The Global Nursing Shortage:
Priority Areas for Intervention
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A Report From ICN/FNIF
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About the International Council of Nurses

The International Council of Nurses (ICN) was founded in 1899 and today speaks on behalf of more than 13 million nurses in 129 countries. It is the world's first and widest reaching international organisation for health professionals and continues to work to unite nurses worldwide and improve standards of nursing care. It thus addresses nursing regulation, professional practice and socio-economic welfare issues.

ICN is an independent, non-governmental organisation. Operated by nurses, ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce. Through ICN, national nurses’ associations share common interests and knowledge and contribute to strengthening the profession worldwide.

Partnerships and strategic alliances with governmental and non-governmental agencies, foundations, corporations, regional groups, national associations, and individuals, assist ICN in advancing nursing worldwide. The Council is in official relationship with the World Health Organization, the International Labour Office and the United Nations Conference on Trade and Development and has observer status with the United Nations (UN) through the United Nations Economic and Social Council. As well, the organisation works closely with other UN agencies, including the United Nations Children’s Fund and the United Nations Educational, Scientific and Cultural Organization. Based in Geneva, Switzerland, ICN is also a founding member of the World Health Professions Alliance, comprised of the International Council of Nurses, the International Pharmaceutical Federation, the World Dental Federation and the World Medical Association.

For full information on ICN structure, publications and activities, please visit our Web site at www.icn.ch
About the Florence Nightingale International Foundation

The Florence Nightingale International Foundation (FNIF) was first established in 1934 as a living memorial to Florence Nightingale. It is a registered charity in the United Kingdom and maintains its original purpose: to support the advancement of nursing education, research and services for the public good.

As ICN’s premier foundation, FNIF supports and complements the work and objectives of ICN, including:

Expanding Knowledge and Practice
FNIF awards the *International Achievement Award* and the *Alice Girard Travel Grants* which offer international educational and developmental opportunities for outstanding nurses as well as recognition of their work and contribution to health care and nursing.

Advancing Care through Research
Through supporting research, FNIF aims to advance health issues internationally and increase nursing knowledge. Current research includes the *Girl Child Project: Mobilising Nurses for the Health of Urban Girls*, which addresses the health needs of young girls living in urban areas. The study will serve as a foundation for effective policies and programmes to promote the healthy development of this vulnerable and overlooked group.

As a natural extension of the *Girl Child Project*, ICN/FNIF have established the *Girl-Child Education Fund: A Nursing Initiative for Orphaned Girls*. The fund has been created to support the primary and secondary schooling of girls whose nurse parent or parents have died.

For full information on the Florence Nightingale International Foundation, please consult the FNIF Web site at [www.fnif.org](http://www.fnif.org)

About the Burdett Trust for Nursing

The Burdett Trust for Nursing is an independent charitable Trust named after Sir Henry Burdett KCB, the founder of the Royal National Pension Fund for Nurses (RNP FN). The Trust was set up in recognition of the foundation, philosophy and structure of the RNP FN.

The Trustees aim to make grants to support the nursing contribution to health care. They encourage applications from nurses and other health care professionals involved in a wide range of innovative projects. The Trust targets its grants at projects that are nurse-led, using its funds to empower nurses and make significant improvements to the patient care environment.

For more information, please visit [www.burdettnursingtrust.org.uk](http://www.burdettnursingtrust.org.uk)
Acknowledgements

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Introduction

The nursing shortage occurring in health systems around the world is bringing in its wake a serious crisis in terms of adverse impacts on the health and well-being of populations. It poses unprecedented challenges for policymakers and planners in high and low-income countries alike.

According to one recent report on nursing shortages in sub-Saharan Africa, there is a shortfall of more than 600,000 nurses in relation to the estimated numbers needed to scale up priority interventions, as recommended by the Commission on Macroeconomics and Health. Currently, in a number of countries, it is not a rare situation to find one nurse responsible for 50 patients.

Nursing shortages are not a new phenomenon. Many countries have experienced cyclical shortages in the past, usually caused by an increased demand which exceeded a static or more slowly growing supply of nurses (ICN 2004). However, the current shortage differs markedly from past ones in that today's health systems are suffering from pressures exerted on both supply and demand.

Demand for health services and nurses continues to grow due to aging populations, increasing population growth rates, and a growing burden of chronic and noncommunicable disease. At the same time the supply of available nurses in some countries is dwindling and is expected to worsen due to an aging nursing workforce, inadequate funding to support new recruits into the profession and the growth of alternative career opportunities for women.

Inadequate human resources (HR) planning and management, poor deployment practices, internal and external migration, high attrition (due to poor work environments, low professional satisfaction and inadequate remuneration), the impact of HIV/AIDS, and underinvestment in human resources are just some of the critical issues driving nursing shortages.

While recent years have witnessed a growing recognition of the critical issues contributing to nurse shortages around the world, some of which are highlighted above, the political will to address these challenges remains weak in most nations. In many countries, the shortage of qualified health workers, particularly nurses, has become one of the greatest obstacles to achieving the United Nations Millennium Development Goals (MDGs). Adopted in 2000 by 189 Member States, the MDGs represent eight goals, each with a set of measurable targets aimed at reducing poverty by 2015. Of these eight goals, three are directly related to health: 1) to reduce infant and under-five mortality by two-thirds; 2) to reduce maternal mortality by three-fourths; and 3) to halt and reverse HIV/AIDS, tuberculosis and malaria epidemics. It is now widely acknowledged that the health MDGs, and development initiatives in general, are jeopardized by inadequate investments in health human resources and ineffective actions to develop and sustain an appropriately prepared, equitably deployed, well-motivated and well-supported health workforce.

In virtually all countries, nurses make up the largest group of health care providers. Their services are essential to the provision of safe and effective care and are a vital resource for meeting the health-related MDG targets. Strengthening health systems and attaining the MDGs is thus critically dependant on increasing efforts to address the current nursing shortage. For instance, by increasing the rate of births attended by skilled professionals, maternal mortality can be significantly reduced (WHO 2005). Furthermore, strengthening the nursing workforce leads to better access to preventive, curative and rehabilitative care and, in turn, improved health systems performance.
Overcoming this crisis will require building on the current momentum and on the progress, albeit limited, that has been made. It will require determined advocacy, leadership and a deep and sustained political and financial commitment on the part of individual nations and the international community. There is no one action that will resolve the current nursing crisis. The issues are complex and the solutions must necessarily be multi-faceted. The response will require intensified, innovative and sustainable solutions that address the root causes of nursing shortages, exploit synergies, minimise duplication of efforts, and contribute to improved health systems performance both in terms of quality and coverage. Sharing of knowledge, learning, research and networking will be critical to an effective response.

This report is the result of a two-year project, *The Global Nursing Review Initiative: Policy Options and Solutions*, led by the International Council of Nurses and its sister organisation, the Florence Nightingale International Foundation, and supported by the Burdett Trust for Nursing. The aim of the project was to examine the crucial issue of nursing shortages and identify priority areas for intervention.

To achieve this aim, ICN/FNIF undertook a wide-range of activities including commissioning a series of detailed reports (see Appendix B for executive summaries of the reports or visit www.icn.ch/global to access the full reports) that served to inform discussions at the *High-level Consultation on the Global Nursing Workforce* held in Geneva, Switzerland, March 2005. The meeting brought together more than 50 representatives of governments, employers, donors, policy analysts, planners, researchers, economists and nursing organisations to address key nursing workforce issues and identify priority areas for intervention. In follow up to this event, ICN convened the *International Summit on the Global Nursing Workforce* in May 2005 during ICN's 23rd Quadrennial Congress in Taipei, Taiwan. Nurse leaders from research, management, professional associations, practice and education joined representatives from health sector planning and human resources development to exchange ideas, opinions and solutions on key workforce issues.

Combined, these activities culminated in the identification and validation of five priority areas of intervention for ICN and nursing. The areas should not be considered in isolation, but be seen as mutually connected and interrelated. The five areas are:

- Macroeconomic and health sector funding policies;
- Workforce policy and planning, including regulation;
- Positive practice environments and organisational performance;
- Recruitment and retention; addressing in-country maldistribution, and out-migration; and
- Nursing leadership.

This report summarises the two-year programme of work and serves as an important tool for advocacy and policy support, and as a means to engage key stakeholders and ICN partners in developing, implementing and financing interventions that reflect the five priority areas identified in this report. Effective and lasting change will require the joint efforts of many groups including donors, United Nations and intergovernmental agencies, policy-makers and planners, nurses and nursing associations, regional nursing bodies, other health professionals, educators, employers, civil society, foundations, labour organisations, etc.

Section One of this report examines key issues within the five priority intervention areas and presents information on what actions ICN, in collaboration with its partners, will undertake to address the numerous challenges facing the global nursing workforce. The actions are presented under the following headings: Advocacy, Research and Publications, and Other Actions. In addition to the issues and actions contained in this report, there are a number of priority interventions related to health human resources development raised by other organisations and groups which ICN endorses, but which fall outside our scope of work and require the attention of other agencies/organisations. The interventions supported by ICN are addressed in Section Two. Concluding remarks are presented in Section Three. Notes to pages 5-26 can be found on page 27.
Section One: Priority Areas for Intervention

A. Macroeconomic and health sector funding policies

Macroeconomic policies set the stage for overall spending in national budgets including financing for health, levels of staffing and workforce development. In order to ensure a strong health sector workforce, it is imperative that countries establish sound and responsive macroeconomic policies and practices. However, many countries, particularly those highly dependent on external financial aid, are facing macroeconomic constraints that are impacting their ability to increase much needed social spending for health and workforce development.

According to a recent report, “...many countries are only now emerging from demoralizing hiring caps and salary freezes. Bans on recruitment and staffing are still in force in many countries, and in others the public expenditure budgets are still highly restrictive. Even with severe worker shortages, countries with a wage bill that is considered beyond affordability face continuing staff cuts” (JLI 2004 p.84). It is not clear to what extent ceilings on public health expenditure are the result of national decisions or the result of loan conditions imposed by international financial institutions such as the International Monetary Fund (IMF) and the World Bank. However, countries tell us that one of the prevailing issues is that, in order to reach their economic targets, budgetary cuts are required. However, the current lending policies of international financial institutions often do not provide ministries of finance with guidance on how funds should be allocated between the various public sectors. Since the health and education budgets of many countries comprise the largest portion of overall national budgets, they are the sectors most frequently targeted for cuts.

It is tragic that, in the midst of a serious and growing nursing shortage, we have nurses who are educated and want to work, but who remain unemployed as a result of spending limits.

In numerous countries, caps on national health spending are having a detrimental effect on the nursing workforce. Recruitment ceilings adopted by governments have resulted in a large number of unemployed nurses in some countries. It is tragic that, in the midst of a serious and growing nursing shortage, we have nurses who are educated and want to work, but who remain unemployed as a result of spending limits. It is clear that without lifting public expenditure ceilings, expansion of the workforce and improvements in salaries and financing incentives will be impossible (JLI 2004).

In a number of regions, investments in national public infrastructure are inadequate. Poor infrastructure – lack of roads, energy, information technology, telecommunications, transportation, water and sanitation – are directly and negatively impacting access to education (e.g. learning opportunities via clinical placements) as well as the provision of health services. Limited access to transportation, either because of physical or financial barriers, is making it difficult, if not impossible, for nurses to reach their places of employment, for student nurses to reach school and for patients to reach health care facilities (Box 1).

Box 1: The patient experience

“I asked the nurses at T Hospital to transfer me to M Hospital because T is too far from here. At M they said I should get my tablets from the mobile clinic that visits this area once a month. My problem is that when it rains, this mobile clinic does not come here because the roads are very bad. Because of this, they told me to go to N (a local clinic approximately 20 km away) to collect my medication. To go to N, I have to hire a car, as I can’t walk. To go to the main road I have to use a chair to support me when I walk.”

Campbell, Nair, Maimane and Sibiya (2005 p.2)
Nurses in resource-poor countries in general, and Africa in particular, struggle on a daily basis with an acute shortage of drugs, safe water, medical equipment and essential supplies such as gloves, bandages, dressings, etc. needed to carry out their work. The shortage of these essential resources is creating extremely frustrating and demoralising working conditions for nurses and limiting their ability to provide quality and consistent care to patients at all levels of the health care system.

The negative impacts of such conditions are best expressed in the words of a Zimbabwean nurse. “Almost on [a] daily basis we lose at least three babies in our ward. Sometimes we work without gloves, sometimes there are no drugs for patients and food is rationed. When we see patients dying, this affects us as well” (UN Office for the Coordination of Humanitarian Affairs 2005 p.2). A nurse from South Africa shares a similar story. “For several weeks we did not have Disprin. We have also run out of medication for diabetics and that poses serious challenges” (Health Systems Trust 2005 p.117).

Governments and international financial institutions must work together to ensure informed macroeconomic decision-making that creates enabling fiscal environments supportive to workforce development and well-functioning, responsive health systems. New and existing national agreements with the IMF or other financial institutions should not require or lead to freezes in the recruitment of health workers (including nurses), prevent payment of salaries, or prevent the hiring of unemployed health personnel (ICN 2005a). Policies should be in line with national health and development priorities and should not result in fewer resources for education or other sectors central to advancing development.

There also needs to be a greater focus on macroeconomics and health sector funding policies by the nursing community. Nurses should have an understanding of how fiscal policies are operationalised and the implications of such policies and practices on health and development.

In support of strengthening macroeconomic and health sector funding policies, ICN will undertake to:

**ADVOCACY**

- Work with partners to ensure policy makers and planners in ministries of health, finance, education, etc. give greater attention to the evidence linking health sector investment and economic growth and development.
- Advocate for macroeconomic policies and practices that create the political and financial environments needed to strengthen the nursing workforce to meet national health system and development priorities, including policies that support adequate financing for education and enhancing national infrastructure. This can be accomplished by using existing local, national and regional networks and through the development of agreed position statements on macroeconomic concerns.
- Advocate for the teaching of macroeconomic policy and practice in nursing curricula and work with relevant partners to develop curriculum guidelines, including mechanisms to stimulate nursing research in relation to macroeconomics and health human resources.
- Advocate the use of global health funds to strengthen human resources.
RESEARCH AND PUBLICATIONS

- Develop tools to equip the nursing profession to engage in making the case for adequate investments in health and nursing workforce development.
- Publish an e-news bulletin that overviews current trends, developments and activities affecting the nursing workforce, including new developments and thinking in the area of macroeconomics and health.

