NURSES
A VOICE TO LEAD
HEALTH IS A HUMAN RIGHT

HEALTH IS A HUMAN RIGHT
ACCESS, INVESTMENT AND ECONOMIC GROWTH

INTERNATIONAL NURSES DAY
RESOURCES AND EVIDENCE

INTERNATIONAL COUNCIL OF NURSES

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MESSAGE FROM THE ICN PRESIDENT

The International Council of Nurses (ICN) believes that health is a human right. ICN is at the forefront of advocating for access to health and nurses are the key to delivering it. All over the world, there are individuals and communities who are suffering from illness due to a lack of accessible and affordable health care. But we must also remember that the right to health applies to nurses as well! We know that improved quality and safety for patients depends on positive working environments for staff. That means the right to a safe working environment, adequate remuneration, and access to resources, and education. We must add to this the right to be heard and have a voice in decision making and policy development implementation!

As the global voice of nursing, ICN will continue to speak up and speak out. In 2018, ICN is doing this louder and stronger than ever before. Following the 2018 IND theme, Nurses: A Voice to Lead, Health is a Human Right, this toolkit presents compelling evidence showing how investment in nursing leads to economic development; and how improving conditions in which people live leads to cohesive societies and productive economies.

For nurses, Health is a Human Right means that all humans have the right to access affordable and quality health care at a time when they need it most. And there are nurses working in everyday health care settings and in positions of influence and decision making that are doing this right now!

This International Nurses Day, let us join together to share how nurses are transforming health care and health systems so that no person is left behind. Let us join our voices together to be a voice to lead by supporting a people–centred approach to care and health systems, and ensuring our voices are heard in influencing health policy, planning and provision.

On behalf of us all at ICN, Happy International Nurses Day!

Annette Kennedy

President
International Council of Nurses

PART ONE:
HEALTH IS A HUMAN RIGHT

> For me, the key question of Universal Health Coverage is an ethical one. Do we want our fellow citizens to die because they are poor? Or millions of families impoverished by catastrophic health expenditures because they lack financial risk protection? Universal Health Coverage is a human right."
>
> –Dr Tedros Adhanom Ghebreyesus (Director General, WHO)[1]

The challenge set before us

In June 2017, Dainius Puras, the United Nations Special Rapporteur[a] presented his report on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health to the Human Rights Council of the United Nations.[2] The report focused on mental health care to which the Rapporteur concluded *"nothing short of a 'sea change' will end years of neglect in mental health care."*[3] The report highlighted decades of neglect, abuse and violence against socially challenged groups including persons with intellectual, cognitive and psychosocial disabilities suffered either because of the absence of care and support or receiving care that was ineffective and harmful.

The UN Special Rapporteur stated that "where mental health systems exist, they are segregated from other health care and based on outdated practices that violate human rights." He also believed "that mental health policies and services are in crisis–not a crisis of chemical imbalances, but of power imbalances"–and called for bold political commitments, urgent policy responses and immediate remedial action.

One of the reasons for this, he believes, is the dominance of biomedical models, with a dependence on medication, and a failure to respect, protect and fulfil the right to health. The treatments focus on pathology alone at the expense of the person's wellbeing in the broader terrain of personal, social, political and economic lives.

[a]The current UN Special Rapporteur is Dainius Puras, a psychiatrist from Lithuania. Special Rapporteurs and independent experts are appointed by the Geneva–based UN Human Rights Council to examine and report back on a specific human rights theme or a country situation. The positions are honorary and the experts are not UN staff, nor are they paid for their work.

The report even highlights that public policies neglect the importance of preconditions of poor mental health such as violence, disempowerment, social exclusion and isolation and the breakdown of communities, systemic socioeconomic disadvantage and harmful conditions at work and in schools. The report concludes that approaches that fail to protect the social, economic and cultural environment are not just failing people with disabilities; they are failing to promote mental health and wellbeing across the life course.

Through the example of mental health, Dr Puras clearly shows that the fundamental issue constraining our ability to attain health for all is the lack of a people–centred approach to health. As health, including the ability to access care is a human right, we must move beyond the biological and pathological view of health.

There are political, social, economic, scientific and cultural actions that can advance good health for all. Good health depends on access to safe drinking water and good nutrition, adequate sanitation, education, the extent of equality and freedom in society and other underlying determinants of health.

The conditions in which people are born, grow, live, work and age have a predominant effect on the burdens of illness and the premature loss of life. It is here that nursing can have a profound effect on enabling a human rights perspective of health. Historically, the foundation of nursing practice is caring for the health and wellbeing of individuals and communities. The philosophical basis of nursing is a people–centred approach to health.

> There is a moral crisis in mental health treatment. We have failed human rights in hospitals in many countries."
>
> –Prof. Vikram Patel

The right to health and the ICN focus for the year

Why is ICN focusing on health as a human right? This broad focus enables nurses to understand the philosophical basis of all of our practice, whether that is in health promotion, illness or trauma prevention, or in acute and chronic treatment. It enables us to locate the health effects of the social determinants of health such as sanitation, adequate food, decent housing, good working conditions, education, equality and a clean environment.[4] The role of nursing in addressing the inequalities, discriminatory practices and unjust power relations in the social determinants of health was the focus of International Nurses Day (IND) 2017 ('Nurses: A Voice to Lead–Achieving the Sustainable Development Goals'). It allows us also to understand the health care system from a person–centred and community–centred perspective. This year's IND builds on the messages of the 2017 IND by now exploring issues of **access** to health care and the impact of access issues on health outcomes.

> The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal."
>
> –Francis W. Peabody[5]

Health systems are an essential element of a healthy and equitable society. When health is viewed as a human right, there is a demand on us to take action and a responsibility to enable access to a health system. This belief should be the cornerstone of an effective system, and the benefits of this will ultimately flow to communities and countries. The right to health is more than a catch phrase for health workers, civil society groups and non–government organisations in an effort to positively change the world. In the majority of cases, the right to health is a legal instrument that can be used to hold governments and the international community to account. It can and it should be used as a constructive tool for the health sector to provide the best care for individuals, communities and populations.[6]

UHC and how it translates in various countries is highly contextual. Fundamentally, no one should be denied access to their country's appropriate standard of health care because of their financial status, where the health care provided leads them deeper into poverty. A human rights perspective on health means that wherever you live, you can receive health care to assist with your health needs.

In September 2015, **193 COUNTRIES FORMALLY ENDORSED A NEW BLUEPRINT FOR THE WORLD THAT WE WANT**–this included UHC–the right to health without financial hardship.[7]

AT LEAST 400 MILLION PEOPLE GLOBALLY LACK ACCESS to one or more essential health services.

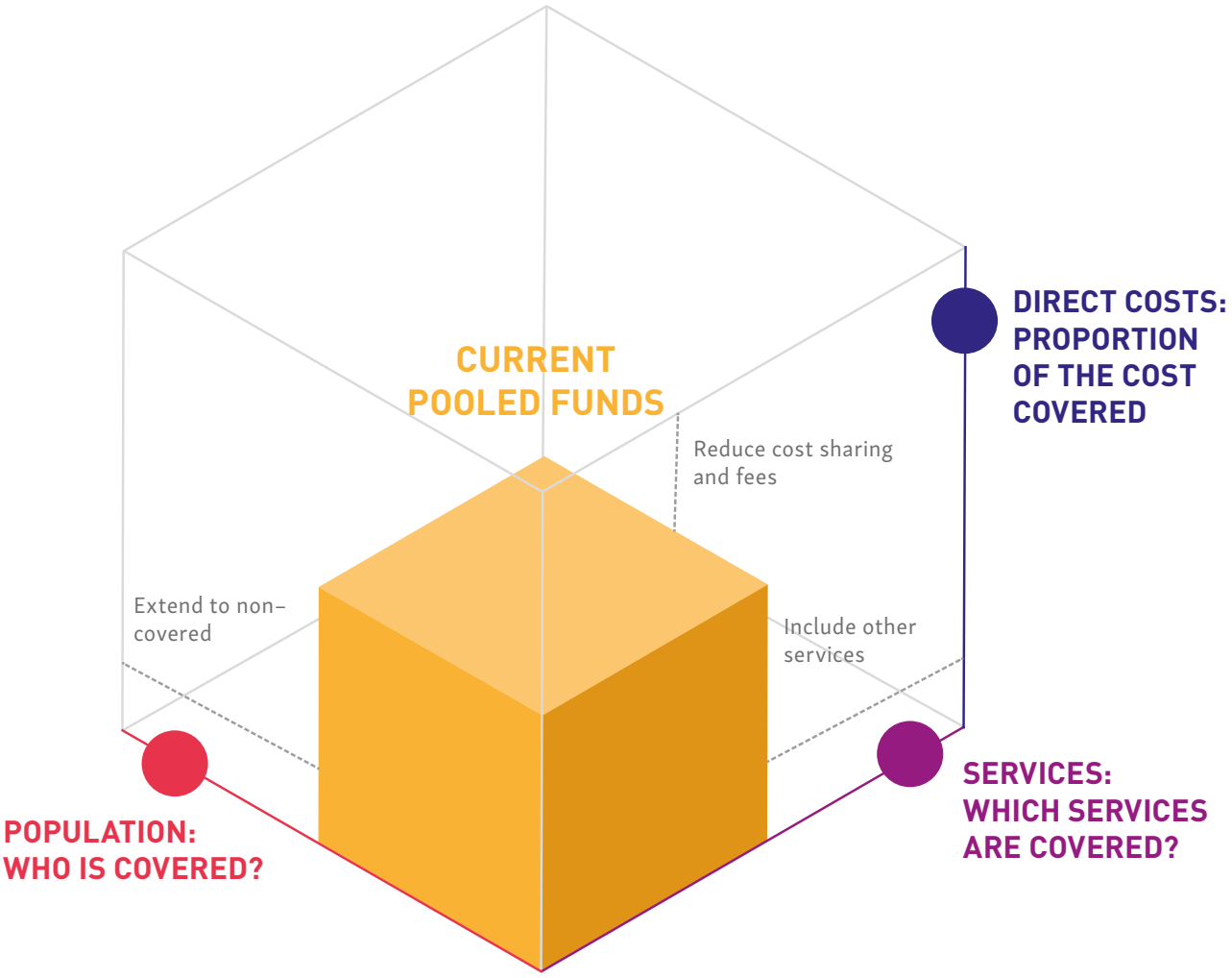
EACH YEAR 100 MILLION PEOPLE FALL INTO POVERTY paying for essential services.[7]

On average, about **32% OF EACH COUNTRY'S HEALTH EXPENDITURE** comes from out–of–pocket payments.[7]

40% OF THE WORLD'S POPULATION lack social protection.[8]

A MINIMUM OF US$44 IS NEEDED PER PERSON PER YEAR to provide basic, life–saving health services: 26 WHO Member States spent less than this in 2011.[8]

Figure 1: WHO's three dimensions to consider when moving towards universal coverage[9]



Key elements of a rights approach to a health system

A core building block of the right to health and the aspiration for the highest attainable standard of health is an effective and integrated health system that encompasses health care that is concerned about the determinants of health. This health system also needs to be responsive to both local and national priorities and be accessible to all. When this is achieved, the foundations are set in place for a healthy and equitable society.

Figure 2: The general principles of a health system based on the right to health[10]

OUTCOMES AND PROCESSES

Concerned with how the health system works and how it does it (i.e. transparent, participatory and without discrimination).

CULTURALLY APPROPRIATE

A health system should be respectful of cultural differences.

PROGRESSIVE REALISATION

The right to the highest attainable standard of health is subject to progressive realisation and resource availability. In other words a comprehensive, integrated health system cannot be constructed overnight. However progress should occur and be measured against benchmarks.

EQUITY, EQUALITY AND NON–DISCRIMINATION

A health system should be accessible to all without discrimination including those living in poverty, minorities, indigenous peoples, women, children, people with disabilities the elderly, etc.

DETERMINANTS OF HEALTH

The health of individuals and communities require more than medical care. It includes addressing the determinants of health.

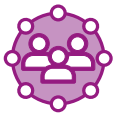
QUALITY

Health service must be of good quality with access to essential medicines. Quality also extends to how patients are treated within the health system.

HOLISTIC PEOPLE–CENTERED APPROACH

CONTINUUM OF CARE

There needs to be an appropriate mix of primary, secondary and tertiary services providing a continuum of prevention and care. This also incorporates appropriate referral processes.



COORDINATION

An effective health system requires coordination between various sectors and departments such as health, environment, water, transport, etc. Coordination needs to extend from policy making to the actual delivery of services.

INTERNATIONAL COOPERATION

Global cooperation is required for the 'global public good'. This may include control of infectious diseases, the dissemination of health research and international regulatory initiatives. This may extend to doing no harm to neighbouring countries and supporting low income countries.

STRIKING BALANCES

Sometimes there is competition between different needs. These should be considered in their context. There are not always neat answers to difficult questions, particularly in a resource constrained environment.

MONITORING AND ACCOUNTABILITY

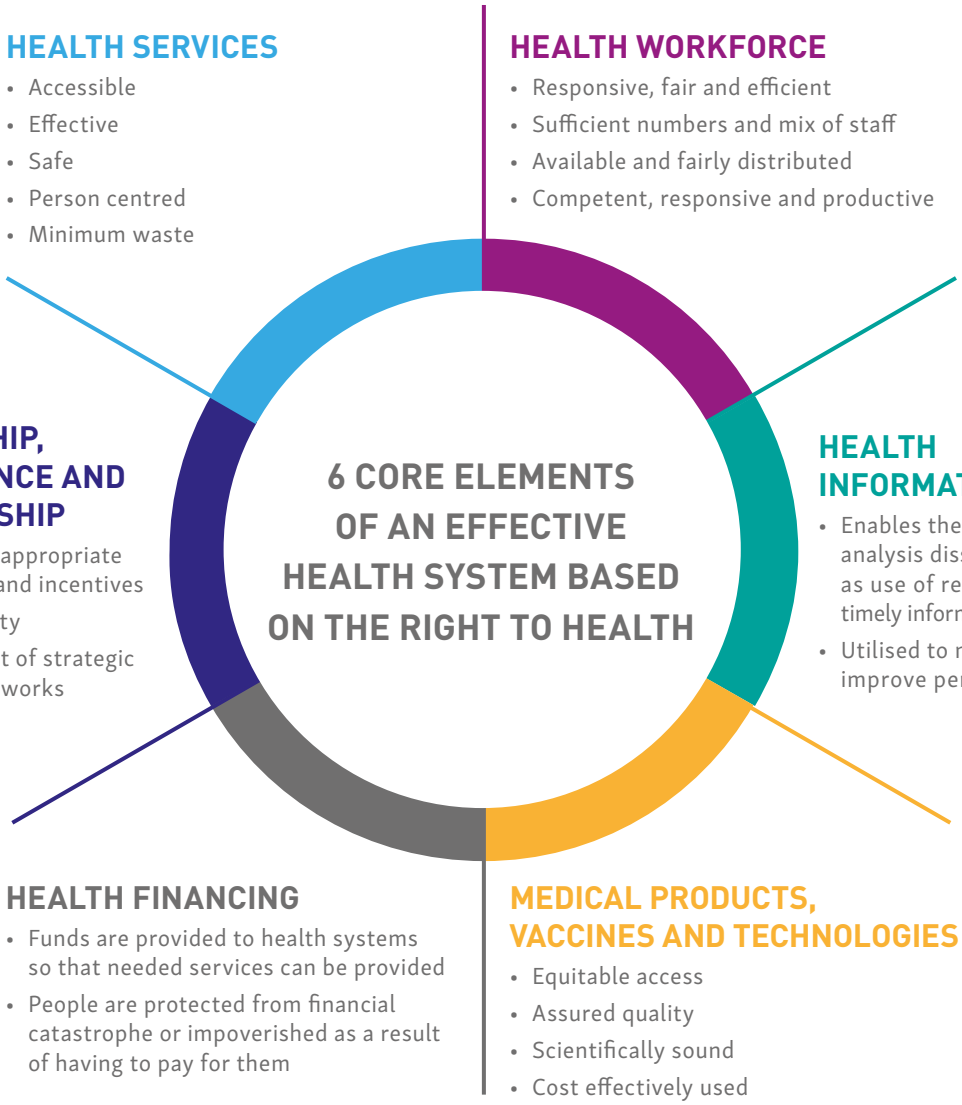
Rights imply duties, and duties require accountability. Accountability includes the monitoring of conduct, performance and outcomes.

LEGAL OBLIGATIONS

The right to highest attainable standard of health gives rise to legally binding obligations including those mentioned here.

In 2007, the World Health Organization (WHO)[11] outlined a general approach of the right to health through strengthening health systems. These have been listed in the following diagram as six core elements of a functioning health system.

Figure 3: The six core elements of a functioning health system



Why should nurses be interested in the right to health as an approach to health care?

It is evidence based: The right to health approach to health systems is evidence based and is an important proven way of improving health and equity within a population. The approach is pivotal in providing structure and discipline to the approach of health policy making within a country and enables governments to be held to account.[12]

Each person has intrinsic value/worth and an expression of humanity: Many health systems have an historic approach of being led from the 'top down' when looking for economic efficiencies. The individual is sometimes lost in these approaches. Other approaches have led from a disease perspective rather than looking at the person as a whole, whose body and mind are linked and who is to be treated with dignity and respect. Historically, nurses have undertaken a holistic view of the individual and their personhood within the community. Nurses can lead by supporting a people–centred approach to care and the health system. This places the wellbeing of individuals, communities and populations at the centre of the health system. The health system cannot be technocratic or removed from the people it is meant to serve.[13]

Legal obligation: There are numerous legally binding obligations related to the right to the highest attainable health. This means that governments and health systems have responsibilities to provide a certain standard of care to communities and populations.

