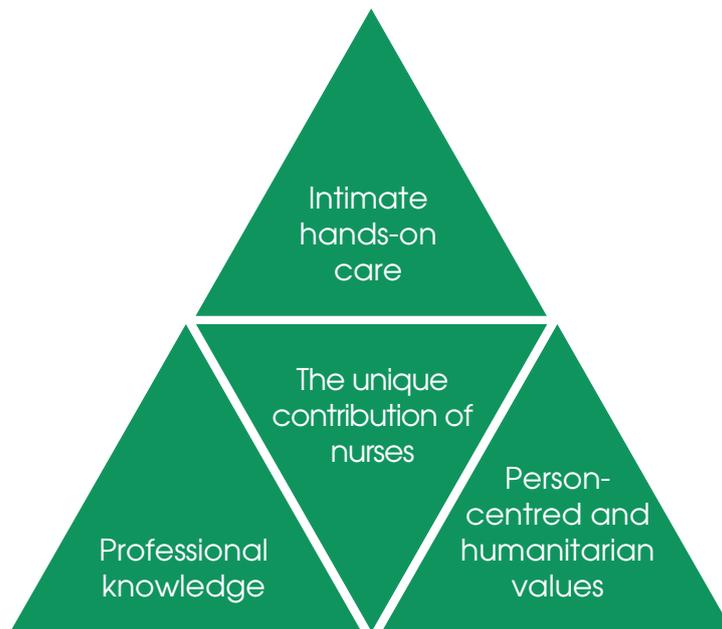
All these important features contribute to the very wide-ranging roles that nurses perform. Paul Magesa Mashauri, President, Tanzania National Nursing Association, illustrated the holistic nature of nurses' work when he told the APPG that nurses can help people to live better: 'Nurses meet many people when they are providing care. They can meet the patient, they meet the family members, they meet the relatives, (and) they meet friends. So they are in a good position to assist people to understand how to live better.'

Belonging to their local community means that nurses can understand the local culture, customs, belief systems and social norms. This cultural competency and sensitivity is invaluable, whether in encouraging parents to vaccinate their children, discussing family planning options with new mothers, or explaining the care associated with managing diabetes.

One practical example comes from South Africa, where nurses in an HIV clinic understood that local women were reluctant to be tested for HIV because of the stigma attached to testing and diagnosis. They accordingly devised a system to make any testing a routine part of antenatal care – so no one could tell who had been tested and who had not, or who was HIV-positive and who was not. The success of the whole programme for reducing mother to child transmissions depended on this simple system: 'It could all have failed at the last hurdle, however, if women attending this clinic hadn't been able to trust the nurses and if these nurses hadn't been able to understand the women's worries and needs.'⁵

Nurses undertake different roles in different circumstances, but they all share in the combination of knowledge, practical skills and values that makes them particularly well placed to meet both present and future needs. While other professions share some or all of these features, the nursing contribution is unique because of its scale and the range of roles nurses play (Figure 1.1). This combination means that nurses are very well positioned to respond to the growing need for more person and community-centred care, and for a greater focus on health promotion and disease prevention.

Figure 1.1 The unique contribution of nurses



The definition of a nurse

The most commonly used definition of a nurse was created by Virginia Henderson and adopted by the International Council of Nurses (ICN) in 1960: ‘The unique function of nurses in caring for individuals, sick or well, is to assess their responses to their health status and to assist them in the performance of those activities contributing to health or recovery or to dignified death that they would perform unaided if they had the necessary strength, will, or knowledge and to do this in such a way as to help them gain full or partial independence as rapidly as possible.’⁶

More recently ICN widened this definition, adding: ‘The nurse is a person who has completed a program of basic, generalised nursing education and is authorised by the appropriate regulatory authority to practice nursing in his/her country. Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.’⁷

These definitions embrace the whole of the nursing profession, whether nurses are working in hospitals, clinics, community services, or in any of a vast range of other settings including schools, factories, other workplaces, social services, residential homes for people with dementia and long-term conditions, hospices, prisons, on the streets with homeless people and sex workers, in the armed forces in conflict zones, or in humanitarian organisations caring for the victims of conflict, refugees and internally displaced people, and those affected by human and natural disasters.

The changing global context

Enormous changes in the global context are affecting nurses alongside all other health workers. These include:

- changes in the burden of disease, with more long-term conditions and non-communicable diseases affecting countries throughout the world;
- increased demand for health care from ageing populations in the North and West and from increasingly affluent populations in the East and South;
- migration of people fleeing conflicts or seeking better futures, and of health workers moving within a global market place;
- climate change and other environmental issues;
- changes in labour market composition and expectations;
- the increasing commodification of health, that places a premium on measurable procedures;
- global and national policies that prioritise health and have helped make it the largest sector in the global economy, and one of the fastest-growing;
- scientific and technological advances.

It is impossible to be certain of the long-term impact on health and health care of these profound changes. Some trends, however, are already clearly established (Box 1.1).

Box 1.1 Some global trends

- There is demand for a big expansion in the health workforce.
- Work roles are changing as needs change.
- Some traditional models of delivery are disappearing – with a shift away from hospitals and towards communities and homes.
- There is greater emphasis on disease prevention and health promotion.
- The engagement of patients and citizens alongside health workers is increasingly seen as essential in improving access, quality and costs.
- Technology is beginning to play a more prominent part – as the internet becomes the organising principle of the age.
- Knowledge of what works is at a premium as countries struggle to achieve the goal of good access, high quality and value for money.

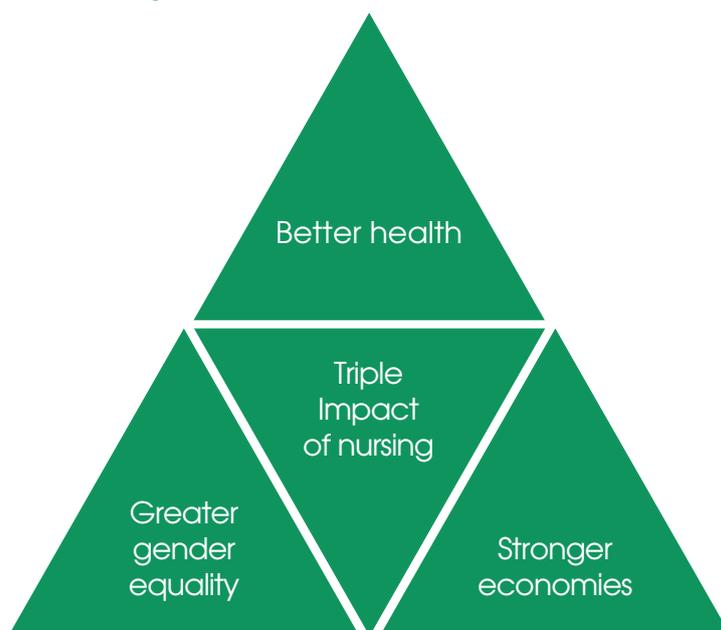
Gender equality and the changing roles of women

One other trend particularly important for nurses is the move towards gender equality and the changing roles of women. Nursing should not be seen as a gender-based profession, although the vast majority of nurses are women and this is likely to continue for the foreseeable future. Global development policy from the SDGs onwards emphasises the fundamental importance of promoting gender equality in social and economic development. An important part of this in health is improving access for women to high quality health care, as well as tackling the different genders' differing needs. Investing in nursing and raising its status will have the additional effects of empowering more women socially, politically and economically, and helping establish their status as important figures in their local communities.

Nursing policy and practice cannot of course change social trends by themselves but can and should contribute through developing women in leadership roles, empowering them economically and helping them reach their potential. James Buchan, Queen Margaret's University, Edinburgh, and others suggested to the Review Board that investing in and developing nursing would have a triple impact as shown in Figure 1.2 – better health, greater gender equality and stronger economies. These three areas align with the SDGs, especially Goal 3: Good health and well-being, Goal 5: Gender equality, and Goal 8: Inclusive and sustainable economic growth. It is a theme to which we will return.

The UN's High-Level Commission on Health Employment and Economic Growth has demonstrated the links between the employment of health workers and economic growth.⁸ This report argues that the employment of nurses will also bring benefits in health and gender equality.

Figure 1.2 The triple impact of nursing: better health, greater gender equality and stronger economies



Policy and practice development

There have been a number of important reviews of nursing in recent years. Others are under way and policy is continuously being developed. Most recently, as this report was being prepared, WHO published *Global strategic directions for strengthening nursing and midwifery 2016-2020*.⁹ This focuses on four themes:

- accessibility, acceptability of safe and cost-effective nursing and midwifery care based on population needs, addressing UHC and the attainment of the SDGs;
- optimising leadership and governance accountability;
- maximising capabilities and capacities of nurses and midwives at all levels through collaborative intra- and inter-professional partnerships;
- mobilising political will to invest in building effective governance for nursing and midwifery workforce actions founded on evidence.

The 2016 WHO Global Forum for Government Chief Nursing and Midwifery Officers enthusiastically endorsed this approach and agreed to work on these four themes individually and collectively. Other recent country-specific reviews addressing similar issues include:

- *Front Line Care*, the report by the Prime Minister’s Commission on the Future of Nursing and Midwifery in England, 2010.¹⁰
- *The Future of Nursing: leading change, advancing health*, the report of the Robert Wood Johnson Foundation Initiative on the Future of Nursing, US, 2011.¹¹
- *Raising the Bar. Shape of Caring: a review of the future education and training of registered nurses and care assistants*, commissioned by Health Education England, 2015.¹²
- The Lancet Commission on UK Nursing, launched in 2014, still under way.¹³

All these reviews were designed to address the changing context and find better and more sustainable ways to provide nursing and midwifery care in the longer term, locally and globally. Many other countries have also undertaken reviews. All have common themes including considering whether nurse education remains fit for purpose, how to improve leadership and motivation, and the relationship of nurses to other health workers. Most recently, NHS England published *Leading Change, Adding Value – a framework for nursing, midwifery and care staff*, which brings together much current thinking about how nursing can develop in the UK.¹⁴ Some of the broader issues raised are discussed in the following chapters.

The APPG notes, however, that no substantial commission or review has taken a completely global approach to nursing and married together the insights and experiences of people from all parts of the world. This is picked up in our recommendations.

The APPG also recognises that nursing is affected by wider health policy and cannot develop in isolation from the other professions, but is intimately connected with and affected by developments in all of them.

The impact of nursing

There is considerable evidence, as described in Chapter 4, about the impacts of nursing on quality, access and costs of treatment and about the relationships between nursing education, workload and environment and reduced patient morbidity and mortality. As nurse entrepreneur Heather Henry, co-chair of the New NHS Alliance, says, ‘We need to market nursing as if it were a new drug or treatment.’¹⁵

“ We need to market nursing as if it were a new drug or treatment ”

Heather Henry, UK nurse entrepreneur

A new story of nursing

The nursing profession itself is changing and new approaches are needed. The need to open up debate and engage the public and leaders outside the profession was highlighted to the Review Board by three very senior nurses.

Maureen Bisognano, President Emerita and Senior Fellow, Institute for Healthcare Improvement, US, said there were now four generations of nurses working together, and policy, management and leadership needed to address their different needs. The oldest group, the ‘baby boomers’, are concerned about retirement and pensions; ‘generation X’ believe money is less important but status and titles are more important; ‘generation Y’, ‘the millennials’, are interested in recognition but not titles; and the youngest, ‘generation Z’, see no distinction between work and personal life. People from each generation are motivated differently and work and learn differently.

The modern workplace needs to reflect this diversity of perspectives and find ways to recruit and retain all these generations. Moreover, research shows how engaging health workers fully in decision-making helps improve health outcomes.¹⁶ Equally, she said, there is a need to change relationships with patients and carers completely: this can be empowering for both parties and helps improve outcomes.

Barbara Parfitt, former Dean of Nursing, Glasgow Caledonian University, and Founding Principal, Grameen-Caledonian College of Nursing, Bangladesh, told a workshop in 2014 that women are disadvantaged in countries in South and Central Asia, which reduces their employment opportunities and has an effect on nursing. Nursing is a low-status profession, she explained, with low salaries, poor working conditions and little investment. ‘It is primarily controlled by doctors who make all of the decisions around what nurses do, and in some cases, inhibit the development of nursing ... Nurses are considered “extra hands” for doctors and are not given much agency.’

At the same time, she said, the environment is changing rapidly: ‘Educational qualifications attract prestige, which can help improve the status of nursing and of women. Younger nurses are more oriented to business and leadership; with the proper support they could be transformational in health systems. The government is issuing new policies toward the goal of improving nursing care, but sometimes the top-down process is slow and difficult to implement.’

