NURSES
A VOICE TO LEAD
HEALTH FOR ALL

HEALTH FOR ALL
NURSING, GLOBAL HEALTH AND UNIVERSAL HEALTH COVERAGE

INTERNATIONAL NURSES DAY 2019
RESOURCES AND EVIDENCE

INTERNATIONAL COUNCIL OF NURSES

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MESSAGE FROM THE ICN PRESIDENT

Every year, the International Council of Nurses chooses a theme for International Nurses Day, celebrated on 12 May, the birthday of Florence Nightingale. For the past two years we have celebrated the voice of nursing with the theme Nurses: A Voice to Lead. In 2017, we discussed the role of the nursing voice in achieving the Sustainable Development Goals, and in 2018, we looked at the human right to health. This year, we look at the nursing voice from the standpoint of **Health for All.**

Nurses all over the world every day are advocating for Health for All in the most challenging circumstances with limited resources to deliver health care to those most in need. This can be seen in Uganda (p. 20) where the nursing staff visit villages to teach basic health tips particularly related to personal and household hygiene and sanitation. The nurses build close relationships with the community and collaborate with the local Village Health Worker. It can also be seen in the USA (p. 6), where nurses are partnering with social workers to develop deep community relationships and local expertise to bring high-quality health care and coordinated services to individuals struggling with homelessness, addiction and transition from incarceration.

And nurses, who are closest to the patient, are also helping to bring their voice to the policy table. The first ever UN High-Level Meeting (HLM) on Universal Health Coverage (UHC) will be held during the 2019 United Nations General Assembly (UNGA). This is an opportunity for nursing to let our voice be heard. We need to be prepared, and this resource and evidence document will help nurses around the globe understand the various aspects of universal health coverage and the role of nurses.

ICN believes that nurses, as part of a multidisciplinary team, can create health systems that take into account the social, economic, cultural and political determinants of health. We can address health inequalities and, through a refocusing on health promotion and illness prevention, using a population health approach, we can improve the health of everyone everywhere.

And finally, we believe that the time is ripe for nurses to assert their leadership. As the largest health profession across the world, working in all areas where health care is provided, nursing has vast potential and value if appropriately harnessed to finally achieve the vision of Health for All.

Annette Kennedy
President International Council of Nurses

PART ONE
HEALTH FOR ALL

"There is no commodity in the world more precious than health." – Dr Tedros Adhanom Ghebreyesus, WHO Director-General[1]

On 12 September 1978, 134 countries met in Alma Ata, Kazakhstan (now known as Almaty) for the international conference on Primary Health Care (PHC). This event marked an important turning point in the history of public health and was the first of its kind to commit government, health and development workers, and the global community to protect and promote the health of the world's population through a PHC approach.[2]

The declaration was profound in its messages as it supported community leadership in health planning, reducing the elitism in modern medicine, and tackling social inequality for better health outcomes.[3] It was at this time that 'Health for All', was first articulated with guidelines and actions.

At its core, 'the Declaration of Alma Ata' affirmed that improvements to health can only be obtained through the combination of health science, sound economics and policies, and actions against social injustices. It boldly stated, 'Health is a Human Right.' Whilst there is inequity and injustices, 'Health for All' will not be achieved.

Forty years later, the messages contained in the Alma Ata Declaration are still relevant. Although progress has been made in some areas since 1978, we have seen a change in the breadth of health vulnerabilities. Changes to lifestyles and environment have created new health challenges: chronic diseases now kill more people than infectious diseases. Wealth inequalities and political exclusion have continued and the gap between the rich and the poor has widened. Globally, we have become increasingly connected through travel, trade and cultural exchange. This has led to new commercial interests in food, alcohol and tobacco that often undermine countries' efforts and complicate their responses to reduce rates of non-communicable diseases. As such, Health for All is not an end point but a call for action in the area of social justice with the core principle for all countries and the international community to seek to improve people's health.

THE CHALLENGE SET BEFORE US

Whilst there have been significant achievements in medical and technological advancements around the world, there are growing disparities between and within countries in the improvement of health. Biomedical and technological approaches to health have limitations to improving health, particularly when health is considered in its entirety of the "complete physical, mental and social wellbeing".[4] In fact, one could argue that a biomedical model approach to health has led to the neglect of the other determinants of health.

This is noted in the recent World Health Organization (WHO) High Level Commission on Non-Communicable Diseases (NCDs), also known as chronic diseases. The Commission reports that if the status quo remains in place, the SDG target of reducing premature death from NCDs by 30% by 2030 will not be achieved. It has stated the main reason for this is that "many policy commitments are not being implemented, countries are not on track to achieve this target. Countries' actions are uneven at best. National investments remain woefully small and not enough funds are mobilised internationally".[5] The approach required to reduce premature mortality is through 'health in all policies, whole of government, whole of society in the tackling of the social determinants of health including the lifestyle and environment. However, the report states that there is a "lack of political will, commitment, capacity and action on NCDs." The report concludes that for success to be achieved, those activities be framed on a human rights approach.

The challenge is not exclusive to NCDs. As the data demonstrates, in the 20th century (Figure 4), health and wellbeing is affected by disasters, poverty, infectious diseases, war and other humanitarian factors.

For Governments and health services to get the best out of the finite resources available to them, difficult decisions will need to be made. Nurses are ideally placed to lead and inform health services decision making and policy development because of their role as patient advocate, their scientific reasoning skills, and their numbers and range of care provided across the life-cycle and care continuum.

Case Study

Photo Credit – Cyrus Batheja

PROVIDING CARE TO FREQUENT VISITORS WHO ARE FACING HOMELESSNESS, ADDICTION AND TRANSITIONS FROM INCARCERATION
– Dr. Cyrus Batheja, USA

The "spend more, get less" paradox of American medical care is well documented. Underinvestment in social services and poor coordination of supports underlie a fragmented system that fails to produce acceptable patient outcomes. The financial and non-financial impact of ineffective health care for the most complex individuals affects state and local communities everywhere. Social determinants of health have a profound impact on health outcomes, driving up health care costs. Achieving the best outcomes for the most complex individuals requires addressing the social challenges that underpin health. It also requires specialized models of care to support traditionally marginalized patients.