Nurses have a critical contribution to make: Whilst laws have been created to support the right to the highest attainable standard of health, many organisations, institutions and governments are exploring what this means and how to put it into practice. The right to health is not static but continues to evolve as progress in the fields of science and technologies are made. Nurses need to be making the decisive contribution to this process as they possess the scientific reasoning, philosophical underpinnings and proximity to the patient, family and community.

The success of UHC through people–centred care is dependent on the nursing profession providing a transformational approach to the way health is conceptualised and how health care is delivered. This includes forming and fostering partnerships with individuals and communities, policy makers, governments, and other health professionals to modify the effects of the social determinants of health; to conceptualise health care providers as inclusive of the community; and to develop and scale up innovative models of health service delivery.

A people–centred approach, a functional health system, the availability of an appropriately skilled workforce and addressing the issues of access are the critical building blocks for Universal Health Coverage. Part Two explores issues of access in more detail.

PART TWO:
UNPACKING THE COMPLEXITY OF ACCESS TO HEALTH CARE

> If we do not engage consumers, patients, and family members in health care process, we will not be effective at eliminating inequalities and improving health for all."
>
> –Kalahn Talyor–Clark[14]

The nurse's unique and intimate view

There is no other profession that attends to people's needs in their most vulnerable periods of time as nursing does. The relationship between the client and the nurse provides a unique and intimate view of a person's life. Take for example these real patients' stories told by nurses.

Recently diagnosed with breast cancer, Amelia's real tragedy has been losing her husband two months prior to her diagnosis. One year away from retirement, he had refused to go to the hospital to enquire about the pain in his chest. Instead, he said that it was just indigestion and went back to bed, never to wake again. Amelia's pain comes more from the loss of her husband than from her cancer.

Admitted to the hospital for a three–month treatment for a haematological condition, Yusuf was given an injection that was meant for a different patient without his consent. This risked the effectiveness of the treatment and delayed his discharge for another month. Yusuf is furious both at the way the hospital had dealt with the problem and at how they had notified him of the mistake.

José is always laughing but behind the laughter, he hides terrible fears. Although he has never smoked, he is in remission from stage 4 lung cancer. Despite this, José still requires monthly chemotherapy that lasts a week. Three days before each regime of chemotherapy, he suffers terrible panic attacks.

Even as the chemotherapy enters his body, José wants nothing more but to rip out the line and go home, for he knows what the next week will be like once the chemotherapy has poisoned his body.

Beatrice has obviously lost a lot of weight and is becoming increasingly fragile. She was once a singer, but the strength in her voice has gone. For many months, she has seen blood in her faeces. Beatrice has been placed on a waiting list for a colonoscopy. The list is so long, that the hospital has recommended that she go privately for treatment, but she is unable to afford this option and so she waits. After two years she has had her procedure. During a ward round with teaching students, the doctor stood at the foot of her bed and informed her that she has stage 4 bowel cancer. "They were talking like I wasn't even in the room," Beatrice says. "I was just a 'specimen' on the bed."

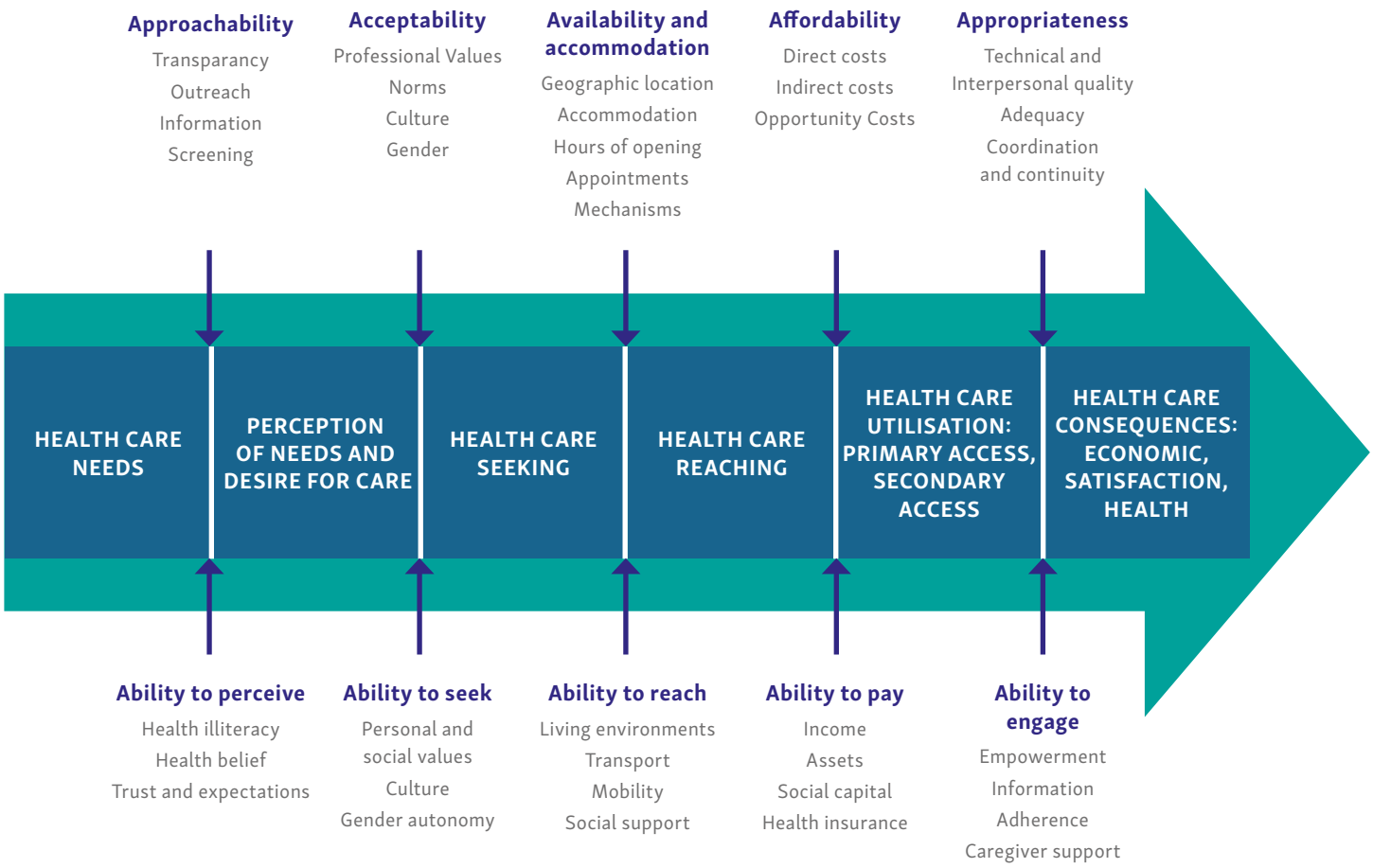
More than any other health speciality, nurses spend the most time with patients and their families and have firsthand knowledge of the stories that have an impact on the health and wellbeing of patients. Everyone has a story and every story has the potential to improve the health system and enable individuals and communities to achieve their highest attainable standard of health. From these insights comes the power for change. Policy makers are distanced from the requirements that make an effective and people–centred health system; to them it is peripheral. To nurses, it is the daily lived experience. The right to the highest attainable standard of health requires nursing insight to challenge how the system works and how it can be improved (further articulated in Part Four).

Access to health care is a key determinant of how well the health system is meeting the health needs of individuals and communities. It is central to the belief that health is a human right and is the cornerstone of UHC and people–centred care.

For this IND publication, 'access' is defined as "the opportunity to reach and obtain appropriate health care services in situations of perceived need for care."[15] Access is about enabling people to make the right steps of being able to contact or obtain health care as their needs require and having these health care needs fulfilled. This view is a holistic understanding of 'access' as it incorporates both user and health service provider factors, rather than simply seeing access as one of affordability.

This section will explore the various dimensions and determinants of access and how they interact using a dynamic framework (Figure 4) developed by Lesvesque, Harris, and Russell[15] that considers access to be the result of an accumulation of experiences and resistances faced by individuals. This section aims to cultivate a better understanding of the complexities that make up access to both inform nursing practice on the ground and to enable the nursing community to effectively inform policy that aims to approach UHC.

Figure 4: A conceptual framework of access to health care[15]



ACCESS TO HEALTH CARE:
Awareness and identifying unmet needs

In 2014, 422 million people in the world had diabetes which directly caused more than 1.6 million deaths.[16] Diabetes is a complicated and costly chronic disease that affects nearly 1 in 11 people worldwide at the global expense of US$673 billion (12% of global health expenditure).[17] The prevalence of diabetes globally has exploded with the number of adults diagnosed with the disease rapidly increasing. However, the extent of the problem is not fully realised as many people are unaware that they even have the disease and require treatment.

In South Africa, researchers believe that over 53% of the population are not aware that they have diabetes. Of those who have been diagnosed, over 80% do not have their blood sugar levels under control and have major unmet care needs.[18] This problem is not unique to South Africa; it is seen across the world. There are several causes for this high rate of unmet need. They relate to both individuals' understanding of the signs and symptoms of the disease, thereby seeking clinical care, as well as the ability of health systems to provide the necessary services and information regarding diabetes.

Individuals' understanding and knowledge about diabetes affects their attitudes towards treatment, lifestyle options and the ability to self–manage the condition. When health literacy is poor, there is a higher incidence of other chronic conditions, poorer health and diminished quality of life. Inadequate health literacy is a contributor to the disproportionate burden of diabetes–related problems among disadvantaged populations.[19]

There are also health system challenges. Many organisations, both public and private, are attempting to implement strategies to improve detection and management of diabetes. But many of these strategies are not only failing, they are also costly. The ones that have been deemed successful have several similar characteristics. They shift the care closer to the consumer[b]; they improve engagement with the individual and community to improve knowledge and understanding of diabetes and the types of services that are available; and they focus on aligning the holistic needs of the consumer with the appropriate health care professionals.[20] The main driver of this is to improve health care access and managing diabetes as a chronic condition with major lifestyle implications.

For health services to be accessible, people need to be aware that they exist, understand how they can be accessed and have a desire to use them. The first step to accessing health care is knowing that you need it. The second is that health services are provided in a way that assists in empowering the user to identify health needs and access the appropriate health services.

[b]There are insufficient specialists to meet the demands of diabetes, so centres of excellence have moved 80-90% of diabetic patients to primary or community care.

CASE STUDY: **Integrated health services and promotion for non–communicable diseases in the elderly**

Contributor: Baithesda, Wenda Oroh **Country:** Indonesia

The Community Health Centre in Ranomut sub–district, Indonesia is one of several community health centres commissioned by the Government to address public health issues in Manado City. There are currently 1,214 elderly people who are registered with this Community Health Centre which provides integrated health services and health promotion for noncommunicable disease amongst the elderly population. The centres use 'Posbindu PTM' which is a framework for promotive and preventative community–based health efforts. The aim of Posbindu PTM is to increase public participation in prevention and early discovery of non–communicable disease (NCD) risk factors. For people at risk or with NCDs, the programme aims to control and maintain optimal health.

The services offered under this framework include counselling, sharing experiences and knowledge; early detection of NCDs through examination of mental health status; and nutritional status through weight and height measurement, blood pressure measurement, haemoglobin, and urinalysis. Depending on local needs, the centres carry out other activities such as supplementary feeding and sports. Posbindu PTM activities are community–owned and fully implemented by the community for the community with the support of nurses and other health professionals.

This service in Ranomut seeks to increase the reach of health services to elderly people within the community. The programme is tailored to meet local needs and increase participation. It aims to improve accessibility of health services to the elderly, particularly the poor and vulnerable. Not only is it focused on the health of the individual, it is focused on the health of the community.

The programme has been developed in response to increasing demand for health services caused by NCDs and the limited supply of health workers. In 2014, there were approximately 892,000 health workers for a population of 250 million people. Even with the shortfall of workers, there is an uneven distribution of health workers. About half of health workers in Indonesia are concentrated in Bali and Java.

This programme has been successful in improving healthy ageing. The benefits have come through peer–supported community participation which has helped to change the way people view their health. Nurses in this service have been leading the engagement and contact with the community. They have challenged the communities' perception of healthy living and empowered individuals to take greater control over their own health and wellbeing.

CASE STUDY: **Providing health services at the heart of the community: The National Hospital of Sri Lanka**

Contributor: K.M.Sriyani Padmalatha **Country:** Sri Lanka

As part of the multidisciplinary team, nurses from the National Hospital of Sri Lanka provide outreach services to improve access to essential health care services closer to where people live. This includes homes, schools, working environments and community centres. Using a mobile clinic, they are able to reach the community, identify their health needs and provide access to health services accordingly.

The services that are offered include: physical assessment, blood pressure monitoring, blood sugar testing, height and weight, blood and urinalysis; family planning and fertility care; nutritional support; eye clinic; ear, nose and throat clinic; health education for disease prevention and early detection; healthy lifestyles counselling; exercise and weight management; sleep and health; mental health and meditation.

Historically, a key challenge in Sri Lanka is the limited availability of community–based services to provide diagnostic, investigation and screening within the community. As such, the hospitals are filled to capacity with a large number of avoidable admissions. A large proportion of the community is unaware of their health status and there is a large number of undiagnosed non–communicable diseases.

As a result of this service, over 350 consultations are offered free of charge each day. Over the last three years, over 300,000 people have been seen in these clinics. The services reach people within the community that would otherwise not receive health services and are therefore well respected and appreciated by the community. The key to the service is that there is community engagement and involvement in how care is provided.

Because the service is offered free of charge, all staff are volunteers. Many nurses use their personal leave to support the clinics. A review is currently being undertaken to analyse the benefits of the service. This will be presented to the Ministry of Health for future support of the project.

ACCESS TO HEALTH CARE:
Meeting diverse needs

Indigenous people around the world generally have poorer health outcomes than non–indigenous populations. The gap in life expectancy between indigenous and non–indigenous populations is estimated to be 21.5 years in Cameroon, 13.1 years in Kenya, 12.5 in Canada, and 10 years in Australia.[21] These disparities in health are a major concern and there is a need to understand how access to health services affects these outcomes.

Indigenous persons are less likely to use preventative health care services and are also less likely to engage in early intervention when symptoms first arise. This increases the risk of hospitalisation and mortality. Numerous studies have been conducted to ascertain the reasons why indigenous peoples do not engage or access health services at the same rate as their non–indigenous counterparts. The studies identify several key factors for this including a lack of culturally appropriate health care services; racist or discriminatory behaviour by health care staff; the unaffordable cost of seeking health care and a lack of ability to attend appointments.[21, 22]

As stated above, one of the primary reasons for delaying or not seeking care is a lack of trust of mainstream health services. One Indigenous community leader reflected on this issue and stated:

"...a lot of people didn't want to go there [the local mainstream health service] because they felt the place was unfriendly, the staff were not friendly towards them and there was a lot of attitudes happening, people felt they were discriminated against, and the place was very sterile... it wasn't a comfortable environment... didn't speak in the way we speak... like very abrupt, loud and abrupt, communication wasn't there too, you know? Just that lack of understanding in how you talk, the tone you use for Indigenous people... so there was that, where there was no probably no cultural knowledge with the staff... like discrimination, racism, or you know, just ignorance and no sensitivity and no understanding of Indigenous health issues..."[23]

There are multiple strategies that have been used to address these culture differences. One of these is improving cultural appropriateness of health care services by ensuring that racism and discrimination do not occur. The onus of improving cultural safety is on the health care provider, rather than the patient, to ensure that the services are tailored to and culturally acceptable for every patient.[23]

Acceptability of health services extends to more than just cultural awareness. It includes other components such as gender, religion and other social factors. For example, there may be a reduced desire by women to seek health care if the providers are mostly men (and vice versa). As Levesque et al.[15] state, "the ability to seek health care relates to the concepts of personal autonomy and capacity to choose to seek care, knowledge about health care options and individual rights that would determine expressing the intention to obtain health care."