The focus is not only on rural health, she told the Review Board, but on equipping intelligent young women from rural, disadvantaged areas to develop the skills and expertise to be leaders and change agents for both women and for nursing in Bangladesh. ‘*In many ways for me this was even more important than persuading them to return to their own communities. Influencing long-term policies to empower women from rural areas and to empower nursing is critical for any sustainable change,*’ she said.

“ Influencing long-term policies to empower women from rural areas and to empower nursing is critical for any sustainable change ”

Barbara Parfitt, former Dean of Nursing, Glasgow Caledonian University, and Founding Principal, Grameen-Caledonian College of Nursing, Bangladesh

Jane Salvage, APPG adviser and former WHO Chief Nurse, described the deep-seated problems affecting nursing worldwide and said, ‘If nursing leaders could solve them, they would already have done so; but these deep and broad social and cultural realities and attitudes are too difficult to be tackled by nurses alone. We have to help opinion-leaders and policy-makers within and beyond health and social care to understand these issues, appreciate their gravity, and lend their weight to solving them.’

Part of this campaigning approach involves the need to tell a new story of nursing, she said: ‘Rooted in reality, yet able to reach for the stars, it will move away from the stereotypical public image to reflect the diversity and richness of nursing work, and the contribution to health and wellbeing made by everyone from newly qualified

staff nurses to clinical nurse specialists with PhDs. Health services fit for the future, and responsive to the needs exacerbated by turbulent times, cannot be developed without nurses at their heart, as leading actors in a new story of healthcare.’

Pointers for the future

Amid all the uncertainty, many innovative practitioners and programmes are finding new ways for nurses to work effectively. The three examples in this section – wise women, health promoters and entrepreneurs – are all very much focused on the future. Community-based, they combine treatment with health promotion, and they learn from the past while using the science and methods of the future.

Wise women – Tajikistan

Gulnar works as a family health nurse in Tajikistan, a Central Asian republic formerly part of the USSR. Her innovative post arose from one of many programmes funded by foreign donors to revitalise the country’s failing health system. The aim was to develop a new approach to nursing education that would create skills and expertise in primary health care, within a national service framework.

She undertook her initial nursing training in the Soviet system, starting in a vocational programme at school when she was just 14. Nurses had very low status and were expected to work only as doctors’ assistants. But she was intrigued by the role of the feldsher, a middle-level practitioner who offered health education as well as treatment and care. The feldsher is still often people’s first point of contact with health services in small towns and rural villages across the Russian Federation, Central and Inner Asia and elsewhere.

At a WHO workshop, Gulnar and other Central Asian nurses were encouraged to talk about why they wanted to be nurses, and what they hoped to achieve – a question they had never been asked before. She thought about the village where she grew up in the remote Pamir Mountains, and its feldsher, who was the local ‘wise woman’, the only person you could turn to with health problems apart from the shaman.

Equipped with her new knowledge, Gulnar knew that the feldsher’s advice and practice had been based more on experience than on recent scientific evidence. She also knew that women’s lives back in her village were still hard, and their health often poor, especially from having many children. She found her voice in the workshop, and said to everyone: ‘I want to return to my village and teach the women what I needed to know for myself – family planning!’ And that is what Gulnar now does as a family health nurse, a similar role to the feldsher but with additional knowledge and expertise provided by her continuing nursing education.

Health promoters – Mozambique

A nurse-led project designed to improve women’s lives in Mozambique recruited members of women’s groups as project leaders. They returned to their communities after training and identified community development committees; collaborated with them to identify priority needs; shared information; and worked together to address the priorities. They were designated as ‘promoterases’ (promoters) of community development and health.

The promotoras assumed responsibility for conducting training, budgeting, field supervision and compiling reports. Evaluation showed that the project had a positive impact on the lives of people in the areas where the promotoras lived. A key lesson was that development, like a tree, must grow from the ground upward and cannot be imposed from above.

Entrepreneurs – Rwanda

A private franchised nurse-led network which links with the public health system and the national health insurance scheme to ensure widespread coverage was founded in 2012 by Dr Gunther Faber and colleagues at One Family Health in Rwanda.

By the end of 2014 it had developed a franchise network of 92 clinics providing services to about 4% of the population. These clinics are particularly innovative because each franchise is owned and operated by nurses, who treat and prevent the most common causes of community illness, such as respiratory infections and parasites. They had seen almost 310,000 patients by the end of 2014. Backed by international donors, One Family Health works in close partnership with the Ministry of Health so that the nurse proprietors have access to the national health insurance programme and can provide care in the poorest areas.¹⁷

2. Today's challenges

Summary

This chapter describes what nurses told the APPG Review Board about the challenges they faced.

Despite many differences between countries, there was a great deal of consistency in the issues raised. Nurses were concerned about staff shortages and resources; the undervaluing of the workforce; not being allowed to work to their full potential; and challenges with recruitment, retention and return to nursing, education and training, and leadership.

The chapter provides a brief overview of each area, with staffing numbers and education and training addressed in more detail in Chapter 3.

The main challenges

Although there are large variations between countries in resources, health systems and population health needs, the Review Board heard about a consistent set of challenges that nurses faced irrespective of setting. There were of course differences of degree, for example with staff shortages in Malawi of a much greater scale than in the UK or US. The main challenges (Box 2.1) are discussed in the following sections. Nurses also told us about many more specific concerns that reflected their own positions and circumstances.

Box 2.1 The main challenges facing nurses globally

- Staff shortages and lack of resources.
- Undervaluing of the nursing contribution and not being allowed to work to their full potential.
- Poor quality and/or lack of education and training.
- Difficulties with recruitment, retention and return to nursing.
- Weak and, in some cases, reducing leadership.

Staff shortages and resources

Many respondents raised concerns about staff numbers and current and projected shortfalls. This is a very serious problem globally and locally. The figures in Chapter 3 reveal both the scale of the shortfall against current and projected future demand, and unequal distribution around the world. Most nurses were also very concerned about lack of equipment, medicines and other resources. These concerns reflect the pressures which health systems are experiencing around the world.

Undervaluing of the nursing contribution

Nurses throughout the world frequently expressed concern about the undervaluing of the nursing contribution and not being allowed to work to their full potential. They repeatedly told the Review Board that nurses and their contributions remain largely invisible and undervalued, and that the low status of nursing extends beyond clinical and health system settings to public opinion, policy circles and research and education environments.

Anita Anand Deodhar, President, Trained Nurses Association of India, put it very simply: 'We [nurses] need to have more respect and recognition from society, from doctors, from all other faculties.'

João Marçal-Grilo, Founding Director of Unity in Health, a UK-based NGO, summed up many of the concerns and identified some of the barriers to greater recognition. 'The way in which nurses are perceived by other health professionals is one which often hinders their confidence and assurance, perpetuating unfair systems of strict pecking orders in which only some get to have a say in any form of decision-making processes,' he said.

'In many regions, the role of the nurse remains undervalued and unrecognised; in several countries there is no equivalent to a nursing council [i.e. regulatory or professional body] and/or no legal representative of the profession, creating significant obstacles to those trying to advocate for the rights and duties of nurses,' he said. The absence of legal frameworks supporting the role of nurses and their participation in the planning and delivery of care reinforced the difficulties and challenges nurses experienced in low and middle-income countries.

This lack of respect and recognition is visible not just in terms of autonomy and freedom to make decisions about patient management, but also in terms of pay and financial recognition. Although these issues affect the nursing workforce as a whole, the Review Board received several reports of advanced practice/specialist nurses being particularly restricted in their scope to practise despite having extensive qualifications and experience.

There are many contributing factors including the dominance of the medical profession, which has high status and power and controls much of the health care environment. The Review Board heard that more recently professional non-nurse managers have taken over some of the planning and leadership functions previously undertaken by senior nurses. The low status of nursing is also partly attributable to the low status of women in many societies, and the undervaluing of forms of care frequently associated with women, such as hands-on intimate care and emotional support. Even among nurses, the higher-status, better-paid roles are very largely those linked with medical specialities in high-tech environments, or management roles with few if any clinical responsibilities.

Whatever the reasons, the very common complaint that nurses are not being permitted to carry out the full range of the work they were trained for indicates a waste of a valuable resource and of the opportunity to provide high quality care. These concerns were also voiced by some doctors.

On the more positive side, 'there is a large amount of evidence internationally that enabling nurses to lead and shape delivery of care and health services not only improves patient outcomes but promotes innovation and leads to better recruitment and retention,' as the RCN told the Review Board. The Buurtzorg district care model in the Netherlands, for example, founded by a nurse in 2006, has reduced the costs of care significantly by empowering frontline nurses to deliver care autonomously, and delivers better patient care and satisfaction.¹⁸

Education and training

Nurses around the world are also concerned about education and training. They described limited access to education, training and the continuing professional development opportunities necessary to enable the workforce to deliver high quality, compassionate and context-appropriate care. They cited many examples of barriers to better education and training, including financial limitations; the lack of availability of courses, particularly for nurses in rural areas; the shortage of teaching and training staff; and, very frequently, heavy workloads.

There was also criticism of the shortcomings of current nursing curricula and programmes, with respondents pointing to a disconnect between current education and clinical practice. Some also deplored the very limited training available in leadership, research, broader health determinants, and the development of a multi-professional, multi-generational and multi-ethnic workforce. Others said that in some countries doctors often do much of the teaching of nurses, despite having no nursing experience or qualifications, as a consequence of the lack of training for nurse educators as well as restrictive legislation.

These critical issues are discussed further in Chapter 3.

Recruitment, retention and return to nursing

Policy-makers and health service leaders, as well as nurses, are very concerned about difficulties in recruiting nurses, retaining them and encouraging them to return following a career break. Much of this is associated with poor morale and low job satisfaction. Too often there are poor working conditions, increased workloads due to staff shortages, and a lack of basic equipment and amenities. These are compounded by factors already noted including low pay, undervaluing of the nursing workforce, and limited professional development and career progression.

‘I have not heard of promotion since I came here,’ said a Ghanaian nurse working in a rural area. ‘If you apply, they don’t call you... they told us in school it takes three years to the next level. I have been working at this post for 12 years. The promotion (is) too slow. I went for promotion interview last year, up till now no results, so we are always demoralised.’

Many respondents also referred to the welfare and quality of life of nurses and their families. In high-income countries this often related to inflexible rotas and shift patterns that prevent many nurses from achieving a good life-work balance, as well as a lack of child care facilities and family-friendly policies – which discouraged many from returning to nursing after a career break. Poor accommodation; limited access to good schools, amenities, basic necessities, and transport; and isolation were all seen as contributing factors in low and middle-income countries.

These concerns about morale and satisfaction are important in themselves and their immediate impact on the welfare and recruitment of nurses. Furthermore, there is evidence of a strong correlation between staff satisfaction and patient outcomes.¹⁹

Several respondents described efforts to address these issues. Voluntary Service Overseas (VSO), for example, says there is clear evidence that incentives represent one of the main factors influencing health worker performance. Opportunities and formalised government systems for continuing professional development, which can then feed into a merit-based promotion system, were perceived as positive and motivating in two VSO projects, Valuing Health Workers²⁰ and Continuing Professional Development for Health Workers.²¹

‘To improve nurse retention and motivation it is essential to examine non-monetary incentives such as work autonomy, career development and flexible working hours/ shifts,’ VSO said. ‘In a study reviewing nursing in hospitals, work autonomy was reported as a significant factor in explaining job satisfaction. It has also been demonstrated that hospitals experience lower turnover rates where supportive management structures are in place and nurses are more involved in decision-making processes.’²²

These challenges and concerns all argue very strongly for the need to improve the management and operation of health services. There is also a need for greater understanding of the potential workforce. As noted in Chapter 1, there are now four different generations in the workforce with different expectations. As Emma Coyle, Centre for Maternal and Newborn Health, Liverpool School of Tropical Medicine, told the Review Board, ‘There is a need for greater understanding of why people choose to enter nursing and whether (or not) attrition rates are associated with pay, working conditions, training, career development etc. The demographic factors which affect nurse recruitment and retention will vary from country to country and greater understanding of these is needed.’

Respondents from low and middle-income countries pointed to a shortage of educated young people able to access nurse training, largely because of poor primary and secondary educational systems. They also cited international and internal migration as a problem. This is discussed in Chapter 3.

Leadership at all levels

The Review Board received overwhelming evidence that nurse leaders were not sufficiently involved in policy-making and decision-making locally, nationally and internationally, and this was essential for improving patient care and service design.