OTHER ACTIONS

- Build issues related to macroeconomics and health into ICN's Leadership for Change™ and Leadership in Negotiation programmes.
B. Workforce policy and planning, including regulation

National strategic plans for health human resources (HR) development are critical to the realisation of national health goals and to improving population health. As such, every country should have one; unfortunately, this is not the case in many countries. Some countries still lack a national plan and, in cases where they do exist, they are often poorly executed or not implemented at all. In the absence of national plans, countries make decisions that result in adverse consequences for health systems, the health of populations and those providing the services.

Appropriate planning and management of the health care workforce is fundamental to achieving and maintaining an optimal workforce and a well-functioning health system. Despite its importance, workforce planning and management have traditionally been viewed as low priority by many countries. In most countries, planning for HR requirements is fragmented and inadequate. Traditional approaches have not recognised the importance of long-term strategic planning or the need for broad stakeholder involvement in the planning process (ICN 2005b). HR planning has been supply driven with limited attention afforded to population health needs, service demand factors and social, political, geographical, technological and economic factors (ICN 2005c). Furthermore, planning activities have frequently been carried out in occupational specific silos rather than integrated across the various health disciplines/occupations. There has been limited emphasis on the impact of geographical distribution and skill mix and, in addition, HR planning has often not been linked effectively with service planning (ICN 2005c).

The capacity of most countries to plan for HR requirements is weak. One of the most critical requirements to HR planning and decision-making is access to quality national labour market indicators. However, for some countries, the availability of such data is either limited or unreliable thus making the formulation of effective policies and plans virtually impossible. Some countries lack the organisational structures and information technology necessary to collect data (ICN 2005c). This is particularly the case in countries that struggle to provide the most basic of health services. According to a recent report, the current HR challenges faced by a number of countries may be directly related to the paucity of such data and related planning (ICN 2005c). In addition, many countries lack access to appropriate methods and tools needed to undertake the planning process. These deficits are further compounded by a short supply of personnel qualified in workforce planning and management resulting from inadequate access to training and education.

A critical input to the development of HR policies and practices is the opportunity to share and learn from local experiences and innovative practices and approaches. However, few if any systems/forums exist to support and engage countries in this process. The creation of a web-based HR innovations database is one approach that could be used to capture local innovations and allow them to be shared between and within countries.

Skill mix, expanded roles and new cadres

A common challenge facing HR managers is determining the most effective mix of staff and skills needed to deliver quality and cost-effective patient care. Rising demand for health services, cost containment and shortages of nurses and other health workers are cited as the major catalyst for skill mix changes (ICN 2005d). The evidence base in the area of skill mix is limited, but growing. To date, there are two main areas of research which can be used to guide current policy and practice in this area: skill mix within nursing and skill mix between nurses and physicians (ICN 2004).
Studies examining qualified and unqualified mix in nursing have primarily been undertaken in the United States of America (USA) (ICN 2004). According to a recent report, “there are examples of studies that report cost and quality improvements after introducing care assistants, but other studies suggest that the scope for improvement may be more apparent than real. These latter studies argue that there has been decreased quality of care, and increases in cost factors such as on call, sick leave and overtime working, higher workloads for registered nurse, and higher turnover and absence rates” (ICN 2004 p.43).

“Studies on substitution of nurses for doctors generally support the contention that there is scope for effective substitution in defined areas of care, with much greater scope to support the establishment of advanced practice roles for nurses” (ICN 2004 p.43). Research suggests that, by increasing the role and deployment of clinical nurse specialists, nurse practitioners and clinical nurse-midwives, the quality of patient care can be maintained or improved (ICN 2004).

Buchan et al. report three key limitations of research on skill mix: 1) most studies originate from the USA and focus on either skill mix within nursing or skill substitution of physicians with nurses; 2) most studies don’t provide rationale for the approach to skill mix chosen or sufficient information about the organisational setting; and 3) most research does not provide any evaluation of the quality and cost to enable an objective analysis of the skill mix studied. These limitations indicate the need for more research in the area of skill mix in order to inform decision-making processes.

An important element of any discussion related to substitution is the acknowledgment of shared competencies either within nursing or across health professions. The time has come to recognise, legitimise and determine the context for shared competencies between nurses and those with whom their roles overlap. ICN is keen to explore this important area of work and to collaborate with others in order to move it forward.

In response to gaps in access to care and the current global shortage of nurses, many countries are considering or already using “new” cadres of workers to undertake a range of functions normally performed by more qualified health professionals, such as physicians and nurses. Certain policy makers and planners view the introduction of new cadres as a viable strategy for expanding the health workforce in countries facing severe shortages of skilled workers. This is particularly the case in sub-Saharan Africa where the shortage of qualified health workers is most acute.

Planning for the introduction of new cadres should be country-specific and take account of local service delivery needs, the current configuration of health services and provider mix, available resources, and production and training capacity. Policy makers and planners should engage all relevant stakeholders in the process including professional associations, employers, regulators, academic institutions and the public. Prior to embarking on developing new roles or cadres, it is important that an assessment is made to ensure current workers and existing roles are being fully utilised. Emphasis should be placed on job redesign and optimising the current roles of nurses and other groups of workers as opposed to creating new categories of personnel. Additionally, investments in developing new cadres should not undermine strategies to mobilise members of the professional health workforce who are currently either under-employed or unemployed or working in other sectors; nor approaches to attract back professionals who have migrated or abandoned active practice. Clearly defined roles, scopes of practice and methods for integrating new cadre into the current workforce and career systems are needed (ICN 2005i). Lastly, it is unlikely that adding more or new cadres of workers will be effective if the existing cadres of professionals are not retained in safe and productive practice environments.
Workforce imbalances
Imbalances in the deployment of nursing personnel are a feature of both developed and developing countries and have been reported across regions, health sectors and clinical specialties. Imbalances are frequently seen between urban, rural and remote regions. Several countries have undertaken policy initiatives to address nursing workforce imbalances; however, these initiatives have had limited success (ICN 2005c).

Workforce imbalances are a key consideration in the HR planning process to ensure health service provision to under-serviced areas. Policy makers and planners must be cautious that, when implementing incentives to redistribute the nursing workforce, unintended shortages do not occur in other sectors or regions (ICN 2005c).

International recruitment and migration of nurses
International recruitment and migration of nurses have become issues of global concern in the past decade. Nurses have always embraced the opportunity to move across national borders in search of better pay, career advancements, better working conditions and quality of life. However, the movement of nurses, particularly from developing to developed countries, has been accelerating. It is expected to continue, facilitated by globalisation, the liberalisation of trade, easier transport and communications, and active recruitment by some developed countries that are facing domestic issues of supply and demand. For some developing countries, the loss of highly skilled nurses to developed countries is threatening their capacity to achieve health systems improvements and to meet national and global health and development targets, such as those set out in the MDGs (ICN 2005e).

The paucity of data on the flows of international nurses is a major constraint to effective monitoring and the ability to assess the impact of nurse migration, as well as develop effective policy options. Hence, stakeholders at national level and international agencies need to collaborate to devise and implement improved systems that track and monitor international flows of nurses. Inadequate workforce data and planning capacity in many developing countries make it difficult to determine how much of a problem outflow to other countries is in comparison to the numbers of under-employed or unemployed nurses in the country. These countries must examine and improve their workforce planning systems while giving more policy attention to encouraging and supporting non-practicing nurses to return to nursing employment. As well as finding the necessary funds to create or re-establish the required number of nursing positions (ICN 2005e).

According to a recent report the main cause of the relatively high levels of nurse migration today is nursing shortages in developed countries, combined with “push” factors that cause nurses to leave their home countries. These include low wages, poor career opportunities, unsafe practice environments and political instability in some developing countries (ICN 2005e). Hence, the importance of building national self-sufficiency to manage domestic issues of supply and demand, in rich and poor countries alike, is critical.

A key driver in the current increase in nurse migration is active recruitment by a number of countries. There have been reports of “unethical” behaviour on the part of some recruitment agencies, including “providing misleading information to nurses about conditions in destination countries, or charging nurses unnecessary or inflated fees for travel” (ICN 2005e p.19). The following excerpt (Box 2) from a recently published book on nurse migration (Kingma 2006) highlights the personal experience of a nurse from Tanzania.
Concerns about unethical recruitment behaviours have led some countries to introduce codes of practice at the national level. At the international level, the International Council of Nurses has developed a position statement on ethical nurse recruitment which calls for a regulated recruitment process based on ethical principles and sound employment policies and practices. In addition, the Commonwealth Secretariat and the World Health Assembly have made calls for improved monitoring and more ethical approaches to the migration of all health workers (ICN 2005). However, the impact and universality of any such calls is directly dependant on the political will of health sector stakeholders and the regulatory mechanisms introduced for their application and monitoring (ICN 2001).

The issue of how – or if – to manage migration is important to national policy makers and international agencies. It requires more careful investigation and systematic assessment and evaluation of the various models of managed migration, such as bilateral agreements, ethical codes, return migrant schemes and possible models of “training for export” in order to support more effective approaches to the international recruitment of nurses (ICN 2005).

In support of this priority area for intervention, ICN will address workforce policy and planning and international recruitment and migration, and will undertake to:

**ADVOCACY**

**Workforce policy and planning**

- Advocate for the development and/or revision of national strategic workforce plans that reflect integrated HR planning approaches which are needs-based, outcome oriented, informed by service planning and take into account the demographic, social, economic, political, technological factors, etc. that impact planning decisions.
- Advocate for the creation of a HR intersectoral planning body at national levels involving all key stakeholders (e.g. providers, planners, policy makers, employers, education, finance, civil society, etc.) to assess, plan, implement, monitor and evaluate national strategic plans.
- Advocate for investments in creating and maintaining HR data collection and information systems to inform policy and planning practices at the national level. This includes enhancing the role of regulatory bodies as a source for data on the status of nurses in their country and developing local, national and regional capacity to collect, analyse and utilise HR data.
- Lobby for and help develop HR national minimum data sets.
- Lobby for standards for accreditation processes.
- Advocate for the development of a web-based HR innovations database that captures local innovations and allows them to be shared nationally and internationally.
- Lobby to get monitoring and evaluation built into donor activity.
- Advocate that countries consider the range of health care personnel required to ensure the health needs of populations are met and create conditions that maximise the potential of the professional nurse and other categories of workers. This includes embracing new models of care delivery, promoting advanced roles for nurses and addressing issues of skill mix and the devolution of some tasks to other workers.

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**Box 2: The experience of a migrant nurse**

“Vicki Bigambo* faced serious professional and personal problems in her home country of Tanzania. A recruitment agency convinced her that she would find a better life if she went to Glasgow to work for a private nursing home. Upon arrival she found quite the opposite. The recruiter had led her to believe that the home was in the heart of the city. In fact, it was located a hundred miles out of town. Bigambo had been promised a salary of £16,000 per year and told that her travel costs would be covered. She was, however, never reimbursed for her travel expenses of over £1,000.”

Furthermore, “…once in Scotland, agency representatives informed her that if she wanted to stay, she would have to sign a new contract for £11,000 per year, even though she was fully responsible for the 100-bed home and was entitled to a much higher salary.”

* Pseudonym

Kingma (2006 p.10)
International recruitment and migration

- Lobby for ethical international recruitment policies and practices and work with National Nurses Associations (NNAs) to monitor and report on country level trends related to in- and out-migration and the activities of recruitment agencies.
- Advocate for increased national and international cooperation to implement improved systems for monitoring international flows of nurses and other health care workers, including the development of standardised international data collection instruments.
- Lobby for more research and analysis to inform national stakeholders and international agencies of the true impact and costs and/or benefits of nurse migration.
- Promote the establishment of a global body to credential international recruiters.
- Advocate for more research and evaluation to highlight good practice and expose poor practice in the treatment of migrant nurses.

RESEARCH AND PUBLICATIONS

- Publish a series of internationally applicable Fact Sheets on key issues highlighted in the papers commissioned for this project.
- Develop a policy statement on new cadres of workers.
- Secure research on such issues as the nature and magnitude of temporary versus permanent nurse migration; trends in nurse remittance flows; best practice retention incentives in developing countries; impact of Recruitment Codes of Practice; impact of international labour market demand on the number of nursing students in a given exporting country; gender implications of nurse migration; the cost / impact of nurse migration on source countries; and the impact of bilateral/international agreements such as the General Agreement on Trade in Services (GATS), etc.
- Contribute to the mobilisation of funds for research on health workers in general, and nurses specifically (e.g. via global funds and large foundations).

OTHER ACTIONS

- Review ICN’s principles and framework for regulation.
- Work with others to develop an accepted framework for shared competencies.
- Contribute available data on nurses, participate in the standardisation of indicators and data collection tools, and in the strengthening of data collection and analysis capacity.
- Make expertise on nursing issues available to international agencies, which influence workforce policies in the health sector (e.g. access to a pool of nurse experts, participation in research projects, secondments, etc.).
- Work with others to strengthen strategic and technical capacities of individuals, organisations and systems to plan and manage human resources in the health care sector.
  - Develop international standards and competencies for HR planning and management.
  - Publish Fact Sheets on approaches to workforce planning.
  - Develop “good practice guidelines” for HR planning and management which can be adapted to the national and/or local context.
  - Advocate for the incorporation of HR planning, management and research into pre-service training and continuing education programmes.
  - Develop a policy brief to promote and advocate for the importance of effective HR planning and management.
- Develop education materials and tools for HR managers derived from international standards and competencies for HR planning and management.
- Advocate for improved access to quality technical assistance through the development of “twinning” relationships and other strategies.
  - Examine the positives and negatives of using international volunteers.
  - Develop a credentialing mechanism for international health consultants.
- Establish an international resource to compile, consolidate, synthesize and disseminate good practice interventions, research, and tools required to formulate and implement effective and appropriate HR policy.
C. Positive practice environments and organisational performance

The varying and often poor quality of the environments in which nurses practice is widely recognised as being one of the greatest factors contributing to the global challenge of attracting new recruits into the profession and retaining existing ones. Inadequate staffing and heavy workloads; excessive overtime; inflexible scheduling; exposure to occupational hazards, violence and abuse; lack of autonomy; poor HR management practices and leadership; lack of access to necessary supplies, medication and technology; inefficient incentives, and poor career development opportunities are just some of the many factors impacting on the quality of nurses’ practice environments (Box 3).