In a human rights approach to health, health systems must provide care based on non–discrimination. The WHO states that the principle of non–discrimination seeks *"...to guarantee that human rights are exercised without discrimination of any kind based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation".*[25]

> Cultural proficiency requires more than becoming culturally aware or practicing tolerance. It is the ability to identify and challenge one's own cultural assumptions, values and beliefs, and to make a commitment to communicating at the cultural interface."
>
> –Secretariat of National Aboriginal and Islander Child Care[24]

CASE STUDY: **Right to Care: expanding access to health care to provide complementary HIV testing services**

Contributor: Letsatsi Paul Potsane **Country:** South Africa

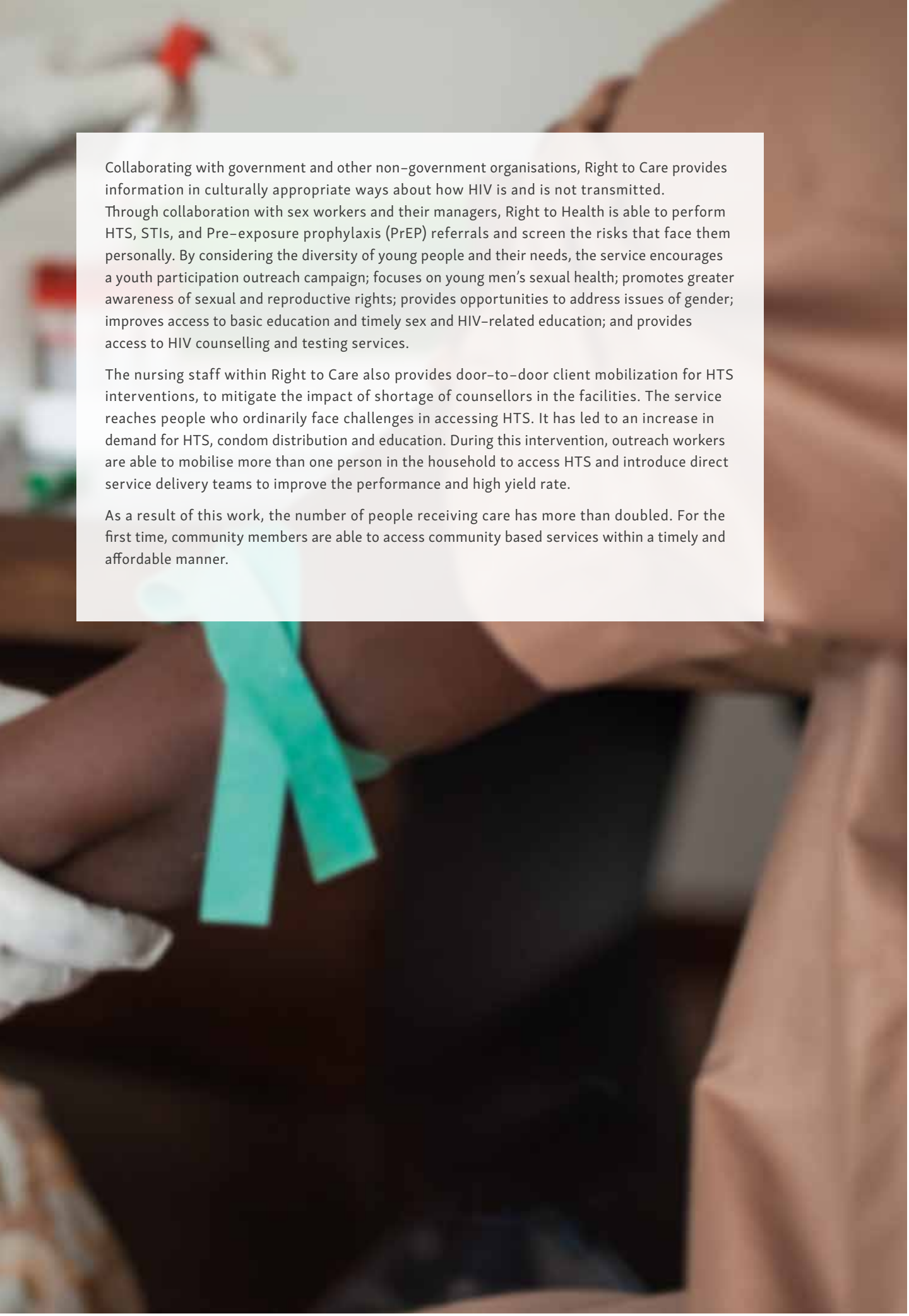
Right to Care is at the vanguard of supporting and delivering prevention, care and treatment services for people with HIV and TB and other associated diseases. Located in Region A of the Northern Gateway to Johannesburg, the Right to Care service is staffed by two Registered Nurses and eight HIV Counsellors. Working closely with the community, the team provides comprehensive HIV Testing Services (HTS) such as HIV counselling and testing, and access and initiation on anti–retroviral therapy (ART). They also provide screening for tuberculosis, sexually transmitted infections (STIs) and, noncommunicable disease (NCD) along with pregnancy tests, and referral to medical circumcision. The availability of NCD screening contributes to HTS uptake and reducing stigma and discrimination. All community HTS outreach campaigns are focused and targeted on key hard–to–reach populations in underserviced areas, using mobile clinics to reach community members in various areas.

The organisation works in partnership with government and communities to find pioneering solutions to build and strengthen public health care. The areas of expertise include HIV and TB care and treatment, pharmacy automation, medical male circumcision, and cervical cancer diagnosis and treatment.

In Region A, there is a mixture of urban and rural living. The region has a number of informal settlements and is home to more than 250,000 people. Poverty and unemployment are major issues within this region. In one settlement of 56,000 people, the unemployment rate is higher than 50% and more than 70% of residents live below the poverty line. The population has low levels of education and is relatively young with approximately 24% of the population aged between 20-29.

As a result of these circumstances, there is a high burden of disease, particularly HIV. The traditional models of care have struggled to meet the needs of the community because of capacity and resourcing. As such, there is a low uptake of Provider–Initiated Counselling and Testing (PICT), poor coordination of data, a shortage of counsellors and space for counselling and testing. Another issue is that health facilities have limited opening hours and young school children are unable to access services. Sex workers also face difficulty in accessing health services.

The impact of the problem is devastating. There are an elevated number of orphans and children in distress caused by AIDS; and an increased number of clients requiring hospitalisation due to HIV–related illnesses because of late treatment, high cost to care, and a shortage of medical, nursing and allied health professionals.



Collaborating with government and other non–government organisations, Right to Care provides information in culturally appropriate ways about how HIV is and is not transmitted. Through collaboration with sex workers and their managers, Right to Health is able to perform HTS, STIs, and Pre–exposure prophylaxis (PrEP) referrals and screen the risks that face them personally. By considering the diversity of young people and their needs, the service encourages a youth participation outreach campaign; focuses on young men's sexual health; promotes greater awareness of sexual and reproductive rights; provides opportunities to address issues of gender; improves access to basic education and timely sex and HIV–related education; and provides access to HIV counselling and testing services.

The nursing staff within Right to Care also provides door–to–door client mobilization for HTS interventions, to mitigate the impact of shortage of counsellors in the facilities. The service reaches people who ordinarily face challenges in accessing HTS. It has led to an increase in demand for HTS, condom distribution and education. During this intervention, outreach workers are able to mobilise more than one person in the household to access HTS and introduce direct service delivery teams to improve the performance and high yield rate.

As a result of this work, the number of people receiving care has more than doubled. For the first time, community members are able to access community based services within a timely and affordable manner.

> Some countries have set out to give priority to equity and have built an inclusive system from the start, but historical... data also suggests that many countries that have accelerated progress towards Universal Health Coverage have left the poor and rural population behind."
>
> –WHO[27]

ACCESS TO HEALTH CARE:
Availability and easy to reach services

In the majority of countries in the world, the suicide rate is much higher for those living in rural areas. In fact it is alarming to consider that the risk of suicide is double if you live in a rural region compared to a metropolitan area.[26]

It is unlikely that there is only one explanation to why the rates of suicide are higher amongst rural populations, as suicide is a multi–dimensional phenomenon and appears to be driven by a mixture of contextual social, cultural and economic factors, as well as individual factors.[28] A compounding factor is the differences in access to and uptake of effective treatments and services. There is often a significant difference between rural and urban areas in relation to access, utilisation and mental health spending. The National Rural Health Alliance[28] stated, "Timely diagnosis, treatment and ongoing management of a mental health condition in rural and remote areas is likely to occur later or not at all, often resulting in an increased likelihood of hospitalisation and sometimes leading to the most tragic of outcomes–self–harm and suicide."

People living in rural areas also often have poorer general health than those living in metropolitan areas due to significant differences in the social determinants of health.

Whilst these social determinants of health may not be unique to rural areas, isolation may exacerbate them. This includes, but is not limited to, access to communications (e.g. mobile phone coverage and internet) and environmental changes (e.g. droughts and floods affecting livelihoods).

Access in terms of availability of health services is a critical component to health and wellbeing. Availability includes the ability to access health care resources whether they be infrastructure or human resources, and whether health professionals have the appropriate education, experience and abilities to provide the necessary services. It is this availability of resources which is often unevenly distributed amongst metropolitan, regional and rural areas. This is particularly true in the areas of specialisation such as mental health.[18] Vikram Patel, an international authority on mental health, has stated that "There are more psychiatrists in California than all of Africa...There is an enormous treatment gap with 50% of those who need mental health care not able to access it in high income countries and 90% missing out on care in low income. In some countries such as India and China for most, there is simply no treatment."[29]

Accessibility of or the ability to reach services is also affected by a range of other factors. This includes mobility and the utilisation of accessible transport to reach health services. This particularly affects the most vulnerable in our community such as those with special needs and the elderly. It also includes those whose work demands affect their ability to access health services during hours of operation.

CASE STUDY: **The Bega Teen Clinic: improving access to care and health education for young people in rural towns**

Contributor: Jodie Meaker **Country:** Australia

The Bega Teen Clinic is a nurse–led, early intervention model of access to primary health care for teenagers, which sits within existing general practices providing a drop–in service for young people in rural towns. Located in Bega, New South Wales, Australia, the aim of the Teen Clinic model is to break down barriers for young people accessing preventative health care. The long–term health and social benefits of being able to prevent an unwanted pregnancy or linking someone to psychological interventions prior to them becoming suicidal are life changing.

The Teen Clinic was born out of need. The town of Bega is an area of high socio–economic need and access to public transport is poor. About three years ago a spate of youth suicides occurred in the small town which had a significant and lasting impact on the community. The pathways between local schools, young people and the health system were poor, and it was clear that the traditional ways of accessing care such as making appointments with the family General Practitioner (GP) were seen as large barriers for young people. Transitioning from seeing a doctor as a child accompanied by parents to seeing a doctor alone, with new health concerns and issues, can be scary for many teens.

A Practice Nurse is available two afternoons a week at the Teen Clinic for drop–in consults. Teens may attend for STI screening, contraception advice, relationship concerns, mental health issues or general health and education. The nurse's role is to be a soft entry point to triage the teenagers, provide initial screening and/or health education and to act as a facilitator to GPs and other providers as needed.

The Teen Clinic model utilises existing infrastructure, clinicians and staff and is therefore a financially and resource efficient model for delivering youth services in rural towns. This team–based model of care includes reception staff, nursing staff, psychologists and GPs within the practice, but also aims to build community engagement and relationships with other services such as teachers and counsellors, mental health workers, family support services, and employment and housing support agencies. The Teen Clinic brings a comprehensive community approach to care coordination for this at–risk group.

This innovative model of care has only been made possible by nurses working to their full scope of practice. Teen Clinic nurses working to an expanded scope, provide a high quality link in the communities, supporting young people to become educated health care users.

CASE STUDY: **Engaging with the education sector for the promotion of mental health and the prevention of suicidal behaviour**

Contributor: José Carlos Santos, Ordem dos Enfermeiros
Country: Portugal

An innovative programme has been developed in Portugal to address mental health problems in schools. The programme focuses on engaging with the education community and is a multi-level approach to mental health promotion and suicidal behaviour prevention. By intervening with teachers and ancillary staff, parents and students, the aim of the service is to promote well-being, self-esteem and the development of coping strategies, as well as to combat stigma and depressive symptomatology. It is operated by primary health care professionals who conduct educational sessions for the school staff and parents and socio–therapeutic sessions for the students.

The burden of mental illness among teenagers is increasing. Despite this, due to poor mental health literacy, lack of access and stigma (particularly surrounding suicidal behaviour), only about 20% of those in need seek the help of a mental health professional. In addition, suicide is the third cause of death among teenagers, and self–inflicted injuries are increasing in this age group.

A community intervention directed at the clearly deprived area of mental health, the programme uses an innovative approach comprising active dynamics, socio-therapeutic and proximity games and the involvement of local health services. The success of the programme is due to the active participation of several local and national partners and the activities carried out in the classroom, in the whole school, in the community and across Portugal. The coordinating team consists exclusively of nurses (mental health and public health nurses) and the driving forces are also mainly nurses.

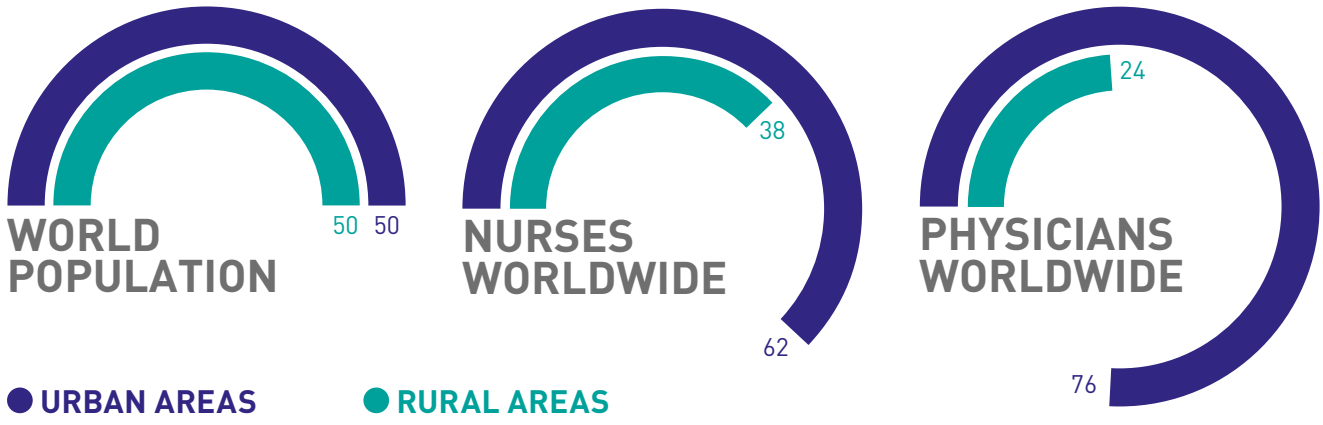
There have been significant improvements in the well-being, coping, self-esteem as well as a reduction in depressive symptoms leading to suicidal behaviours. Since the beginning of the programme, there has been an increase in the acceptance of this approach to mental health and suicidal behaviour in schools. At the same time, the programme has led to the identification of an increased need for extra school time in health and citizenship.

Health systems around the world struggle to achieve equity of access to health services for their populations. This is especially true for the vulnerable, disadvantaged and for those living in rural areas. There is great difficulty in ensuring the right workforce, with the right skills, in the right place at the right time to deliver effective and reliable health services to improve health outcomes.

It is estimated that half of the world's population live in rural areas, yet these areas are served by less than 38% of the total nursing workforce. In some countries it is even worse than this.

The distribution of health workers is often a serious constraint to ensuring equity of access to essential health services and achieving health systems goals.

Figure 5: Rural/urban worldwide distribution of physicians and nurses[30]



> Poverty is not just a lack of money; it is not having the capability to realise one's full potential as a human being."
>
> –Amartya Sen[33]

ACCESS TO HEALTH CARE: Affordability of care

Mary was 60 years old and living in a rural area when she was diagnosed with breast cancer. The specialist recommended to her to have radiotherapy treatment. This would mean daily treatment over a five–week period. Being from a rural area, this meant that she had to leave her family and drive more than five hours to a metropolitan area with appropriate cancer facilities. This was a difficult decision for Mary with the time away from loved ones and the costs to receive care. After all the bills for travel, accommodation and living expenses, there would also be the treatment costs of US$4,000. "We can't afford it." Mary said. "How can I afford it, amongst all of our other bills?"

On average, in OECD countries, 19% of health care spending is paid directly by patients. In terms of the overall household budget, medical expenditure accounts for on average approximately 2.8% of spending towards medical goods and services. The two main sources of out of pocket expenditure are curative care and pharmaceuticals.[31] But obtaining care also includes travel costs, time away from work, child care or other parental arrangements and these costs are exacerbated when care is sought after hours.

This is a substantial cost and it dramatically affects the most vulnerable within our communities. In a study of 37 low and middle–income countries conducted by WHO, it was estimated that between 6-17% of people within these populations are tipped into extreme poverty as a result of medical expenses.[32]

The rising costs of hospital expenditure combined with increasing out of pocket expenditure are a big source of personal budget concerns. Evidence from around the world shows that when households face difficulties paying medical bills, they delay or even forgo needed health care. Whilst some may consider this is saving money through reducing unnecessary health care visits, it costs patients, the health system and the broader economy much more when the simple health problems become increasingly complex.[34] When health problems are not detected or treated early, they often become worse resulting in longer hospital stays or more treatments in hospitals. These costs could have been avoided through earlier intervention in primary health care.

However, the costs go well beyond the health system. The sicker people become, the less likely they are to work, pay taxes and be actively involved in the community. This impacts negatively on governments' tax revenue and eventually national budgets.

The ability for people to pay for health care is a widely used model throughout the world. If this model is in place, if people are to pay for health care services, they need to be able to do so without catastrophic consequences on resources required for necessities (e.g. food, accommodation, transport). Poverty, social isolation or indebtedness limit peoples capacity to pay for services and drives them even further into poverty, thereby reducing their ability to break the poverty chain.[16]

CASE STUDY: **The future generation of retail health care in the USA**

Contributor: Tracey J. Kniess, DNP, CRNP, FNP-BC
Country: USA

Walmart Care Clinics are full–service clinics, providing full, accessible and affordable primary care right where people need it–in retail centres. The clinics have multiple examination rooms and provide full service labs by point of care testing or send out testing.

Located in rural Health Professional Shortage (HPSA) areas, Walmart Care Clinics provide primary care to the communities they serve. Sixty–three percent of the clinics are located in the Appalachian area or other HPSA.[35] Many of the patients are uninsured or underinsured and the cost of care in the clinics is affordable to most. These Nurse Practitioner (NP) led clinics also provide high quality primary care to those marginalized by society.

It is important that increased access to primary care be accompanied by improved efficacy and high–quality care. Walmart Care Clinics NPs practice evidence–based care in collaboration with physicians, pharmacists and other health care providers. A systematic review of NP outcomes shows similar outcomes to physician–only provided care. Care provided with collaboration between NPs and physicians reflects even better outcomes.[36] NP clinics are crucial in providing care to those who otherwise may not have care.