United Healthcare recognised the challenges faced by thousands of Americans and developed a localised solution called myConnections which supports frequent visitors to hospital emergency rooms who are struggling with homelessness, addiction and transitions from incarceration. Using an evidence-based, biopsychosocial solution that integrates health care and social services to transform human lives, the teams work within community pods to bring together housing with high-quality, evidence-based trauma-informed services to improve outcomes and decrease inefficient healthcare utilisation for high risk, high cost patients. With a focus on social determinants of health, myConnections develops deep community relationships and local expertise to bring high-quality health care and coordinated services to the most complex individuals.

Using internal medical claims data, myConnections has created a data-driven technique to "hotspot" subgroups of the most complex patients/members across the country. Using this approach myConnections has identified over 25,000 homeless patients of which they are targeting the top 10%.

The myConnection's care model involves dyadic partnerships between social workers and nurses who connect with patients and custom tailor a programme based on strengths and desires of the patient. The dyad works closely with the patient to navigate toward safe housing which is provided at low or no cost for 12 to 24 months. They also navigate toward elite behavioural health services such as dialectical behavioural therapy, medication assistant therapy, and trauma-informed primary care. The approach involves motivational interviewing and positive psychology. Moreover, the dyad also helps to navigate to social entitlements like Social Security Income and food and housing vouchers to create long-term self-sufficiency.

WHAT IS HEALTH FOR ALL?

"Health for All means that health is brought into reach of everyone in a given country." Health in this context means not just the availability of health services, but a complete state of physical and mental health that enables a person to lead a socially and economically productive life.[6]

Figure 1: 'Health for All' is (Mahler, 2016)[6]
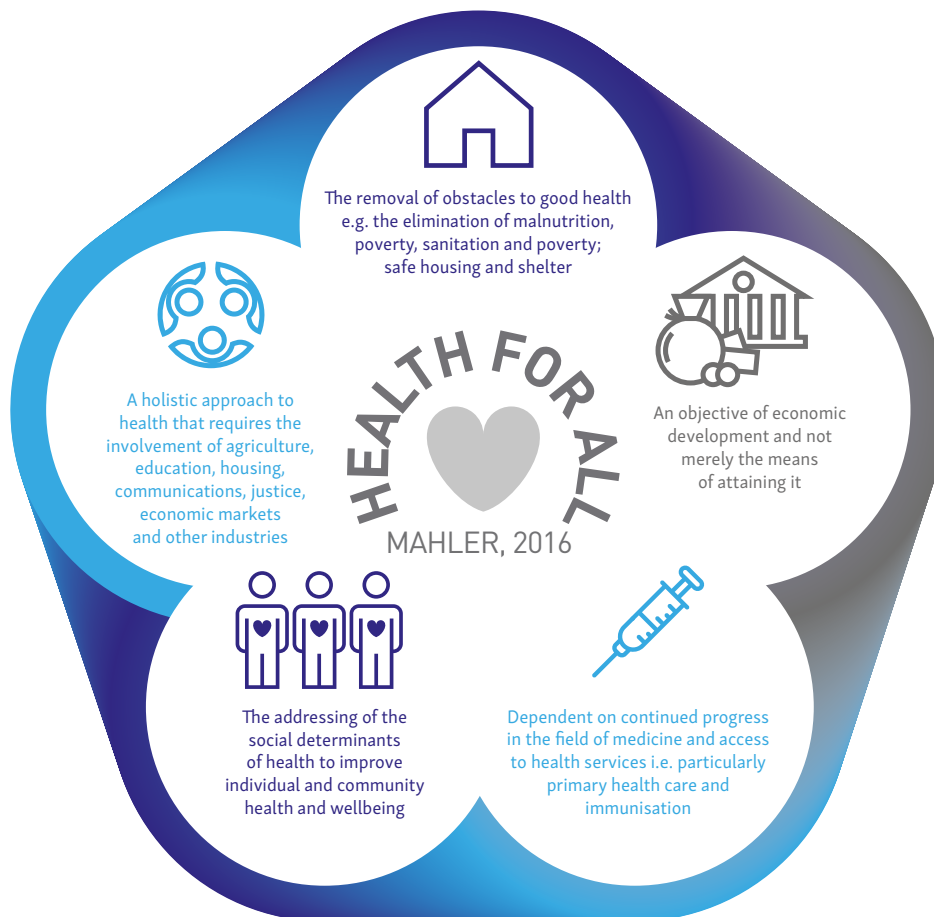
It is within this framework that health is seen as a human right where social development and economic factors are a predeterminate for Health for All. Emphasis is placed on the protection and promotion of health which include the elimination of social exclusion and disparities in health. This in turn, has positive effects on economic and social development and on world peace. The evidence for this was published by the Lancet Commission which found that every US$1 invested from now until 2035 would yield US$9 to US$20 return.[7]

Nurses are at the forefront of promoting the rights of consumers, seeing it as a human right and duty for people to participate as a group or individually in planning and implementing their care. The ICN Code of Ethics states that "Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status. Nurses render health services to the individual, the family and the community and coordinate their services with those of related groups. The need for nursing is universal".[8]

The ideals and core elements of 'Health for All' announced in 1978 have not yet been achieved. However there has been significant progress towards them. With the agreement by countries to the Sustainable Development Goals (SDGs), action is being taken in the right direction to address the scourges of our time.