Paulette Cash, President, Nurses Association of the Commonwealth of The Bahamas, said nurses were strategically positioned to be able to influence social, public and health policies. ‘Therefore it’s so very important that we’re engaged, totally engaged, within the design, the implementation, monitoring and evaluation of such programmes [UHC]. Often they engage us at a level of implementation, but it needs to go beyond that.’

‘It’s important that nurses are around the decision-making table and there when initiatives are being designed – because nurses are often the gate-keepers, they are on the front line and they understand the healthcare system at all levels, so it’s going to be important that nurses are engaged at all levels. Nurses can represent nursing well and health well. Nurses are leaders, nurses are innovative and nurses are drivers of public health policy and decision-making,’ she said.

Nursing did not have a strong enough voice in many countries, said Ms Coyle. ‘Nursing needs to be on the political agenda at the highest level in all countries and international agencies, on a par with medicine. Strong professional bodies (or associations) and boards of nursing are needed to regulate and advocate for nursing.’

Respondents described occasions when nurse leadership and engagement had been critical, such as tackling SARS in Taiwan, where nurse leaders played a prominent role.²³

Leadership and other aspects of the challenges described here came together in evidence from Aisha Holloway and Pam Smith, University of Edinburgh. ‘The nursing profession is severely challenged globally by its ability to be visible, credible and influential in directly shaping and developing evidence based health and social care policy within the political arena and across governments,’ they said.

Dr Holloway used evidence gathered during a leadership scholarship awarded by the Florence Nightingale Foundation to conclude: ‘Nursing globally requires a critical mass of nurses that have:

- capability and capacity to shape, develop, support and drive forward evidence-based health and social care policy;
- political, strategic and advocacy skills to navigate, negotiate and influence evidence-based health and social care policy;
- political leadership skills to secure and sustain a credible position at the highest level of policy development within government;
- highest standards of research education to support the ability to frame the evidence base within the relevant local, national and international political and health and social care context;
- ability to identify, understand and work with key stakeholders both within nursing, e.g. statutory bodies and professional organisations, and without nursing, e.g. civil servants, special advisers, government, ministers, international agencies including WHO and the UN, and NGOs.’

More pointers for the future

Nurses and other health professionals could take on greater leadership roles as ‘agents of change’ - guiding developments, engaging patients and communities and making best use of non-professional staff (such as health care support workers) and the new technologies being developed around the world. The following three examples of advanced nursing practice – nurse prescribing and nurse-led clinics, submitted by the RCN, and developing nursing services, submitted by Sally Kendall, University of Kent, illustrate different aspects of this.

Nurse prescribing in Botswana

Nurse prescribing delivers parity of outcomes with doctors. The Botswana Baylor Children’s Clinical Centre of Excellence conducted a cross-sectional study in 2009 that compared the performance of nurse prescribers to doctors caring for HIV-infected paediatric patients. Selected by stratified random sampling, 100 physician and 97 nurse prescriber encounters were reviewed. The results showed that nurse prescribers and doctors respectively correctly documented 96% and 94.9% of the time. There was also evidence that nurses undertook a higher level of social history documentation.

The findings led the centre to reaffirm its support for continued investment in employing nurses to provide quality care and antiretroviral treatment services to infected children. It is also advocating for this approach to be adopted across southern Africa. Its report concluded that task-shifting to nurses continues to show great promise for scaling up and sustaining adult and paediatric antiretroviral treatment, particularly where provider shortages threaten rollout.²⁴

Nurse-led clinics in Hong Kong

Advanced nursing practice began in Hong Kong in the 1990s. These nurses often carry their own patient load, but may also see patients with specialty needs on other wards. Their roles vary according to hospital and specialty, and have developed significantly.

Hong Kong's health system does not have significant primary health care capacity, and people with serious problems are usually first seen in the emergency department. Once diagnosed and stabilised to need no further inpatient treatment, they are referred to a specialty outpatient clinic, but owing to the lack of such clinics, the Hospital Authority developed the concept of nurse-led clinics, with specialist nurses providing care and management. For example, a patient with chronic obstructive pulmonary disease will go to a nurse-led COPD clinic.

These nurse-led clinics continue to expand and have demonstrated good improvements in care. The nurses can manage up to 90% of patients for outpatient disease-specific care. They practise independently or with some supervision, adjusting medication and initiating diagnostics and treatments according to protocols.²⁵

Developing new services in England

Viv Marsh is a registered general nurse, sick children's nurse and school nurse who coordinated a school nursing service in the Midlands, England. Asthma, a common long-term condition among young British people, is a frequent cause of hospital admission. She inspired her colleagues to develop and implement a strategic policy for asthma management in 110 schools, adopting a public health approach that resulted in healthier children and probably saved lives.

With collaborative multiagency working between health, education and the voluntary sectors, the programme covered the whole school population in the area, raising awareness and knowledge to improve respiratory health and prevent acute attacks and child mortality. Each school health advisor (mostly registered school nurses) ensured the development and implementation of the asthma policy, trained and worked closely with community health link workers, and had a caseload of 'high need' children.

Young people were actively involved, and could now access a well coordinated service that enabled major reductions in emergency admissions. The introduction of a generic emergency inhaler into schools kept children out of hospital and almost certainly saved lives.

An independent evaluation, part of a larger study of nurses' role in managing long-term conditions, highlighted many positive outcomes. It said nursing education, leadership, vision and the navigator role were key to success – the art and science of navigating the health system and keeping children, schools and families at the centre. Specialist professional associations provide advocacy and development opportunities for public health nurses in the UK.^{26 27}

Viv's vision, persistence, leadership and knowledge were key, built on her sound nursing education and specialist training. Her work demonstrates how nurses, when trained and enabled to lead, and empowered to seize the opportunity, can develop high quality, cost-effective systems of care that enact the principles of a primary care system orientated to public health.²⁸

3. Workforce, professional education and regulation

Summary

This chapter describes the current shortfall in health workers globally and the projections of still greater shortages in future. It considers how WHO and its member states propose to address this, and reviews how education and regulation can contribute.

Nurses and midwives make up almost half the world's health workforce but are spread very unequally, with the largest proportion working in urban areas in high-income countries. This maldistribution is made worse by internal and international migration and, as significantly, by large numbers of nurses taking up employment outside the health sector.

The biggest problem in terms of numbers, however, is simply that not enough nurses are being trained, and the estimated shortfall in nurses and other health workers is therefore growing.

To mitigate these problems, countries around the world are reviewing their approaches to education and regulation, and looking for new ways to train and deploy health workers.

Numbers of nurses, midwives and other health workers

Nurses and midwives, taken together, are by far the largest professional group in the health workforce globally. In 2013 there were over 42 million health workers, according to WHO (Table 3.1).²⁹ Among them were 9.7 million doctors, 19.7 million nurses and midwives – just under half the total workforce – and 12.6 million health workers from other professions or with some level of training.

Table 3.1 Stock of health workers globally, 2013

	Medical doctors	Nurses/ midwives	All other cadres ¹	Total ²	Medical doctors per 1000	Nurses/ midwives per 1000	All other cadres per 1000	Total per 1000 ²
Region								
Africa	225,120	1,039,709	620,315	1,885,144	0.27	1.22	0.73	2.22
Americas	2,025,041	4,629,099	2,637,289	9,354,429	2.09	4.85	2.73	9.68
Eastern Mediterranean	785,629	1,295,020	979,097	3,059,747	1.26	2.08	1.57	4.91
Europe	2,909,059	5,314,157	3,308,690	11,531,897	3.20	5.84	3.64	12.68
South-East Asia	1,062,373	2,776,662	2,093,276	5,932,311	0.57	1.50	1.13	3.20
Western Pacific	2,721,036	4,624,862	2,959,246	10,305,145	1.49	2.54	1.62	5.66
Income ³								
Low	144,826	399,478	323,979	868,284	0.19	0.51	0.41	1.11
Lower-middle	1,977,455	4,475,914	3,543,241	9,996,609	0.77	1.75	1.39	3.91
Upper-middle	3,880,669	6,603,520	4,259,087	14,743,276	1.61	2.74	1.77	6.12
High	3,725,300	8,263,597	4,471,607	16,460,504	2.92	6.48	3.51	12.91
World ⁴	9,728,249	19,742,509	12,597,914	42,068,673	1.38	2.81	1.79	5.99

¹ Refers to the seven other broad categories of the health workforce as defined by the WHO Global Health Workforce Statistics Database, i.e. dentistry personnel, pharmaceutical personnel, laboratory health workers, environment and public health workers, community and traditional health workers, health management and support workers, and other health workers. A cadre multiplier was determined by taking, for each World Bank income region, with non-missing "all other cadres" values, the average number of "all other cadres" relative to medical doctors/nurses/midwives. This yielded the following workforce multiples: 0.595 (low); 0.549 (lower-middle); 0.406 (upper-middle); and 0.373 (high). Multiplying the total medical doctors/nurses/ by this cadre multiplier yielded the estimated number of "all other cadres" for that region.

² Counts and rates may not equal row/column totals due to rounding or to missing data in income or region.

³ Income-specific "all other cadres" multipliers are as indicated under note (1) above.

⁴ Comprises 210 countries for which the United Nations publishes population estimates, at a total estimated population in 2013 of 7,024,094,223

Table 3.1 estimates that in 2013 (latest available data) the global health workforce was slightly over 42 million, including 9.7 million physicians, 19.7 million nurses/midwives, and approximately 12.6 million other health workers. The global nurse/midwife to physician ratio was 207.

WHO estimates there is a shortage globally of more than 7.2 million health workers, based on current demand, and that this will increase to 12.9 million by 2035.³⁰

Demand for health care is growing globally for a variety of reasons, including increased demand from high-income countries as their populations age, and from low and middle-income countries as they progress towards UHC. Health care is already a \$7.2 trillion a year industry, equivalent to 10.6% of global domestic product. It is growing at 5.2% annually – with Asia and Australia expected to see growth of 8.1% a year – and may reach \$9.3 trillion by 2018.³¹

This growth in demand is in turn generating a need for health workers that far outstrips current supply. On current trends the number of nurses and midwives in Africa will grow from 1.0 million to 1.5 million between 2013 and 2030, but the shortfall in the number required to meet the need will grow from 1.8 million today

to 2.8 million by 2030.³² In other words, the shortage is growing faster than the increase in supply.

Governments and health policy-makers everywhere, as described below, are looking to innovative models of service delivery and staffing to mitigate the problems these shortages cause, for example through greater engagement of patients, better use of technology and changes to skill mix.

The distribution of health workers

Shortages in many countries are made worse by maldistribution of health workers. Most nurses, like other health professionals, work in richer countries and in urban areas where there are better opportunities in terms of income, training, career progression, work environment, employment and access to services and amenities. This uneven distribution across and within countries often means that the people most in need do not have access to health services.

Table 3.1 also shows the distribution of health workers and nurses and midwives across the six WHO regions. The quality of the data provided to WHO is patchy and in some cases poor; however, it is sufficiently good to reveal the scale of differences between countries. Europe, the region with most nurses and midwives, has 5.84 per 1000 population while Africa, the region with the least, has 1.22 per 1000. These regional averages mask greater differences, for example between African countries such as Mozambique, Ethiopia and Kenya, which have respectively 0.34, 0.28 and 0.79 nurses and midwives per 1000 population, and the UK, US and Norway with respectively 6.9, 9.4 and 14.2.³³ Thus the UK has around 20 times more nurses and midwives in proportion to its population than Mozambique and Ethiopia, the US about 30 times as many, and Norway 40 times as many.

“ The UK has around 20 times more nurses and midwives in proportion to its population than Mozambique and Ethiopia, the US about 30 times as many, and Norway 40 times as many ”

Most countries in the Organization for Economic Co-operation and Development (OECD) report nurse shortages despite their relative advantage in numbers; Australia, for example, predicts a shortfall of 85,000 by 2025.³⁴ Recently 83% of organisations surveyed in the UK reported shortages of qualified nurse supply.

Paradoxically, qualified nurses in some countries are unable to find work, a problem in some countries for many years according to ICN. It arises both from a mismatch in supply and demand and because governments often lack the funds to employ the nurses who have been trained.³⁵ The government of Zambia told the Review Board that many newly qualified nurses were unemployed in 2016 for this reason, but it plans to rectify this.

Migration of health workers

The international migration of nurses to countries offering better opportunities occurs at both global and regional levels and disadvantages the poorest countries. Many nurses from Zambia and Zimbabwe, for example, migrate to South Africa where salaries and work environments are better. In Trinidad and Tobago, local nurses leave for opportunities in the US and the UK while the government of Trinidad and Tobago in turn recruits nurses from the Philippines, Cuba and other islands in the Caribbean to cover the deficit.