Retail clinics and urgent care centres can be cost–effective and time–saving alternatives to hospital emergency departments (EDs) for nonemergency care. It is estimated that 13.7%–27.1% percent of all ED visits could take place at a retail clinic or urgent care centre, with potential cost savings to the health care system of approximately US$4.4 billion annually.[37]

With retail clinics' low per–visit cost (US$79) compared to the cost of a physician office visit (US$160-US$230), the total savings across all diabetes patients covered by commercial, Medicare, or Medicaid insurance could total over US$100 million (US$7 per person per year) under conservative assumptions and as high as US$2.7 billion (US$164 per person per year) if half of diabetes–related office visits migrated to retail clinics.[38]

IN A STUDY CONDUCTED IN 2016[41]

33% of respondents in the USA, **REPORTED COST-RELATED PROBLEMS** to medical care.

15% of respondents in Canada had **OUT-OF-POCKET EXPENSES MORE THAN US$1,000** in the past year.

23% of respondent in France **HAD SERIOUS PROBLEMS PAYING** or were unable to pay for their medical bills.

EACH YEAR:

100 MILLION PEOPLE GLOBALLY are pushed below the poverty line as a result of health care expenditure.[7]

In some countries, **2%** of the population **SPEND MORE THAN 40% OF THEIR NON-FOOD HOUSEHOLD EXPENDITURE** on health care.[39]

150 MILLION PEOPLE SUFFER FINANCIAL CATASTROPHE because of out of pocket expenditure.[7]

Typically **20-40%** of health **SPENDING IS WASTED.**[40]

ACCESS TO HEALTH CARE: Safe, quality care

In November 2007, Bella Bailey died in Stafford Hospital, UK, after being admitted for hernia surgery. Her death resulted from a multitude of errors, culminating in the final failure to give her vital medication. According to her daughter and other witnesses, she spent the last few weeks of her life in the hospital frightened and in pain. Her daughter led a campaign to have the circumstances surrounding her death investigated. By early 2008, numerous patient safety alerts were received by the health watchdog and an inquiry was led by Robert Francis QC.[42] The public inquiry investigated how those responsible for overseeing the NHS–the national regulators, the local health authority and the hospital board–failed to prevent the terrible events at Stafford Hospital, where hundreds of people died unnecessarily because of poor care. Sir Ian Keened, Chairman of the Healthcare Commission, described it as "the worst hospital care scandal of recent times".[43]

The inquiry found that the basic elements of care were neglected. Medications were either delayed or not given; patients were left unwashed for up to a month and patients feared to be in hospital. The report concluded that the primary cause of this substandard care was "a chronic shortage of staff, particularly nursing staff."[43] The other major problems related to heavy workloads, poor culture, poor leadership and limited resources.

The people of Stafford were let down by their local hospital. This is a terrible outcome and an example of what happens when there is poor quality care. Unfortunately, the case example is not unique. Patient safety is a fundamental principle of health care but as numerous studies from around the world show, many patients are harmed during health care, either resulting in permanent injury, increased length of stay, or even death. In the USA, it has been estimated that the third leading cause of death is caused by medical errors. In the UK, one incident of patient harm is reported every 35 seconds.[44]

It is obvious that services that are unsafe and of low quality lead to diminished health outcomes and even harm. Levesque et al.[15] believe that as part of access to care, the quality of that care needs to be considered. If individuals and communities only have access to poor quality services, this is a restriction of access to health care. Access is not just about availability and affordability, but also whether it is acceptable and effective.

This appropriateness of care is never more apparent than in mental health. There is a significant difference in outcomes, social isolation and the upholding of the rights of individuals depending on the appropriateness of treatment they receive. According to the UN Special Rapporteur to the Human Rights Council[2], "treatments that involve coercion, medicalization and exclusion, which are vestiges of traditional psychiatric care relationships" lead to violations of human rights.

Whereas a modern understanding of recovery, evidence based services, and integrated population–based services restore dignity and empower the individual to return as rights holders to their families and communities. Utilisation of services with inherently varying quality of treatment cannot be seen as equally appropriate care.[15]

In 2001, as a strategy to improve the quality of care, the Institute of Medicine (IOM) released a book entitled 'Crossing the Quality Chasm'.[45] The problems outlined in the book still resonate today. "Health care is categorised by more to know, more to manage, more to watch, more to do, and more people involved in doing it at any time in history". [45] Given these complexities, individual nurses (and other clinicians) cannot recall and apply all knowledge necessary for the delivery of safe, high quality, family or community care.

It has been 16 years since this IOM report was published. There is now strong evidence as to the strategies most likely to achieve the goals it outlined. This evidence has been undertaken internationally and is compelling for action. The evidence of quality improvement through nursing relate to: skill–mix; culture; education; staffing levels; leadership; interdisciplinary care; research; and informatics.

Globally, the cost associated with medication errors has been estimated at US$42 billion annually or almost 1% of total global health expenditure.[46]

Of every 100 hospitalisations at any given time, seven in developed countries and 10 in developing countries will acquire health care–associated infections.[44]

50% of surgical complications associated with surgical care are avoidable.[44]

It is commonly reported that around 1 in 10 hospitalised patients experience harm, with at least 50% preventability.[44]

In a study on frequency and preventability of adverse events, across 26 low–and middle–income countries, the rate of adverse events was around 8%, of which 83% could have been prevented and 30% led to death.[44]

It is estimated that 421 million hospitalisations take place in the world annually, and approximately 42.7 million adverse events occur in patients during those hospitalizations.[44]

Figure 6: Quality improvement through nursing[47-65]

LEADERSHIP

When nurses participate in health service decision making and policy development:
- Improved hospital experience for patients
- Improved patient involvement in care
- Improved health literacy
- Better quality care at lower cost
- Improved financial performance of an organisation
- More highly educated workforce
- Higher staff satisfaction
- Improved patient safety
- Improved quality measures.

QUALITY IMPROVEMENT

SKILL MIX

- Each 10% decrease in proportion of nurses is associated with 12% increased risk of death.
- Adding one assistant per 25 patients instead of adding a nurse is associated with a 21% increase odds of dying.

EDUCATION

- Each 10% increase in proportion of nurses with bachelor's qualifications associated with 7% decline in mortality.

INFORMATICS

Research findings indicate that IT applications can enhance patient safety by standardising, flagging errors, and eliminating handwritten data, among other functions.

INTERDISCIPLINARY CARE

Interdisciplinary teams have been shown to enhance quality and lower costs.

RESEARCH

When nurses are actively involved in research:
- Increased uptake of evidenced based practice
- Increased access to continuing education.

CULTURE

- Hospitals with good staffing and work environments had significantly lower mortality and lower costs for patients at every risk level
- Higher patient satisfaction
- Lower readmissions
- Fewer infections
- Fewer falls
- Lower staff burnout
- Higher survival after complications.

STAFFING LEVELS

- Each 1 patient increase in nurses' workloads is associated with 7% increase in mortality
- Improved staffing levels reduces mortality risk
- Each 1 patient increase in patient to nurse workloads increases readmissions by:
  - 9% for heart failure, pneumonia, AMI
  - 11% for children
  - 3% for general surgery
  - 8% hip and knee replacements
- Hospitals with good nurses staffing levels have 30% fewer hospital acquired infections
- Each 1 patient increase to nursing workloads increases missed care.

CASE STUDY: **Setting the standard in providing quality nursing care**

Contributor: Beth Matarasso, Sean Birgan, Veronica Casey
Country: Australia

The Princess Alexandra Hospital (PAH) in Queensland, Australia, has a three–time designation as a Magnet facility and a reputation for setting the standard in providing quality nursing care. Magnet status is an award given by the American Nurses' Credentialing Centre (ANCC) to hospitals that satisfy a set of criteria designed to measure the strength and quality of their nursing.

In 2001, the facility was facing many challenges, including 28% nursing turnover, 12% vacancy rates, 12% bed closures and unprecedented agency nurse usage which hampered provision of care. These factors were reflected in a nursing culture hallmarked by a blame mentality, decreased work satisfaction and patient experiences and outcomes that challenged the nursing ethos of custodians for providing compassionate, safe care enabled through advocacy, quality and holism.

In seeking solutions to these complex and persistent problems, PAH turned its gaze outward to the Magnet Recognition Program, an ANCC nursing excellence programme. The Magnet Recognition Program provides the framework to guide cultural transformation and innovative and research–informed nursing practice. This quality improvement initiative provided the impetus for the organisation to implement nurse–led actions that produced positive changes such as improved patient safety and patient satisfaction.

Today, nursing leadership at PAH is defined by the nursing values of integrity, accountability and professionalism. Nurses work collaboratively with interprofessional colleagues, upholding the commitment to safe and effective patient care and outcomes.

Interprofessional respect for nursing knowledge and practice is evident in the many nurse–led interprofessional initiatives that have led to change across the practice environment. As such, nursing pride and expertise is strengthened and enables strong nursing leadership across all levels of nursing and contexts.

Fundamental to the integrity and professionalism of PAH nurses is a mindset of continuous improvement, evidenced through robust reporting and data analysis, both of which signify a strong culture of commitment to growth, change and patient care.

The PAH has been recognised as an employer of choice through both graduate preferences, being amongst the highest in the state, and improved retention of nurses, with a current turnover of approximately 10%. The nursing team at PAH seeks to learn more about how the patients and consumers experience and feel satisfied with their care and interactions with nurses, and they have seen an 9% overall increase in both inpatient and ambulatory experience and satisfaction.

There are two further aspects of appropriateness, namely 'timeliness' and 'engagement' that are sufficiently important to be explored in more detail.

ACCESS TO HEALTH CARE: Timeliness of access

A son caring for his father, reflecting on his father's journey through the health care system, said *"In 2009, my father was diagnosed with pancreatic cancer. From the time of diagnosis to his final day was nine weeks. During those first seven weeks, prior to hospitalisation and palliative care, visits to the outpatient's centre were categorised by long periods of waiting. Sometimes we would wait five hours in the clinic waiting to see the specialist. The specialist visit would then last between five to ten minutes. By the end of the day my father would be in agony, tired and emotionally unable to cope. The next day we would be waiting again. This time for pathology and chemotherapy. Another eight hours gone. With such a short time to spend with my father before his death, it is tragic that so much of it was spent in a clinic waiting room."*

Unfortunately, this is the experience of many patients– some who have travelled long distances to reach the clinic, many who have had to give up a day's wages to be there, and others who have had to find child care while they wait. Despite the scheduling of appointments, patients may spend significant time in clinics waiting for services to be delivered. The degree to which health consumers are satisfied with care received is strongly correlated to the waiting room experience. Positive experiences are generally associated with greater adherence to recommended care, better clinical care, less health care utilisation and better health quality outcomes.[66] Long wait times may cause frustration, inconvenience, suffering and dissatisfaction with the health care system.

The IOM recommended that 90% of patients should be seen within 30 minutes of their scheduled appointment.[66] However in countries throughout the world it is not unusual for patients to be waiting two to four hours before being seen.[67] Long waiting times are barriers to accessing services and are a major source of anxiety and distress to patients and their support.

Timeliness of access is also critical in preventing potentially harmful delays in the delivery of health care. In many instances, the earlier the treatment, the better the health outcome. Delays in treatment increase the likelihood of preoperative death and unplanned emergency admission, and lead to poorer outcomes in terms of physical and social functioning. Long wait times potentially worsen symptoms, deteriorate the patient's condition and lead to worse clinical outcomes.[68]

Extended waiting times result from the complex interaction between supply and demand. Demand is affected by issues such as population health status, patient preferences, expenses and emerging types of medical treatments. Supply on the other hand is affected by a range of workforce issues and infrastructure, policies and procedures. However, waiting times are not exclusively an issue of supply. There are many countries with high levels of spending, sufficient workforce and infrastructure that still have long wait times due to inefficiencies.

Article 25 of the UN Declaration of Human Rights states that "everyone has the right to medical care... and the right of security in the event of... sickness and disability..." As charters have further been developed to articulate this, they recommend that member states provide "equitable access to health care of appropriate quality." Equitable access is about ensuring that no one is denied access. It is also a matter of scale and timing. Appropriate quality also implies that services will be delivered at the right time. Timing is an aspect of appropriateness and is closely correlated with the effectiveness of an intervention.[69]

Registered Nurses (RNs) are at the front lines of care and their expertise and sustained leadership are critical for enabling health system transformation. RNs triage emergency services, coordinate care and navigate patients through the system; they reduce length of stays and expedite patient discharge. RNs across the entire continuum of care are all critical contributors to preventing hospital admissions, improving waiting times, and reducing inefficiencies thereby creating accessible health services.

CASE STUDY: **Twin Bridges Nurse Practitioner–Led Clinic**

Contributor: Valerie Winberg **Country:** Canada

The Twin Bridges Nurse Practitioner–Led Clinic in Ontario, Canada, is an interdisciplinary primary care clinic that provides people–centred care to 3,200 patients. Nurse Practitioner–Led Clinics (NPLC) are an innovative model for delivery of comprehensive health care, designed to improve access to care for thousands of individuals and families who currently do not have a primary healthcare provider.

Ontario has struggled with a shortage of primary care providers for over 10 years with many regions being severely underserviced. The shortage has led to communities with large numbers of "unattached" or "orphaned" patients (i.e. with no primary provider) whose only access to care was local emergency departments. This has caused overcrowding in emergency departments and long wait times. Furthermore, lack of access to preventative care and regular monitoring and maintenance of chronic disease conditions results in even greater hospital utilization.

These nurse–led clinics provide services to people throughout the lifespan. Services include periodic health exams, episodic illness care, immunisations, injury prevention, advanced wound assessment and management of chronic diseases. It also includes individual and group programmes aimed at physical and mental wellness such as mindfulness, meditation, anxiety management, physical fitness through exercise and yoga, tobacco use cessation, healthy eating and food preparation skills. The clinic also has a collaborative partnership with the Aamjiwnaang First Nation to provide primary care services to individuals of this First Nations community.

As a result of this service, Twin Bridges has provided a new access point for patients into health care and received very high patient satisfaction scores on survey responses. The project has greatly reduced the number of unattached patients across the province of Ontario and provided access to comprehensive services in one location. It has also enabled the services to remain highly affordable and empowered the patients so that they feel heard and can openly interact with staff. Twin Bridges has implemented a shared care model between Nurse Practitioners which enables access to same day appointments and ensures that all patients have a primary provider and has enabled improved shared care experience to assist in the care of complex patients.

The model of care at Twin Bridges is exceptionally innovative within its context. A truly unique aspect of the model is the incorporation of nursing leadership within an interprofessional team. With Nurse Practitioners partnering with individuals and communities to improve health and wellbeing, patients are at the centre of the service and are fully engaged in the services provided by team based carers. The success of the clinic has led the Ministry of Health and Long–term Care to fund an additional 25 clinics across the province of Ontario.

CASE STUDY: **Outcome Health: providing emergency mental health services**

Contributor: Kate Cogan **Country:** Australia

Outcome Health, in the state of Victoria, Australia is a team of senior Credentialed Mental Health Nurses (CMHNs) who work alongside the emergency call centre staff providing specialised mental health support.

Ambulance Victoria provides emergency response to medical emergencies and life–threatening illness and provides transport to emergency departments across the state, which has a population of approximately 5.8 million people.

Approximately 25% of the calls received for emergency help are related to mental health. While the call centre staff have some mental health training, they lack the complex mental health skills required to confidently determine which calls represent an emergency. Outcome Health fills the need for specialised mental health support within emergency services to ensure appropriate support is delivered to where it is most needed in the community.

The CMHNs triage mental health callers to either upgrade or downgrade the dispatch of an emergency vehicle allowing the most appropriate services to be allocated. They keep the caller on the line until an emergency vehicle arrives and provide de–escalation and crisis management. Developing an alternative course of action with the caller keeps callers with severe mental health emergencies safe until emergency support arrives. It also reduces the number of emergency vehicles dispatched to non–emergency situations.

During telephone assessment, risk assessment is paramount. This complex task is done quickly and decisions are negotiated with the caller. Through the engagement of the caller, the CMHN will consider risk to attending emergency service crews and are able to disarm callers who are threatening to use weapons. This information is transferred live to other services to ensure their safety when entering a scene. Through interaction with the CMHNs, callers and their families learn how and when to seek appropriate mental health help. Whilst the urgency of cases may not change, this role has enabled families and significant others to support and assist their loved ones. The CMHNs also provide support to ambulance clinicians and call centre staff.

The success of the programme has led to an expansion of the service to provide community–based emergency appointments by established providers to develop ongoing care plans and support. This important service ensures the appropriate level of emergency care is delivered where it is most needed during critical life–threatening events, saving time and money. The service is the first of its kind around the globe.

IN A STUDY CONDUCTED IN 2016:[41]

56% of respondents in France **WERE ABLE TO SEE A DOCTOR OR NURSE** on the same or next day, last time they needed medical care.

50% of respondents in Canada visiting an emergency room **WAITED MORE THAN TWO HOURS FOR CARE.**

64% of respondents in Germany requiring medical care **FOUND IT DIFFICULT TO OBTAIN AFTER HOURS CARE.**

IN A STUDY OF HEALTH SYSTEM PERFORMANCE:[71]

50% of respondents in Sweden stated that their specialists told them about **TREATMENT CHOICES AND INVOLVED THEM IN DECISIONS ABOUT THEIR CARE.**

5% of respondents in France **HAD A WRITTEN PLAN DESCRIBING TREATMENT THEY WANT AT THE END OF LIFE** (adults aged >65 years).