Case Study

RACHEL HOUSE – PROVIDING COMMUNITY PALLIATIVE CARE – Indonesia

Across Indonesia, there are 1,200 new cancer cases for patients under the age of 18, as well as a very large number of children with HIV/AIDS. This highlights the enormous need for palliative care in the area of paediatrics.[9]

Motivated by a desire to address the lack of paediatric palliative care services, and with a vision for an Indonesia where no child will ever have to live or die in pain, Rachel House was established as Indonesia's first paediatric palliative care service. The majority of Rachel House's patients are from marginalised communities where their parents earn a daily income of US$ 3-5. This means that if the children are hospitalised rather than at home, the entire family will have to go without food. In response to this harsh reality, the nurses traded their uniforms for motorcycle helmets and jackets to travel the crowded streets of Jakarta to provide community-based palliative care.

The nurses have led the development of this vital service. Highly skilled and provided with training to conduct both physical and psychosocial assessments of the patients, the nurses spend time with the children and their families to understand their stories and social circumstances before and after the illness. The nurses seek to understand the child, first as a human being rather than a patient with symptoms. This has generated enormous compassion amongst the nurses and ultimately a growing dedication to those whom they serve.

A multidisciplinary team has been established to provide care for the children. The nurses, at the core of this team, work to build networks of support around the children's homes: by rallying the support of the local community health volunteers trained by Rachel House; connecting with and preparing the local primary care officials; ensuring availability of required medications at the local pharmacy; and working with partner NGOs for nutritional and other social support for the child. The team also trains the communities to help increase awareness of palliative care amongst the public and health professionals and increase the capacity for pain and symptom management.

After 12 years of service, Rachel House has cared for close to 3000 children and their families. Seen as national leaders in home-based paediatric palliative care, the nurses are often invited to share their knowledge with hospital staff throughout Indonesia. In addition, Rachel House now provides international-standard palliative care education for nurses and supports hospitals keen to develop integrated palliative care services. Rachel House is committed to building a palliative care ecosystem across Indonesia, to help ensure that pain and symptom management is available and accessible by all to prevent and relieve suffering.[10]

FROM HEALTH FOR ALL TO UNIVERSAL HEALTH COVERAGE

"We know that, when universal health coverage is achieved, poverty will be reduced, jobs will be created, economies will grow, and communities will be protected against disease outbreaks. But we also know women's economic opportunities will advance, and their children's health and development will follow in step."

**WHO Director-General
Dr Tedros Adhanom Ghebreyesus[11]**

Universal Health Coverage (UHC) addresses the vision of Health for All more than the original Alma Ata Declaration. The main reason for this is that it provides a more comprehensive approach to essential health services (more than just PHC) and it considers the financial aspect to them as well. However, a current shortfall of UHC compared to the original Alma Ata declaration is the lack of focus on the involvement of family and community in the decisions of health care. The next steps and challenge for UHC in the next few years is the empowerment of people and communities to be involved in decision making to create a more humane, self-reliant and less financially burdensome health care system.[12]

Universal Health Coverage

"Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship." [13]

Even though the 1978 Declaration of Health for All by 2000 was signed with the overwhelming support of Governments, momentum quickly fizzled out. It took over 20 years from this initial declaration for the movement to start up again due to the influence of global health challenges such as HIV/AIDS and TB. Then in 2005, countries committed to reforming financial mechanisms in order to improve access to health services. This commitment was fulfilled eight years later at the 67th United Nations General Assembly, with a resolution endorsing UHC.[12]

Photo Credit – Kithsiri Mahasen Mulleriyawa

Photo Credit – Rita Melifonwu

Figure 2: Three related objectives of UHC

The quality of health services should be good enough to improve the health of those receiving services.

Equity in access to health services-everyone who needs services should get them, not only those who can pay for them.

People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.
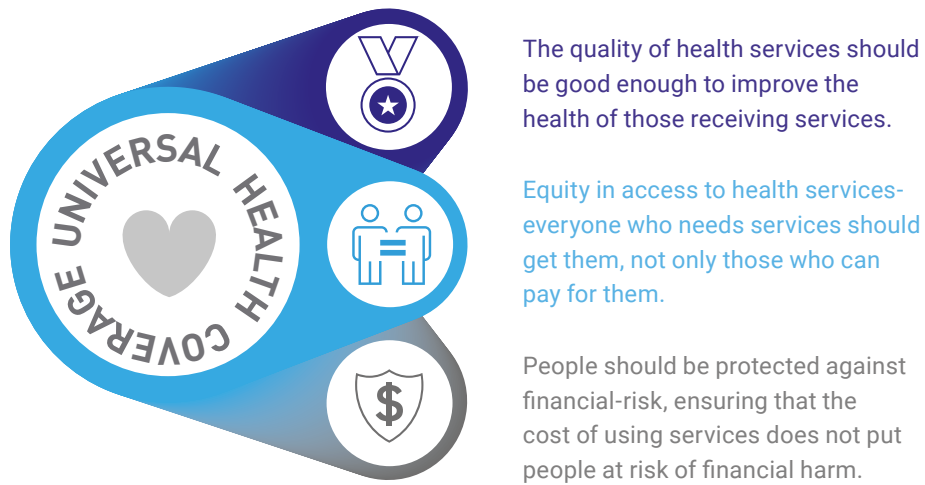
Figure 3: The benefits of UHC