The issues contributing to poor quality practice environments have been explored and discussed extensively over the past decade or more. Numerous studies and reports originating from various countries have identified the problems and have put forth recommendations to improve the quality of nurses’ practice environments. However, very few of the recommended strategies have been implemented, largely due to a lack of political will to address the issues and make the necessary changes.

The quality of nurses’ practice environments has been linked to issues of job satisfaction, motivation, productivity, performance and patient outcomes.

Evidence demonstrates that work overload is having a detrimental effect on quality of patient care and on nurses themselves. A recent study of approximately 10,000 nurses in 168 hospitals in the USA found that, in hospitals with low nurse:patient ratios, surgical patients experienced higher risk-adjusted 30-day mortality and failure-to-rescue rates, and nurses were more likely to experience burnout and job dissatisfaction. Another study found that higher nurse:patient ratios were associated with a 3–12% reduction in the rates of outcomes potentially sensitive to nursing, including urinary track infections and hospital acquired pneumonia.

Several countries, including the USA and Australia, are turning to minimum, mandated nurse:patient ratios as one of a number of strategies to improve working conditions and facilitate the return of nurses to practice, as well as promote safe staffing and patient care. Shortly after the implementation of mandated ratios in Victoria, Australia “five thousand unemployed nurses applied to return to work and fill vacant posts in the health services” (Kingma 2006 p.225). Further, research commissioned by the Australian Nursing Federation (ANF) found that “more than half of Victoria’s nurses would resign, retire early or reduce their hours if mandated, minimum nurse:patient ratios were abolished” (ANF 2004 p.1).
Research demonstrates that nurses are attracted to and retained at their place of employment when opportunities exist that allow them to advance professionally, to gain autonomy and participate in decision-making, while being fairly compensated. Factors in the workplace can be critical in both encouraging retention and in reducing turnover of nurses. According to a recent overview of the global shortage of registered nurses undertaken by Buchan and Calman, there is some evidence that participative management styles, flexible employment opportunities and access to continuing education and professional development can improve retention of nursing staff as well as patient care. Buchan and Calman state that many of these issues are addressed in the “magnet hospital model” which has been developed over the last 20 years (Box 4). The model highlights the benefits of a systematic approach to staff involvement in improvements in nurse recruitment and retention and improved health outcomes for patients.

Box 4: The case for being a “good” employer – Magnet Institutions

The concept of the magnet hospital was developed initially in the 1980s in the USA. At a time of staffing shortages, policy attention turned to identifying the characteristics of “successful” health care employers in challenging labour markets. The initial focus of that research was to identify the human resource practices and associated organisational characteristics that enabled these hospitals to attract and retain staff, even in difficult labour market conditions. Some of the key characteristics of successful hospitals were:

- participatory and supportive management style,
- well prepared and qualified nurse executives,
- flexible working schedules,
- clinical career opportunities,
- emphasis on in-service/continuing education.

The idea of the magnet institution has been sustained and developed over the successive decades through a series of research studies, and by the development of a magnet nursing services accreditation programme. This and similar approaches are now being investigated in several countries.

The main message from the various research studies is that “magnetism” does appear to be related to “better” staffing indicators, such as reduced turnover and absenteeism, and to improved quality of care. This has been attributed to the sustained implementation of a “bundle” of human resource management (HRM) interventions which fit with organisational priorities, and which support autonomous working by nurses, enable participation in decision-making, facilitate career development and enable high level skills to be deployed effectively.

According to Rafferty et al., research substantiates that health services are improved when health care professionals work together in teams. In terms of the ‘good employer’, effective teamwork enhances staff motivation, job satisfaction and mental health, improves retention and reduces turnover.

Numerous reports suggest that investing in developing and maintaining effective human resource management (HRM) policies and practices can make an important positive contribution to organisational performance. Effective HRM can be linked to both staff and patient care outcomes (ICN 2005h). In addition, the management of people can significantly influence the health and well-being of employees, as well as the performance of individuals, groups and organisations. Despite the importance of good HRM, its application is not evident in everyday practice in many organisations (ICN 2005h).
In support of this priority area for intervention, ICN will undertake to:

**ADVOCACY**
- Initiate a global campaign on positive practice environments.

**RESEARCH AND PUBLICATIONS**
- Secure research on the cost/impacts of turnover and the benefits of stability, particularly in Africa.
- Develop standards for positive practice environments.
- Develop monographs on priority issues, such as nurse:patient ratios, rostering systems, working conditions and violence in the workplace.
- Demonstrate the return on investment and benefits of the full utilisation of nurses.
- Develop guidelines on delegation and supervision, mentoring and coaching.

**OTHER ACTIONS**
- Consider developing, in partnership with ICN member associations, a Good Employer Award initiated at the national level and promoted internationally.
- Develop, in partnership with others, initiatives to increase competencies of line managers.
- Work with regulators to address full utilisation and new roles for nurses.
- Address increased community involvement (formal and informal workforce; community development; integrated community care and improved communication with communities).
- Examine interdisciplinary collaboration, including interprofessional education.
- Explore how policies, accreditation and other structures can enhance work environments.
D. Recruitment and retention; addressing in-country maldistribution and out-migration

Difficulties in recruiting new nurses into the profession and retaining nurses in the system are common issues reported in both developed and developing countries. The inability to recruit and retain qualified nurses is having an adverse impact on the provision and quality of health services, as well as costs (ICN 2005g). Within this context, policy makers and planners at both national and organisational levels must look at recruitment and retention strategies as critical elements to maintaining staffing levels, reducing turnover and containing costs in order to ensure safe and effective nursing care.

Nursing has traditionally relied on recruiting from a narrowly defined group of school leavers (ICN 2004). However, it is widely acknowledged that, in order to ensure an adequate supply of nurses, the profession must widen its recruitment net to include a broader range of applicants including “mature entrants, entrants from ethnic minorities, and entrants with vocational qualifications or work-based experience” (ICN 2004 p.37). It is also evident that, in order to attract new recruits into the profession, nursing must devise strategies to enhance the image of nursing as a career (ICN 2004).

At the organisational level, employers need to review their recruitment advertising processes to ensure that they effectively target potential sources of recruits. In addition, organisations must ensure that effective induction and orientation processes are in place to allow new recruits to be effective in their role.

“Returners” – nurses who are not working in the nursing labour market – are a possible source of recruits (ICN 2004). Nurses often leave the profession prematurely due to inadequate/inflexible policies that prevent them from choosing either part-time or full-time employment or do not allow them to have managed career breaks or re-enter employment in nursing (ICN 2004). Older, experienced nurses may represent a more stable workforce; hence policies to attract them back to work, such as opportunities for retraining and flexible scheduling, should be considered (ICN 2005g). Redesigning jobs for an older workforce can be an effective strategy.

While the reasons nurses leave the profession and the policies and strategies needed to attract them back are well known, there is little evidence of political will to apply this knowledge.

In-country maldistribution and out-migration

Geographical imbalances in the distribution of the nursing workforce are most pronounced in rural, remote and underserviced areas. For example, the distribution of registered nurses in the Ghana Health Service favours the greater Accra region which has 18.5% of the population and 30.9% of the country’s professional nurses. The three northern regions (more rural, on balance, and generally deprived) together contain 18.3% of the population, but have just 15.6% of the country’s nurses (see ICNi p.10). Nurses often prefer to migrate to urban areas where they have better career opportunities and more rewarding social and economic conditions. Recruiting and retaining nurses in rural, remote and underserviced areas is a problem faced by both developed and developing countries.

Working in rural and remote areas presents several challenges, including social isolation, lack of access to basic amenities, difficulties with transportation and lack of housing. These challenges are exacerbated in resource-poor settings where basic infrastructure such as roads, transportation, schools and housing are commonly underdeveloped (ICN 2005g). Inadequate salaries and poor working conditions, including lack of equipment and supplies; poor...
access to in-service and continuing education opportunities; inadequate support and supervisory structures and mentorship opportunities are frequently cited as major factors contributing to difficulties in recruiting and retaining nurses in rural and remote settings. In addition, obstacles to exercising professional autonomy and lack of participation in decision-making are common frustrations voiced by nurses. Nurses, who are often held accountable for patient care, feel demoralised and frustrated when they are not given the authority to make fundamental care delivery decisions. Investments in strategies to improve basic amenities and infrastructure, working conditions and just financial compensation could go a long way in improving motivation, retention and recruitment of nurses in underserviced areas.

Strategies to improve recruitment and retention include “mandatory rural service, tuition reimbursement for working in underserviced areas, relocating nurse education establishments to rural areas, pay incentives to work in underserviced areas, clinical placements in underserviced areas and providing rotation schemes that temporarily locate staff in underserviced areas” (ICN 2004 p.38). Ghana has tried enhancing incomes in the form of Deprived Area Posting Allowances to boost take-home pay above civil service norms. However, it has been reported that the non-discriminatory nature of such allowances can contribute to decreasing staff motivation (ICN 2005i). Many of the strategies highlighted above remain relatively under-explored in nursing, having been more focused on physicians (ICN 2004). More research and evaluation on the impact of such strategies for nursing is needed.

One of the most controversial migration flows is the out-migration of highly skilled nurses from developing to developed countries. Nurses’ decisions to migrate are said to be influenced by a number of “push” and “pull” factors. As noted earlier in the report, a recent review on international migration of nurses highlighted a number of “push” factors, which are encouraging nurses to emigrate (ICN 2005e). Nurses may migrate to other countries due to “pull” factors such as “better pay, professional development and improved career opportunities, or the opportunity to experience life and work in a different culture” (ICN 2005e p.28).

In recognising that nurses will continue to exercise their right to choose where they live and work, source countries must focus their policy responses on addressing “push” factors that cause nurses to emigrate. These include addressing issues related to poor pay and career prospects, poor working conditions and heavy workloads, responding to issues of security and improving educational opportunities, etc. (ICN 2005e). The managed migration project initiated by the Caribbean Nurses Organization and the Caribbean Office of the Pan American Health Organization is one example of a broad-based attempt to take a more proactive position on migration while recognising that it is not realistic to stop nurses from migrating where serious push factors exist (see ICN 2005e).

Pay and non-monetary incentives
There is clear evidence that incentives represent one of the main factors influencing health worker performance (ICN 2005g). Financial incentives are the most common approaches used to improve recruitment, retention, motivation and performance (ICN 2005g). Financial incentives involve direct or indirect payment such as “wages or salary, bonuses, pension, insurance, allowances, fellowships, loans and tuition reimbursement” (ICN 2005g p.19). The benefit of financial incentives has been questioned. For instance, Kingma reports that nurses tend to respond negatively or indifferently to economic incentives once an adequate standard of living is achieved. According to the nurse respondents in Kingma’s research, “Financial incentives were never recognized as being positive and at best were received with ambiguous reactions. Indifference, however, clearly dominated the recorded perceptions of monetary rewards” (cited in ICN 2005g p. 21). Conversely, direct and indirect financial rewards, such as opportunities for professional development and continuing education, were perceived as positive and motivating (ICN 2005g).
To improve retention and motivation of nurses it is essential to examine non-monetary incentives such as work autonomy, career development, and flexible working hours/shifts. In a study reviewing nursing in hospitals, work autonomy was reported as a significant factor in explaining job satisfaction.\textsuperscript{14} 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.\textsuperscript{15}

There is also evidence to suggest that access to career development opportunities encourages the retention of nurses.\textsuperscript{16} In addition, opportunities for internal promotion have been shown to reduce turnover of nurses in large hospitals.\textsuperscript{17}

According to the International Labour Organization, boundaries on working hours and the provision of rest periods directly impact the quality of health services and thus are of significant importance to nurses. In times of shortages, many institutions have relied on overtime to fill the gap. Redesigning shifts to reflect greater flexibility, choice and adequate off-time are all important means of improving satisfaction with working hours and bolstering nurse recruitment and retention (ICN 2005g).

According to Buchan et al., the challenge for health care systems is to identify and put in place a package of incentives that is best suited to meet its specific needs. It is unlikely that one package of incentives will be suitable for all organisations or contexts. For instance, the effect of financial rewards will be dependant on the steady provision of sufficient money to meet basic cost of living needs (ICN 2005g). In countries with limited resources, financial incentives are likely to assume more importance than in more developed countries where salary is more of less taken for granted.\textsuperscript{18}

**Nursing education**

Central to ensuring the production and retention of a competent nursing workforce is the need to educate nurses using a curriculum based on the knowledge, skills and competencies needed to practice in the role (ICN 2005d). In recent years, nursing education in numerous countries has come under scrutiny by employers who feel that the preparation of graduates is not meeting health service delivery needs. In order to address the education-service gap, these countries must work to reform and reorient nursing education to ensure the curriculum is relevant to health service needs and sufficiently flexible to meet future service demands (ICN 2005i; ICN 2005f). To ensure the curriculum reflects these needs, all relevant stakeholders must be involved in the development process. This includes regulators, employers, educators and clinicians.

In a number of countries there is a trend towards educating nurses for export whereby the curriculum is more reflective of the needs of the external market than to requirements of the country. Educating for export is becoming a more prominent practice and deserves further attention by the nursing profession.