ACCESS TO HEALTH CARE: People–centred care

The client, not the nurse is the authority figure and decision maker, the nurse's role involves helping individuals and families in choosing the responsibilities for changing the health process."–Rose Marie Risso Parse (Nursing Theorist)[69]

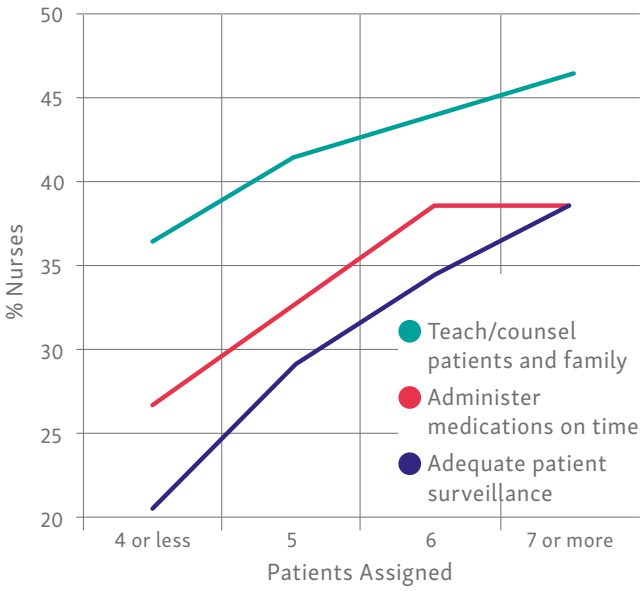
In 2015, a systematic review[70] was undertaken on missed nursing care. Of the 42 studies undertaken in this area 55-98% of nurses reported missing one or more items of care during the time of assessment. The activities that were most frequently missed were those related to emotional and psychological needs, rather than those related to physiological needs. The most common cause of missed work was related to high workloads and insufficient nursing numbers.

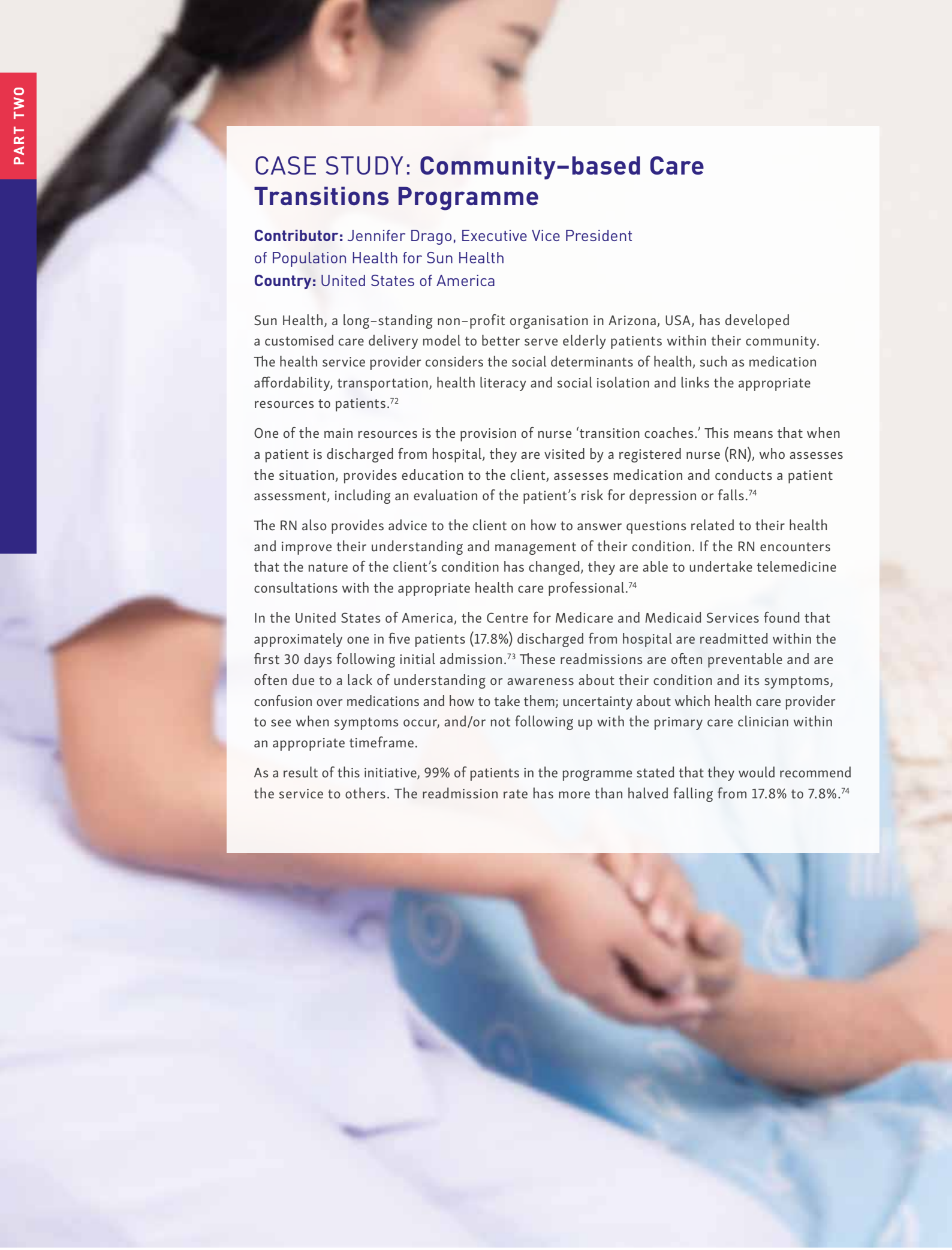
Reflecting on these studies, it is hard to see how these health services can be delivering a people–centred approach to care delivery, where there is an ability to engage and participate in the decision making and treatment decisions. There is a risk that, with associated high workloads, nursing moves towards a pattern–centred approach to care rather than a people–centred approach. Pattern–centred care refers to completing numerous tasks within a specific amount of time with the risk that these tasks take precedent over engaging and meeting the holistic needs of the client.

As we slip into the routine or delve into an overcrowded workplace, we lose the awareness of the person as a whole, and lose sight of their uniqueness. When this happens, we risk losing the person's capacity and motivation to be involved in their care and commit to completing treatment. As Levesque et al.[15] state, "Access to optimal care ultimately requires the person to be fully engaged in care and this is seen as interacting with the nature of the service actually offered and provided."

The importance of participation in care is evidence based. It is also an international human right. In Article 12 of the International Covenant on Economic, Social and Cultural Rights, persons requiring care have rights to free, informed, active and meaningful participation in decisions that affect their lives.[71] The right to participation extends further than receiving care, it also involves the organisation and implementation of health care services.

Figure 7: Nurses reporting missed care on last shift by workload, RN4CAST2017[72]





CASE STUDY: **Community–based Care Transitions Programme**

Contributor: Jennifer Drago, Executive Vice President of Population Health for Sun Health
Country: United States of America

Sun Health, a long–standing non–profit organisation in Arizona, USA, has developed a customised care delivery model to better serve elderly patients within their community. The health service provider considers the social determinants of health, such as medication affordability, transportation, health literacy and social isolation and links the appropriate resources to patients.[72]

One of the main resources is the provision of nurse 'transition coaches.' This means that when a patient is discharged from hospital, they are visited by a registered nurse (RN), who assesses the situation, provides education to the client, assesses medication and conducts a patient assessment, including an evaluation of the patient's risk for depression or falls.[74]

The RN also provides advice to the client on how to answer questions related to their health and improve their understanding and management of their condition. If the RN encounters that the nature of the client's condition has changed, they are able to undertake telemedicine consultations with the appropriate health care professional.[74]

In the United States of America, the Centre for Medicare and Medicaid Services found that approximately one in five patients (17.8%) discharged from hospital are readmitted within the first 30 days following initial admission.[73] These readmissions are often preventable and are often due to a lack of understanding or awareness about their condition and its symptoms, confusion over medications and how to take them; uncertainty about which health care provider to see when symptoms occur, and/or not following up with the primary care clinician within an appropriate timeframe.

As a result of this initiative, 99% of patients in the programme stated that they would recommend the service to others. The readmission rate has more than halved falling from 17.8% to 7.8%.[74]

PART THREE:
INVESTMENT AND ECONOMIC GROWTH

> Economic growth without investment in human development is unsustainable–and unethical"
>
> –Amartya Sen[33]

A common story in politics is a discussion of the allocation of resources at budget time: the Minister of Agriculture might say, "If we buy this much fertilizer and plant this much acreage, we can produce this much, and if the world market price is this much, our income will be this much." The Minister of Transport might reply, "But we can't get our products to the port because the roads are in terrible condition, and if we invest in roads our export earnings will go up by this much." Then the Minister of Health would speak up and say, "Health is a Human Right."[75] Sir George Alleyne[c], former UN Special Envoy for HIV/AIDS in the Caribbean, recounts this as a true story of a conversation with a cabinet minister. He makes the important point that health ministers are poor at persuading other ministers that health is a good investment, and subsequently, they fail to appreciate the inseparable nature of health as a human right with health as the backbone of the economy–no health, no work, no wealth.

Investment in health has been seen in many countries as a cost burden to the country's resources. As such, there has often been a significant focus on economic constraint towards the health sector and a focus on efficiency. This occurs despite the high value that people place on health. In an extensive worldwide poll[d], people valued health as their number one priority. They valued this more than a happy family life, or employment or even living in peace.

The relationship between the health of the population and economic growth and prosperity is poorly articulated. Investing in health saves lives, prevents disease, heals, repairs and rehabilitates. It is therefore an investment in the wider economy. Poor health impairs productivity, hinders job prospects and adversely affects human development.[76] The health care system can therefore be viewed as a positive contributor to the economy through a healthy workforce, increased GDP, innovation and exports.

[c]Sir George Alleyne served as the United Nations Secretary–Generals Special Envoy for HIV/AIDS in the Caribbean region from 2003-2010.
[d]Gallup International Millennium Survey, www.gallup-international.com/. At the turn of the millennium, 50,000 people in 60 countries were asked to rate "the most important things in life." "Good health" topped the list for 44% of the respondents, followed by "happy family life" (38%), "employment" (27%), and "live in a country without war" (17%).

Numerous studies have been conducted in this area and demonstrate that health positively affects the economy. For example, the increase in life expectancy from 50 to 70 years increases the economic growth rate by 1.4% per annum. A 10% decrease in malaria is associated with an annual growth of 0.3%.[76] These strong arguments demonstrate that investing in health can meet peoples increasing expectations of the health system and governments, decrease persistent inequities in access and improve or sustain economic performance.

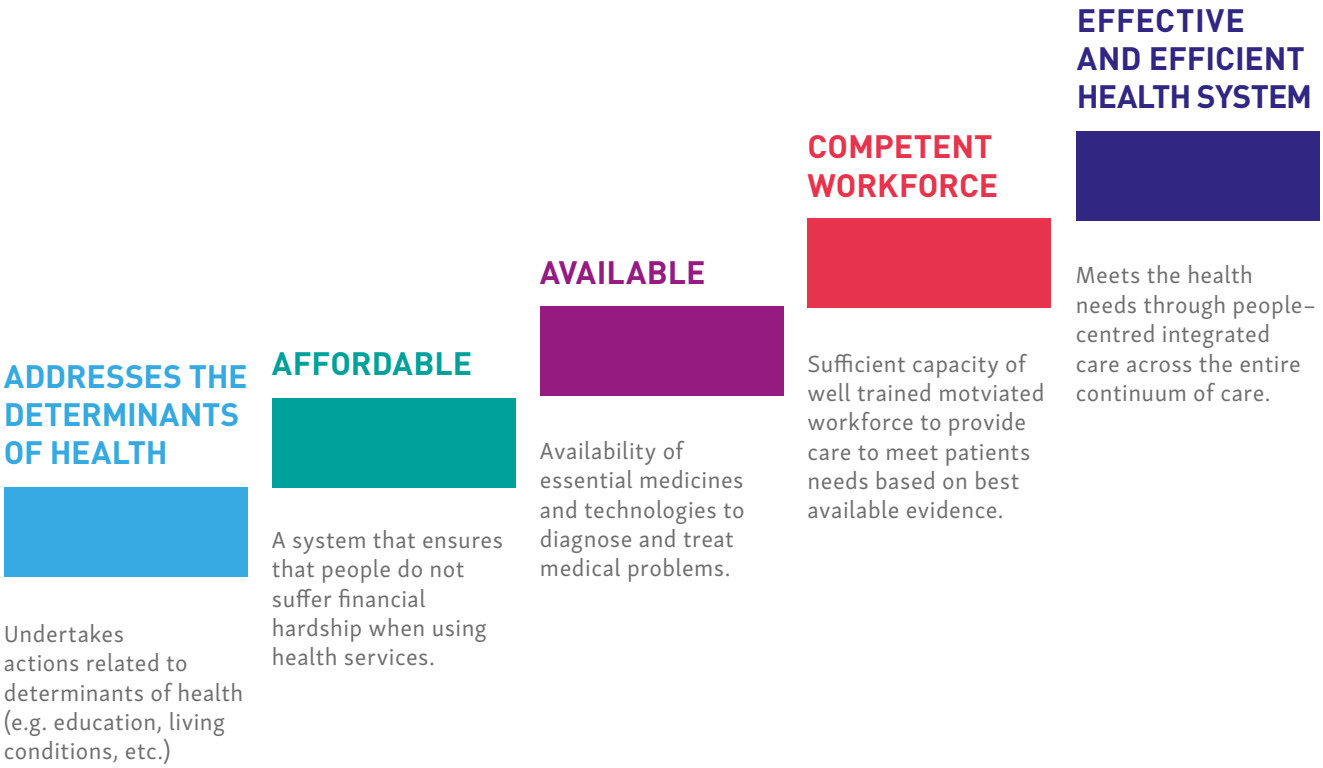
For policy makers and public officials there are difficult decisions to make in terms of investment in health. Decisions that occur within the sphere of health never occur in isolation. They have finite budgets and a profound impact on the stakeholders and policies in other areas, and hence are always contested. The challenge becomes the harmonisation of health and economic policies to improve health outcomes whilst minimising the negative effects on others.[77] The health and wellness of people should be the central dimension of all policies, because it is the health of the population that underpins all other sectors of the economy.

The following section focuses on three policy directions that enable health as a human right, improve access to care and are economic investments. These are: Universal Health Coverage; People–Centred Care; and Human Resources for Health.

Figure 8: Health expenditure data[44]

Total expenditure for health for 2011:	**US$6.9 TRILLION**
Average amount spent per person on health in countries belonging to the Organisation for Economic Co–operation and Development (OECD):	**US$4,584**
Percentage of the world's population living in the OECD countries:	**18%**
WHO estimate of minimum spending per person per year needed to provide basic, life–saving services[1]:	**US$44**
Number of WHO Member States where health spending–including spending by government, households and the private sector and funds provided by external donors–is lower than US$44 per person per year:	**26**
Number of WHO Member States where health spending is lower than US$20 per person per year:	**6**
Percentage of funds spent on health in the WHO African Region that has been provided by donors:	**9.4%**

Figure 9: Factors required to achieve Universal Health Coverage[7, 82]



Universal Health Coverage

We face many fears when we are sick. These may come in the form of uncertainty and fear of the future; the disability; the pain or the isolation; the side effects of the treatments or potentially even being harmed by the treatments themselves; the complexity of navigating the health system; or being unable to work and bring in the resources required for daily living. On top of this, health care in many places around the world is becoming more expensive which means that a large proportion of people question whether or not they will be able to afford treatment when faced with a diagnosis of a significant disease.

When appropriately implemented, UHC ensures that every citizen has access to care regardless of their ability to pay. UHC has been successfully implemented to some degree in 60 out of the world's 195 countries, but WHO and the World Bank estimate that 400 million do not have access to essential health services and 40% of the world's population live without health care coverage.[78] However, UHC has been incorporated as a sub–goal within the Sustainable Development Goals meaning that all UN member countries will aim to have it implemented by 2030.

This is an ambitious target to achieve, but it will have a profound effect on global health and welfare. Access to UHC enables people, as a result of both being healthier and not forced into poverty to cover health costs, to be more productive and active contributors to the family and community. It means children have greater possibility of receiving education, and it protects the vulnerable from moving further into extreme poverty.

UHC is a policy that countries can use to achieve health as a human right. It achieves this in many ways including:

- It improves access to quality health services for all people irrespective of social status
- It promotes comprehensive health care services as opposed to disease or issue specific services
- It ends discrimination caused by cost or financial hardship
- It prioritises services to the most vulnerable.[12]

Whilst UHC meets a number of the criteria for the right to the health, it is also a good investment. An economic and qualitative analysis was undertaken of the introduction of a National Health Insurance[e] scheme in the Bahamas.[79] The analysis showed that apart from any addition to health and wellbeing benefits, "the policy was [is] an investment in the economy of the country, capable of generating many times its costs in addition to economic growth."[79] The report stated that the economy of the Bahamas is likely to be around 3.7% larger as a result of this initiative (US$350 million). This is estimated to increase to nearly 5% by 2040 adding an additional US$500 million to the economy.