Economic growth and development is facilitated

Life Expectancy is improved

Reduces child mortality

THE BENEFIT OF UHC

Improves health and wellbeing

Mortality rates from communicable diseases are reduced

UHC is affordable for middle-income countries
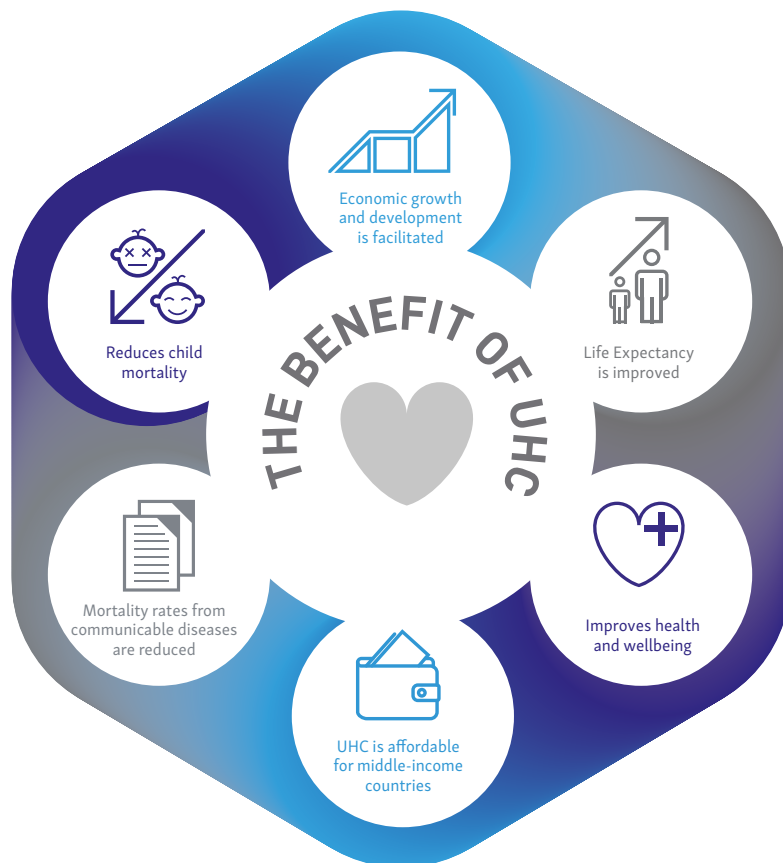
WHY SHOULD NURSES BE INTERESTED IN GLOBAL HEALTH CHALLENGES THAT IMPACT 'HEALTH FOR ALL'?

According to their scope of practice, nurses provide appropriate, accessible and evidence-based care. Nurses work independently, as part of multidisciplinary teams and participate in intersectoral relationships to:

- Give priority to those most in need and addresses health inequalities

- Maximise community and individual self-reliance, participation and control

- Ensure collaboration and partnership with other sectors to promote and maximise health.

Advocate and provider of care for individuals and communities.

Nurses respond to the health needs of individuals, communities and the world. Part of this equation is the proximity of the nursing role with the person. Nurses can and do work with individuals and communities and are in the best position to develop health systems that are better equipped to meet populations' health needs.

Skilled professionals with the potential to improve Health for All.

Nursing has been the profession which has promoted public health; advocated for the rights of all including the world's most vulnerable; providing care across the life span; and educating the community to achieve better health and wellbeing. As the largest health profession across the world, working in all areas where health care is provided, nursing has vast potential and value if appropriately harnessed to finally achieve the vision of 'Health for All.'

The world is looking for ways to achieve Health for All.

The Alma Ata Declaration has failed in its attempt to provide 'Health for All.' 40 years later half of the world's population has no access to essential health services.[14] The dominance of an 'absence of illness approach to health' and the prominence of the medical model means that 'Health for All' will never be achieved. Ageing populations and changing patterns of disease require a different approach to health that considers a holistic people centred model. This framework is at the centre of nursing and coupled with nursing's increasing body of scientific knowledge and broadening scope of practice (e.g. potential to prescribe, performing procedures and refer etc).

Nursing as part of a multidisciplinary team and intersectoral collaborative, can create a health system that takes into account the social, economic, cultural and political determinants of health, health inequalities, health promotion, illness prevention, treatment and care of the sick, community development, advocacy, rehabilitation, intersectoral action and population's health approaches.[15]

Figure 4: Causes of 20th century mortality[16]
Information is beautiful (2012)

Air Pollution 116m

Drugs 115m
6.5m Illegal Drugs
9m Alcohol

Road Traffic 60m
Accidents 298m
Falls 39m
Drownings 39m
Poisonings 35m
Fires 31m

HUMANITY 980m

Suicide 89m
Murder 177m
Homicide 58m
Genocide 30m — 14m Others

WWI 37m
Others 6m
Civil Wars 39.5m
War 131m
WWII 66m

China 65m
Communism 94m
Soviet Union 20m
6.5m Others

Ideology 142m
15m Democracy
Fascism 28m
Nazi-Germany (1933-45)
21m — Double Count — Nazi 16m
6m Japan

China 1943 5m
3m North Korea 1995-99
Soviet Union 1918-19 9m
Famine 101m
China 1958-62 30m

THE NATURAL WORLD 136m
7m Animals
4m Others
24m Natural Disasters
20m Extreme Weather

Hypertension 9m
10m Sepsis
Abortion 8m
14m Other
Hemmorhage 7m
Maternal Conditions 64m
Obstructed Labor 5m

Birth Defects 64m — Heart 27m
Other 23m

Liver 46m
Colorectal 47m
Stomach 64m
Others 66m

Others 10m
Iron 7m
Protein 32m
Nutritional Deficiencies 59m

HEALTH COMPLICATIONS 278m

CANCER 530m

Breast 36m
10m Ovarian
13m Bladder
17m Pancreatic
18m Cervical
Lymphomas 36m
Esophageal 33m
Mouth 24m
Leukemia 20m
20m Prostate

Birth Asphyxia 94m
Perinatal Conditions 155m
Other 61m

Seasonal flu

"Spanish flu" pandemic (1918-19)