One critical issue currently facing a number of countries is a shortage of nursing faculty owing to the impact of an aging faculty workforce and retirements and a limited pool of younger faculty. Reduced pools of nursing faculty are serving to intensify the nursing shortages by reducing the ability of education providers to increase their intake of applicants to meet future demand. According to a report by the American Association of Colleges of Nursing (AACN) on 2003-2004 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing, “U.S. nursing schools turned away 15,944 qualified applicants to entry-level baccalaureate nursing programs in 2003 due to insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints” (p. 2). At the same time, more than 110,000 qualified students were turned away from diploma and associate degree programmes. The shortfall of educators is also having an impact in developing countries. For example, the Nurses Council in Ghana estimates a 20-30% loss of tutors over the past several years.
which is expected to seriously limit the country's capacity to educate future generations of nurses. In some countries, financial incentives introduced in clinical practice, while ignoring the remuneration levels in nursing education, attracted educators back into care delivery thus exacerbating the shortage of faculty and the future shortage of nurses. A number of countries are also reporting high rates of attrition among nursing students.

There is also a trend towards the establishment of private education institutions in a number of countries. Vigilance on the part of governments, regulatory bodies and the nursing profession in these countries is necessary to ensure quality programmes. Regulation of private education institutions needs to be in place and enforced.

In support of this priority area for intervention, ICN will undertake to:

**ADVOCACY**
- Develop a position statement on the importance of continuing professional development to recruiting and retaining nurses.
- Develop an image campaign linked to the good employer.

**RESEARCH AND PUBLICATIONS**
- Explore ways to better understand and address the gap between service and education, such as examining the use of joint appointments.
- Develop monographs on common issues e.g. rural/remote incentives and pensions.
- Develop Fact Sheets on encouraging returners and employing older nurses.
- Undertake/promote research on what motivates nurses to stay/return.
- Develop a concept paper on managed migration (e.g. what models are currently available and any gaps).

**OTHER ACTIONS**
- Address issues pertaining to attrition of students, educators and decreased access to clinical placements and preceptorships.
- Consider international standards for education programmes.
E. Nursing leadership

Addressing the challenges facing the nursing profession, including the impact of constantly changing health systems and nurses’ work environments, requires effective leadership and management abilities at all levels – organisational, local, regional and national. Leadership development is a critical aspect for positive and sustainable change today and into the future. Nurses who are or will be in key leadership and management positions need to be prepared to manage rapid change in a globalised and technologically driven world and a world with limited financial and human resources.

Today’s and tomorrow’s nurse leaders and managers need to demonstrate competence in such areas as strategic thinking and planning, staff development and management, performance appraisal systems, organisation culture and development, communication, negotiation, interpersonal relations, problem-solving, conflict resolution, customer service, equipment and resource management, quality improvement, safety and disaster planning, financial management, networking, politics and policy development, teamwork, and fundraising.

Nurse leaders in executive level management and policy positions must not only exhibit excellence in the above competencies but also understand global governance and finance mechanisms, regulation, how to network and how to build alliances and coalitions to politically leverage and articulate the value of nursing with key players in national, regional and international organisations. These nurse leaders need to be prepared to navigate the political and policy-making systems in their countries. In order to influence changes needed to positively impact health systems and the nursing profession, they need to understand how systems work in the international world of policy-making and politics.

ICN recognises the importance of new and innovative vehicles to address these needs and is currently undertaking work to establish a Global Nursing Leadership Institute for nurses in senior level and/or executive positions. The initiative will be tailored to enhance existing leadership knowledge and skills around specific issues and themes pertinent nationally and in the international health arena.

The International Council of Nurses has been a pioneer in leadership and management development for nurses for many years. Our member associations continue to improve the way nurses prepare for and execute leadership and management roles in their countries. Today, through our Leadership for Change™ and Leadership in Negotiation programmes, ICN is making a difference in developing and strengthening the leadership and management capacity of nurses worldwide (Box 5).
In support of this priority area for intervention, ICN will undertake to:

**ADVOCACY**
- Promote management concepts such as delegation and supervision in basic nursing programmes.

**RESEARCH AND PUBLICATIONS**
- Develop tools for policy and advocacy.

**OTHER ACTIONS**
- Expand ICN’s Leadership for Change™ and Leadership in Negotiation programmes worldwide.
- Plan for a Global Nursing Leadership Institute for nurses in senior level and/or executive positions.

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**Box 5: ICN leadership development programmes**

**Leadership for Change™**
The Leadership for Change™ (LFC) is an action-learning programme that develops nurses at a country or organisational level to be effective leaders and managers in a constantly changing health environment.

LFC focuses on effectiveness in:
- Health planning and policy development
- Leadership and management in nursing and health services
- Developing quality cost-effective nursing services
- Preparing future managers and leaders, nurses and non-nurses
- Sustaining development
- Contributing within the broader health and management teams
- Influencing curricula changes
- Networking nationally, regionally and internationally

The programme has been implemented in various regions of the world including Latin America, the Caribbean, East, Central and Southern Africa, the South Pacific, Asia and the Middle East. In addition to the ICN delivered programme, more than 20 countries now have certified national trainers who are reaching a critical mass of nurses and other health care professionals. A longitudinal study of LFC graduates is also underway.

**Leadership in Negotiation**
The Leadership in Negotiation project equips nurses with the skills to secure fair wages, benefits and decent working conditions.

The objectives of this programme are:
- To support national nurses’ associations in their efforts to exercise leadership in the delivery of health care and for the nursing profession.
- To provide nurse leaders with knowledge and skill development in the area of negotiation and human resources development.
- To provide basic knowledge in occupational health and safety, economics and management sciences.

The project has been developed in several regions of the world. It was initially undertaken in Africa and has since been adapted to the needs of nurses in the Caribbean, Eastern Europe, Latin America, South East Asia, the Pacific Rim and the South Pacific. At present, national nurses’ associations in Cook islands, Fiji, Samoa and South Africa are training nurse leaders in negotiation, worker representation, communication and marketing while sensitising members to the impact of the work environment and workplace issues on the delivery of care. Another dimension of the programme is the strengthening of national nurses’ associations – recognising nurses’ need a strong, united voice in order to introduce positive reform and sustainable advances. Adaptations of this project have been introduced by ICN member associations in recent years to train nurse leaders in Eastern Europe, Malawi, Nepal and Zambia.
Section Two: Interventions Supported by the International Council of Nurses

The following presents a number of key recommendations and actions related to health human resources development raised by other organisations and groups which ICN endorses, but which fall outside our scope of work and require the attention of other agencies/organisations.

ICN supports the following:

Joint Learning Initiative on Human Resources for Health and Development
- Global health and financial policymakers should work together to ensure an enabling fiscal environment for health workforce development. Donors should harmonise their investments. Of national investments, funds should be earmarked for strengthening technical and policy cooperation on human resources at the regional and global levels (JLI 2004 p.8).
- Bring together country, regional, and global technical expertise on human resources for health through “virtual” and “operational” networks that can disseminate best practices and provide effective technical support to country-based and country-led actions (JLI 2004 p.9).
- Create an enabling policy and financing environment by specifically ensuring supportive macroeconomic policies and the coherence of categorical funds for HIV/AIDS and other priority problems consistent with national workforce plans. Disease control programmes should seek to achieve their priority targets while strengthening, not fragmenting, a sustainable workforce in the overall health system (JLI 2004 p.9).
- Funders, both national and international, should significantly enhance their investments in information and knowledge on human resources. In addition to strengthening country actions, these investments would provide a global public good (JLI 2004 p. 9).

Physicians for Human Rights
- Countries in Africa and elsewhere should develop policies that ensure health facilities have adequate levels of essential supplies for infection prevention and control (PHR 2004 p.4).
- Donors should provide funds and technical assistance to help African countries: improve drug distribution systems, purchase and maintain communications equipment needed to strengthen referral systems, and invest in computer systems, programmes and training to enhance health information management (PHR 2004 p.4).
- Donor governments should assist African health sciences libraries obtain up-to-date materials and maintain up-to-date collections (PHR 2004 p.5).
- Medical and other health-related journals should be made available for free or at a nominal cost to health professionals in Africa and other parts of the developing world (PHR 2004 p.5).
- African and other countries suffering from the emigration of health professionals should maintain a database of job openings that could be filled by members of the health professional diaspora (PHR 2004 p.8).
- The World Health Organization and the World Bank should collaborate to educate finance ministries on the economic benefits of investing in health. Health ministries should also receive this information (PHR 2004 p.9).
- The IMF, World Bank, and finance ministries should publicise the precise nature of existing economic restraints that may limit substantially higher country spending on health and other social sectors, and create mechanisms for on-going transparency of macroeconomic policies and how they impact the health and education sectors (PHR 2004 p.9).
Section Three: Conclusion

This report has highlighted the five priority areas of intervention for ICN and nursing and the actions we will pursue, in collaboration with existing partners and with the engagement of new partners, to address the global nursing shortage. While implementation has already begun in several of the priority areas, much more work remains to be done.

It is clear that the scale of the nursing shortage requires system wide solutions at the national and international level. Overcoming this crisis also requires strong linkages and the collective efforts of many groups including donors, United Nations and intergovernmental agencies, policy-makers and planners, nurses and nursing associations, regional nursing bodies, other health professionals, educators, employers, civil society, foundations, labour organisations, international financial institutions, etc.

Strong leadership, ownership and major political commitment and investment on the part of individual nations as well as accelerated, deepened support from the international community, are critical to ensuring effective and sustainable strategies to address this crisis.

Given the health and social challenges facing developed and developing nations, there is no room for complacency in our actions to address the state of the world’s nursing workforce. Nursing services are a vital resource to the attainment of the health MDGs, to overall improvements in the performance of health systems and, ultimately, the lives and health of people worldwide.
Notes to Pages 5-26

1. Kurowski et al. cited in ICN 2004p.21
15. Mason 2000; Aiken et al. 2000, cited in ICN 2005g p.21
References


ICN (2005f). Overview of the nursing workforce in Latin America, Silvina Maria Malvarez and Maria Consuelo Castrillon Agudelo, ICN, Geneva, Switzerland.


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Appendix A

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James Buchan and Lynn Calman, The Global Shortage
of Registered Nurses: An Overview of Issues and Actions.

Rosemary Bryant, Issue Paper 1: Regulation, roles and
competency development.

Linda O’Brien-Pallas, Christine Duffield, Gail
Tomblin Murphy, Stephen Birch and Raquel Meyer,
Issue Paper 2: Nursing workforce planning: mapping the
policy trail.

Anne Marie Rafferty, Jill Maben, Elizabeth West and
Dilys Robinson, Issue Paper 3: What makes a good
employer?

Pascal Zurn, Carmen Dolea and Barbara Stilwell,
Issue Paper 4: Nurse Retention and recruitment:
developing a motivated workforce.

James Buchan, Mireille Kingma and F. Marilyn
Lorenzo, Issue Paper 5: International migration of
nurses: trends and policy implications.

Silvina Maria Malvarez and Maria Consuelo
Castrillon Agudelo, Issue Paper 6: Overview of the
nursing workforce in Latin America.

Olive Kopolo Munjanja, Sarah Kibuka and
Delanyo Dovlo, Issue Paper 7: The nursing workforce in
sub-Saharan Africa.
Appendix B

The following section contains the executive summaries of a series of detailed reports commissioned for this project. The reports examine specific global and regional aspects of the nursing workforce. The full reports are available on the ICN Global Nursing Workforce Project web site at www.icn.ch/global
The Global Shortage of Registered Nurses: An Overview of Issues and Actions
James Buchan and Lynn Calman

Executive Summary
This report on the global nursing workforce was led by the International Council of Nurses (ICN) and its sister organisation the Florence Nightingale International Foundation (FNIF), and supported by the Burdett Trust for Nursing. The report is the first output from a programme of work examining the crucial issue of nursing shortages, and identifying a framework for policy interventions.

The world has entered a critical period for human resources for health. The scarcity of qualified health personnel, including nurses, is being highlighted as one of the biggest obstacles to achieving the Millennium Development Goals (MDGs) for improving the health and well being of the global population.

Against this backdrop of growing concern about shortages of health personnel, the report focuses on one of the most critical components of the workforce – nurses. Nurses are the “front line” staff in most health systems, and their contribution is recognised as essential to meeting these development goals and delivering safe and effective care.

In presenting a global overview, the paper reports on key trends, main challenges and potential solutions. The emphasis is on breadth of coverage, but specific nursing workforce issues in different countries are highlighted to illustrate the main challenges facing those responsible for developing and implementing policies on the nursing workforce. The report presents a snapshot of a dynamic and challenging situation worldwide.

A Global Overview

- There is huge variation in the nurse:population ratios throughout the world.
- At country level, the reported nurse:population ratio varies in different countries from less than 10 nurses per 100,000 population to more than 1,000 nurses per 100,000, a variation of more than one hundredfold.
- The average ratio in Europe, the region with the highest ratios, is 10 times that of the lowest regions – Africa and South East Asia.
- The average ratio in North America is 10 times that in South America.
- The average nurse:population ratio in high-income countries is almost eight times greater than in low-income countries.
- The low availability of nurses in many developing countries is exacerbated by geographical maldistribution – there are even fewer nurses available in rural and remote areas.
Skill mix and staff mix vary among organisations, systems and countries, and there is no single “optimal” mix of nurses and other staff to which all can aspire. However, many countries, particularly in Africa, Asia and Central/South America, are struggling to provide a minimum level of nurse staffing. Some countries, most notably in Central/South America, report employing many more physicians than nurses. Even in countries with low nurse:population ratios, there is often a maldistribution of available nurses, which exacerbates the impact of shortages. Rural areas in developing countries tend to be the most underserved areas.

**Nursing Shortages and Critical Challenges**

-Whilst there is no universal definition of a nursing shortage, there is increasing evidence of nurse supply/demand imbalances in many countries.

- Supply of nurses in many low-income and high-income countries is failing to keep pace with increasing demand.

- One recent estimate is that sub-Saharan African countries have a shortfall of more than 600,000 nurses needed to meet the Millennium Development Goals.

- The Organisation for Economic Co-operation and Development (OECD) reports that many of its (high-income) member countries have increasing problems of nursing shortages.

- There is a link between adequate nurse staffing levels and positive care outcomes.

- Gender-based discrimination continues in many countries and cultures, with nursing being undervalued or downgraded as “women’s work”.

- Violence against health workers persists in many countries, with nurses often taking the brunt because they are in the forefront of the direct delivery of care.

- Three critical challenges related to nursing shortages are:
  - the impact of HIV/AIDS;
  - internal and international migration of nurses;
  - achieving effective health sector reform and reorganisation.