The above analysis is in line with the results of other studies such as that conducted by the Lancet Commission.[80] The Lancet study found that 11% of economic growth in low and middle–income countries between 2000-2011 was due to reduced mortality. When extrapolating to national income and other prosperity, economic growth was 24% suggesting that there is a "9 to 1 return on health expenditure over 20 years." The overall conclusion from this report was that **"there is an enormous payoff from investing in health."**

In an unprecedented event, 257 economists[81] around the world showed their support for UHC endorsing the words of Amartya Sen that UHC is an "affordable dream." The economists believe that there are sufficient resources to globally implement UHC and that there is an array of benefits for doing so, including transforming lives and livelihoods; and eradicating poverty. In times of crisis UHC mitigates the effects on communities; in times of calm, it fosters more cohesive societies and productive economies.

In summary, the economists concluded that **the economic benefits of investment are nearly 10 times greater than the costs**.

These examples show that there is a strong relationship between investing in health and economic development. Healthy citizens are able to achieve the education and skills they need to thrive in a global economy. Health does improve wealth and in turn improves the conditions of the society in which people live. Universal Health Coverage is an investment.

> It's time for the health care sector to harness its collective capability and build around our people a fortress of UHC–every CEO, insurer, professor, doctor, nurse, patient and person who lives in this country should consider what they can do to contribute, raising their levels of engagement and placing their brick in the wall."
>
> –Dr Anuschka Coovadia[78]

CLARIFYING UNIVERSAL HEALTH COVERAGE[82]

Universal Health Coverage means people having access to quality health care without suffering financial hardship.

It includes health services across the entire continuum of care including promotion, prevention, treatment, rehabilitation and palliative care.

It does not mean free coverage for all possible health interventions regardless of cost.

It is not just about ensuring a minimum package of health services, but a progressive expansion of health care and financial protection.

It includes both individual treatment and population based services.

Universal Health Coverage includes addressing the determinants of health by improving equity, social inclusion and cohesion.

[e]The Bahamas has implemented the primary care phase of the national Health Insurance Scheme. A comprehensive health system will be developed in later stages.

Figure 10: The benefits of Universal Health Coverage[79]

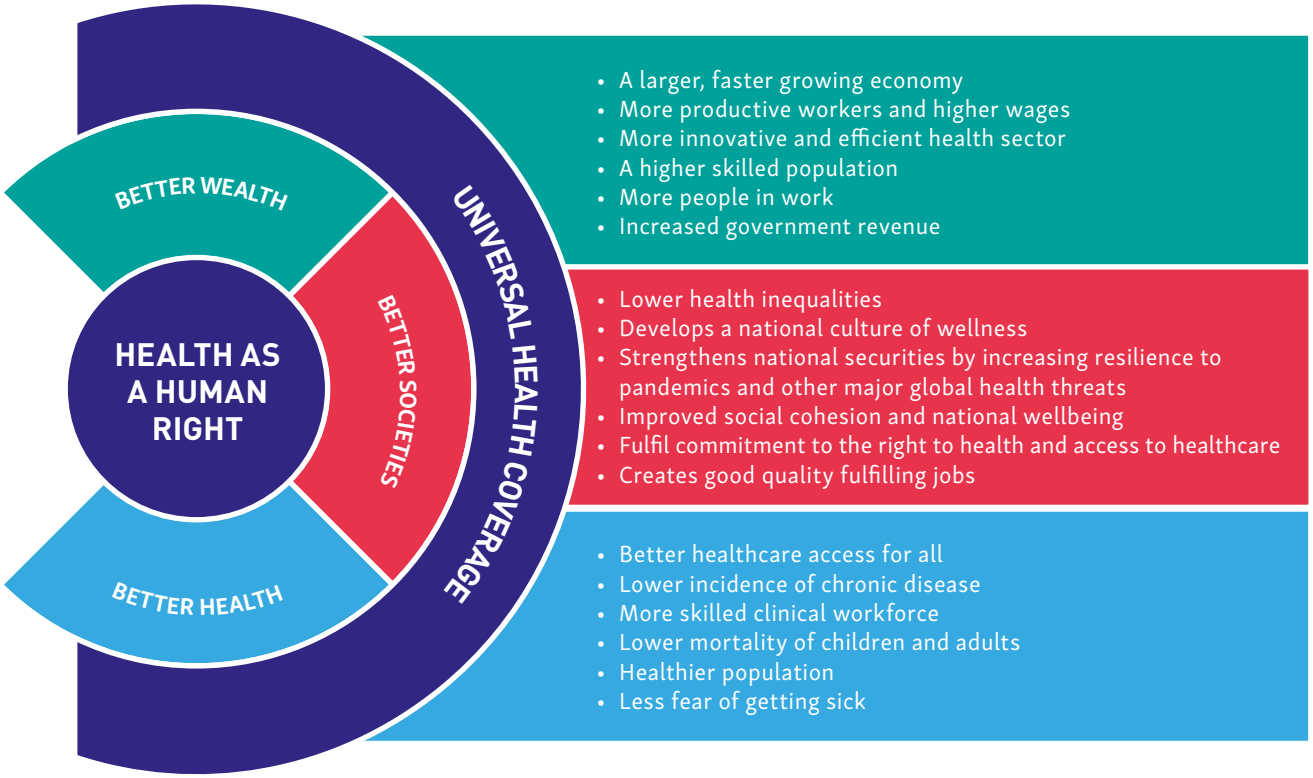
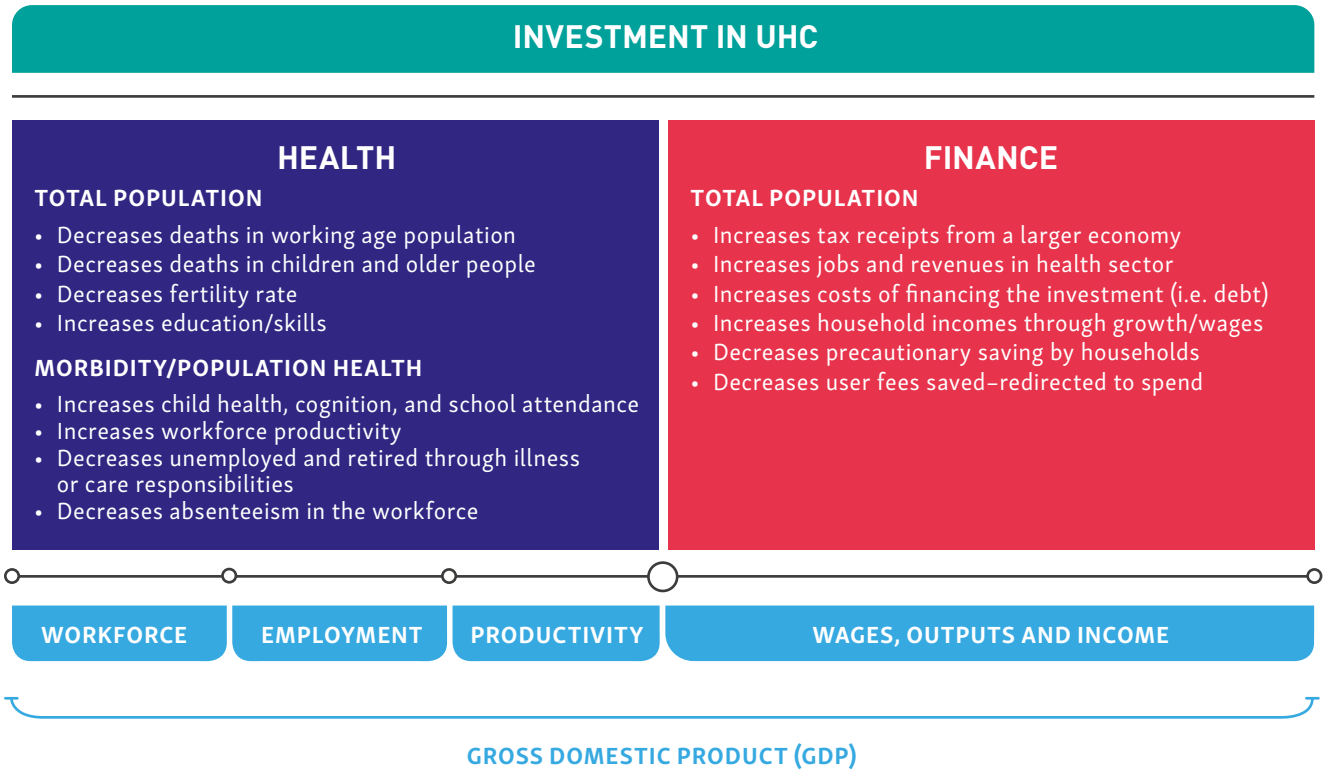


Figure 11: Comprehensive framework for the economic impacts of UHC investments (adapted from KPMG)[83]



> You treat a disease: You win, you lose. You treat a person, I guarantee you win–no matter the outcome."
>
> –Patch Adams

People–centred care

People–centred care has become the new buzzword of many health services. But as many studies point out, we are so far from it. Many clinicians pay lip service to putting patients first, but in practice, professional and organisational needs come first. In addition, so often when performance of health systems is analysed, the focus tends to be on tangible, easily measurable indicators such as money spent on beds and staff rather than the outcomes and experiences of people receiving care.

Why does this happen and why is this so pervasive in health systems? It is not because there is a lack of research and evidence. There have been over 750 systematic reviews (in English) conducted on this area between 1998 and 2013. Within this research, there are consistent themes as to what patients consider good care. This includes: good information and communication from health professionals; involvement in decisions yet respectful for preference; emotional support and empathy; and continuation and coordination of care.[84]

A more logical conclusion as to why people–centred care is practiced in rhetoric rather than reality is the dominance of the medical model of treatment that focuses on the disease process which struggles to see the person as a whole. This is often reinforced by funding models and cost controls[f] where greater priority is given to transactions rather than to building relationships and seeing the holistic needs of the individual. The UN Special Rapporteur came to this conclusion in his report to the United Nations Human Rights Commission. In fact, he believed that the biomedical model of care was so detrimental that the rights and freedoms of those with mental illness were removed.[11]

There is a different and better way; a way that is more likely to improve patient experiences, promote public health and reduce health inequalities; a way that improves the success of health interventions and reduce waste of finite resource. It does not require expensive innovation. It is a return to the basics and to the evidence of putting people at the heart of health care. It is about nurses being true to what is at the heart of the nursing profession.

People–centred care is enshrined in human rights. It supports dignity, non–discrimination, participation, empowerment, access, equity and a partnership of equals. Not only are these principles outlined in international law, they are also at the core of how we would like ourselves and our families to be treated.

[f] Health care finance mechanisms often push provider behaviours towards short consultations, inadequate case management, under or even over servicing.

Figure 12: Core investments required for building a people–centred approach to health care (adapted from the People–Centred Health Care Policy Framework)[85]

BUILDING A PEOPLE–CENTRED APPROACH TO HEALTH CARE

INVESTING IN INDIVIDUAL, FAMILIES AND COMMUNITIES

- Increasing health literacy
- Developing strategies to support meaningful participation in decision making
- Supporting capacity to improve self–management
- Increased capacity within the community to improve participation in health service planning

INVESTING IN HEALTH CARE ORGANISATIONS

- Creating supportive environments for people needing care
- Supporting integrated and effective care
- Strengthening and promoting multidisciplinary teams
- Strengthening the partnership approach to care amongst the patient, family and carers
- Setting standards of care for quality and ethical services

INVESTING IN THE HEALTH WORKFORCE

- Increase capacity and capability for the workforce to practice people–centred care
- Support commitment to quality, safe and ethical services

INVESTING IN THE HEALTH SYSTEM

- Developing financial incentives that enable positive health provider behaviour
- Implementation of appropriate technology to support business
- Improving monitoring and reporting of health care quality, outcomes and patient experience
- Strengthening professional standards for practice and monitoring their implementation
- Establishing standards for the utilisation and protection of patient information

As health systems struggle to cope with demand and contain health care costs, there is a risk that investments will be taken away from the people–centred care approach and that there will be a focus on a paternalistic model where professionals 'do things to people'. But apart from the many benefits that people–centred care brings, there is a strong economic argument for it. Research shows that patient–centred care[8] reduces costs and assists in managing demand. It is specifically linked with:

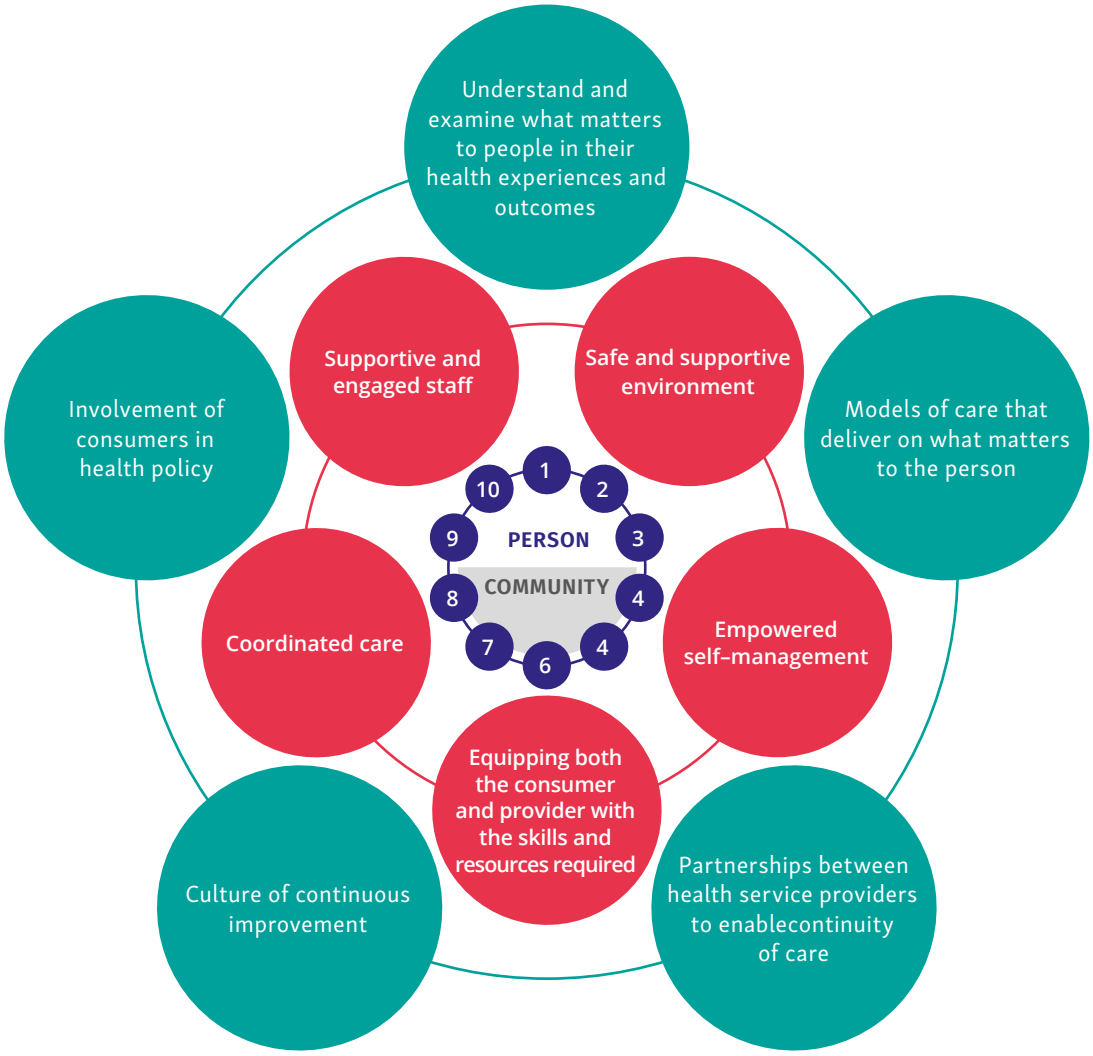
- Reduced length of stay[86]
- Fewer attendances to hospitals emergency departments and admissions[86, 87]
- Decreased visits for specialty care[88]
- Fewer laboratory test and invasive procedures[87]
- Earlier intervention through earlier recognition of disease exacerbations[88]
- Improved initiation of appropriate therapy[88]
- Increasing self–care and self–management behaviours[88]
- Significant reduction in total medical charges[87]
- Increased compliance with treatment plans and appropriate management of medications[87]

For our objectives of improving the health and wellbeing of individual, people–centred care is the cornerstone of the way health care is delivered. There are benefits for the individual, health practitioners, the health system and entire populations. The time to reorient health systems to this approach is now.

> People–centeredness means treating people, patients, their loved ones, carers and others with compassion, dignity and respect. It means involving them in decision–making about their health and their care. It means doing things 'with' people, not 'to' them. It means involving people in system design and in policy making. To deliver the people-centred health systems of tomorrow, we need to change how we provide care and how we measure health systems today."
>
> –Angel Gurría, OECD Secretary–General[89]

[8] A sub–element of people–centred care.

Figure 13: Realignment required within the health system to focus on people–centred care[90]



1. Individualised approach to care
2. Seeing people as vital contributors to their health
3. Recognition of the health needs of people seeking care
4. Transparency of approach
5. Enabling access to quality information
6. Getting to know the person and recognising individuality
7. Respect for patients and their decisions
8. Sharing power and responsibility
9. Inclusive of family and carers where appropriate
10. A holistic approach to care that consider physical, cultural psychosocial

ECONOMIC BENEFITS

The American Nurses Association reported that for every US$1 invested in care coordination, the hospital realised an US$8 reduction in health care charges. Partnering with patients, the nursing care coordinators led a service that resulted in fewer, less critical and shorter hospital stays.[91]

A study conducted by Basu et al. in 2015[92] examined the cost effectiveness of chronic disease self–management models of care. The median cost efficiency was approximately US$50,000 per quality–adjusted–life–year.