36m

40m

Tobacco 100m

Respiratory 485m

Whooping Cough

38m

Smallpox 400m

Malaria 194m

7m Rabies

Diarrhea 226m

INFECTIOUS DISEASES 1,680m

12.5m HIV/AIDS

Tuberculosis 100m

16m

2.5m Dengue

19m Hepatitis B&C

22m Meningitis

Measles 97m

37m Tetanus

16m Syphillis

22m STDs

1m Chlamydia

Other Cardio-vascular 178m

Ischemic heart disease 540m

CARDIOVASCULAR DISEASES (excluding cancer) 1,246m

68m Hypertensive

30m Inflammatory

25m Rheumatic

Stroke 410m

Other 36m

29m Alzheimers & Dementia

Asthma

18m

Genito-urinary Disease 63m

Neuro-mental Disease 82m

10m Epilepsy

Diabetes 73m

7m Parkinsons

Chronic Obstructive Pulmonary Disease (COPD) 200m

Respiratory Disease 274m

NON-COMMUNICABLE DISEASES (excluding cancer) 1,970m

8m Musculoskeletal

Lung 93m

18m Endocrine Disorders

Cirrhosis of Liver

59m

Digestive Illness 147m

5m Skin Diseases

Peptic Ulcer

20m

1.5m Appendicitis

PART TWO

GLOBAL HEALTH CHALLENGES AFFECTING HEALTH FOR ALL

"The greatest wealth is health." **– Virgil**
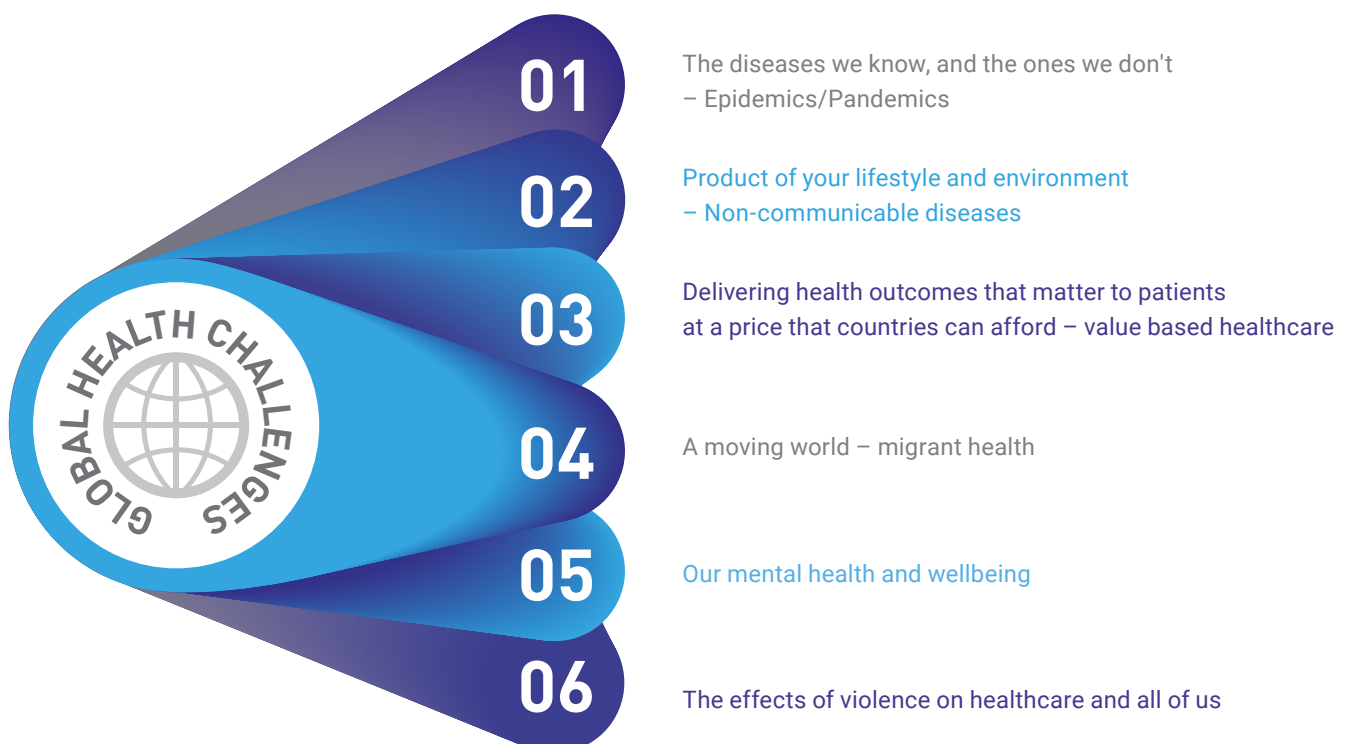
HEALTH FOR ALL AND THE ICN FOCUS FOR THE YEAR

The Alma Ata Declaration envisioned a new way in which health was to be supported. It recognised in addition to access to quality health services the importance of social, economic and environmental factors that affect the health of individuals and populations. The Declaration also affirmed that all people in all countries have a fundamental right to health, and that governments are responsible for upholding this rights.[17]

In the series of International Nurses Day publications, 'Nurses a Voice to Lead', we have focused on both elements: the social determinants of health (Achieving the Sustainable Development Goals – 2017) and access to health services (Health is a Human Right – 2018). This being the last of the three-part series, we consider both elements in relationship to some of the major global health challenges of our time and demonstrate the important role of nursing to improving the health and wellbeing of individuals, communities and the world.

Figure 5: Global Health Challenges affecting Health for All

01 The diseases we know, and the ones we don't – Epidemics/Pandemics

02 Product of your lifestyle and environment – Non-communicable diseases

03 Delivering health outcomes that matter to patients at a price that countries can afford – value based healthcare

04 A moving world – migrant health

05 Our mental health and wellbeing

06 The effects of violence on healthcare and all of us

The SDGs provide strategic focus and coherence to global health security, UHC and population health. They highlight the importance of pursuing the priorities in an integrated way as each affects the other. As such, the WHO workplan over the next several years have three strategic priorities also now known as the Triple Billion goals.