**Critical Challenge # 1: Sub-Saharan Africa – The Impact of HIV/AIDS on the Nursing Workforce**

Whilst HIV/AIDS is a challenge throughout the world, its regional impact has, so far, been most pronounced in sub-Saharan Africa. HIV/AIDS is impacting negatively on health systems both by increasing demand for health services and by reducing health workforce availability and performance. The impact of HIV/AIDS is also a factor in increasing internal and international migration of health workers from sub-Saharan Africa, which in turn creates heavier workloads for the nurses who remain.
Critical Challenge #2: Internal and International Migration

Migration and international recruitment of nurses have become more prominent features in the last few years. Often as important, but less prominent in policy arenas, is internal migration – from rural to urban areas, from public sector employment to private sector employment, and from nursing employment to non-nursing employment (or no employment). The impact of out-migration of nurses on some developing countries is severe. They are losing scarce, and relatively expensive to train, resources. Levels and quality of care are suffering. Many of the nurse recruits who cross national borders are relatively young and well skilled. Similar problems can be created by internal migration, where nurses take their skills and expertise into other types of employment.

Critical Challenge #3: Achieving Effective Health Sector Reform and Organisational Restructuring

Reform of health systems is often an essential component of improving efficiency, access, and outcomes from health service delivery. Many countries are going through a process of health sector reform, and many health organisations within countries are restructuring. However, whilst some approaches have led to improvements, not all attempts at restructuring have been successful, and some “successful” reforms have paid little attention to the impact on human resources within the health sector. Nurses and others working in dysfunctional or “failing” health systems have to develop various coping strategies to survive. Reforms and restructuring of health systems cannot ignore these factors if they hope to achieve the goals of health improvement and improved access to health care.

Policy Interventions Framework

| Four components of a policy framework to address nursing shortages are highlighted in the report: |
| Workforce Planning |
| Recruitment and Retention |
| Deployment and Performance |
| Utilisation and Skill Mix |

- The report stresses that the framework components and associated policy interventions are interdependent.
- The need for effective policy intervention requires leadership and stakeholder involvement is highlighted.
- It is emphasised that policy interventions must be appropriate to the country context and objectives.
- Nursing shortages are not just a “problem for nursing”. They are a health system problem, which undermines health system effectiveness and requires health system solutions. Without effective and sustained interventions, global nursing shortages will persist, undermining attempts to improve care outcomes and the health of nations.
**ISSUE 1:**

**Regulation, roles and competency development**

Rosemary Bryant

**Executive Summary**

This paper aims to provide an overview of the current evidence and opinion concerning the workforce implications of regulation, competency development and role definition. These three elements are inextricably linked to each other and are fundamental to the practice of nursing in today’s environment. Retrieving the evidence for this inquiry was difficult in some cases and, in the main, the literature reviewed was derived from Anglophone countries.

The stated purpose of health professional regulation is to protect the public and one of the ways of fulfilling this mission is to ensure that the health professionals being regulated are competent to practise. Employers and health service administrators also have a responsibility to ensure that the health professionals they employ are competent to provide care which is at a standard acceptable to the public who are recipients of that care. Defining health professional roles is an evolving process as they adapt to new technological developments which, in turn, create the need for new roles in health care. Linking competencies for nursing roles with education and regulation is essential if nurses are to provide care which is competent and safe.

Existing models of regulation such as regulation by statute, voluntary regulation, central government regulation, self-regulation, and umbrella regulation are explored. The impacts of mutual recognition agreements (MRAs) for nurses, such as a diminution of standards for registration, are a threat for nurses. Other forms of regulation such as mandated nurse:patient ratios are also discussed.

Initial and continued competence are particularly relevant today as there is pressure by the public for more transparency in health professional regulation and for greater consumer involvement. This has implications for the trio of educators, regulators and employers. If the notion of regulation in its broadest definition is viewed as the starting point and safe competent care as the end point, the other elements such as education of nurses, initial and continuing competence, employer responsibilities, role definition, overlap and skill mix all interact to reach the end point. What is unambiguous in this rich interplay is the obligation and responsibility of professional nursing organisations to participate in all of these elements.

The development of competencies in a number of settings, including the employment setting, is explored. International competency development and its implications for the movement of nurses globally are also discussed.

Skill mix, new roles and role overlap all have implications for regulation and competency development. New roles, such as that of the nurse practitioner and its impact on patient outcomes, are discussed. Physician:nurse substitution and nurse:unlicensed assistive personnel substitution, and their cost-effectiveness and impact on patient outcomes, have implications for the workforce of the future. Delegation of nursing care and its relationship to regulation is particularly important in this context. Other clinical roles are briefly mentioned.
Recommendations

In summary, the key implications for the nursing workforce are as follows:

1. In order for professional self-regulation to be sustained, consumers must be part of that regulation.
2. Nursing regulation needs to be transparent and flexible enough to reflect the changing work environment and the development of new roles.
3. The boundaries of regulation – professional self-regulation and its interface with other forms of regulation – need to be defined.
4. In an environment of increasing globalisation, registration processes need to be sufficiently flexible to accommodate nurses from other countries.
5. The nursing profession must remain vigilant to ensure that new models of regulation, such as umbrella legislation, and trade agreements do not erode nursing standards or diminish nursing identity.
6. Nurses need to remain competent throughout their working lives and, to achieve this, there is a need for the development of assessment methods.
7. Nurse education programmes at undergraduate, postgraduate and continuing education levels need to be developed jointly by employers, regulators, and the nursing profession.
8. The structural elements of nursing curricula need to be inherently flexible to enable adaptation to changes in service delivery.
9. Some aspects of nurse education should take place in collaboration with other health professionals, particularly in specialties where multiple health professionals practise side by side.
10. Shared competencies between nurses and those with whom their roles overlap need to be developed.
11. In order for nurses to be equipped to take up enhanced roles, all nurse education programmes need to be pitched at a level commensurate with other health professionals.
12. In this era of increasing nurse migration, international competencies need to be evaluated regularly with an established updating cycle.
13. Skill mix research needs to include the effects of changed roles on clinical outcomes.
14. The introduction of changed nursing roles needs to be negotiated with both the profession and nursing regulators.
15. There is a need for more research on the cost implications of different skill mixes, taking account of variables such as the different salary and other employment conditions of different categories of health professionals.
16. Methodologies that enable application in a wide variety of settings need to be developed that can accurately assess long-term patient outcomes and patient satisfaction.
Executive Summary
Planning for the efficient and effective delivery of health care services to meet the health needs of the populations is a significant challenge. Globally policy makers, educators, health service researchers, leaders of unions and professional associations, and other key stakeholders struggle with the best way to plan for a workforce to fulfil the health needs of populations. To meet this challenge, achieving the appropriate balance between human and non-human resources is important and requires continuous monitoring, careful attention to the country specific context in which policy decisions are made, and evidence-based decision-making. This paper provides an overview of current evidence and policy initiatives pertinent to the nursing workforce including: health human resource (HHR) planning, service planning and modelling; nursing workforce imbalances and internal migration; and approaches to nursing deployment and utilisation. Policy implications and recommendations are offered.

Human resource planning needs to be placed within the broader system in which health care services are provided. The effect of social, political, geographical, technological and economic factors and their influence on the efficient and effective mix of human and non-human resources must be considered in planning for and managing the health care workforce. In addition, the issue of political will is an important one. Today’s human resource challenges have evolved slowly over the past 50 years. Past mistakes cannot be overcome within the timeframe of a single or even a second political mandate. Although critical, sustained HHR planning efforts by policymakers and key stakeholders are very difficult given changing governments and political agendas. Policymakers and researchers must work in concert to keep the health policy issues relevant, easily understood, and practical.

HHR planning must promote and support models, practices and strategies, which are needs-based and outcome-directed and explicitly recognise the dynamic nature of the factors that impact HHR planning decisions and allocations. Furthermore, building relationships is critical to successful HHR planning. Effective and ongoing coordination of the interaction among government, research and administrative stakeholders through advisory, research, and communication infrastructures is essential.

Traditionally, HHR planning has been performed independently and in isolation of other aspects of planning in the health care sector (Lomas, Stoddar and Barer 1985; Birch et al. 1994; Denton, Gafni and Spencer 1995; Vujicic 2003). However, important principles of the HHR Conceptual Framework (O’Brien-Pallas et al. 2001a) are that human resources are key inputs in the production of health care services (Birch and Maynard 1985) and that the levels and methods of service production are determined by the prevailing social, economic and political contexts (O’Brien-Pallas et al. 2001a). In this way, the need for human resources is derived from the need for health care services and the methods used to produce those services.
The social, economic and political contexts determine the requirements for health care services. For example, the social and political contexts determine the means of access to health care services (e.g. willingness and ability to pay for care, ability to benefit) while the economic context influences the aggregate level of resources (or share of society’s economic output) to be allocated to health care services (Lavis and Birch 1997). Clearly, planning to produce health care providers to meet all the health needs of the population would be wasteful if no mechanism were in place to fund the provision of these services.

Contextual considerations are not confined to these broad ‘macro-level’ influences on human resource requirements. Human resources do not provide health care services in isolation – instead, the production of health care services generally employs a mixture of human and non-human resources – i.e. a health care production function that uses a range of inputs to generate health care services (Gray 1982; Birch 2002). The health care sector is noted for the high level of ‘labour intensity’ compared to other sectors. If some health care services could be delivered in ways that do not require human resources and that maintained the quality and quantity of outcomes but at a lower cost, there would be no need for human resources in the provision of such services. Since fully automated health care services are a distant future, human resources continue to be key inputs for health care production.

Simulation is a powerful tool for integrating knowledge of the components of complex systems, improving understanding of the dynamics of the system, and rehearsing strategies and policies to avoid hidden pitfalls (Kephart et al. 2004). Simulation modelling being carried out in some countries, particularly in Canada, has provided many insights that are practical for planning. Applied to human resource planning for nursing, dynamic simulation models can provide not only valuable insights on the reasons for the current crisis, but also alternatives for resolving the problem. Simulations allow planners to explore consequences of alternative policies, facilitate input and output sensitivity analysis, and make it easier to involve stakeholders throughout the planning and management process (Kephart, O’Brien-Pallas and Tomblin Murphy 2004). Simulations are a means, not an end, to assist planners in decision-making. The extent to which simulation provides useful scenarios for consideration is dependent upon the quality of the data used in the model and the extent to which the variables modelled reflect the system as a whole.

To be optimally effective, needs-based models of HHR planning require high quality data from a wide variety of sources. Although much of immediate relevance can be accomplished by careful analysis of existing data within a framework of a well-defined needs-based HHR planning model, there is little doubt that research, policy and planning initiatives continue to be significantly hampered by a lack of quality data, which are both comparable and comprehensive.

Nursing workforce imbalances, which have been reported worldwide across regions, health care sectors and clinical specialties (O’Brien-Pallas et al. 1997a) can be exacerbated by migration patterns. Internal migration does not remedy workforce over- or under-supply and compounds planning difficulties at a national level. Currently, the extent of internal migration in most countries is not easy to accurately determine due to inadequate data sources. Many argue that the development of a unique identifier for nurses could aid in tracking workforce imbalances and migration patterns (Tomblin Murphy and O’Brien-Pallas 2004; Baumann et al. 2004a). Planners need to be aware that, when creating new roles or developing incentives that redistribute the workforce, unintended shortages may emerge in other sectors or regions. To build nursing capacity in under-serviced areas and prevent the loss of nurses to large urban areas where educational programmes are often concentrated, access and delivery of nursing education should occur closer to home.
At the organisational level, deployment and utilisation of nursing human resources cannot be considered in isolation of the system in which nursing care is delivered. Provision of nursing services is now understood to result from a complex array of health care system inputs, throughputs, and intermediate and distal outputs (O'Brien-Pallas 1988; O'Brien-Pallas et al. 1997b; O'Brien-Pallas, Irvine Doran et al. 2001c, 2002). Nurse staffing, workload, nursing unit utilisation, and productivity are potential tools for managing the deployment and utilisation of nurses at the local or organisational level.

Nurse staffing measures often calculate the amount of nursing resources available relative to the number of occupied beds. However, simply counting beds provides little information about the care requirements of the patients in the beds. Conceptually, nurse:patient ratios assume an average nurse capacity or a standard time per occupied bed. Developed in the 1980s in North America, diagnostic groupings (e.g. Case Mix Groups in Canada or Diagnosis Related Groups in the United States of America) were used to manage nursing resources, reflecting a return to the standard nursing hour determined by diagnostic grouping as opposed to standard hours per bed. Another aspect of nurse staffing is staff mix (i.e. the types and combinations of health care workers providing direct patient care).

Nursing workload measures focus on patients' requirements for nursing care. Workload and patient classification systems are primarily used for staffing decisions within organisations. When used with experience and judgment in the context of continuing validation and ongoing reliability, these systems can be used effectively to guide staffing decisions. However, when pushed beyond their original purposes (e.g. for case costing or inter-organisational comparisons), the non-equivalence of patient classification systems is problematic. Hospital workload data are necessary for local and national management of nursing resources, but alone, are insufficient to engage in HHR and service planning.

By combining measures of nurse staffing and workload to examine the demands for nursing service relative to the amount of nursing resources used to provide that service, nursing unit utilisation may provide a greater understanding of the effect of the amount of nursing resources on outcomes than either nurse staffing and workload alone. Calculated at the unit level as patient workload divided by nurse worked hours, nursing unit utilisation measures how well an organisation staffs to meet patient care standards and needs (O'Brien-Pallas et al. 2004c). The rate of services per provider is a measure of productivity and forms a major element of estimating the required number of human resources (Birch 2002). This definition of productivity is consistent with concepts of productivity in other sectors of the economy and focuses exclusively on the relationship between outputs and an individual input. However, this differs from traditional uses of productivity in the health care sector that describe the demands placed on a provider (i.e. what proportion of time is devoted to direct patient care) without any reference to the quantity of service outputs (O'Brien-Pallas et al. 2004c). This measure of demands on providers is more accurately described as an indicator of work intensity or utilisation and, although it is not a measure of the rate of output produced, it will have implications for that rate of output. Failure to incorporate considerations of productivity in HHR planning risks overestimating the number of providers required to meet population needs and hence results in an ‘excessive’ number of providers seeking ways of delivering services. It also overlooks an important policy instrument for dealing with imbalances between requirements and availability of HHR.