Even more significantly in terms of the numbers involved, there is also migration within countries, from rural to urban areas and from government health services to NGOs, for-profit organisations and project-based work. Many health workers in low and middle-income countries move to work for ‘vertical programmes’ for specific health conditions, such as those funded through the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance on Vaccines and Immunization (GAVI), and the US President’s Emergency Plan for AIDS Relief (PEPFAR). Many others work outside the health sector for a range of reasons including lack of jobs, low pay and poor working conditions. This internal migration contributes to shortages in general health services, which are mostly provided by governments, or locally-based charities in some countries.

There is also migration from the countryside to urban areas. Less than 55% of people globally live in urban areas, but more than 75% of doctors, over 60% of nurses and 58% of other health workers. Populations in rural, periurban and inner-city slums are often in most need but are generally the least well served.

Migration and the resulting global and national maldistribution of nurses cause major problems for governments. Paul Magesa Mashauri, President, Tanzania National Nursing Association, told the Review Board that it was not just about numbers but also about who chose to leave – ‘especially those nurses who are more competent are the ones who leave.’ Others described how they were working on these problems by providing incentives to retain nurses and ensure their distribution nationally mirrored population health needs. Nurses working on some of the smaller islands in the Bahamas, for example, receive additional benefits and allowances as they are considered to be working in hardship areas.

A range of approaches is taken in Ghana, Kwansa et al report. ‘Like many countries in sub-Saharan Africa, Ghana is faced with the simultaneous challenges of increasing its health workforce, retaining them in-country and promoting a rational distribution of staff in remote or deprived areas. Recent increases in both public sector doctor and nurse salaries have contributed to a decline in international out-migration, but problems of geographic maldistribution remain.’³⁶

Proposed non-fiscal incentives in Ghana included clearer terms of contract detailing length of stay at a post, and transparent procedures for transfer and promotion; career opportunities for all cadres of nursing; and benefits such as better on-the-job housing, better mentoring and more recognition from leaders. ‘An integrated set of recruitment and retention policies focusing on career development may improve job satisfaction and retention of nurses in rural Ghana,’ they say.

The UK has long been a major beneficiary from inward migration: many nurses from Ireland, for example, worked in UK institutions before the foundation of the NHS. In the early 1950s the UK actively recruited nurses from the Caribbean and doctors from India to support the expanding NHS. More recently it has benefited from large numbers of European Union (EU) health workers coming to the UK, but this trend is likely to disappear and perhaps reverse. UK withdrawal from the EU will probably lead to pressure for increased recruitment from other countries.

Since 2000 the UK has worked to reduce the number of trained health workers coming from countries with severe shortages. It signed a series of agreements, starting with a bilateral one with South Africa, followed by a Commonwealth concordat, and the WHO *Global Code of Practice on the International Recruitment of Health Personnel* in 2010.³⁷ This code seeks not only to safeguard countries with major shortages from active recruitment by other countries, but also to uphold the rights of migrants and ensure they are treated appropriately.

These agreements have contributed to large reductions in immigration to the UK from the countries with the greatest shortages. For example, the number of Africans registering with the Nursing and Midwifery Council (NMC) for the first time has fallen, from a peak of over 2000 a year at the turn of the century to below 200. Other factors have also played their part, including free movement of labour within the EU and the boom and bust cycle of nurse training and workforce planning, with its alternating peaks and troughs in UK nurse numbers. UK withdrawal from the EU, as noted above, could increase these flows.

Many nurses raised concerns about migration in interviews and written evidence. The APPG therefore recommends that the UK reaffirms its support for the WHO code, and publishes a report on its progress on implementation since 2010. In particular it should monitor and report annually on data on inflow and source countries, and demonstrate how it will meet the commitment in the 2016 WHO global strategy to reduce reliance on international recruits by half.

The emigration of health workers is a very significant issue for low and middle-income countries and needs to be tackled. However, dealing with migration alone is only a part of the problem. For example, it has been estimated that if every African health worker who had received some level of health worker training and then emigrated were to return home, this would only address about 10% of the shortage in the continent.³⁸ There are many interconnected problems but in numbers terms the single biggest factor is that not enough nurses and other health workers are trained in the first place.

The WHO global strategy on human resources for health

WHO, its member states and partners have developed a global strategy on human resources for health, *Workforce 2030*, adopted by the 2016 World Health Assembly of member states. It has four main objectives to address these fundamental issues, by securing investment in increased numbers of health workers and also by improving the ways in which they work and are managed and deployed:

- optimise performance, quality and impact of the health workforce through evidence-informed policies on human resources for health, contributing to healthy lives and wellbeing, effective UHC, resilience and health security at all levels;
- align investment in human resources for health with the current and future needs of the population, taking account of labour market dynamics, to enable maximum improvements in health outcomes, employment creation and economic growth;
- build the capacity of institutions at subnational, national and international levels for effective leadership and governance of actions on human resources for health;
- strengthen data on human resources for health for monitoring and accountability of the both national strategies and the global strategy.³⁹

UHC will be won or lost with nursing and midwifery, the Review Board heard from Jim Campbell, Director, Health Workforce Department, WHO and Executive Director, Global Health Workforce Alliance, who led the development of the strategy.

“ Universal health coverage globally will be won or lost with nursing and midwifery ”

Jim Campbell, Director, Health Workforce Department, WHO, and Executive Director, Global Health Workforce Alliance

The strategy provides a global framework within which countries should develop their own plans. It provides a comprehensive overview but recognises that investments and policies have to be determined nationally in the light of local priorities, circumstances and resources. As noted in Chapter 2, many countries are reviewing their strategies for nursing and considering its future contribution. Developments in professional education and regulation are central to these approaches.

The challenges to governments

APPG co-chair Lord Crisp met many nursing and government health leaders in Zambia during this review. The Permanent Secretary of its Ministry of Health is leading the country's approach to strengthening its health system and working towards UHC – and the development of nursing is seen as an important part. The challenges, familiar to other countries, include:

- decisions about the level of education needed for nurses – with increases in the proportion of registered nurses (RNs);
- how best to train nurses to be able to work independently in rural areas without immediate access to doctors – with an accompanying extension of their scope of practice to include prescribing and other elements;
- the need to train specialist nurses as the country develops services for cancer and other conditions;
- training increased numbers of community health workers in rural areas, and health care assistants in hospitals.

Every country in the world is likely to face broadly similar issues as they grapple with moving towards UHC or, in the case of many European countries, work to maintain and improve existing services and systems. These commonalities suggest there is much that countries can learn from each other and considerable scope for sharing good practice and learning.

These discussions and decisions are taking place at the same time as far-reaching developments in the education and training of health professionals, their regulation, and the concept of professionalism itself. Full consideration of these issues goes far beyond the scope of this report, but some key features to note here include:

- the continuing shift towards competency-based and system-based education and training;
- the related approach to competency-based regulation;
- new approaches that embrace greater teamwork and the full engagement of patients, carers and communities.

Before looking at the differences between countries, it is worth noting that if nurses in any country are to fulfil the potential of the combination of knowledge, practical skills and values described in Figure 1.1, Chapter 1, both their education and their employment need to support it. This means that every country needs a strong cadre

of well-educated RNs who can work as team leaders, navigators and facilitators, and that their employment must enable them to work to the full extent of their training and potential.

As the APPG notes, there is good evidence of a positive correlation between quality of care and outcomes, including mortality, and the proportion of RNs in the workplace with nursing-related degrees.⁴⁰ The APPG therefore supports the WHO aspiration that an undergraduate (bachelor's) degree in nursing should become the entry qualification for all RNs. This will also help the profession to attract the recruits it needs. This aspiration will take years to achieve in many countries, and countries will find their own routes towards it.

Differences between countries

There are obvious differences in needs between countries. As the many examples in this report show, low and middle-income countries like Zambia need large numbers of nurses with very good generalist skills so that they can cope with all the different situations they face, in hospital wards as much as community settings. In effect, they need to specialise as general nurses. These countries also need speciality-based nurses, and richer countries also need generalists, but in a different proportion and often with substantially different skill sets from colleagues in high-income countries.

The entry requirements, academic units, type of training and duration of training for each group vary from country to country and sometimes between institutions within a country. There is also a growth in some countries of unregulated private providers offering professional training in nursing and medicine. The proportion of nurses in each group also varies between countries: in Cuba and the UK, to take two examples, all nurses are educated to degree level while in Rwanda, as in many countries in sub-Saharan Africa, the majority of the nursing workforce is trained to enrolled nurse or nursing auxiliary level.^{41 42} In addition, the relationship between nursing and midwifery education and training varies from country to country.

There is a clear trend across countries of upgrading the nursing workforce, with many aiming to train most RNs to degree level.⁴³ Not only are there strong policy and quality arguments for this, as noted above, but this shift is also driven by demand, with more nurses choosing to get a degree instead of a diploma/certificate. Zambian nurse leaders said there was no point in training enrolled nurses any more as so many applied for RN training as soon as they qualified.

Funding for education also varies. In some countries the government pays most of the costs, while in others students depend entirely on government loans or private and charitable sources. Similarly, nurses have many different employers across the range of health services, whether public, private, faith-based or NGOs. Although government is the main employer in many low and middle-income countries, funding for staff salaries can come from a variety of sources including the private sector and bilateral and multilateral aid.²⁹ Moreover, nurses working in the public sector often supplement their income by taking on additional work in private practice or outside nursing, or working extra hours through nurse banks or other systems.

Competency-based and system-based education

There is a long-term movement towards basing professional education on acquiring competency rather than on completion of a prescribed and profession-specific course of instruction, a movement from specifying education attainment by inputs to measuring achievement in terms of outputs. As defined by Epstein and Hundert,

‘competency is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served.’⁴⁴

The Lancet Commission on the Education of Health Professionals for the 21st Century argued in 2010 that education should be based not only on competency but also on understanding systems. As epidemiological trends have changed and awareness of the wider determinants of health has risen, there is a need for better understanding of systems and for professionals, including nurses, to develop leadership roles and lead improvement and development of services as ‘change agents’. As a professional it is not enough to know what needs doing, you also need to know how to get it done within a health system.⁴⁵

The commission also emphasised how professionals and ideas about professionalism needed to change. ‘Professionals...have special obligations and responsibilities to acquire competencies and to undertake functions beyond purely technical tasks - such as teamwork, ethical conduct, critical analysis, coping with uncertainty, scientific inquiry, anticipating and planning for the future, and most importantly leadership of effective health systems,’ it said.

This bringing together of education for the different professions, while maintaining their distinctive roles, describes and reinforces the way in which practice is already developing. Many of the skills, knowledge and attitudes of practitioners cut across professional boundaries; for example, all need some knowledge of applied anatomy and physiology, good communication skills, and emotional literacy. Moreover, learning these together at the outset makes sense, not least in creating a shared, holistic understanding of health, health care, people and communities, and laying a foundation of mutual respect for each specific contribution.

Competency-based regulation

The regulation and registration of professionals is vital for providing protection for the public, and providing assurance about the competence, integrity and values of professionals. Just as with education, there is a move towards a competency-based approach.

Regulation varies from country to country. In the UK, for example, acts of parliament in 1902 (for midwives) and 1919 (for nurses) established independent regulation for nursing and midwifery. The NMC ‘sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers’. In education, it:

- sets education standards, which shape the content and design of programmes and state the competences of a nurse and midwife;
- approves education institutions and maintains a database of approved programmes;
- delivers quality assurance of its approved programmes;
- registers nurses and midwives when they have successfully completed their courses;
- assesses and ensures the quality of practice placements for students.

The NMC provides a very clear link between regulation and education and ensures that both operate on the same principles. In some countries, however, such as the former Soviet countries and many others worldwide, nursing regulation has comprised little more than legislation that specifies lists of tasks nurses are entitled to perform. Many countries still have no independent regulatory body for nursing.

The scope of practice of a profession will change as governments or independent regulators decide to change, expand or extend roles and practice, just as the government of Zambia is currently considering. It is helpful to separate the concepts of role and scope of practice because the role may be very wide – as described in the definition of nursing in Chapter 1 – while the scope of practice may vary from time to time as needs and circumstances dictate.

The complaints from nurses in Chapter 2 about not being able to practise to the extent of their competence partly arise from their particular country having a very limited scope of practice, and partly, as in the example of the US in Chapter 1, from not being allowed to practise to its full extent. The development of nursing globally will embrace both aspects – enabling nurses to do what they are competent to do today, and extending the boundaries of the scope of practice for the future.

Pointers for the future – nurses as change agents

Nurses act as change agents in many ways, as illustrated in the following two studies submitted by the RCN.