CASE STUDY: **Innovative models for palliative care in rural India**

Contributor: Barbara Pesut, Brenda Hooper, Marnie Jacobsen, Barabra Nielsen, Miranda Falk, Brian P.O'Connor
Country: India

A recent pilot of a nurse–led palliative care service in India has sought to address the challenge of the provision of palliative care services to people living in rural India through a community capacity building approach. People with advanced chronic disease received home visits by a nurse who performs a supportive navigation role. Patients were seen by the nurse either weekly or biweekly with a variety of services being provided for a wide range of issues. Problems included family conflict, community isolation, financial challenges, troubling symptoms and mobility issues. The nurse navigator addressed these problems over time by bridging the gaps between health and social care.[93]

The primary interventions by nurses were education about the management of symptoms and psychosocial support for the emotional challenges of living with advanced illness. They would also assist people to comprehend the health care information and make decisions about possible treatments to manage the symptoms of the disease. The domains of supportive care provided by the nurse navigators were extremely diverse ranging from disease management; spiritual and physical care; advanced care planning; psychological support; and social support.[93]

It is estimated that 34 million people in India would benefit from palliative care, but less than 1% of these people have access to it.[94] Many people with late stage conditions have 'heavy' symptom burden and are at risk of increasing social isolation. Patients and family members are often unaware of the health and social services available to them in their community. The lack of appropriate and suitable support for palliative care has terrible consequences to people's final stages of life. Rurality also adds a layer of complexity to this challenging situation. Rural health services are often limited and inaccessible. This is mostly due to skilled workforce shortages.[93]

As a result of this service, it is believed that there is reduced emergency room usage, hospital admissions and primary care physician visits. Patient satisfaction is higher, and more people can choose to die at home. The service also meant that the nurse navigator was able to assist clients identify available benefits and cost–effective alternatives to care, thereby creating cost savings to the family.[93]

Whether implemented independently, or partnered with volunteers, a nurse–led navigation service can meet the unique needs of rural communities by enhancing support and access in the face of limited health care resources.[93]

> A strong nursing sector is the necessary building block of a strong health care sector. Nurses must be encouraged to take significant leadership roles in health policy, planning, and provision"
>
> –C.K. Mishra, Secretary, Ministry of Health & Family Welfare, Government of India

Human Resources for Health

Across the world, health systems are under pressure– to meet the rapidly rising demand; to meet growing consumer expectations; and to reduce the rate of increasing expenditure and pursue value. In 2013, the growth in global health spending was 2.6%. With changes to lifestyles, increasing costs of services, treatments and technologies, demographics and economic conditions, it is expected that the nominal growth to health care spending is increasing at an average of 5.3% per annum between 2014–2018.[94] These factors, described in numerous reports, are considered to constitute the perfect storm of making health care unaffordable and unsustainable.

How then is it achievable to implement UHC and people–centred care when human resources, the very thing required to achieve these two elements, form the largest single cost element in any health system? On average, 60–80% of total recurrent expenditure is allocated to human resources. On top of the financial cost is the supply of health workers. By 2030, it is estimated that another 40 million health care jobs will need to be created. Under current strategies, the projected workforce shortage will be approximately 18 million.[95]

A UN High–Level Commission was established to examine this very issue. In its report on 'Health Employment and Economic Growth'[95] it "dismantled the long–held belief that investment into the health sector drags the economy." It believed that investments coupled with the right policy actions could make dramatic improvements in socioeconomic gains such as in education, gender equality, employment, and health. It concluded that investment in the health sector, can "create the conditions for inclusive economic growth and job creation as well as for greater economic stability and security."

The health workforce is responsible for caring for the health and wellbeing of individuals and communities. They also have a pivotal role of providing resilience to health systems to respond to disasters caused by natural, environmental, technological or biological hazards. These events can cause long term damage to community interests, but can to some degree be mitigated by the health workforce.

As has been analysed throughout this report, health systems can only function with appropriately skilled and available health workers. If the right to the highest attainable standard of health is to be achieved, it is dependent on the accessibility, availability and quality of health systems and the people who work in them.

For this to be achievable, there are multiple challenges that need to be addressed, including a host of human resource issues related to the shortage of qualified staff; unequal distribution between urban and rural areas as well as disparities between primary health care and hospitals; unbalanced skill mix; low compensation and remuneration; high workloads; perverse financial incentives; unsafe workplaces and a raft of other human resource issues. The current approach to the health workforce will not meet the requirements of a well–functioning universal health care system where people are at the centre. These issues need to be addressed along with a change to the current focus of care. There needs to be a rethink of the way in which the health workforce is deployed and motivated. The features of this include the central role of primary care; a focus on the continuum of care and the holistic needs of the individual; risk stratification and prioritisation of population needs; an emphasis on prevention and health management; the use of multidisciplinary teams; and key linkages to community and social services. This kind of transformation to the health workforce is required for it to be successful and sustainable. Investment in these areas of the health workforce will lead to improved health and economic growth.

Investing in the nursing workforce will see major returns on investment. In analyses of hospital quality, cost controls and nursing care have taken place independently of each other. It is time for this to change. These discussions need to be interwoven because improving health outcomes and creating efficiencies in health requires the effective utilisation and investment in the nursing workforce.[96]

Nursing forms the largest segment of the health care workforce and is the major player in achieving high quality, effective and efficient health care. Nurses are the backbone of the health care system and in the acute sector are the professionals who provide 24-hour care and support to patients. When other health professions have left for the day, nurses are still providing care and support to patients' needs. In the community, in rural and remote areas, they are often the only health care providers. They plan and coordinate all patient care activities in a complex and fast changing environment which increasingly requires higher technical competencies, as well as increasing expectations from clients.

In 1996, the IOM report on 'Nursing staff in hospitals and Nursing Homes: is it adequate?'[97] concluded that although nursing services are central to the provision of health care, "little empirical evidence is available to support the anecdotal and other informal information that hospital quality of care is being adversely affected by hospital restructuring and changes in [nurse] staffing patterns."

Since this time there have been a plethora of studies and research demonstrating the added value of nursing to improved health outcomes.[98] Research shows that the quality of nursing, the culture and associated workloads are associated with patient outcomes including length of stays, mortality, morbidity, patient satisfaction and a range of other quality measures.

Despite the body of evidence and research, the public and health policy makers do not understand the full nature of nursing work. A study of the public found that the overwhelming majority of people were confused regarding what nurses do, the kind of education and training they receive and what distinguishes them from other less trained personnel.[96]

People perceive accurately that nursing work can be demanding both physically and emotionally. Unfortunately, there is a misperception that nursing work is limited to being a 'hand maiden' following orders provided by physicians and providing physical and emotional support to patients and their families. However, nursing work is much more than this and is both an art and science requiring substantial intellectual, clinical and organisational competence. Amongst other critical activities carried out by frontline nurses, they also provide holistic care across the continuum, assessment and monitoring of patients and, as necessary, initiating interventions to improve health outcomes; address complications or reduce risks; navigate and coordinate care delivered by other providers; providing education to patients, families and carers; empowering and partnering with patients to improve health outcomes; and advocating for individual and community health needs.

Nurses have a unique understanding of the health system. They are aware of its strengths and weaknesses and how to overcome challenges posed by broken or dysfunctional systems. With health systems attempting to improve access, affordability, quality, efficiency, equity and people centeredness, nursing knowledge and commitment to the health and wellbeing of individuals needs to be effectively harnessed, empowered and mobilised. For this to be a reality, nursing perspectives and opinions must be represented at the highest levels of health leadership and integrated into decision making. Mechanisms need to be developed to engage with nurses at all levels to affect lasting and worthy change.[99]

The first step in making this happen is for nurses to have a better understanding of the highly complex nature of policy influence and policy making. This is addressed in Part Four.

Figure 14: Strategies for strengthening the global health workforce[95]

PLAN AND INVEST

- Develop policies and strategies to quantify health workforce needs, demands and supply
- Establish national health workforce registries and appropriate regulations to support improved performance
- Promote intersectoral collaboration
- Advance international recognition of health workers qualifications
- Raise adequate funding to invest in the right skills, decent working conditions and an appropriate number of health workers
- Strengthen evidence and research into the health workforce

DEVELOP AND ENABLE

- Stimulate investments in creating decent health sector jobs
- Maximize women's economic participation and foster empowerment
- Scale up transformative, high quality education and life-long learning opportunities
- Develop capacity to manage complex humanitarian emergencies or crisis
- Invest in analytical capacity and capabilities for HRH and health system data

STRATEGIES FOR STRENGTHENING THE GLOBAL HEALTH WORKFORCE

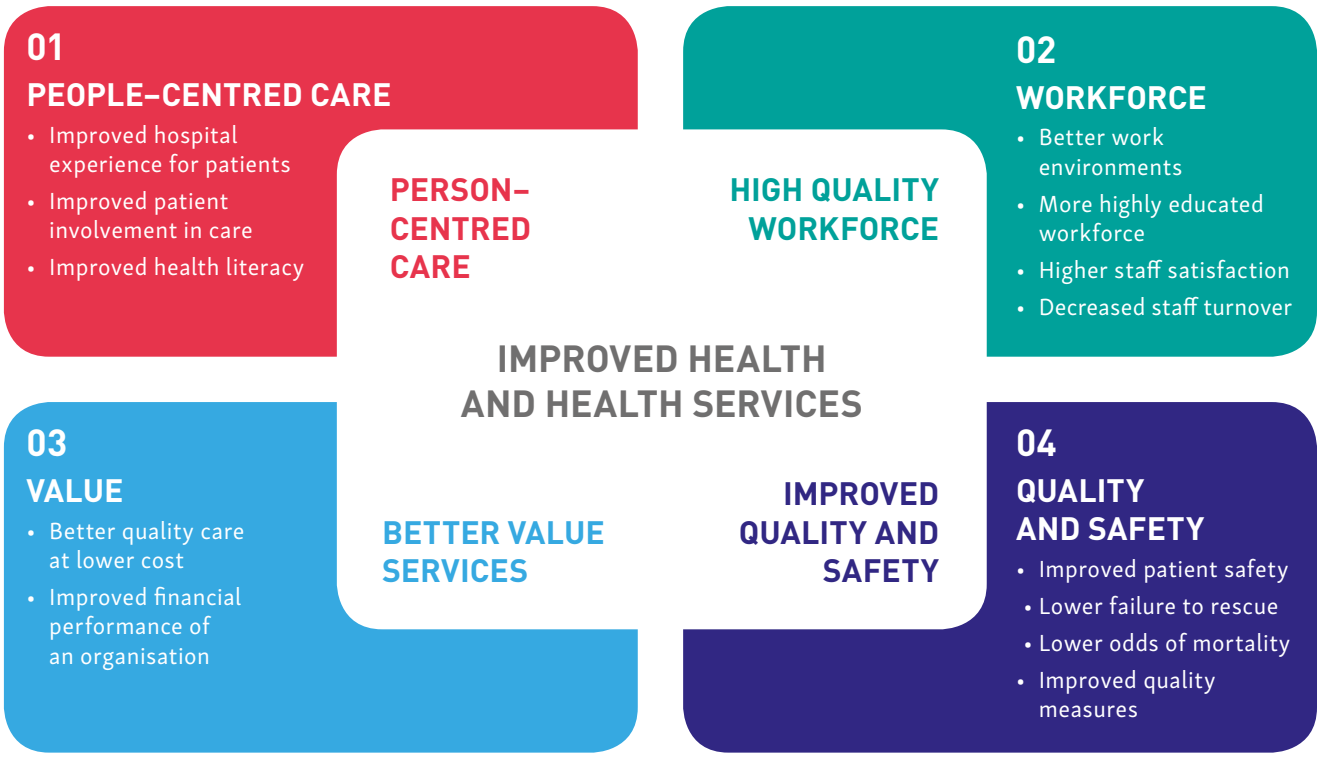
TRANSFORM AND EMPOWER

- Reform service models concentrated on hospital care and focus instead on prevention and on the efficient provision of high-quality, affordable, integrated, community-based, people-centred primary and ambulatory care, paying special attention to underserved areas
- Align health workforce with social services workforce to effectively address the determinants of health
- Effectively harness the leadership capabilities within the health workforce

RETAIN AND OPTIMISE

- Match the skills to the health needs of populations
- Harness the power of cost effective information and communication technologies
- Ensure protection of all health workers and health facilities in all settings
- Promote and Invest in decent working conditions
- Optimize health worker motivation, satisfaction, retention, equitable distribution and performance
- Support practitioners to work to their full scope of practice
- Strengthen multi-disciplinary approach and collective competence approach to health care
- Celebrate successes

Figure 15: The benefits received when nurses are involved in leadership positions



CASE STUDY: **Realising the full potential of nursing: CNO Wales**

Contributor: Professor Jean White CBE, Chief Nursing Officer Wales, UK
Country: Wales

In November 2016, the Chief Nursing Officer (CNO) of Wales set the national strategic goal: *"to realise the full potential of the nursing and midwifery professions in order to meet, in partnership with others, the changing health and well-being needs of people living in Wales"*. The strategy has eight priority areas: professionalism; voice and leadership; workforce and education; informatics; research, development and innovation; promoting population health and well-being; quality and safety of care; and promoting integration of care (people-centred approach).[100]

The key actions were developed in consultation with nurses and midwives in Wales and were drafted according to its four principles.[101]

1. Achieve health and wellbeing with the public, patients and professionals as equal partners and through co-production.
2. Care for those with the greatest health needs first, making the most effective use of all skills and resources.
3. Do only what is needed, no more, no less; and do no harm.
4. Reduce inappropriate variation using evidence-based practices consistently and transparently.

The first prudent health care principle focuses attention on people, particularly in adjusting the power dynamic that currently exists between health professionals and patients so that patients are equal partners in deciding what should be done.

In 2016, the UK CNOs decided to explore what professionalism means to nurses and midwives and understand how a people-centred approach to care could be instilled in practice. Working with the Nursing and Midwifery Council (UK professional regulator) they developed guidance[102] to support practitioners in applying their Code of Conduct to their daily practice identify what employers should do to enable professional practice to flourish in organisations.

The Nurse Staffing Levels (Wales) Act 2016, unique in Europe, requires the National Health Service (NHS) to consider whether it has sufficient nurses to care for patients sensitively in all areas and sets out a methodology[103] for calculating the nursing workforce attached to specific service areas. At the heart of this law is the recognition of the professional voice of senior front-line nurses in determining the staff they need to care for their patients.

In order to feel confident in raising their professional voice, nurses and midwives need to be educated appropriately-Wales was the first country in the UK to have all baccalaureate degree education for nurses and midwives and since 2010 has standards for advanced practice.[104] As a result, Wales has been forging ahead with developing specialist and advanced roles and having nurse and midwife led services to the betterment of patient care.

CASE STUDY: **The Global Nurse Capacity Building Program**

Contributor: Susan Michaels–Strasser **Country:** Sub–Saharan Africa

The Global Nurse Capacity Building Program (GNCBP), led by ICAP at Columbia University's Mailman School of Public Health with funding from the PEPFAR through the US Health Resources and Services Administration (HRSA), aims to improve population health and combat HIV in sub–Saharan Africa by strengthening the quantity and quality of the nursing and midwifery workforce.

GNCBP employs a holistic model to strengthen nursing and midwifery from education to practice through two sub–projects. The Nursing Education Partnership Initiative (NEPI) promotes the production of a new workforce and General Nursing (GN) supports the maintenance of a skilled workforce.

GNCBP provides services across six building blocks of nursing workforce development including: 1) infrastructure improvement; 2) curricula revision; 3) faculty development; 4) clinical skills; 5) continuing professional development; and 6) partnerships for policy and regulation.

GNCBP provides a long overdue and much–needed infusion of expertise and resources and generates valuable lessons to inform efforts to enhance nursing and midwifery in sub Saharan Africa. Combined nursing and midwifery training and the redesign of curricula to be competency–based are fundamental changes to the way that nurses are educated. Increasingly, preservice education addresses HIV core competencies and the expanded role of nurses in HIV care and treatment, while innovations such as simulation–based training and e–learning have been shown to be both acceptable and feasible in low–resource settings.

Sub–Saharan Africa faces a critical health workforce shortage, which inhibits access to quality health care and contributes directly to poor health outcomes. The region faces a significant burden of disease and very limited availability of human resources for health. In 2006, WHO reported that 25% of the global disease burden was concentrated in sub–Saharan Africa among just 11% of the world's population. In addition, the region accounted for only 3% of the world's total health workforce and a mere 1% of global health expenditure. Ever larger cadres of well–trained nurses are needed in high HIV burden, low–resource settings, as test and treat approaches to comprehensive HIV care are implemented and more patients require care for comorbidities and concurrent chronic diseases.

To date, GNCBP has achieved impressive results, with 13,146 nursing and midwifery students having graduated from 22 schools and 5,550 nurses having received in–service training. Over 4,000 faculty in 22 nursing schools in six countries have received continuing education through GNCBP in clinical skills, education, and research at the specialty certificate, Master's and PhD levels. These schools also received installation enhancements and nationally accredited curricula was developed or revised. GNCBP has supported enhancement of nursing policy and regulation in each country.

PART FOUR:
POLICY TO PRACTICE –PRACTICE TO POLICY

As evidenced in Part Two, nurses know much about access issues, so where does nursing's responsibility lie in ensuring that this knowledge is included and influential in policy making?