Internationally, nursing workforce planning is a priority for policy planners. Strategies to effectively plan for and manage nurses and other health care providers are of utmost importance. In addition, adequately resourced policies to deal with the ongoing issues of recruitment and retention need to be developed, implemented, and evaluated to determine their utility.
ISSUE 3:
What makes a good employer?

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Executive Summary

Introduction
This document summarises underlying evidence and issues related to good human resource management (HRM) in the health sector with reference to: (a) indicators of performance and measurement of nursing outcomes; (b) performance issues related to individuals and teams; and (c) employee engagement, commitment and organisational citizenship behaviour (OCB). There are two key themes: What are the interventions and indicators associated with good HRM outcomes, and how can these be measured?

Reviews suggest investment in developing and maintaining effective HRM policy and practice makes a significant and measurably positive contribution to organisational performance (CIPD 2001; Caulkin 2001; Richardson and Thompson 1999; West et al. 1997). Human resource (HR) practice contributes to business performance in ways influenced by three broad perspectives: ‘Best practice’, ‘contingency’ and through ‘bundles’ (Richardson and Thomson 1999). However, there is no ‘magic bullet’. Claims of a universal best practice are premature; adopting a specified set of HR strategies will not in itself lead to organisational success, and the same ‘bundle’ of HR policies may not be universally applicable (Richardson and Thomson 1999). Exactly how and in what combination the linkages between management practices and superior function are enacted remain an enigma (Caulkin 2001), and the examination of HRM remains a ‘young field of research’ (Guest 2001).

HRM in the health sector has a unique set of circumstances and characteristics (e.g. a workforce comprising separate occupations and professions). HRM in health care is under-researched with most work being undertaken in North America (Buchan 2004). The challenge for researchers and policy analysts in the health sector is to bridge the current knowledge gap – between what we know from the general evidence base on HRM inputs and performance, and what we know from the health-specific evidence base.

Nurse performance indicators: Evidence base
Nursing performance indicators may be of interest to the ‘good employer’ for a number of reasons. These include improving the quality of care, facilitating recruitment and retention of staff, and providing information to underpin rational and defensible decision-making. Nursing performance indicators are the result of a convergence of forces, including rising demands for care, concerns about quality, and cultural changes that seek greater transparency and accountability in public services. Indicators are often selected for pragmatic reasons, but there is increasing reliance on scientific methods, such as systematic reviews of the literature combined with consensus methods. An integrated approach to the development of measures of team effectiveness and functioning has been advocated (Lovett et al. 2002). This has stimulated interest in structural, process and outcomes measures, and researchers have recently focused on the latter. The outcomes of medical care are evaluated as death, disease, disability, discomfort and dissatisfaction (Lohr 1988).

1 Human resource management (HRM) is a much defined and somewhat contested concept and its definition varies depending upon the setting. It is primarily the branch of organisational science that deals with the entire employment relationship, along with all the decisions, actions and issues involved in that relationship. In business (and more recently in health care), it may be used to gain a competitive advantage over others through the strategic deployment of a highly committed and capable workforce, using an array of cultural, structural and personnel techniques (Storey 1995).
Nursing sensitive outcomes are variously defined, but emphasise variables dependent on nursing interventions. Reservations about their use have included the difficulty of evaluating the input of one profession in multi-professional teamwork; the difficulty of measuring important aspects of nursing care; and the additional stress performance indicators may place on already overworked staff. A growing body of evidence suggests small changes in characteristics of the nursing workforce are associated with large changes in patient outcomes (e.g. the mix of nursing skills, education, experience and workload have an impact on patient mortality, failure to rescue, adverse events and length of stay).

Performance of individual workers and teams in health care

Objectives and effective methods of assessment: Evidence base
Research suggests that where health care professionals work together in teams, an improved service to clients can be delivered (Zwarenstein et al. 1997; Aiken et al. 1998; Schmitt 2001; Rafferty et al. 2001). In terms of a ‘good employer’, effective teamwork enhances staff motivation (Wood et al. 1994), job satisfaction and mental health (Borrill et al. 2000; Peiro et al. 1992), improves retention and reduces turnover (Borrill et al. 2001). There is a well-established body of literature which identifies the effectiveness of teams, both in terms of their development and functioning (e.g. stages of development and team communication, flexibility, innovation, team roles and leadership) (Borrill et al. 2001; Heinemann and Zeiss 2002b).

The convergence of both external and internal forces has resulted in the development of performance management in health care. External factors may include political pressures and health care reforms; financial pressures such as efficiency drives and budget cuts; the introduction of purchaser/provider split and service contracts; and pressure from increased expectations of clients and users. Within organisations, internal pressures and effects that have given rise to the desire to at least define, if not measure performance, include resources such as staffing, the physical environment, people management and the organisational culture (Michie and West 2003).

To evaluate performance, various dimensions of staff performance need to be taken into account, including individual and team performance, task and contextual performance, and both process and outcome measures. To measure performance in health care, HRM should monitor the antecedents of both task and contextual performance. Until now, the focus has been predominantly on task performance (Michie and West 2003). Although studies in health care consistently support the value of team-based working, much of the performance measurement in health care remains driven by the measurement of individual performance, notably the individual performance appraisal. A plethora of appraisal systems and tools are available to managers including the more recent approach to individual assessment of performance – ‘360 degree feedback’ (Armstrong and Baron 2005). Sound instruments for measuring team performance are presented as both ‘state of the art’ instruments, such as team climate inventory (Anderson and West 1998) and ‘honourable mention’ instruments, such as team collaboration index (Aram et al. 1971; Lovett et al. 2002). Measurement of team performance highlights many difficulties common to the measurement of any performance, including lack of a common language among different disciplines and adaptation to local conditions, such as the development of virtual teams.
Employee engagement: Evidence base

Employee engagement has two well-researched precursors as its foundation – employee commitment and organisational citizenship behaviour. Both have a good research base and make engagement worth closer scrutiny than some other HR initiatives. There is a growing consensus that employee commitment should be viewed as a multidimensional construct and a two-way process. Organisations see the need to create commitment because it has positive benefits for the organisation, such as increased job satisfaction (Vandenberg and Lance 1992) and job performance (Mathieu and Zajac 1990), as well as decreased employee turnover (Cohen 1991), absenteeism (Cohen 1993; Barber et al. 1999) and intention to leave (Balfour and Wechsler 1996). Research focusing on ‘met expectations’ suggests that employees will be more committed if there is a good match between what the person reads in a job advertisement and what the job provides (Dawis 1992). Unmet expectations are commonly cited as a cause of dissatisfaction (Sturges and Guest 2000). A link between early job experiences and commitment has also been demonstrated (Mignerey et al. 1995) and the importance of a good induction programme and training emphasised.

Four areas have been identified where an employee’s sense of trust in the employer can be developed (O’Mally 2000). These areas are (1) growth (attending to employees’ developmental needs), (2) work-life balance, (3) individual accommodation (flexibility or benevolence towards employees) and (4) health and safety.

Organisational citizenship behaviour (OCB) or contextual performance (Michie and West 2003) is likely to be particularly important in health care where a high level of inter-disciplinary and inter-agency collaboration is required. The link between OCB and organisational performance is supported but not definitive (Podsakoff et al. 2000), and it may be fruitful to discover how to promote OCB. However, OCB may require greater definition and clarity and may need to be incorporated into the organisation’s values and ethos if it is to be made more explicit and if employees are to be appraised on it.

Employee engagement has a limited research base and work has, to date, concentrated on its definition, devising a measure of engagement and what influences it most. Employee engagement overlaps with the concepts of employee commitment and OCB, but it is not a perfect match with either. Employee engagement is not an academic construct (most work comes from consultancies and survey houses), but some practitioner-led research has been undertaken in this field.
Executive Summary

Background
Recruiting and keeping the right staff are key challenges for health policy-makers. The performance and quality of a health system ultimately depend on the quality and motivation of health human resources. Therefore, recruitment and retention problems should be appropriately addressed, as nursing staff shortages and low motivation are likely to have adverse effects on the delivery of health services and the outcome of care.

Objective
The main objective of this paper is to examine how to develop and retain a motivated nursing workforce.

Recruitment and retention problems
Data from both developed and developing countries tend to indicate that nursing recruitment and retention are serious issues. Vacancies are reported in many countries, including developing countries such as South Africa, which had 30,000 vacant posts for nurses in 2003.

An alternative indicator to vacancy is job turnover, which is often used to evaluate retention difficulties. In countries such as the United Kingdom (UK) and the United States of America (USA), turnover rates are quite significant, as they are estimated to be around 20%.

Various consequences are associated with the inability to recruit and retain nursing staff. Closure of, or reduced access to, clinics and wards, as well as lower quality of care and productivity, are common examples of nursing shortages. In addition, high turnover is likely to lead to higher provider costs, such as in recruitment and training of new staff and increased overtime and use of temporary agency staff to fill gaps. Turnover costs also include the initial reduction in the efficiency of new staff and decreased staff morale and group productivity. The literature shows that the costs associated with recruitment and retention problems are substantial.
Factors affecting motivation and performance

From a policy perspective, keeping the “right nurses in the right place” requires identifying and understanding the factors affecting nurses’ motivation and performance. In that context, linking incentives and performance is crucial. Incentives are important because they can influence key determinants of performance.

Motivation at work is widely believed to be a key factor for performance of individuals and organisations and is also a significant predictor of intention to quit the workplace. There is empirical support for the link between job dissatisfaction, lack of motivation and intention to quit. Health managers need to understand the crucial importance of motivation for the performance of health workers in the context of scarce resources. Three factors play a key role in nursing performance:

- the ability of staff to do their job; (their knowledge, skills and experience to perform the job: the capacity or “can do” factors);
- the motivation of staff to put in effort to do the job (the ability or “will do” factors);
- the organisational support or opportunity to do the job well (availability of resources, the presence of policies and practices conducive to performance, physical and social environment).

In other words, performance depends on whether the staff perceive themselves as able to do things, whether they are willing to do things and whether they have the means to do them.

Policy interventions

A range of relevant policy interventions is crucial to keep nurses in the workforce and to improve recruitment. There are three main approaches to developing the nursing labour market:

- increase input, e.g. increase the number of nursing students;
- decrease the attrition rate, e.g. improve retention of students and promote retention of existing nursing staff;
- attract nurses who are not in the national nursing workforce, e.g. attract nurses otherwise employed, retired or out of the labour force, or nurses from other countries.

To retain and develop the nursing workforce, different policy options can be considered to operationalise the approaches.

1. Policies targeting personal characteristics of nurses

Personal characteristics relate mainly to age, sex and education. The weakness of empirical data and the ethics of targeting specific personal characteristics explain why such a policy has not been systematically implemented. Nevertheless, there could be benefits in recognising that younger, well-educated nurses are likely to want to develop their careers and that this is likely to mean they may change their employer or even their profession. Offering good professional development opportunities, reflected in career structure and pay enhancement, may reduce turnover. Older nurses are likely to be a more stable workforce; policies to attract them back to work (e.g. retraining, flexible shifts or child care facilities) should be considered.

2. Monetary incentives

Monetary incentives are certainly the most common approaches used to improve recruitment, retention, motivation and performance. Financial incentives include direct or indirect payment such as wages or salary, bonuses, pension, insurance, allowances, fellowships, loans and tuition reimbursement. Providing adequate and timely remuneration is important to guarantee the recruitment of motivated and qualified staff.
The impact of wages appears to be mixed. An increase in wages will not lead to a substantial increase in labour participation. However, it should be noted that most studies on wages were performed in developed countries, in particular the USA and the UK, and that the wage context is quite different in developing countries. For instance, wage differentials between developed and developing countries, between public and private sectors and the long delays in salary payment in the public sector, are all likely to influence recruitment and retention of the nursing workforce in developing countries. Therefore, it is likely that a wage increase in developing countries will have a greater impact on nursing retention and recruitment than in developed countries. Other financial benefits that are commonly used include bonus, pension, insurance, allowances, fellowship, loans, tuition reimbursement, etc.

3. Non-monetary incentives
Promoting work autonomy
Work autonomy can be defined as control over one's own work, and is among the key variables explaining job satisfaction.

Encouraging career development
The possibility of career development for nurses is crucial, especially in an environment characterised by a phenomenal growth in knowledge related to health sciences, coupled with technological advances. Evidence suggests that career development opportunities encourage the retention of nurses.

Adapting working time and shift work
Limitations on working hours and the provision of rest periods have a direct impact on the quality of services and therefore are of particular importance to nurses. Moreover, redesigning shifts to allow more off-time, allowing flexibility in shifts and more choice of shifts are all ways of improving satisfaction with working hours, and enhancing both recruitment and retention of nurses.

4. Reducing violence in the workplace
Violence against nurses seems to be a growing problem. Some findings suggest a direct link between aggression and increases in sick leave, burnout and staff turnover. Therefore, reducing violence in the workplace must be considered in order to reduce attrition.

5. Leadership
Many studies have found that leadership is positively correlated with nurses' job satisfaction and commitment towards institutional goals. The challenge for leaders in the health sector is to be able to build and sustain a long-term vision, to build teams and increase commitment to effect organisational change. Leaders will have therefore to focus on motivating, inspiring and empowering their employees.

6. Policy targeting contextual factors
Contextual factors, such as job market, family support and location of work, play a significant role in recruitment. In particular, working in a rural area can be challenging for a number of reasons – for example, lack of social life and amenities, difficulties of travelling and lack of accommodation. Such challenges will be greatly enhanced in resource-poor settings, where the infrastructure is likely to be undeveloped, so that roads, transport, schools and housing are not adequate. Investing in improving these basic amenities pays dividends in terms of improved motivation, retention and recruitment, since poor working conditions, including lack of equipment, are often reported as a major element affecting staff motivation.
Effectiveness and costs
From a policy perspective, one essential question is how to select the most appropriate incentives. One approach to answering that question is to assess the cost and the effectiveness of each policy option. It has been observed that some hospitals are more successful in recruiting and retaining health care staff than others. Those hospitals have been designated as "magnet hospitals". Research shows superior outcomes for magnet hospitals, such as lower risk-adjusted hospital mortality, higher ratings of quality of care, higher patient satisfaction, lower rates of nurse burnout and higher rates of nurse job satisfaction.