Tackling AIDS in Andhra Pradesh, India

Andhra Pradesh is the fifth largest state in India, with a population of around 80 million (73% of whom live in rural areas). It is also among the six Indian states with the highest prevalence of HIV/AIDS, estimated among adults at 1%, or 21% of all people living with HIV/AIDS in India. The decentralisation of HIV/AIDS services to regional level has been critical for people living in rural and remote areas, especially for access to counselling and testing services, which provide a gateway for the entire range of HIV/AIDS treatments.

A pilot project was launched through a novel task-shifting model whereby nurses were trained for extended roles as counsellor, lab technician and outreach worker. The programme was stringently monitored and evaluated, including the supervision of nurses by medical officers and nurse supervisors. In 2009 nurses in primary health care were assessed: 80% were rated as excellent, while the remaining 20% needed upgrading. A subsequent evaluation indicated more positive results for the programme, particularly with respect to the nurses' roles.⁴⁶

Improving TB services in the Republic of South Africa

In 2000, the Lung Institute at the University of Cape Town developed a series of innovative packages to train nurses in rural, underserved areas to lead in screening patients at high risk of tuberculosis (TB) and other respiratory diseases. Over a period of 14 years, a randomised trial cluster of 40 clinics with over 200 nurses showed a substantial improvement in early detection of TB. A follow-up programme was developed following this success, which extended the training of clinic nurses to include HIV/AIDS screening and referral to doctors for diagnosis and initial prescribing of treatment, with patients then returning to nurses for monitoring.

A second cluster of randomised trials for this extended programme again confirmed a substantial positive impact on case detection of TB and HIV. There was also a surprising improvement in successful outcomes for retreatment of patients with TB, suggesting that the training had a positive impact on nurse–patient relationships. The trials also found that nurse-led care of HIV/AIDS caseloads resulted in patients being managed as effectively as they would have been in doctor-led programmes. Qualitative evaluations alongside these trials also showed that front-line clinic staff felt empowered by their training, allaying fears that responsibility for clinical diagnosis and treatment would be overpowering and result in burnout.⁴⁷

4. Opportunities and impacts

Summary

The first three chapters of this report reviewed the current situation and described many long-standing problems. The final three chapters look forward, towards opportunities and possibilities.

This chapter starts by considering evidence of the positive impact of nurses on quality, access to care and costs. There are many small-scale studies of this impact, and even more examples and anecdotes, but few large-scale studies, and most research is limited to high-income countries.

It goes on to look at how nurses can be enabled to fulfil their potential and take on new roles, making an even greater impact as a result, and at how sharing good practice, task-shifting and task-sharing can help.

The chapter concludes with the triple impact of nursing on improving health, promoting gender equality and strengthening economies.

The impact of nursing

Many studies show the beneficial impact of nursing across the different settings of homes, communities and hospitals, and in public health as well as clinical care. This section looks in turn at impacts on improved quality, access and value for money; patient outcomes; and service design and policy-making.

Quality, access and value for money

Several organisations have brought together existing research about the impact of nurses in high-income countries. These include the Institute of Education, University College London, which in 2010 did a rapid systematic review of reviews of the socioeconomic value of nursing and midwifery;⁴⁸ the Department of Health and Public Health England; WHO;⁴⁹ and ICN⁵⁰. Many of these studies make comparisons between nurses and doctors. The results all show that there are no easy generalisations about impact. All describe positive impacts on quality, access to services and value for money in particular circumstances and for specific ranges of patients – and not for others. The Institute of Education, for example, reviewed 32 systematic reviews conducted in OECD countries and concluded as follows:

- Interventions provided by specialist nurses or led by nurses were shown to have a beneficial impact on a range of outcomes for long-term conditions when compared with usual care. While there was little evidence of a difference

in clinical benefit of such interventions, there was persuasive evidence that specialised cancer nursing produced benefits in terms of patients' ability to cope with their condition.

- Enhanced nursing care for respiratory conditions may result in fewer visits to accident and emergency departments, though there was little evidence of benefit for other outcomes. There may be cost savings associated with nurse-led hospital at home care.
- General practice nurses may have some benefit in reducing some of the risk factors for heart disease when compared with usual or no care. While cost estimates were provided, overall cost-effectiveness was unclear.

Individual studies show benefits from nurse-led care including reduced costs,⁵¹ higher patient satisfaction,⁵² shorter hospital admissions,⁵³ better access to care, and fewer hospital-acquired infections. Nurse-led interventions for chronic conditions such as HIV and diabetes have resulted in patients making more informed decisions about their care and being more likely to adhere to treatment.⁵⁴

Advanced nurse practitioners (NPs) not only improved access to services and reduced waiting times, but also delivered the same quality of care as doctors for a range of patients, including those with minor illnesses and those requiring routine follow-up, according to an evaluation by the OECD across high-income countries.⁵⁵

“ An OECD evaluation... found that advanced practitioners not only improved access to services and reduced waiting times, but that they also delivered the same quality of care as doctors for a range of patients, including those with minor illnesses and those requiring routine follow-up ”

Department of Health and Public Health England

A systematic review of comparison of NPs with physicians in primary health care settings in Canada, the UK and the US showed low to moderate quality evidence that patient health outcomes were similar for NPs and physicians, but that patient satisfaction and quality of care were better for NPs.⁵⁶ Similarly, an English study showed that in a comparison of care effectiveness and cost effectiveness of general practitioners and NPs in primary health care, outcome indicators were similar for nurses and doctors, but patients cared for by nurses were more satisfied. NPs were slightly more cost-effective than general practitioners.⁵⁷

Globally, home-based, nurse-led health promotion and case management offer clinical benefits across a number of important health dimensions for older people (benefits in mortality, functionality, self-perceived health status, and caregivers' mental health), the International Collaboration for Community Health Nursing Research (ICCHNR) told the Review Board. 'Home-based early intervention delivered by community nurses is effective in preventing obesity in children, reducing mental health problems in mothers and children, promoting parenting self-efficacy and in providing access to basic primary care in remote and rural areas where other health services are not available,' it said.

By being embedded within communities, many respondents pointed out, nurses are able to promote public health and disease prevention. They can educate their local populations to make healthy choices, empower patients and families with knowledge and skills to encourage individual ownership of health, and help to build health resilience in their communities. In the current global climate of increasing burdens of more complex and chronic conditions, a nurse's role as a culturally attuned health promoter is invaluable.

As ICCHNR argued, ‘The foundational characteristics of many of these services provided by community nurses include a patient-and family-centred approach, a proactive orientation, an emphasis on promoting self-care skills and independence, and cross-organisational relationships with other providers and institutions.’

Nurses working in primary care settings have a critical role in supporting patients to self-manage their long-term conditions, taking an assets-based and health coaching approach and making use of opportunities for social prescribing, said Crystal Oldman, Chief Executive, Queen’s Nursing Institute (QNI). ‘Nurses make up the majority of health practitioners who support people among the most vulnerable in society, such individuals and families who are homeless,’ she told the Review Board.

The outcome studies are mainly from Europe and the US, although there are some from other countries. In studies in the Republic of Korea, primary care services provided by nurses were of the same quality as those provided by physicians, and also more cost-effective. Furthermore, ‘many of these nurses function as community development agents, working not only to improve the health status of the community but also to improve the quality of the environment and the standard of living.’⁵⁸

Patient outcomes and safety

Several studies show the relationship between the number of nurses on a ward, their workload, education and the environment on the one hand, and inpatient morbidity, mortality and safety on the other.^{59 60 61 62}

The RN4CAST Collaboration was set up to investigate these linkages further and provide better evidence for the deployment of nurses in hospitals. It started from the basis that ‘current human resources planning models in nursing are unreliable and ineffective as they consider volumes, but ignore effects on quality in patient care’. The project aims at innovative forecasting methods by addressing not only volumes, but also quality of nursing staff and quality of patient care.⁶³

The first major RN4CAST observational study obtained discharge data for 422 730 patients aged 50 or older who underwent common surgical procedures in 300 hospitals in nine European countries. It drew some clear conclusions. ‘An increase in a nurse’s workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7% (odds ratio 1.068, 95% CI 1.031–1.106), and every 10% increase in bachelor’s degree nurses was associated with a decrease in this likelihood by 7% (0.929, 0.886–0.973). These associations imply that patients in hospitals in which 60% of nurses had bachelor’s degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of nurses had bachelor’s degrees and nurses cared for an average of eight patients.’⁶⁴

‘Nurse staffing cuts to save money might adversely affect patient outcomes. An increased emphasis on bachelor’s education for nurses could reduce preventable hospital deaths,’ the study concluded. The collaboration is continuing its work in Europe and the US; however, there are as yet no comparable studies for low and middle-income countries or for primary health care and community settings.

“ Nurse staffing cuts to save money might adversely affect patient outcomes. An increased emphasis on bachelor’s education for nurses could reduce preventable hospital deaths ”

Linda Aiken and colleagues, RN4CAST Collaboration

Service design and policy-making

There are great benefits in involving nurses and other health workers in both service design and policy-making and, as the following paragraphs show, great dangers from not doing so.

The Ebola virus disease outbreak in West Africa killed many health workers and became known to some as the ‘caregivers’ disease’. It also led to many health workers and their families being stigmatised and shunned in their local communities. The European Federation of Nurses Associations, reviewing the extent of involvement of health workers in preparedness for Ebola and other infectious diseases, was surprised to find that ‘health professionals do not feel they are being consulted enough on the equipment and protocols they are to use, and are not adequately briefed from their organisation.’

Its report, aptly called *We are not prepared unless we are all prepared*, argued that ‘overall, awareness-raising initiatives are imperative in improving preparedness for Ebola and other infectious diseases of high consequences (IDHC); nurses have first-hand knowledge and experience of the reality of caring for patients with IDHC and Ebola, can give valuable contributions and consequently need to be involved in the decision-making, selection of material, development of protocols, as well as the design of policies and procedures which are “fit for practice”’⁶⁵

“ We are not prepared unless we are all prepared ”

European Federation of Nurses Associations

The comment that nurses have first-hand knowledge and experience of the reality of caring for patients has great relevance in many different situations. ICN summed up the many ways in which nurses can play a vital role in making decisions about how services are delivered and improvements introduced, saying that nurses as a force for change have opportunities to improve efficiency and reduce waste. In collaboration with other health professionals and decision-makers, it said, nurses and other health professionals can:

- improve prescribing guidance, information, training and practice;
- educate individuals and communities on detection and surveillance of counterfeit medicines;
- develop and implement clinical and evidence-based best practice guidelines;
- implement task-shifting and other ways of matching skills to needs;
- adhere to and champion infection control procedures;
- improve hygiene standards in hospitals;
- provide more continuity of care;
- undertake more clinical audits;
- monitor hospital performance and use the data to guide clinical decisions;
- reduce administrative burdens;
- evaluate and incorporate into policy evidence on the costs and impact of interventions, technologies, medicines, and policy options.

Nurses hold a wealth of knowledge about health and health systems that needs to feed into decisions about service design and policy-making. Due to their roles, the intimate care they frequently provide, and their mostly belonging to the same community and culture as their patients' nurses often understand patient needs better than doctors and policy-makers.

The point was made to us very powerfully by Peggy Vidot, Principal Secretary, Ministry of Health, Republic of Seychelles, describing how nurses can contribute to policy. 'People tend to believe that policies are done at a high level. But for policies that are generated at that level, one requires the information, the evidence from further down and I think this is where nursing can contribute. Nurses know what it is that we need to address in their communities, what services we need to bring, or how those services can be given more effectively so that we can be looking at attaining the different goals and health targets in those goals.'

“ People tend to believe that policies are done at a high level. But for policies that are generated at that level, one requires the information, the evidence from further down and I think this is where nursing can contribute ”

Peggy Vidot, Ministry of Health, Republic of Seychelles

The quality of the evidence

This brief review of the evidence shows that it is not very extensive and that some is of poor quality. However, the APPG also noted both that existing evidence was often ignored and not acted on and that it was very difficult to undertake research on nursing in low and middle income countries. Moreover, many of the services provided by nurses are invisible and the impact of this evidence is therefore low, as the ICCHNR told the Review Board. However, available evidence does illustrate two key points:

- There are many opportunities for nurses to have an even bigger impact on improving health and health care.
- Better evidence needs to be collected and disseminated to enable countries to make their own business cases for where and how investing and developing nursing in their country will have significant benefits.

More generally, many respondents told the APPG about small-scale initiatives undertaken by nurses – innovative, sometimes experimental, patient-focused and practical. There is a large reservoir of talent available that could have greater impact in the future. Despite the paucity of evidence, there is already enough for action to be taken. More evidence is needed but existing evidence needs to be used.