1. 1 billion more people benefiting from UHC

2. 1 billion more people better protected from health emergencies

3. 1 billion more people enjoying better health and wellbeing

Figure 6: **Set of interconnected strategic priorities and goals to ensure healthy lives and promote wellbeing for all at all ages from WHO's general programme of work 2019–2023**[11]

HEALTHIER POPULATIONS

1 billion more people enjoying better health and wellbeing

HEALTH EMERGENCIES

1 billion more people better protected from health emergencies

UNIVERSAL HEALTHCARE COVERAGE

1 billion more people benefitting from universal health coverage
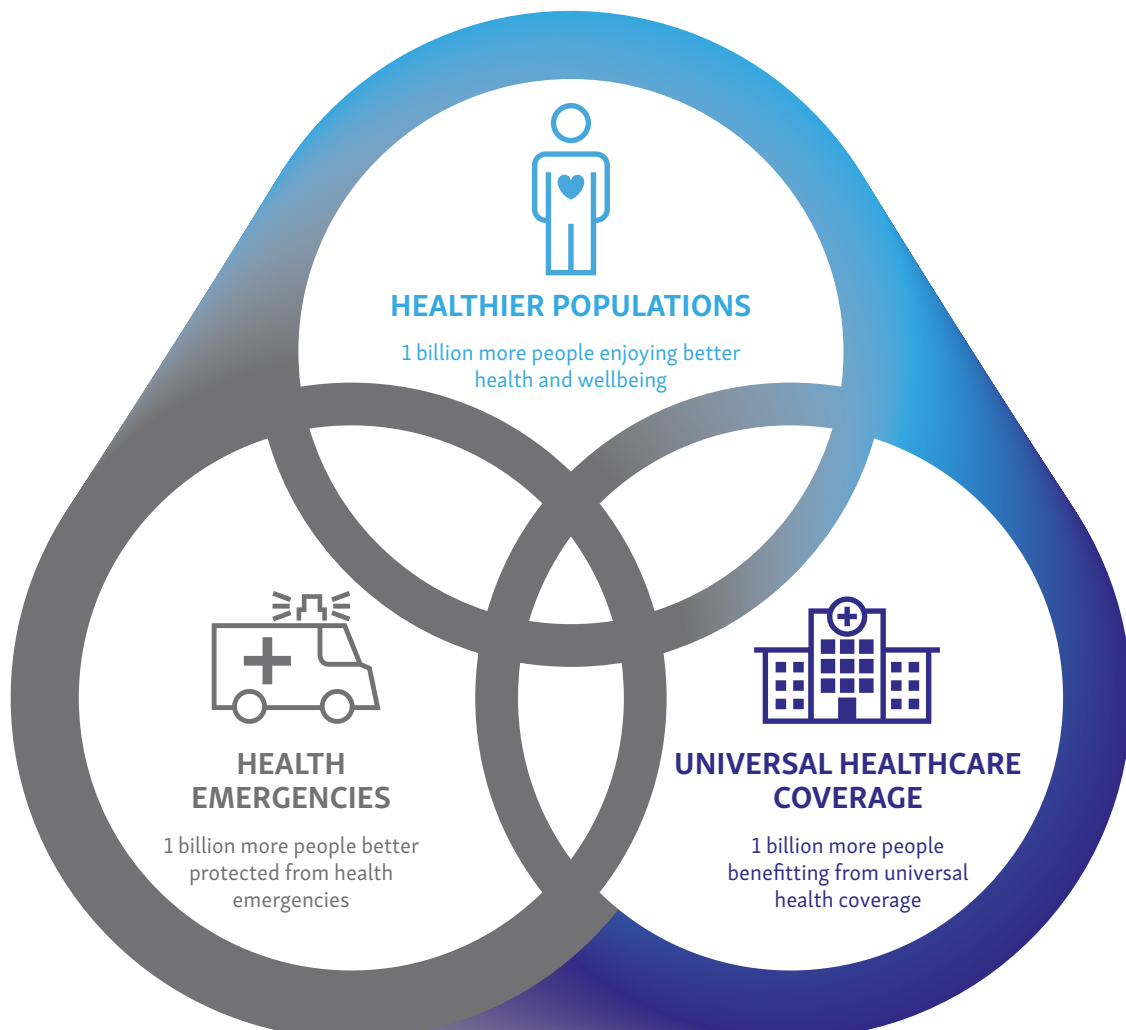
GLOBAL HEALTH CHALLENGE 1
THE DISEASES WE KNOW AND THE ONES WE DON'T: EPIDEMICS/PANDEMICS

"Epidemics on the other side of the world are a threat to us all. No epidemic is just local."

Professor. Peter Piot, London School of Hygiene and Tropical Medicine. Co-discoverer of Ebola in 1976

Among various large scale public health emergencies, infectious disease outbreak is one of the most imminent threats facing the general public.[18] As the frequency at which infectious disease outbreaks and epidemics have occurred, it demonstrates the public health threat to communities and the need to have strong and resilient health care systems. Infectious diseases can break out at any time and at any place, but their potency is greatest where there are weakened and unprepared health systems. Over the last few years, infectious disease outbreaks have occurred across the globe without warning. This includes the Ebola Virus in West Africa, Middle East Respiratory Syndrome (MERS) in Korea, Cholera in Yemen, Bubonic plague in Madagascar.[19]

These outbreaks are not new. 2018 marked the 100-year anniversary of the beginning of the great influenza pandemic of 1918 (commonly referred to as the Spanish Flu). Although estimates vary, the deaths directly attributed to the influenza were between 50-100 million people. This represented 5% of the world's population at the time. Half a billion people were infected (1/3 of the world).[20]

"If you would ask me the three things Philadelphia most needs to conquer the epidemic, I would tell you, 'Nurses, more nurses and yet more nurses' "

Philadelphia official, 1918[21]

The flu pandemic occurred during World War I when health systems were at their weakest. Nursing and medical staff were drained from health systems from around the world as most skilled health care workers were used to support the war effort in Europe (e.g. 80% of nurses from the East Coast of the USA).[21] This led to wide spread shortages of nurses.

As the influenza continued to spread with devastating effects, nurses were caring for 50 to 60 patients a day. Neighbours and even family members were often reluctant to help the sick fearing that they might become infected. Ultimately it was nurses who were there on the front lines until the end.

As part of the response to health workforce shortage during this time, many parts of the world commenced differing pathways of training health professionals.