In addition, one should also account for the cost of each policy, in particular the implementation costs. Measures favouring financial incentives are likely to face different financial and implementation constraints than non-financial incentives.

However, currently, there is not much information regarding both effectiveness and costs of incentives. More studies should be performed that combine both effectiveness and costs, in order to facilitate decision-making and contribute to better decisions from a social perspective.

Summation
The challenge for each health system is to identify and implement a package of different types of incentives that will meet its needs; it is unlikely that one package of incentives will be right for all organisations or contexts. Most of the research on increasing motivation and job satisfaction in health workers has been undertaken in developed countries, where the resources for such activities are available. However, situations in developing countries are markedly different. Health workers function in situations of resource scarcity of all kinds: salaries are likely to be low, and may not even be at subsistence level; instruments and equipment may be missing or broken; workers in remote areas may be alone for much of the time; and there may be little or no budget for staff development. The link between policy development and personal motivation of health workers is complex and requires recognition of the importance of individual, organisation and societal factors in motivation.
ISSUE 5:

International migration of nurses: trends and policy implications

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Executive Summary
This report focuses primarily on the policy implications of the international migration of nurses, and highlights recent trends. International recruitment and migration of nurses has been a growing feature of the global health agenda since the late 1990s. Nurses have always taken the opportunity to move across national borders in pursuit of new opportunities and better career prospects, but in the last few years nurse migration appears to have grown significantly, with the potential to undermine attempts to achieve health system improvement in some developing countries.

Whilst the issue of international migration of nurses is sometimes presented as a one-way linear "brain drain", the dynamics of international mobility, migration and recruitment are complex, covering individual rights and choice; motivations and attitudes of nurses to career development; the relative status of nurses (and women) in different systems; the differing approaches of country governments to managing, facilitating or attempting to limit outflow or inflow of nurses; and the role of recruitment agencies as intermediaries in the process. This report provides an overview of this dynamic situation.

Country-level data are used to examine trends in nurse migration. Both "source" and "destination" countries are used to provide comprehensive background information. As there are no common or "standard" data or methods of tracking trends in migration of nurses, there can be no universal assessment of flows between countries. Any analysis of trends in migration of nurses is therefore constrained by data limitations and gaps.

The report emphasises that, in order to undertake an accurate assessment of the impact and policy implications of migration of nurses, it is necessary to assess the level of migration within the broader context of trends and dynamics in the national nursing workforce. For example, it is important that any examination of out-migration of nurses relates the numbers leaving the country to the overall numbers leaving the nursing workforce – many nurses may actually remain in the country, but leave nursing. Out-migration may be the most obvious and media-worthy aspect of outflow of nurses, but it will not necessarily be the biggest flow of nurses from the system.

It is also important to note that migration is not just about a one-way flow from "source" to "destination" – nurses may leave one country to work in a second, and then either return to their home country, or move onto a third. They may even live in one country and cross a national border on a regular basis to work in another. Improvements in travel and communication, combined with availability of employment, can encourage this circulation.
The increases in flows of nurses across national boundaries create a series of policy questions for national governments and international agencies. The report assesses the main policy issues, and also discusses where the current knowledge gaps are most critical in preventing a full assessment and understanding of the dynamics of nurse migration. The main gaps, and recommendations for policy action, are summarised below:

- One crucial gap is the absence of accurate data on the flows of international nurses; this is a constraint on any effective monitoring, and also limits the ability to assess impact. **Stakeholders at national level, and international agencies, need to collaborate to agree and implement improved systems to monitor international flows of nurses and other health workers.**

- The position of many developing countries, which are sources of international nurse workers, is weakened by inadequate workforce data and planning capacity, and it is difficult to assess how much of a "problem" outflow to other countries is in comparison to the numbers of underemployed or unemployed nurses in the country. **These countries must assess and improve their planning systems, and give more policy attention to encouraging and supporting non-practising nurses to return to nursing employment.**

- The overall impact of out-migration of nurses on source countries, in terms of its effect on health systems and on remaining staff, requires more systematic assessment. **More research and evaluation are required to inform national stakeholders and international agencies of the true costs (and/or benefits) and impact of nurse migration.**

- Relatively little is known about the experiences of international nurses now working in destination countries, in terms of their profile and future career plans (including likelihood of return to source countries or onward movement to other countries), and equality of treatment. **Research and evaluation are required to highlight good practice and expose poor practice in the treatment of migrant nurses.**

- The gender issue in relation to the migration of nurses is an important factor; there is a need for donors to support strengthened professional nurses associations in source countries, so that the position of nurses in society can be promoted by stronger advocacy. **Donors need to focus attention on supporting the strengthening of representative organisations for nurses.**

- The issue of how – or if – to "manage" migration is important, and requires more considered investigation, with systematic assessment of the various models of managed migration. **The various policies and models of managed migration, bilateral agreement, ethical codes, return migrant schemes and possible models of "training for export" require examination and evaluation to support a more effective approach to international recruitment of nurses at national and international levels.**
Executive Summary

Over recent years health care has taken centre stage on the global agenda as a key development issue. The increase in poverty and the inequities in the globalised world, the risks attributable to ecological, demographic and socio-economic changes, the understanding of macro-determinants, the negative effects of reforms and their impact on public health – all of these define this priority and the creation of global alliances for development, the control of illnesses and renewed action in favour of primary health care.

Human resources become increasingly relevant in this context. Health human resource (HHR) is currently experiencing a three-fold problem, which encompasses old issues, together with the effects of reform, and the consequences of globalisation. This includes the workforce crisis in nursing which, facing all kinds of difficulties, requires complex in-depth analysis, synergies and alliances in order to ensure quality nursing services.

This paper was drafted by the Pan-American Health Organization (PAHO) as the basis for the examination of this important aspect of health care in the region of Latin America, and as a contribution to the International Council of Nurses (ICN). The analysis takes as its framework Pedro Brito Quintana’s concept of field of human resources for health. That is, the health care workforce is structured and dynamised by all its aspects, activating processes, tensions and conflicts in accordance with the delivery of health care services. The four central aspects consist of work, education, the labour market and professionalisation processes. These variables are subject to and produce policies, regulations and management mechanisms. Different parties participate with various interests, abilities and degrees of power in the context of their social dynamics.

The study refers to nurses, auxiliaries and nursing technicians. The data have been obtained from the World Health Organization (WHO), PAHO, the International Labour Organization (ILO) and the Inter-American Development Bank (IDB), from investigations, reports of events, web portals, professional nursing bodies, and newspaper and magazine articles. The information gathered reveals shortages, inadequacies, poor registration of basic data and disparity in years of information. This proves the importance of monitoring the dynamics of the nursing workforce and of producing evidence on the key aspects on which there is currently little or no information.

Overview

Regarding practice and the nursing workforce in Latin America, it can be said that the demand for nurses in hospital administration, organising services and supervising auxiliary staff, has increased as a result of:

- The increased division of labour in health care;
- The introduction of technology and medical specialisations;
- The low level of professionalisation in nursing; and
- The demands of health care reforms.

Various studies state that the management role is undertaken by nurses, thus reducing the amount of time available for patient care, which thus falls to auxiliary staff.
In the community sphere, particularly since Alma Ata (WHO 1978), in which the primary health care strategy was prioritised, nursing has developed its role and incorporated health promotion, risk prevention and the management of priority programmes into its practices. A recent study published by PAHO indicates that nurses have played an important role in community health programmes in the Americas (McElmurry 2004:30).

As regards the composition and dynamic of the nursing workforce, it can be said that, in Latin America, it is structured into various levels of training, with titles varying from country to country and with a predominance of women.

The indicator of nurses per 10,000 inhabitants shows a range between 1.1 in Haiti and 97 in the United States of America (USA). Indicators in South American countries vary between 1.2 in Paraguay and 7.9 in Venezuela. In Central America, the Hispanic Caribbean and Mexico the greatest disparity, ranges from 39.5% in Mexico to 82.0% in Guatemala. The average for nursing auxiliaries in the sub-regions is: Southern Cone 77%; Andean area 72%; and Central America 70%.

The composition of the nursing workforce shows that Mexico is the country with the highest proportion of nurses (61.5%), while Uruguay has the lowest proportion (12.2%). In the Southern Cone, the proportion of nursing auxiliaries varies between 62.3% in Argentina and 87.8% in Uruguay. In the Andean area, the range goes from 67.7% in Ecuador to 78.1% in Colombia. In Central America, the Hispanic Caribbean and Mexico the greatest disparity, ranges from 39.5% in Mexico to 82.0% in Guatemala. The average for the nursing auxiliaries in the sub-regions is: Southern Cone 77%; Andean area 72%; and Central America 70%.

This overview indicates that the nursing resources to attend to populations lies predominantly in the hands of staff with basic training. In this sense, in the last 20 years, countries have developed initiatives to increase the qualification of the nursing workforce, which have improved these indicators to a large degree; converting a large group of workers who only had in-service training into nursing auxiliaries, a large number of nursing auxiliaries into nursing technicians, and an additional large group of auxiliaries and technicians into professionals. A study conducted by the PAHO/WHO (2004) on 10 countries indicates that more than 140,000 nursing personnel were scaled-up over the last few years.

As regards working conditions, it is known that hospital nursing work is both physically and mentally demanding with long working hours, particularly in intensive care units. The most frequently encountered work pattern is 8 hours per day and 45 hours per week, though it ranges from 6 hours a day and 30 hours a week to 9 hours a day and over 50 hours a week. Working conditions for nurses are characterised by an excessive workload, long working days, rotating shifts, night shifts, frequent changes in departments, and a psychological burden in handling critical situations. This is a personnel exposed to biological, chemical and physical risks. Studies of nurses’ occupational health show that the main health problems are osteo-muscular and articular, those caused by cuts from sharp instruments and sleep-pattern disturbances.

Institutional shortages in human resources and equipment, supplies and timely maintenance of equipment, which gradually lead to the deterioration of health care services, create dissatisfaction at work. These conditions often push hospital nurses to resign. Nurses’ dissatisfaction is a constant in the different investigations reviewed.

The State was the main employer up until the recent sectoral reforms, when a movement towards private institutions began to be seen. Since the 1990s, there has been a proliferation of temporary contracts for the provision of services and a generalised out-sourcing of services, even in the public sector.
Salaries are generally low and vary from country to country (e.g. around US$100 a month in Nicaragua and US$ 1,100 in Costa Rica for nurses working in public hospitals). The average in Latin America is US$ 400-500 per month for nurses, while it is 30% less for nursing auxiliaries. The majority of nurses enjoy social and salary benefits: medical insurance, different kinds of incentives depending on disadvantaged geographical areas, risky or dangerous work, age, professional qualifications and others.

Nursing shortage and migration are central issues owing to the social repercussions, in both the educational and health care systems. Private recruitment agencies that charge fees are increasingly involved in international migration. The differences in nursing education between countries show gaps as regards training models, the duration of nursing studies (3, 4 and 5 years), theory and practical hours (between 3,500 and 10,000 hours) and requirements for both admission into courses and obtaining qualifications. Some informal reference materials on the migration of nurses in Latin America show that this is a constant that affects different countries to varying degrees; for example, South American countries present lower levels of migration than those in Central America, where migration is seen to a large extent. The majority of migrants go to the USA and some to Spain and Italy. Some Central American countries, such as Panama and El Salvador, train nurses who later emigrate, despite there not being enough nurses in the countries themselves.

The social and economic crisis in many countries has had a considerable impact on migration. However, there are no formal studies, which would allow this aspect of the migration problem in Latin America to be analysed in depth. Migration and nursing shortages are two closely linked phenomena that are not exclusively bound together, it being understood that they are not only seen in the most developed countries but also in developing countries. However, there is little talk about nursing shortage in Latin American countries. Various circumstances have determined that the term "shortage" is seldom used or present in the agendas of health care systems and policies.

In any case, the problem of the imbalances in the production, supply and maintenance of qualified nursing staff constitutes a strategic situation to be examined and reported on. It requires the rigorous, complex analysis of its context.

Concerning regulation, the countries in the region of Latin America have begun processes for the accreditation of nursing programmes and professional certification. Agreements signed by sub-regional groups and the establishment of common standards are being addressed in order to facilitate academic mobility for students and professionals.

Regulatory frameworks governing nursing practices exist in many countries, along with specific nursing legislation. However, although the terms of that legislation are in force, they are not commonly respected or monitored by health care institutions or by professional nursing organisations. Nurses’ salaries, working days, and the scope of their responsibilities are largely unregulated. Working conditions are mostly governed by national and/or jurisdictional regulations, which cover health care workers.

As regards the regulation of professional ethics, the ICN Code of Ethics and that of the Pan-American Federation of Nursing Professionals (FEPPEN) are acknowledged frameworks for nurses in all Latin American countries. The Consejo Regional de Enfermería (Regional Council of Nursing) of Mercosur has, in turn, enacted its own code of ethics; the Grupo de Profesionales de Enfermería de Centro América y el Caribe (Nursing Professionals Group of Central America and the Caribbean) is also involved in that process. It is important to stress, however, that the mechanisms for monitoring professional ethics in nursing are weak and rarely implemented.
Regulating nursing is an aspect of considerable importance in the structure and dynamics of the nursing workforce. Latin America is making good progress in enacting laws and rules regulating the profession; however, there is only a little monitoring of these rules.

Regarding training human resources, nursing education in Latin America began its connections with universities in the 1930s. Degrees were developed in the 1960s; and post-graduate studies began with specialisations and master degrees in the 1980s.