Current potential and future possibilities

Looking forward, this evidence and the discussions in earlier chapters show that there is enormous potential to enable nurses to realise their full current potential and to develop still further. This section looks briefly at four actions to help begin to make this happen – each of which will influence the others and all of which need to be undertaken.

First, this will require systematically removing barriers and changing mind-sets. This is very difficult and can only be achieved with high-level leadership linked with practical actions taken locally. The first APPG recommendation is that the UK government, working with partners, is very well placed to help make this happen – and should initiate a process to do so.

Second, political and non-nursing leadership is important in making this happen but nursing leadership is also crucial. Earlier chapters show that in many countries and in WHO there has been a reduction in nurse leadership roles, rather than a strengthening. This needs to be reversed.

As the Department of Health and Public Health England report quoted earlier argues, ‘What this reinforces is a need to build and strengthen leadership at all levels for the long term – including within health service providers and ministries and enhancing the role of chief nursing and midwifery officers. Maintaining and enhancing this positive influence remains a challenge in the UK countries as well as more resource poor countries.’⁶⁶ As part of this, the APPG believes there needs to be major investment globally in leadership programmes which will help nurses engage in policy-making as well as in service design and organisational leadership. It notes that ICN is in the process of developing a programme that could potentially meet this need with the right support and funding.

Third, there need to be better ways of sharing and learning from good practice and from research locally, nationally and globally. There are already a number of ways in which this happens within particular communities – with, for example, both ICN and RCN using their extensive networks to do so. However, little of this evidence is seen outside nursing circles and many respondents saw a need for this to be more extensive and better supported by ministries and non-nursing leaders. The APPG suggests that the Commonwealth’s newly created Health Hub may have a useful role here.⁶⁷

Finally, the development of nurses needs to be undertaken as part of a balanced approach to the whole health workforce. The WHO strategy described in Chapter 3 provides an overall framework and there is a great deal of recent research and policy development on teamwork and skill mix, including, for example, guidelines on task shifting and task sharing from WHO and the World Health Professions Alliance.^{68 69}

The global shortage of health workers and the need to achieve the best possible value for money are leading policy-makers to look at many different options for how services will be delivered, health workers deployed and professionals educated in future. A very common approach is to look to skill-mix change, task-shifting or task-sharing, approaches through which tasks traditionally performed by one group of health workers are undertaken by another or by patients and their carers. In Zambia, as noted in Chapter 3, the Ministry of Health is both enhancing the roles and scope of practice of nurses working alone in country areas and introducing health care assistants in hospitals. In England work is under way to pilot proposals for a new nursing support role, the ‘nursing associate’.

In some cases, this approach is about extending the scope of practice, for example of nurses; in others, about creating new roles or cadres; and in yet others about supporting patients to do more for themselves.

There are many excellent and successful examples of each, including:

- **Extended scope of practice.** Nurse prescribing in England has worked successfully. Similarly, the enabling of nurses to initiate ARV therapy in South Africa played a major part in bringing down HIV/AIDS deaths.

- **Creating a new cadre.** The creation of ‘tecnicos di cirurgia’ to undertake obstetric surgery in Mozambique – many previously trained as nurses – contributed enormously to improving maternal and child mortality and morbidity.⁷⁰
- **Self-care.** The introduction of patient-managed dialysis in hospitals in Sweden – not just in their homes – improved quality and satisfaction and reduced costs.

The Lancet Commission on the Education of Health Professionals for the 21st Century describes how these approaches relate to the earlier discussion on competences and professionalism. ‘Individual professions might have distinctive and complementary skills that could be considered the core of their special niche. But there is an imperative for bringing such expertise together into teams for effective patient-centred and population-based health work. Moreover, the walls between task competencies of different professions are porous, allowing for task-shifting and task-sharing to produce practical health outputs that would not be possible with sealed competencies.’⁴⁵

There are risks with this approach. In part these arise from staff not following guidelines described above with, for example, tasks of intimate physical care, or care for people with mental illnesses or learning difficulties, being undertaken by people who may not be properly trained for the task or able to follow the patient’s care plan. This can result in the delivery of poor care and these assistants being mistaken for nurses by patients, the public and the media.

On the other hand, there are also risks when NPs and other specialist nurses take on tasks performed by doctors. This is partly about workforce planning. ‘Task shifting from medicine to nursing needs to be evaluated for its impact on the provision of nursing care,’ Emma Coyle told us. ‘The development of new cadres of health care workers to fill the shortage left by too few nurses and doctors could take away from those who would normally enter nurse education. If there is a finite human resource for nursing, then fragmentation of that resource may not be conducive to achieving universal health coverage.’

Furthermore, the distinctive and wide-ranging role of the nurse should not be lost by becoming more focused on specific processes and procedures. As Heather Henry put it, nurses should not just be used as a cheap way to plug gaps in services – nursing must remain distinct from medicine, ‘maxi nurse not mini medic’.⁷¹

An earlier APPG report, *All the Talents*, identified five groups of factors consistently present in successful examples of task-shifting but absent where it failed.⁷² These success factors are individually very obvious and simple-sounding but collectively quite hard to deliver. Many low and middle-income countries lack resources to do all these things all the time, such as provide supervision in remote areas. The more of these factors that are in place at any time, the more likely any change is to be successful.

The upward spiral in Figure 4.1 illustrates how these factors reinforce each other when building from a sound basis of planning and leadership, with the full engagement and leadership of local teams. Turning the spiral upside down, it is easy to see why many such examples fail – poor planning without engaging those who will actually do the work, recruiting the wrong people, inadequate training, no supervision and no authority or ability to refer are all major contributors to failure.

Figure 4.1 Success factors in changing skill mix



Recognition and teamwork

All health workers should receive adequate recognition for their work and be supported to work in teams with other professionals, lay workers and patients.

Supervision and referral

Supervision and clear referral pathways – involving all groups of health workers – are essential to ensure the best quality of care.

Formal training and progression

Formal training is needed to develop skills, and opportunities for progression can be important in enabling individuals to achieve their potential.

Job design and recruitment

Tasks must be defined and recruitment targeted accordingly.

Leadership and planning

Success is based on careful preparation and planning – with a leader, institution or government taking responsibility for all aspects of planning and implementation.

Triple impact

This chapter has concentrated on nurses' impact on health, but it is also important to recognise how investing in and developing nursing promotes gender equality and strengthens economies – the other two aspects of the triple impact.

Nursing is not and should not be seen as an exclusively female profession. Yet women currently make up the vast majority of the nursing workforce, and the way nurses are treated in a particular society is often a reflection of how women are treated. Becoming a nurse provides many girls and women around the world with access to formal education, training programmes and eventually licensure, a job, and an income, facilitating their economic independence. Through this experience nurses gain confidence and respect in their local communities and can act as role models

and mentors to other women and girls. In addition, a qualified, empowered and competent nurse empowers other women indirectly by helping to improve their health and well-being.

The Grameen Caledonian College of Nursing, Dhaka, Bangladesh, created in partnership between Grameen Bank and Glasgow Caledonian University, is a fine example. It educates girls from the rural communities of Bangladesh to a high and appropriate standard of nursing and midwifery practice, with a focus on rural public health. Their education is paid for by a low-interest social loan that is then repaid when they start working in rural community health. ‘This creates a sustainable training model, equips the students with skills that have a real impact on the health of rural communities, and raises their social status and income, benefiting their family and community.’⁷³

As founding principal Barbara Parfitt says, ‘Our students will be equipped with the skills, knowledge and attitudes that will change their lives and the lives of their communities forever.’ It gives young women opportunities and prepares them to be leaders and change agents in health care for the future, adds Muhammad Yunus, Nobel laureate and Chancellor, Glasgow Caledonian University.⁷⁴

“ Grameen Caledonian College of Nursing gives young women opportunities and prepares them to be leaders and change agents in health care for the future ”

Muhammad Yunus, Chancellor, Glasgow Caledonian University

Turning to economic growth, there has long been an understanding that better health contributes to economic growth and, conversely, that ill health is an economic cost to a country and affects educational attainment and productivity.⁷⁵ Additionally, nursing contributes to economic growth by being a major source of long-term employment and contributing to national and international labour markets. Moreover, there is evidence that health sector employment has significant growth-inducing effects on other economic sectors, as employed health workers spend their income across a wide range of areas.⁷⁶ This causes a cascade effect, with money circulating across the economy and spurring economic growth.

The UN High-Level Commission on Health Employment and Economic Growth was established in 2016 precisely to describe this interface between health worker employment and economic growth.⁷⁷ Its report notes that: ‘First, good health contributes to economic growth. Second, there are important additional pathways by which investments in the health system have spill-over effects that enhance inclusive economic growth, including job creation. Third, new evidence suggests that expenditures on health are not dead-weight drags on the economy, but rather can be associated with productivity gains in other sectors.’⁷⁸ It goes on to argue for the importance of investing in health worker employment as a means of ensuring there is inclusive growth.

While the details will vary from country to country, this triple impact provides a compelling case for developing nursing globally.

5. The UK's contribution to health globally

Summary

This chapter describes the UK's contribution to health globally and its potential to do much more to support the development of nursing globally.

It also outlines the role of partnerships and the scope for mutual learning between nurses in the UK and their counterparts abroad. It concludes by highlighting some existing partnerships.

The UK's contribution to health globally

In 2015 the landmark APPG report, *The UK's Contribution to Health Globally*,⁷⁹ mapped the contribution to global health of actors across four sectors in the UK – government, academia, commerce and not-for-profit activity. It showed that the UK is a world leader in health, with enormous scope both to help improve health worldwide and to continue to develop research, industry and activities that benefit the UK.

The report made little mention of nursing – partly because its contribution is largely small-scale and 'invisible', but also because its potential is unrecognised and unrealised. Yet, with its world-class universities and research institutions, cutting-edge life science, a diverse not-for-profit sector and acknowledged strengths in health care and international development, the UK is very well positioned to contribute significantly to supporting the development of nursing globally.

There are many government bodies and public authorities that can play major roles, including:

- The UK government itself through its international relationships, particularly with the Commonwealth, Europe and countries supported by the Department for International Development through partnerships. The next chapter contains recommendations on how the government can use these great strengths to support the development of nursing globally.
- The NHS in the four countries of the UK, through sharing expertise; creating mutually beneficial relationships with partners in other countries; and strengthening and developing nursing in the UK. Examples of partnerships between UK organisations and others abroad are described below.
- Regulatory and public bodies, such as the NMC, the National Institute for Health and Care Excellence (NICE) and the authorities responsible for public health and education and training in the UK's four countries, can influence the future of nursing in the UK and work with others abroad on global issues.

The UK also has nursing organisations that are themselves world leaders, building on the great traditions of UK nursing and able to influence and partner with others. The RCN, for example, internationally recognised as both professional body and trade union, can play an important role in influencing policy and developments; helping to strengthen national nurses' associations; and collecting and sharing good practice and evidence of impact. It also provides some training and development opportunities for nurses from other countries – its partnership with the Zambia

Union of Nursing Organisation (ZUNO) is described below. The Royal College of Midwives (RCM) undertakes similar work overseas with midwives as well as nurses who work in maternity care. In addition Unison, Unite and other trades unions play a role in bilateral projects and through Public Services International.

Many academic institutions in the UK train nurses and other health workers. They can and do play an important role in education and providing continuing professional development opportunities to overseas nurses, and supporting research by nurses in low and middle-income countries. The UK also has many of the leading nursing and health journals globally which disseminate evidence and best practice. Looking ahead, both the not-for-profit sector and the commercial sector in the UK can also play a larger part in supporting nurses through research and innovation in practice.

The UK will only be able to play this important role, however, if its health and care system is on a sound footing – and if there is no suggestion that it will be competing with low and middle-income countries for health workers and other resources. The vote to leave the EU has, however, created a significant risk that the UK will lose many of the European nationals employed in its health and care system and will be unable to recruit more. The Review Board believes that the UK needs both to find methods for securing the continuing employment of EU citizens in the health and care system and to re-assess and increase levels of nurse education to meet its own needs. It needs also to maintain its commitment not to recruit health workers from countries with major shortages.

Real-life experience and opportunities

A great deal of partnership and development work is under way and there are opportunities for much more, as many respondents said. The following examples, taken from interviews and responses to the APPG call for evidence, reveal some of the complexities, including both risks and benefits.

Dr Oldman gave some historical context. After the Second World War, the QNI played an important role in training district nurses from countries all over the world, including Greece, Malta, Nigeria and Singapore. Some of them returned home while others stayed to work in the UK. At the same time British Queen's Nurses, trained by the QNI as district nurses, were appointed abroad to support overseas community nursing services. 'The QNI is keen to continue this historic relationship with nurses from all over the world and to support the development of global nursing practice, particularly in community and primary care settings,' she said.