Registered nurses were supplemented with practical nurses, who received shorter, six-month course of training. Evidence appears to indicate that the less trained workers and volunteers had increased infection rates and worse patient outcomes.[22]

> There is clear evidence that nursing care was crucially important and was the clearest predictor of survival.[21]

As the world and its economies become increasing globalised, inclusive of international travel and commerce, we must consider health in a global context. The Spanish Flu took 18 months to travel across the entire world. Today an infection can potentially travel from a remote village from anywhere in the world to any major city within 36 hours.[23] Outbreaks may begin where there are weak health systems and limited resources, but the pathogen can quickly spread and be a threat to any country.

The Centre for Diseases Control and Prevention (CDC) states, "While we can't predict exactly when or where the next epidemic or pandemic will begin, we know one is coming".[23] There are frequent news stories of the emergence or re-emergence of an infectious disease somewhere in the world. The 2007 World Health Report entitled 'A Safer Future: global public health security in the 21st century[24] states that "since the 1970s, newly emerging diseases have been identified at the unprecedented rate of one or more per year."

> **80%**
> of assessed countries not ready for an epidemic.[25]

There are many risks that outbreaks will occur and spread very rapidly within countries and across borders. Reasons for this include:

- Increased risk of infectious pathogens "spilling over" from animals to humans
- Development of antimicrobial resistance
- Spread of infectious diseases through global travel and trade
- Acts of bioterrorism
- Weak public health infrastructures[23]

Preventing the next epidemic and pandemic requires:

- **Surveillance systems** to rapidly detect and report cases
- **Laboratory networks** to accurately identify the cause of illness
- **A skilled and competent workforce** to identify, track, manage and contain outbreaks
- **Emergency management** systems to coordinate an effective response
- **Access** to safe, effective and affordable medicines

$6 trillion

Estimates show that pandemics are likely to cost over $6 trillion in the next century, with an annualized expected loss of more than $60 billion for potential pandemics. However, investing $4.5 billion per year in building global capacities could avert these catastrophic costs.[23]

Global health security: Every nurse has a role to play

When SARS struck 15 years ago, frontline health workers - especially nurses - were at the centre of the epidemic. The high number of nurses who contracted and died from SARS was due to their position as health care providers closest to infected patients, often without adequate infection control measures to prevent the spread of what turned out to be a new, highly infectious and easily transmissible virus.

Initial understanding of the importance of infection control in health settings dates back to 1858 when Florence Nightingale championed the need to 'do the sick no harm.' Since then, the knowledge and practice of infection control has improved in leaps and bounds, but substantial gaps remain especially on the front lines of health care. When the West Africa Ebola epidemic emerged in 2014, there was still a disproportionately heavy toll on nurses and other frontline health workers. More than 500 died from Ebola during the course of the outbreak.[26] The lessons learned from SARS and countless epidemics before had not yet been fully applied, especially in resource poor settings, with the same tragic outcome for health workers.

In part catalysed by the huge loss of life from the Ebola epidemic, there is renewed global momentum to improve countries' abilities to find, stop and prevent infectious disease outbreaks. With one new pathogen identified every year on average, the next epidemic is not a matter of "if", but "when." A global pandemic could kill millions, cost over 600 billion dollars in health costs and economic losses and take years for the world to fully recover.[27] It is clear that we need to be better prepared, particularly on the front lines where an infectious disease outbreak will likely hit first and hardest.

Because a disease threat anywhere is a threat everywhere, global health security recognises that the world is responsible for helping countries strengthen their ability to find, stop and prevent infectious disease threats. That is why to date, 86 countries have completed the Joint External Evaluation (JEE), a voluntary, collaborative and multisectoral process that assesses the ability of each participating country to find, stop and prevent public health risks. The JEE helps countries identify the most critical gaps within their health systems to strengthen their ability to prepare for and respond to health threats. Of those 86 countries, the vast majority are not prepared to fully address infectious disease threats.[28]

Filling these preparedness gaps is critical and the frontline health care workforce will be central to these efforts, not only in preparing to prevent and control infectious disease but also to ensuring health services can continue during a crisis. Nurses often make up the core of both response teams and central health care systems, During the West Africa Ebola epidemic, lack of access to safe health care services such as maternity care, vaccination programmes and malaria treatment led to a significant number of deaths and damage to the health system which took years to recover. Epidemics impact the whole health system.

Ensuring the safety of nurses through the uptake of immunisation, proper infection control practices and access to appropriate resources, such as correct personal protective equipment, is critical for staff safety and can also limit the spread of nosocomial infections.

Hospital acquired infections can be a major driver of outbreaks, causing significant clusters of cases and impacting the spread and control of the outbreak. Guaranteeing a safe environment for staff and patients ensures trust in the health system by staff and the community and supports the ability to deliver effective care for all.

Five specific things you can do as a nurse:

1. **Ensure quality infection control practices and procedures are implemented at all times.** Frontline health workers are often among the first casualties of a new infectious disease outbreak, and consequently can act as super spreaders to family, friends and colleagues. Being immunised and practicing proper infection control ensures you and your patients are protected from avoidable infection.

2. **Undertake a JEE** and advocate for participation. Issues affecting the front lines of health care are frequently overlooked during high-level programme planning and implementation, and nurses play an important role in advocating for patient-centred care and response. You can find out if your country has completed a JEE, and their score, at www.preventepidemics.org. Ensure the voices and expertise of nurses are represented in the planning and review of health security at all levels.

3. **See something, say something.** Nurses are the eyes and ears of the health system. Early detection of unusual events is critical in identifying and responding to outbreaks, especially of new or emerging infections. An unusual presentation to a clinic or hospitals can be the first sign that a new outbreak is occurring. Nurses should ensure that surveillance data is properly reported and acted upon. Early reporting can lead to swift action preventing a localized outbreak from spreading further. You can identify what system is in place to report infectious diseases and support other members of your health care team to respond and report appropriately.