It is often said that all action, even inaction, is a political act. Politics is, after all, only the exercise of influence over the allocation of scarce resources, or, as Mason et al. define it, "the use of relationships and power to gain ascendancy among competing stakeholders to influence policy and the allocation of scarce resources".[117] Policy is the mechanism by which this resource allocation is actioned, more formally, policy is "a relatively stable, purposive course of action or inaction followed by an actor or set of actors in dealing with a problem or matter of concern".[105] Competing priorities and concerns, coupled with the inevitable finite nature of resources, leads policy to invariably take place in a political context.

These definitions are really helpful for nurses, as we argue, that because we "know" about patients and families responses to health and social policies, we should be included in health policy decision making.[106] Understanding these definitions help us begin to see the complex nature of policy making. It alerts us to the fact that whilst often appearing in text books as a simple circular process not unlike the nursing process (problem identification–agenda setting–policy formulation–implementation–evaluation), the reality is far more complicated.

As nurses we argue that when policy is made we do not "have a seat at the table". What we must understand is that by the time a policy reaches a consultation "table", the policy making is virtually complete. Where we need to be, therefore, is in the earliest stage of problem identification and solution framing. It is here that real influence happens. Nurses must get more deeply engaged in understanding influence in policy making.

The policy process is messy and unpredictable. In order to better understand this complexity Walt and Gilson[107] introduced the idea of a health policy triangle to simplify these tangled inter–relationships (see Figure 16). As with all models, they simplify processes that are usually highly interconnected and interactive, and this is very much the case here.

While nurses know "content" (i.e. patients' and families' responses to health and social policies), this is just one policy component. We also must take account of the "context", the "process" and the "actors", both individual and organisations.

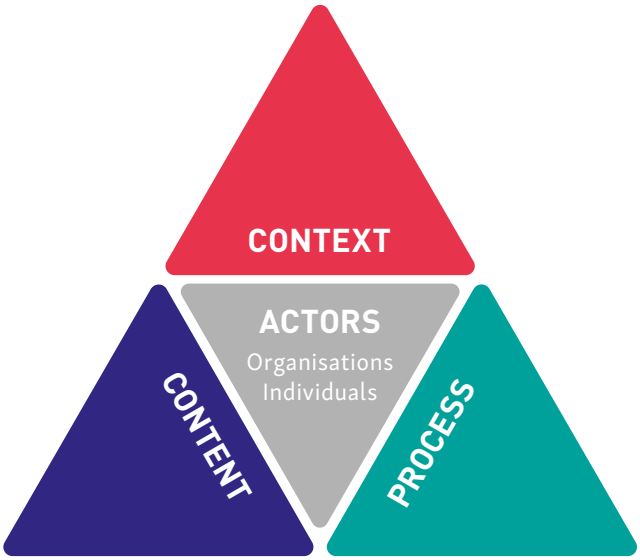
Context: What is going on in the environment at this moment and how might that influence any policy conversations? Context can be seen as inclusive of situational factors (e.g. war, drought, earthquakes); structural factors (e.g. political systems and political cycles, technology, new research); cultural factors (e.g. language, norms, religion, minority groups) or international factors (e.g. infectious disease outbreaks, market changes such as the global financial crisis).[108] Each of these elements can bring your concern to higher attention or take it completely off the agenda. Picking your time by assessing the context is critical to success in influencing policy.

Process: How is the policy decision actually taking place? How is it started, developed, negotiated, communicated, implemented and evaluated (as in the simple cycle above)? Who has and wields the power is a key question during this process? This brings us to consideration of the actors involved in the process.

Actors: Who are the individuals and what are the organisations which may have an interest in the subject of the policy? Having determined who the key stakeholders are one needs to think through the level of their involvement, their interest, their influence or power, the impact of the outcome on them and what their position will be–are they allies or opponents? Knowing the participants enables you to choose who can help you, who to make a coalition with and whose influence needs to be countered and why.

The Walt and Gilson Policy Triangle (Figure 16) was built upon by Jeremy Shiffman and his colleagues[109] to create a new model which explores three main areas: internal factors of the network and their actors; the policy environment; and the characteristics of the issue itself.

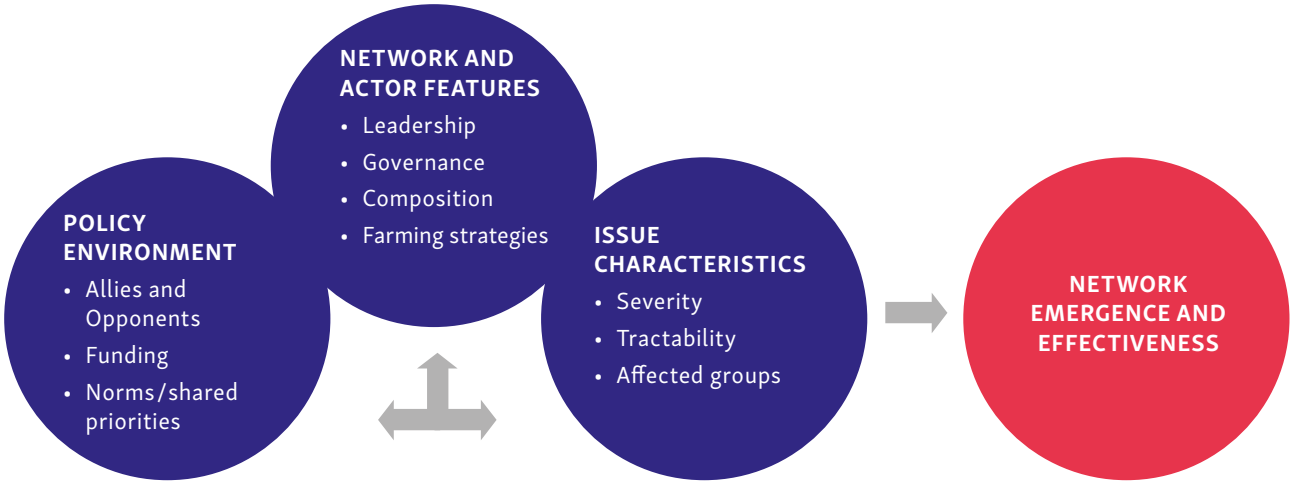
Figure 16: Walt and Gilson Policy Triangle[107]



ACTIVITY:

Think of a recent national policy in which nursing has an interest. Using the policy triangle analyse the actors, process, context and content. Does this help you understand the outcome? How could this analysis suggest something you could do differently next time?

Figure 17: Shiffman Model of Effective Global Health Networks[110]



Of those elements there are a couple of areas in which nursing lags significantly behind other groups of influence in health–framing strategies, internally and externally, which includes the language used; and the building of coalitions.[110] Interestingly these were also elements identified by a group of American nurses 20 years ago in looking at the political development of nursing.[111]

If we are trying to influence policy therefore, we need to start with the characteristics of the issue. We have to do our homework and understand all the evidence there is related to the issue we are trying to influence (its severity and tractability–is there a solution that will be effective?). We need also to look at how we express the groups affected and the degree to which this will engage others. An example here is HIV/AIDS. When this was expressed as a disease of gay men or that of a country far away there was little opportunity for political traction. When it was expressed as a threat to humanity and a disease that could be transmitted in utero to babies it gained immediate attention and action.

Next, we have to look at the politics of the political environment. Are we in tune with the cycle of government budget preparation? Have we done our stakeholder analysis? Are we a group that others will take notice of in relation to this issue or will it be seen as self–interest? Have we framed our interest, our input and our contribution in a way that will be heard by others as relevant and important? Who else is interested in the issue and has a compatible position and value system and are they potential collation partners?

Who, within nursing is most advantageously positioned to take the issue forward to the outside world–is it the union, regulator, senior service leaders, or researchers? Do we have a unified professional message that will be committed to by all and not result in a divided voice? In other words, have we done our homework of working on a consensus position behind closed doors?[112]

Figure 18: Nursing's four stages of political development[111]

	1 BUY–IN	2 SELF–INTEREST	3 POLITICAL SOPHISTICATION	4 LEADING THE WAY
NATURE OF ACTION	Re–active on a focus on nursing issues	Re–active to nursing issues (e.g. funding for nursing education) and broader issues (e.g. long term care and immunisations)	Pro–active on nursing and other health issues (e.g. Cohen et al.'s Nursing's Agenda for Health Reform)	Pro–active on leadership and agenda setting for a broad range of health and social policy issues
LANGUAGE	Learning political language	Using nurse jargon (e.g. caring, nursing diagnosis)	Using parlance and rhetoric common to health policy deliberations	Introducing terms that reorder the debate
COALITION BUILDING	Political awareness: occasional participation in coalitions	Coalition forming among nursing organisations	Coalition forming among nursing groups: active and significant participation in broader health care groups (e.g., Clinton task force on health care reform)	Initiating coalitions beyond nursing for broad health policy concerns
NURSES AS POLICY SHAPERS	Isolated cares of nurses being appointed to policy positions primarily because of individual accomplishments	Professional associations get nurses into nursing–related positions	Professional organisations get nurses appointed to health–related policy positions (e.g. nurse position on Pro–PAC)	Many nurses thought to fill nursing and health policy positions because of value of nursing expertise and knowledge

ACTIVITY: POLITICAL DEVELOPMENT

Explore the four stages of political development above and see where you feel you are in your political development. Where do you think nursing is in your country, and where is nursing globally in its political development? What are the areas in which improvement is needed? How might you get this experience/education?

CASE STUDY: **Coalitions and collaborations to tackle NCDS: nursing stepping up to be a partner in a country wide health improvement initiative**

Country: Tonga

Non–Communicable Diseases (NCDs), which accounted for 75 per cent of all deaths in Tonga in 2008, according to the WHO are due mainly to poor diet, lack of physical exercise, smoking and alcohol consumption.[113] According to Hon. Dr Saia Ma'u Piukala, Minister of Health, 99% of the Tongan adult population is at medium to high risk of developing a NCD.[114]

The focus on NCDs in Tonga began in 2003 with the development of a comprehensive NCD strategy (2004-2009), the first in the Pacific. The then Minister for Health, Lord Viliani Tau' Tangi, has been a mainstay of the NCDs fight and has consistently seen nursing as having a central role to play in arresting and controlling NCDs. The evaluation of this first plan revealed that there were difficulties with both accurate data collection and with implementation. The next NCDs strategy (2010-2015) focused on redressing these issues and Lord Tangi recognised the critical positioning of nurses in the Tongan community as well as the acute care sector. Several years earlier, reproductive health nurses had been specifically educated and stationed in each community health centre resulting in a significant reduction in maternal and infant mortality, morbidity and rise in immunisation rates. This community–based, nursing–led model, it was believed, might also work with NCDs if a role could be introduced which would combine health promotion, early detection, illness prevention, treatment adherence, rehabilitation and palliation. The idea of the Tonga community based NCDs nurse was born.[113]

A pilot was set up in 2012 in five community centres and the efficacy and acceptance of this community based offering quickly became clear. Funding was sought for rolling the NCD nurse programme out to 20 community centres and by early 2014, 20 explicitly chosen experienced community nurses graduated from an innovative collaboratively constructed, and accredited Advanced Nursing Diploma in the Prevention, Detection and Management of Non–Communicable Diseases. To demonstrate the importance placed on this nursing initiative, the graduation ceremony was attended by Her Majesty Queen Nanasipau'u Tuku'aho, and the Minister for Health.[113]

This nurse–led initiative has already enhanced the accuracy of data collection on NCDs; improve diabetes and cardiovascular disease monitoring and treatment; enhance community participation in exercise and nutrition programmes; and reduce the need for amputations.

The latest strategic plan for NCDs (2015-2020) continues the fight in Tonga with an emphasis in this latest plan on young people and a healthy start to life. The community based reproductive health nurses and NCD nurses will continue to have a major role to play, along with many other sectors of society.[114]

Figure 19: A model for getting from issue to action

ISSUE CHARACTERISTICS

What do we know? What is the evidence? (severity, tractability, affected groups)

What are the key reference documents?

POLICY ENVIRONMENT

Who are the key stakeholders already in the area?–non–nursing and nursing, assessing their involvement, interests, philosophical positioning, existing coalitions.

Why is this nursing's business?

Who are the existing key nursing spokespersons? Who are the key nursing researchers?

INTERNAL NURSING NETWORK

With whom should nursing potentially be forming coalitions?

What is the unique contribution nursing brings?

What is ICN's contribution/role?

What is the role of the NNAs?

Who should/could be stepping forward as a nursing lead?

What is the agreed message internal to nursing?

EXTERNAL FRAMING AND OUTCOMES

What is the external message framing which presents a unique addition and justification for inclusion of a nursing voice?

What is the hoped for outcome?

What is the reporting timeframe, how and to whom?

Figure 19 shows how nurses can move from practice to policy or from issue to action as occurred in Tonga (See Case Study). Observations and data from practice inform policy, policy dictates the focus for new practice initiatives, which in turn inform new policy.

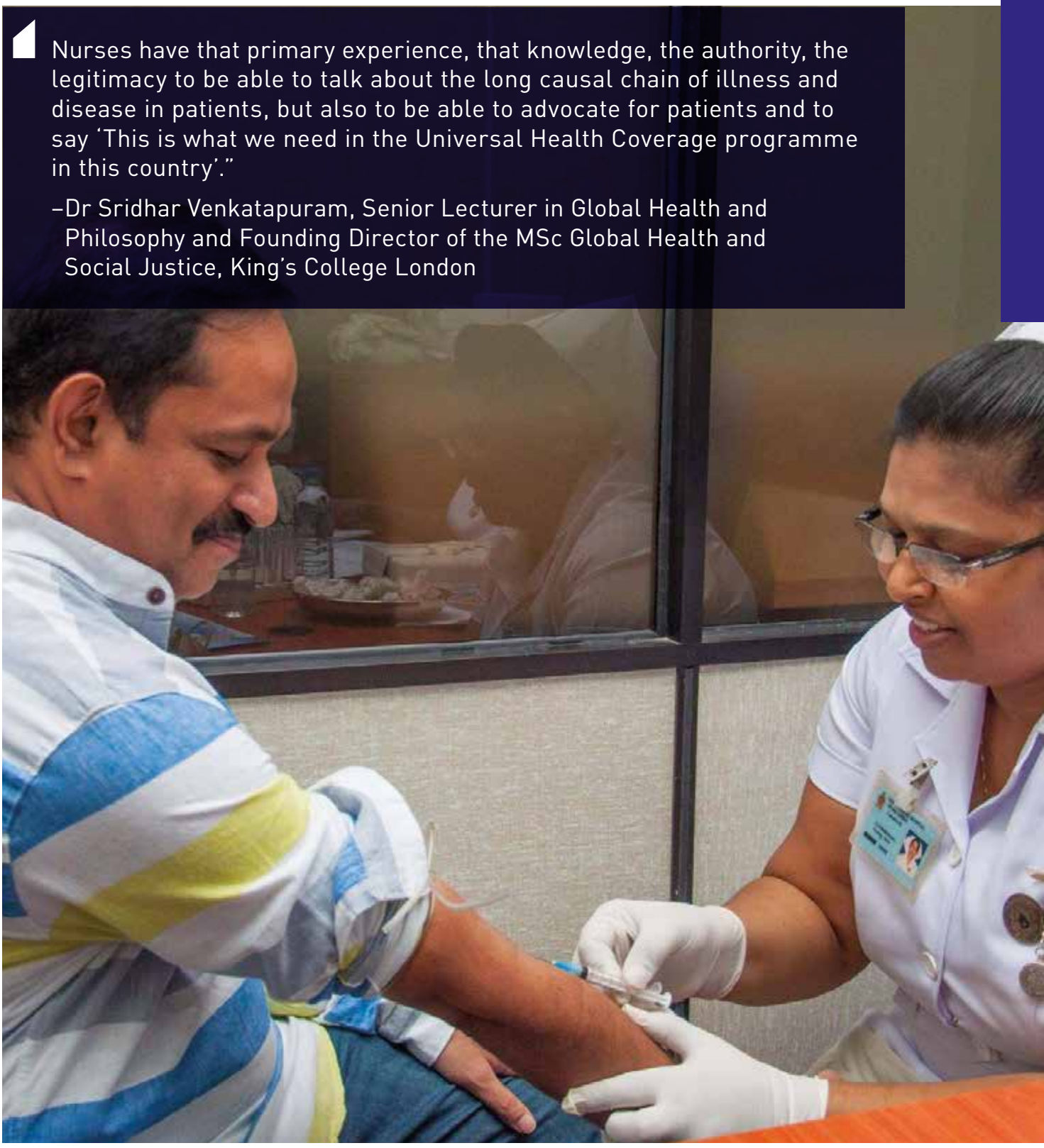
The continued effort with changing emphasis and implementation priorities underlines the critical importance of nurses as accurate data collectors, analysts and spokespersons for their communities to ensure the best policy implementation and evaluation, and then to provide the best advice into new policy and agenda setting.

The final word

Nurses are essential in transforming health care and health systems so that no person is left behind. Nurses can be a voice to lead by improving access to care; enabling a people–centred approach to health; and by ensuring their voices are heard in influencing health policy, planning and provision.

In 2018 it is now time to stand together and speak as one. We must speak louder. We need to speak clearer. With the resources that we currently have available to us, it is no longer acceptable to deny any human the right to health care. Make 2018 your year to be a voice to lead for health is a human right.

> Nurses have that primary experience, that knowledge, the authority, the legitimacy to be able to talk about the long causal chain of illness and disease in patients, but also to be able to advocate for patients and to say 'This is what we need in the Universal Health Coverage programme in this country'."
>
> –Dr Sridhar Venkatapuram, Senior Lecturer in Global Health and Philosophy and Founding Director of the MSc Global Health and Social Justice, King's College London



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