Looking forward, she argued that the NMC-approved Specialist Practitioner: District Nursing qualification is vital to support nurses to develop the unique skills and knowledge required to lead and manage a team of multi-skilled professionals to deliver excellent nursing care to people in their homes and local communities. 'Adopting similar programmes in other countries would help to build the expert clinical, management and leadership skills required to coordinate care provided by the district nursing service in people's homes and communities,' she said.

The RCM argued for strengthening the UK role and placing it in a wider context, pointing out that the UK is an important hub for medical, midwifery and nursing research. 'Our government needs to utilise UK expertise to support global health research, and to commit to integrating the UK's health professional education system into a landscape of global learning, acknowledging that the UK has much to learn from other countries and health care systems and facilitating this learning to help the

UK face the changing landscape of healthcare in the future (particularly in utilising global expertise in non-communicable diseases and new epidemics),’ it told the Review Board.

The RCM said world-renowned UK health professional journals have a key role in providing evidence on the effectiveness of midwifery and nursing. ‘The UK government needs to better utilise this research, in particular the research on the components of quality care.... (it) also has an important role to play in influencing the prioritisation of midwives and nurses in national health care plans, and in raising the status of midwives and nurses through raising the status of women.’

“ ...commit to integrating the UK’s health professional education system into a landscape of global learning ”

Royal College of Midwives, UK

Taking a global perspective, João Marçal-Grilo, Unity in Health, spoke of the ‘enormous potential for both the UK government and UK-based organisations to support the development of nursing globally.’ His NGO is developing programmes in Sri Lanka and Nepal, focusing on training nurses in community mental health nursing skills. In both programmes, UK-trained nurses and other health professionals support local educational bodies and teaching staff in delivering theoretical and practical courses for nurses – ‘support with the planning and designing of course curriculums and course materials, with identifying and creating placement opportunities with local health care services and NGOs, and with the teaching of specific course modules.’

Several respondents spoke of the debt the UK owed to other countries. ‘The UK government and NHS have relied on nurses from other countries over significant years and this has on the whole been a positive experience and brought value to the NHS. I believe it is time to give back support for the development of nursing from vocational to professional nursing in some of the third world countries,’ said Joyce Fletcher, deputy director of nursing, Black Country Partnership NHS Foundation Trust. ‘So there is a role for the UK in proactively sharing our experiences, expertise, systems and processes across the globe and of course learn from other more advanced countries. Development of an exchange system to allow ease of movement of nurses across the globe.’

Nurses in many countries are requesting international support, including Eva Said of the College of Nursing, Hawler Medical University, Erbil, Kurdistan Region, Iraq. She sent the APPG a very moving statement which included the following: ‘The door has been found and left ajar – the door leading to the global nursing community which has shown time and time again that solidarity among nurses has no boundaries. Communication leading to partnerships and cooperation has enormous potential to support self-development of the nursing profession in regions like ours.’

‘Nurses in Kurdistan need and want to learn,’ she continued. ‘Many of those in clinical practice, education, administration and policy development crave guidance and support that will allow them to develop themselves and their profession. International nursing experience and expertise is vital for nursing in the region to consolidate its strengths, face the challenges of healthcare during the time of conflict, and prepare for post-conflict era of restoration and growth. By doing so, nursing in the region can not only continue to develop but contribute to the efforts of global nursing community to face current and future challenges.’

Nurses from outside the UK generally welcomed these approaches but said they need to be done in the right way – if they are not, they will not be sustainable. Michael Koroma, chief executive officer, St John of God Catholic Health Services, Sierra Leone, worked in the Northern Province of Sierra Leone during the Ebola outbreak and noted the challenges of foreign intervention: ‘They often dictate and don’t allow us to be innovative and sometimes their focus does not meet the needs of the local context. They also need to work more with the local populations and ensure projects are sustainable.’

‘Since the British left, you realise that the impact has not been there,’ he added. ‘After millions of pounds spent you see it again as if nothing was done. But you realise that the money was not with the government, the money was with the British NGOs. You don’t see any impact again. They left us in misery. I don’t think the tax-payers will be very happy because they want to give their money to make a change, not to come back to them to ask them again for help.’

This critique is of fundamental importance in pointing to the need to ensure that development work and partnership schemes are undertaken in the right way – professionally, with proper preparation, clear ground rules and mutual respect. Very importantly, funding should not just support the foreign organisation but should go towards building capacity in the country.

The underlying point is that richer countries like the UK, US and others need to approach this work with the humility of understanding that everyone has something to teach and everyone has something to learn. The top-down processes of international development where ‘the West knows best’ often fail because they ignore local circumstances and culture – and because they underestimate and often ignore or dismiss local knowledge and skills. There is a need to go beyond aid into a new world of co-development and mutual learning.⁸⁰

“ Communication leading to partnerships and cooperation has enormous potential to support self-development of the nursing profession in regions like ours ”

Eva Said, Hawler College of Nursing, Kurdistan Region, Iraq

Mutual learning

Many respondents told the APPG that partnerships and overseas volunteering benefited the UK as well as the recipient countries, and argued for more opportunities. In an earlier report, *Improving Health at Home and Abroad*, the APPG identified four areas of benefits from volunteering – benefits for the country in health services, training and outcomes; benefits to the UK in leadership development; shared benefits from shared innovation; and benefits in international relations and enhancing the UK’s soft power.⁸¹

The report noted that working in resource-poor settings was particularly valuable for health workers in building leadership skills such as communication and self-knowledge. The ingenuity and adaptability required for projects in host countries led to first-hand opportunities to develop these skills in ways that few courses could compete with. This fits with a growing appreciation of the value of real world challenges, as opposed to classroom learning, in the field of leadership development. Clinical staff in particular, the APPG heard, returned with new interests in redesigning pathways of care, service integration, and commissioning and teamwork – all key competencies identified as priorities for improvement in the NHS.

The Improving Global Health Fellows Scheme run by the Thames Valley and Wessex Leadership Academy One uses overseas volunteering with the explicit intention of developing its workforce's leadership skills. It places doctors in training and more experienced nurses, midwives, managers and allied health professionals in partner organisations in Cambodia and South Africa for periods of 4–6 months.

The fellows receive initial induction and training, and work on projects that have been identified locally and are therefore designed to be both appropriate and sustainable to provide 'an unparalleled personal and leadership development experience to staff' and 'create a cadre of skilled clinical leaders with quality improvement skills who can make a real difference to the NHS on their return'. Three years in, an independent evaluation found that 'without exception fellows reported outstanding personal development, often described in terms such as "life changing"... The majority emerged with a greater appreciation of the value of audit, teaching, management and their significance for clinicians, and with an enthusiasm for leading service improvement in the NHS.' Such benefits have been recognised both nationally and more locally.

“ A period overseas can broaden experiences and thinking in a whole host of new ways. 'It changes people forever' is the quote that we hear directly back from people. It can revitalise people and helps them realise just how fortunate we are to have the NHS ”

Ian Cumming, Chief Executive, Health Education England

A range of organisations including the Tropical Health and Education Trust (THET), Health Education England (HEE) and Wales for Africa support partnership schemes where the priority is to deliver benefit to the receiving country, and where the incidental benefit to the UK is both acknowledged and welcomed. The Global Health Exchange has been set up in association with HEE to facilitate this mutual learning and co-development and explore how best to support the English NHS by workforce and education transformation through global learning.⁸²

“ Members of staff return from international work highly motivated, with increased work ethic and renewed vocation for the NHS. They are more adaptable and open-minded, innovative in their approach to service delivery and capable of leading change ”

Sheffield Health and Social Care NHS Foundation Trust

Pointers to the future – partnerships

Examples of partnerships involving UK organisations are mentioned elsewhere in this report. Many are small scale, relating to individual specialities or small groups of people. Nurses from Brighton and Sussex University Hospitals NHS Trust, for example, work alongside Zambian colleagues to improve critical care at the University Teaching Hospital, Lusaka, and have helped develop the country's first paediatric nursing course.⁸³ The examples below illustrate the wide range of possible partnerships, whether in professional associations, research, education or public health.

Developing a professional organisation

The RCN is working in partnership with ZUNO to influence nursing policy and improve nursing practice in Zambia. The project focuses on building ZUNO's capacity as a professional association to advocate for better policy and practice at local, district and national levels, and supports it to demonstrate influence on nursing practice at institutional level. As part of this, ZUNO with RCN support is leading a small pilot project at the University Teaching Hospital, Lusaka, on use of the WHO Surgical Safety Checklist. This takes a multi-disciplinary approach, encouraging nursing, surgical and anaesthesia staff to work together as a team.

A research partnership

The International Collaboration for Community Health Nursing Research (ICCHNR) aims to advance and share knowledge of community health care nursing practice through research.⁸⁴ Dr Oldman told the APPG that 'greater investment in networks like the ICCHNR is required, both to develop forums for sharing learning internationally, and to support research to improve the global evidence base for nursing practice in the community and primary care.'

Professional education

The Grameen Caledonian College of Nursing, already mentioned in this report, was established in 2010 in Dhaka, Bangladesh. This visionary college offers students nursing education and clinical practice to international standards. It raises the status of the profession in Bangladesh and provides opportunities, education and training to women from impoverished backgrounds. It celebrated its inaugural graduation in 2013, when 38 graduates were awarded a Diploma in Nursing and Midwifery approved by the Bangladesh Nursing Council.⁷⁴ The impact of its work in health and on gender equality and the economy were noted above in Chapter 4.

Technology to support accessible training programmes

Partnerships extend beyond the public sector and may involve the creation of products and tools that enhance training programmes. For example, as part of the response to the Ebola outbreak in West Africa, the Masanga MENTOR Ebola Initiative brought together experts from public and private sectors to create a digital tool kit to augment traditional training using a blended approach. It is accessible on a tablet that can be adapted to reflect different cultures and languages. The Initiative developed this innovation jointly with Plymouth University Peninsula Schools of Medicine and Dentistry, with funding from donations to *The Telegraph* 2014 Christmas appeal. The US government then supported its further development to support safe triage practice in the aftermath of the outbreak.

Public health

Public Health England is promoting the role of nurses and midwives in public health and working towards designation as a WHO collaborating centre for public health nursing and midwifery. It aims to:

- collaborate with WHO to provide information on models for nurse/midwife practice/service delivery;
- support WHO by providing information about nursing and midwifery education and regulation;

- assist WHO to develop research in the field of nursing/midwifery person-centred public health practice and service delivery and development;
- participate in jointly planned and implemented research about integrating health promotion, improvement and prevention through the life course into service/care delivery;
- collaborate with WHO to provide specialist conferences, training and education on the nurse/midwife role and contribution on the social determinants of health.

Conclusions and recommendations

Summary

This chapter brings together the discussion from earlier chapters and makes seven recommendations about how the UK can support the development of nursing globally.

It sets out each recommendation in turn and summarises the main arguments that support them.

At the outset, the chapter notes that nursing leaders cannot by themselves achieve the development that is needed. Politicians, policy-makers and non-nursing health leaders need to work with nurses to make this happen.

Moreover, if the UK is to play a leading role globally, it needs to apply the findings and recommendations of this report to the UK itself: raising awareness of the potential of nursing, investing in education and training, supporting nurse leadership and ensuring that nurses, with all their depth of experience, are fully involved in policy-making.

Leadership

The APPG believes strongly that major change is needed if nurses are to be enabled to play their full role in improving health and health services globally, and to help achieve UHC. This is not simply a technical matter of adjusting health policies, but requires fundamental change in how nurses are regarded and treated. In turn this relates both to the position of women in societies around the world, and the power and dominance of the medical profession and the biomedical model of health care.

Most of what is said in this report is not new and much of it will be very familiar to nursing leaders. For example, 50 years ago a WHO Expert Committee on Nursing described the rapidly changing social, political and scientific environment in which nursing was operating. It asked whether planners were preparing for a future where women had different roles, where there was mass demand for health care, and where nurses took on tasks traditionally done by doctors and in turn passed on some tasks to others. 'In order to cope with this and other challenges, nursing must break with some of its traditions as well as alter existing stereotypes,' it said.⁸⁵

Much has changed in 50 years, including the huge growth in degree-level nursing education, but more is needed – in particular, action to change the stereotypes. Nurses simply do not have the power and leverage to achieve this by themselves.

This is why this report proposes that the UK government not only takes a leading role in raising the profile of nursing, but also does so in the context of achieving a triple impact of improved health, greater gender equality and stronger economies.