Nursing education varies from country to country. The university level is likely the most homogenous, with two or three separate programmes: a degree, which confers a higher education qualification (4-5 years); diploma (2½-3 years) and technical-level nursing (2 years). The overview for 2004 is heterogeneous with many names for academic departments (faculty, school, programme, course, department), and variations in types of programmes, training methods and duration. It has been reported that, in 2004, there were 1,792 nursing programmes in Latin American countries, of which 988 were university courses. The majority of countries are developing an abundance of courses for nursing auxiliaries, regularly linked to non-university institutions, with varying admission requirements and between 6 to 18 months in duration. There are also technical high-school diploma programmes (second phase of middle school aimed at nursing).

Many nursing programmes are still based on the biomedical model; although some years ago, the curricula began to change to include important public health and social science components, and to focus on nursing care. The university teaching staff at the majority of schools has no post-graduate training. Difficulties in accessing updated bibliographies and indexed magazines are obstacles to the academic modernisation of curricula.

In relation to nursing students, some studies show that registrations at universities, institutes and non-university centres have been on the increase over the last 10 years. The same can be said for the number of graduates. However, nursing leaders indicate that the number of graduates produced has not sufficiently increased to meet the demand for nurses.

But the situation is not all bad. There are important training centres, which offer post-graduate level, master, PhD and specialisation programmes. In particular, there are doctorate programmes in Argentina, Chile, Colombia, Venezuela, Brazil and Mexico. Master degrees have been available for over 20 years and are taught in schools that are better developed in terms of research, with more than 40% of their teaching staff holding master degrees or doctorates. A good number of university nursing schools offer specialisation programmes.

The regulation of further education in nursing is heterogeneous. However, processes for accrediting nursing schools and programmes have begun and are under the responsibility of the State.

In relation to the production and dissemination of nursing knowledge, the organisation of research into groups, lines and research centres is recent, with the exception of Brazil and Colombia, which have longer traditions. Scientific production is strongly related to post-graduate education, which favours the training of researchers and the creation of a critical mass able to generate new knowledge. A recent study showed that most researchers came from the teaching ranks.
Research in nursing has become more visible since the 1970s with the creation of different means of dissemination such as journals, book publishing and reports on scientific events. PAHO has created a free directory of scientific nursing publications in Latin America, with the aim of highlighting their existence and characteristics, making them more accessible, promoting improvements, and supporting international indexing processes. The directory contains 65 nursing journals in circulation. However, highly scientific international publication of investigations in Spanish and Portuguese remains weak. The Coloquios Panamericanos de Investigación en Enfermería (Pan-American Symposiums on Research in Nursing) have played an important role in stimulating research and have promoted the creation of networks and North-South integration.

The production and transfer of knowledge through education represent dynamics that are part of the basic structure of the nursing workforce. If education and research are bolstered in all their aspects, they will contribute to accelerating and improving the professionalisation of the nursing workforce.

The educational and scientific explosion in nursing in Latin America over the last 20 years has led to great advances, but these have not been sufficient to formalise a professional nursing workforce. The predominance of non-professional nursing personnel, and the presence of the majority of professionals in management and teaching posts, are signs of the central role that science and education play in the composition and dynamics of the workforce.

With respect to nursing organisations, nursing in the Americas relies upon the full and active development of professional entities. The PAHO study, entitled Panorama de las Organizaciones de Profesionales Trabajadores de la Salud en la Región de las Américas ("Overview of Organisations for Professional Health Care Workers in the Americas") emphasises that "this category of professionals is the only one present in all countries and indicates that professional nursing groups show a tendency to be integrated into international structures; they are conducting active campaigns to give dignity to the profession and facing challenges from the demands for greater modernisation from organisations representing non-professionals" (Scavino 2004:16). For the most part, these organisations are members of ICN, and 19 of them belong to FEPPEN.

Issues, conflicts and differences exist among nursing groups. One study (Scavino 2004:17) states that "nursing is a human resource in high demand and is facing situations of growing precariousness in work; even though these organisations have a less belligerent profile than the rest". The study also states that the differences between organisations of nursing professionals and nursing auxiliaries' unions have been a cause of conflict. Apart from matters shared with the rest, nursing organisations appear to be interested in aspects of training and professional qualification, and in the training of new professional resources.

A look at professional nursing organisations in Latin America allows the following to be stated: there are national associations for nursing professionals in all Latin American countries; while nursing auxiliaries organise their own union or belong to general unions for health care workers. There are nursing education associations in seven Latin American countries; and there are three international nursing organisations and regional integration groups. All the organisations mentioned above participate in intersectoral development processes, in conjunction with governmental bodies, educational entities and international co-operation organisations.

As for nursing human resource policies, the process of formulating policies and plans for the development of nursing in the Americas over the last 20 years has been intensive. Professional and academic organisations, nursing bodies at governmental and service levels, and international cooperation agencies have agreed on a sustained process of generating initiatives, which have transformed nursing in Latin America. The majority of them involved voluntary, deliberate planning and intervention activities with the aim of improving the quality of nursing care and contributing to improvements in health care. Important protagonists in these projects were foundations, international organisations, professional and academic nursing associations, nursing education bodies and regional integration developments.
PAHO has provided technical co-operation by means of the analysis of human resource development in nursing; support for the development of nursing schools and programmes; training for international leaders, teachers and experts; the textbook programme; meetings of experts to discuss priority problems; multi-centre studies; and support to investigations. These activities have all contributed to the improvement of the quality of nursing in Latin America. Professionalisation and distance-learning programmes have made it possible for nursing assistants and auxiliaries to scale up so as to obtain a degree, with a direct impact on the quality of care.

One singularity in the majority of countries is the structure of intersectoral groups for decision-making in nursing. These groups have come together to carry out strategic analyses, introduce and implement nursing policies, and design and manage development plans. A study of 18 countries identified critical areas and development policies, which are featured in the following section.

Main issues and challenges
The future of health care in Latin America very much depends on the role of nurses. Nursing has made a great deal of progress; however, it still faces difficulties as summarised in the following critical areas and challenges:

- **Strategic analysis, policies and human resource planning in nursing:** Efforts must be intensified in order to structure the analyses towards a strategic view of health care; to understand the capacity of nurses to have an impact; and to intervene on a political level for the development of scientific, educational, working and professional conditions. Formulating policies is central to constituting a qualified, relevant nursing workforce.

- **Composition and distribution of the nursing workforce.** The nursing workforce remains unbalanced, limited and inequitable in relation to health care requirements. The ratio of nurses to population is low, while those of assistants and auxiliaries are high, as they are responsible for nearly all of direct care delivery. There are few professionals working in primary health care. This model requires a rethinking of the criteria, policies and strategies in order to guarantee quality health care. Processes for assigning trained nursing personnel equally among all population areas and for professionalising auxiliaries and technicians must be extended.

- **Dynamics of the nursing workforce:** The shortage of nurses in Latin America is connected to the following processes, which include:
  - The growing mobility of the workforce;
  - The conditions of development;
  - The selected models for the composition of the nursing workforce;
  - The precarious employment and working conditions for nurses; and
  - The difficulties in nursing education.

  These processes result in an increase in migration; a lack of interest in continuing with nursing studies; student attrition from courses; and dual employment, among other matters. These aspects require policy adjustments, improvements in working conditions, the modernisation, qualification and better administration of educational programmes and the development of multilateral programmes for migration management.

- **Management of human resources in nursing:** The following issues require revision and modernisation efforts: strengthening of human resource planning in nursing; and a new nursing organisational model for staffing and assignment of work. It is necessary to devise new management methods, which benefit health care, generate a sense of professionalism and improve nurses’ working conditions. The styles of training on the job, which remain unrelated to actual practice, must be redirected towards health care proposals linking education and work. Nurses’ working conditions, within a framework of flexibility and the growing precariousness of labour, require urgent measures to get to grips with issues of salaries, working days, social benefits, incentives, support in career progress and guaranteeing job security.
• **Issues and challenges in education**: Education plays a central role in the composition and dynamics of the nursing workforce, in the quality and relevance of care given, and in the development of institutional capacities in health care. However, education in nursing needs changes that become challenges:

  - **The challenge of discipline.** The challenge is to introduce nursing knowledge and "de-medicalise" training programmes, provide evidence of good health care practices and show the difference between offering generic care services and qualified nursing care. It presupposes that programmes be based on health care needs, placing emphasis on public health and primary health care.

  - **The challenge of education:** There is a need to redesign the extensive traditional programmes into new ones that have essential, relevant and accessible content. Courses should be flexible with multiple options and articulate the different educational levels and institutions. Pedagogical issues include the need to implement education for adults, integrating theory and practice and promoting critical thinking, citizen awareness and interdisciplinary work. Strategies need to be devised for distance and virtual learning.

    To respond to social demands, three aspects of academic management cannot be postponed: the quality of nurse education, its coverage and relevance.

  - **The political challenge of citizen awareness.** Nurses must be trained to be able to discuss public issues; form political opinions; commit to the protection of users and the well being of communities; and support the construction of public health and nursing policies to strengthen the concept of “social justice for health”. The ultimate aim must be to overcome inequality and exclusion, and guarantee qualified health care for all.

• **Issues and challenges in nursing research**: Enormous progress has been made in the investigation of nursing. However, it requires a major effort to clarify and position this knowledge in the context of the sciences, universal knowledge, and its application to health care. Initiatives and efforts are required in order to clarify the final aim and establish the ethical and political basis of nursing research. Knowledge in nursing and its lines of research need definition. Research methods need to be extended and improved, as do the conditions for the completion and productivity of nursing research.

    A new policy must cover the full range of parties, promote alliances and establish joint strategic agendas. Policies need to be developed in order to:

    • Generate and strengthen processes of change aimed at planned interventions in nursing development;
    • Address the inequitable distribution of nurses in regions and institutions;
    • Address the factors involved in nurses working in dangerous working conditions;
    • Modernise management systems and devise mechanisms for managing migration;
    • Boost the social activities of nursing organisations; and
    • Align nursing education and research with identified health care needs.

    Without a sufficient number of nursing personnel in terms of both quality and quantity, the achievement of the Millennium Development Goals (MDGs) and Health for All may be merely rhetorical.
The nursing workforce in sub-Saharan Africa

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Delanyo Dovlo

Executive Summary
This paper was prepared, at the request of the International Council of Nurses (ICN), as a contribution to its series of papers aimed at addressing nursing workforce issues worldwide.

This paper examines various aspects of the nursing and midwifery workforce in Africa, looking at education and supply systems; recruitment, retention and motivation and career systems. It further investigates attrition from migration and HIV/AIDS, as well as other factors and makes some recommendations on how to move forward using examples of experiences from countries. These experiences, albeit on a small scale, show promise of good results after being scaled up.

Section One provides the regional overview and context of nursing in sub-Saharan Africa (SSA) and points out factors that influence the ability of countries' nursing workforces to cope with their health situations. Some of these factors relate to planning, management, retention and motivation of the nursing workforce, and some also relate to the HIV/AIDS epidemic.

Available data are used to compare countries in the region in terms of nurse:physician ratios and supply per 100,000 of population. The paper looks at the various education and training programmes in some SSA countries. It examines the regulation of nurses and midwives and the key role it plays in addressing nursing workforce shortages through expanding scopes of practice and re-examination of skill mix. The role of gender in nursing is discussed with its influences on the status of nursing and the participation of the profession at the highest health policy decision-making levels. Private sector roles, as investors in the production of nurses and in nurse-based service delivery, are discussed with examples from some countries in the region.

Section Two focuses on the challenges and prospects for the nursing profession. Shortages of nurses and poor retention are addressed in the context of health systems in Africa. Nurse migration, a major factor, is continuing and worsening in some countries. For example, in Zambia, both registered and enrolled nurses (ENs) appear to migrate. Factors that contribute to this migration of nurses are reviewed. These factors are examined as they relate to the challenges raised by health system reform in Africa. The objectives of that reform process in most countries – improving quality, efficiency, cost-effectiveness, coverage and equity in health care – are challenges not readily met when significant health worker shortages persist and emigration continues.

HIV/AIDS is a major challenge to nursing in Africa. The magnitude of its impact on the nursing workforce is still unfolding, and stigma associated with the disease makes it difficult for accurate data to be obtained about its impact on nurses. Findings from Kenya show that HIV/AIDS is affecting the nursing workforce negatively through increased workload, increased patient illness and density, perception of reduced health worker safety in the workplace, and reduced productivity of those nurses who are ill and are frequently absent from work. Deaths among nurses have increased significantly over the past decade, which may be attributable to HIV/AIDS. The absence of adequate workplace programmes for health staff highlights the need to put in place meaningful actions, including counselling and providing anti-retroviral (ARV) treatment for health workers, as well as reinforcing broader policies for Infection Prevention and Control (IPC).
Section Three examines policy opportunities and strategies, including the impact of macro-economic policies on nursing in Africa, and identifies opportunities that new funding mechanisms could generate for health human resources (HHR) if incorporated into Poverty Reduction Strategy Papers (PRSPs) and global disease control initiatives. There is a major role for advocacy and strategic policy development by all key players including national, regional and global organisations, to address the crisis in nursing.

Section Four, entitled “the need for action”, highlights some major action areas such as:
- Increasing supply of nurses;
- Improving productivity of the nursing workforce;
- Improving retention and managing migration;
- Motivating nurses and midwives and other health workers;
- Strengthening governance in nursing through regulatory bodies and nursing and midwifery associations, including strengthening of leadership and management capacities in nursing;
- Tackling HIV/AIDS and other welfare issues affecting nurses;
- Developing and strengthening HHR Management Information Systems.

**Conclusion**

While acknowledging that the challenges in stabilising and sustaining nursing and midwifery services in Africa are enormous and linked to macro-economic and health policy dilemmas, the conclusions are that it is possible to turn the tide on the critical shortage of nurses and midwives in SSA by tackling the challenges effectively. There is need for new thinking in the allocation of resources and investments into the recurrent costs of HHR requirements. Stakeholder consultations are necessary. This should involve wider donor partner and international agencies’ participation and support, so that appropriate conditions, and an enabling environment, are created to address the issues and protect the health of the populations in SSA countries.

Urgent interventions are necessary to initiate a reversal in the current nursing shortages; otherwise, attainment of the Millennium Development Goals (MDGs) by 2015 will remain out of reach for most SSA countries.