The UK has a very strong tradition as a pioneer in nursing, and in health more generally, and enormous strengths on which to build. However, it is essential that the findings and recommendations of this report are taken up within the UK if it is to play a leading role in nursing globally. This will involve raising awareness of the potential of nursing, investing in education and training, supporting nurse leadership, ensuring that nurses with all their depth of experience are fully involved in policy-making, and much more.

Change will take years but a start can be made: the government has the opportunity to set the direction and lead.

Recommendations

The APPG recommends that the UK government, together with the Commonwealth Secretariat, the European Union, the World Health Organization and other international agencies, works to:

1. **Raise the profile of nursing and make it central to health policy.** Nurses have an enormous part to play in achieving universal health coverage, and nursing should be central to global policy and plans.
 - a. Convene a high-level global summit on nursing, aimed particularly at political and health leaders outside nursing, to raise awareness of the opportunities and potential of nursing, create political commitment, and establish a process for supporting development.

This should be part of a longer-term initiative that will embrace all the following recommendations.

The main arguments for this recommendation are that:

- Universal Health Coverage cannot be achieved without strengthening nursing, the largest part of the health workforce globally.
- There is enormous waste in educating and training nurses and not then allowing them to work to their full potential and, often, failing to retain them in the workforce.
- Much of what nurses do is necessarily small-scale, intimate and invisible to the wider world and their collective impact, capability and potential needs to be much better understood.
- Politicians and non-nursing leaders need to work as partners with nurses because nurse leaders alone do not have the power and influence to make the changes needed, in light of the lower status of women and the dominance of the medical profession and the bio-medical model of health care.
- Nurses are very well positioned, thanks to their education, skills and values, to address the needs for more holistic and bio-psycho-social approaches to health which are arising from changing epidemiology and new understanding of the social determinants of health.

- Globally nurses themselves describe their not being permitted to work to their full potential as one of their greatest problems and sources of low job satisfaction.
- The UK has enormous influence globally and can strengthen its own global role still further by establishing a major new initiative on nursing.

2. **Support plans to increase the number of nurses being educated and employed globally.** The World Health Organization global strategy on human resources for health, *Workforce 2030*, adopted by member states in 2016, proposes a framework for making the most effective use of health workers and developing country-specific investment plans to address workforce shortages.
- a. Work with low and middle-income countries to develop and support their workforce plans through funding and partnership schemes.
 - b. Reaffirm support for the WHO *Global Code of Practice on the International Recruitment of Health Personnel*, publish a report on UK progress in implementation since 2010, and provide support for education and employment of health workers in their own countries.
 - c. Assess the impact of leaving the EU on staffing in the UK health and care system, and take mitigating action including finding methods for securing the continuing employment of EU citizens in the health and care system and reviewing and increasing the number of nurses being educated in the UK to meet its needs.

The main arguments for this recommendation are that:

- There are very large shortages of health workers globally – not all of which can be ameliorated by finding more effective ways of deploying staff and delivering services;
 - The needs of countries must be determined and very largely funded locally but the UK and other high income countries can assist with expertise – for example in education and management – and, in some cases, funding;
 - Emigration of health workers remains a very serious problem for many low and middle income countries;
 - Migration to the UK in the past – and the perception that the UK is still encouraging it – can damage relationships with partner countries;
 - There is a significant risk that since the referendum many European nationals working in the UK's health systems will leave the country and not be replaced – raising the fear that it may return to recruiting more health workers from low and middle income countries;
 - Action globally to deal with these problems appears to have slowed down and needs to be given new emphasis and momentum.
3. **Develop nurse leaders and nurse leadership.** Experienced nurse leaders are needed in the right places to help nursing deliver its potential and ensure that the distinctive nursing perspective is included in policy-making and decision-making.

- a. Establish a large-scale new programme globally to develop nurse leaders that will enable them to engage more effectively in policy-making and decision-making. The International Council of Nurses has plans for developing such a programme that could provide a template.
- b. Ensure all countries have appropriate nurse leadership posts throughout all their structures and organisations.

The main arguments for this recommendation are that more nurse leaders need to be appointed and developed to:

- improve the visibility of nursing and ensure that non-nursing leaders understand how nursing can contribute;
- inform and contribute to policy – and they are particularly important in understanding how policy impacts on practice and outcomes in reality;
- lead this very large workforce operationally, improve its management and ensure that nurses are well educated, motivated and supported;
- deliver and develop education, training and research.

4. **Enable nurses to work to their full potential.** Nurses are too often not permitted or enabled to fulfil their true potential. Cultural, regulatory and legislative enablers and barriers need to be identified and removed and good practice shared and acted on.

- a. Develop new ways of sharing good practice – drawing on existing work by nursing organisations, the Commonwealth Health Hub and others – to create more coordinated and effective ways of identifying and sharing good practice globally, and ensure they are brought to the attention of policy-makers and other health leaders.

The main arguments for this recommendation are that:

- There are very many small scale innovations in nursing, sometimes initiated by individual practitioners, which need to be developed and learned from more widely;
- There are a number of existing networks for sharing good practice and learning within nursing which need to be opened up and used by non-nurses;
- Similarly, existing networks outside nursing need to take far greater recognition of the role that nursing can play and engage them in their work.

5. **Collect and disseminate evidence of the impact of nursing on access, quality and costs, and ensure it is incorporated in policy and acted upon.** There are many small-scale studies of the impact of nursing. These need to be brought together with new evaluation and research to demonstrate impact at scale.

- a. Commission research to bring together existing evidence and initiate new studies on how and where nursing improves access, quality and costs and what contribution nursing can make to universal health coverage.

-
- b. Ensure that existing and future research findings are widely disseminated and understood in order to influence both practice and policy.

The main arguments for this recommendation are that:

- There are many smaller-scale evaluations and studies which identify impacts but very few at scale which can help identify where and how nursing can have the greatest beneficial impact
- These studies need to be championed and disseminated outside nursing
- New studies and analysis of impacts will help countries make business cases for investment in nursing and inform global policy making and planning.

- 6. **Develop nursing to have a *triple impact* on health, gender equality and economies.** Developing and investing in nurses – the vast majority of whom are women – will help empower them economically and as community leaders. Improving health and empowering women will in turn strengthen local economies.

- a. Adapt development policy to bring together programmes and funding to address simultaneously, the three Sustainable Development Goals focusing on health, gender equality, and inclusive and sustainable economic growth (numbers 3, 5 and 8) and work with partners throughout the world to develop nursing strategies that work towards achieving all three goals.¹

The main arguments for this recommendation are that:

- There is clear overlap in Sustainable Development Goals 3, 5 and 8.
- UK DFID has prioritised work on gender equality and economic development as well as health, and can realise synergies and benefits from bringing its three programmes in these areas together.

- 7. **Promote partnership and mutual learning between the UK and other countries.** There are many partnerships between British organisations and their counterparts abroad that bring mutual benefit and shared learning.

- a. Expand the DFID Health Partnership Scheme and redesign it so as to engage as many nurses as possible and promote mutual learning and support between UK nurses, their organisations and their counterparts abroad; and support UK agencies including Health Education England, Wales for Africa, and the Scottish government's international development programme to promote the engagement of NHS and other health and care organisations in global partnerships that bring mutual benefits.

The main arguments for this recommendation are that:

- There is a great deal of scope for mutual learning and co-development between UK organisations and their counterparts abroad.

- Partnerships and volunteering abroad, when well organised and supported, bring benefit to the recipient country but also offer scope for personal and leadership development to participants, help all parties to share in innovation, and promote good international relationships and the UK's soft power.
- Greater benefit will come from supporting partnerships at a greater scale.

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The speakers at a public seminar on 24 February 2016

Jim Campbell	Director, Human Resources for Health Department, WHO, and Executive Director, Global Health Workforce Alliance
Francesca Colombo	Head, Health Division, OECD
Richard Horton	Editor-in-Chief, <i>The Lancet</i>
Duncan Selbie	Chief Executive, Public Health England

The people who attended public witness sessions

James Buchan	Queen Margaret University, Edinburgh
Frances Hughes	Chief Executive, International Council of Nurses
Donna Kinnair	Royal College of Nursing
Rachel Mwansa	Zambia Nurses Association
Anne Marie Rafferty	Professor, King's College London
Judith Shamian	President, International Council of Nurses
Susan Williams	Royal College of Nursing

People interviewed

Maureen Bisognano	Institute for Healthcare Improvement
Paulette Cash	The Nurses Association of the Commonwealth of The Bahamas
Isatu Daramy Kabia Datin Paduka HJH Abdullah	Retired nurse and midwife
Anita-Anand Deodhar	The Trained Nurses Association of India
Andre Gitembagara	Rwanda Nurses and Midwives Union
Heather Henry	New NHS Alliance

Chris Hopson	NHS Providers
Michael Musa Koroma	St John of God Catholic Health Services, Sierra Leone
Sunita Lawrence	Madhya Pradesh branch, Trained Nurses Association of India
Gwendolyn Lobbie-Snaggs	Trinidad and Tobago Registered Nurses Association
Salome Madithapo Masemola	Democratic Nursing Organization of South Africa
Paul Magesa Mashauri	Tanzania National Nurses Association
Nga Manea	Cook Islands Nurses Association
Afaf Meleis	University of Pennsylvania
Judy Mewburn	International Development Committee, Association of Surgeons of Great Britain and Ireland
Njoki N'gan'ga	International Organization for Women and Development
Francis Omaswa	African Centre for Global Health and Social Transformation
Anthony Peters	Trinidad and Tobago Registered Nurses Association
Mala Rao	Dept of Primary Care and Public Health, Imperial College London
George Saliba	Malta Union of Midwives and Nurses/ CNMF Board Member, European Region
Peggy Vidot	Ministry of Health, Republic of Seychelles

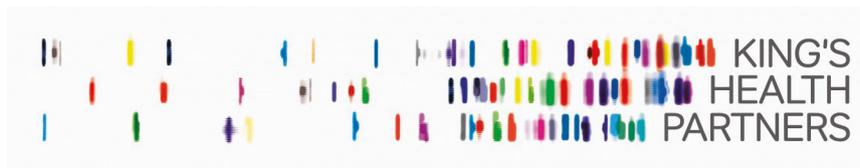
People and organisations who submitted evidence

Heather Alcock	VSO
Jerome Babate	Beta Nu Delta Nursing Society
Andrea Bennett	Your Healthcare
Fleur Blakeman	NHS Eastern Cheshire Clinical Commissioning Group
Mary Chiarella	University of Sydney
Emma Coyle	Centre for Maternal and Newborn Health, Liverpool School of Health and Tropical Medicine
Graeme Chisholm	THET
Joyce Fletcher	Black Country Partnership Foundation Trust
Emma Forster	North East and Cumbria International Health Links Network
Steven Fouch	Christian Medical Fellowship
Finbar Gibbons	Public Health England
Elizabeth Hall	Public Health Wales
Christine Hancock and Pat Hughes	C3 Health

Aisha Holloway	University of Edinburgh
Claire Johnston	Camden and Islington NHS Foundation Mental Health Trust
Peter Jones	Lancaster University
Joy Kemp	Royal College of Midwives
Sally Kendall	International Collaboration for Community Health Nursing Research
Brenda Longstaff	Northumbria Healthcare Trust
João Marçal-Grilo	Unity in Health
Anne Moger	Nursing Directorate, NHS England
Daniel Mortimer	NHS Employers
Tom Murray	Nurse
William Nkata	Mental health practitioner
Crystal Oldman	Queen's Nursing Institute
Eva Said	Hawler University, Kurdistan Region, Iraq
Fiona Sanders	NHS Stockport
Michael Stark	Educators International
Fiona Stephenson	International Training Coordinator, Nepal
Pam Smith	University of Edinburgh
Dawn Tillbrook-Evans	Faculty of Intensive Care Medicine, Royal College of Nursing UK Critical Care Nursing Alliance and Intensive Care Society
Bethan Twigg	WaterAid
Richard Walker	Department of Medicine, North Tyneside General Hospital
Roger Watson	Professor of Nursing, University of Hull
Silvia Cassiani, Maria del Carmen Gutierrez Agudelo, Jacqueline Molina de Uriza, Nathaly Roza Gutierrez, Rosa Zarate, Laura Morán, Lynda Wilson, Doreen Harper	Joint submission from Pan American Health Organization, Colombian Association of Schools of Nursing (ACOFAEN) Collaborating Center for the Development of Innovative Methodologies in the Teaching-Learning in Primary Health Care, Escuela Nacional de Enfermería y Obstetricia de la Universidad Nacional Autónoma de México Collaborating Center for the Development of Professional Nursing, Latin American Association of Nursing Schools, University of Alabama at Birmingham School of Nursing

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