4. **Participate in preparedness planning and simulation exercises.** Nurses should consider how their clinical or practice area would be impacted if an outbreak occurred. Nurses should contribute to the development of contingency plans in the event that the normal chain of care is disrupted and determine how to deliver normal day-to-day operations during and after a public health emergency. You can identify what infection prevention and control measures would be needed to continue service delivery during an outbreak?

5. **Lead.** Most importantly, nurses must take a greater role in leadership in epidemic preparedness so that plans, resources and response are both evidence-based and patient centred. Strong, consistent and knowledgeable leaders can inspire others and support professional nursing practice, including provision of quality patient care and resilient health care systems that have the capacity to address any health threat. **You can be a Voice to Lead.**

When the next epidemic hits, the outcome will improve if nurses and other frontline health workers have been involved in all aspects of epidemic prevention and response. They will act swiftly and decisively knowing they are protected, allowing them to provide the level of care needed to minimize disease spread and impact. Epidemics are inevitable, but we can and must be as prepared as possible. Nurses will be on the front lines of health security preparedness efforts, and ensuring their success is a crucial way to keep a minor outbreak from becoming a devastating epidemic.

The interconnectedness of global health, UHC and population health

The linkage of UHC is vitally important to global Health Security. Past epidemics, such as the Ebola outbreak in 2014, were largely limited to specific regions, such as West Africa, where countries have weakened health systems. Many other epidemics that caused global concern have occurred in those areas where health systems are unable to perform public health functions. Heymann et al[29] state that the "promotion of health security therefore entails ensuring that effective health systems exist before a crisis, are sustained during and after conflict and disaster, and are at all times accessible to the population."

$ 1.6 billion
(US$) the economic impact of the Ebola virus in 2014.[30, 31]

UHC has the potential to mitigate the risks of global health security through a number of different ways. First, it provides the opportunity for early detection which can dictate the length and severity of an outbreak through earlier intervention. It can improve people's access to health services through the removal of financial barriers and protecting people from financial ruin.

This means that people are willing to seek health care earlier preventing the possible further spread of the disease and earlier treatment. UHC builds trust within the community, enabling people to come forward earlier when an infection starts and ensuring that people are more likely to follow the advice of the health worker. The benefits become clearer as strengthening health systems leads to progress towards both UHC and global health security.

"Make global health about care, not fear".

"…Global health is often described as a lexicon of threats, whether from antimicrobial resistance, climate change or epidemics. Safety and security are certainly critical elements of the health systems agenda. But if the rhetoric of fear overcomes that of care, the best-resourced health system will be ineffective in delivering good health equitably. The dream of universal health coverage will be elusive. The WHO has a key role in ensuring that questions of global health security are never divorced from inclusivity."[32, 33]

Photo Credit – Dilla Dijali

Case Study

COMMUNITY OUTREACH PROGRAMMES TO IMPROVE HEALTH AND WELLBEING – Uganda

Nursing staff and volunteers engaged by the Uganda Rural Fund are dedicated to improving the health and wellbeing of children and adults in Uganda rural communities.

Historically, Uganda had one of the worst health systems in the world. However, much has changed, and the country is steadily progressing in its performance. Some of its biggest hurdles to overcome is access to health services and the resources to provide those services.[39]

The Uganda Rural Fund (URF) seeks to improve the health and wellbeing of children and adults in rural communities. To achieve this, they focus on prevention and less on treatment. Much of this work is conducted through community health talks in villages and local schools.

Nursing staff and volunteers visit villages teaching basic health tips particularly related to personal and household hygiene and sanitation (washing hands, cleaning house and compound to remove stagnant water that usually becomes breeding ground for mosquitoes that transmit malaria, boiling water for drinking, washing hands after using latrines, food preservation, etc.)

The nurses build close relationships with the community and collaborate with the local Village Health Worker. Village Health Workers are generally the first responders, particularly with basic health education and health monitoring.

In addition to the health promotion and prevention activities, nurses provide clinics where basic health check-ups and treatments are undertaken. Any difficult cases are referred to the hospital.

The clinic facilitates HIV testing and counselling through a partnership with Uganda Cares! URF also engages in the struggle to prevent malaria which is a leading cause of death and disability in Africa. URF also providesa Women's Health Van which facilitates women and children to access treatment.

Case Study

QUALITY ASSURANCE MECHANISMS FOR EMERGENCY MEDICAL TEAMS – Bronte Martin, World Health Organization

Disasters and disease outbreaks can occur at any given moment and in any place in the world, often wreaking havoc and seriously disrupting and threatening lives in communities. In order to reduce the avoidable loss of life and the burden of disease and disability, coordination is key.[40] Emergency Medical Teams (EMTs) are an important part of the global health workforce. Any nurse, doctor or paramedic team coming from another country to practice health care in an emergency needs to come as a member of a team, which must have training, quality, equipment and supplies so it can respond with success rather than impose a burden on the national system.

The WHO EMTs Initiative was launched in 2016 to assist organisations and member states to build capacity and strengthen health systems by coordinating the deployment of quality assured medical teams in emergencies. When a disaster strikes or an outbreak flares, the more rapid the response, the better the outcome. To date, 22 teams have been classified with an additional 70 teams in progress, working towards classification.

The Global EMT Initiative enables countries to improve their own national capacity, which they are then able to use to assist other countries in emergencies. Host governments and affected populations can depend on EMTs to arrive trained, equipped and capable of providing the intervention promised. The EMTs Initiative facilitates and coordinates the placement of each team, with its unique individuals with various skills sets.[41] Victims and their families are assured that the clinical teams treating them are of a safe minimum standard.

With 22 years' experience as a registered nurse and 17 years in the Royal Australian Air Force Specialist Reserve, Bronte Martin has witnessed first-hand the destruction and devastation a sudden-onset disasters, outbreaks and other emergencies can have on a patient, their family and communities. With her experience, knowledge and skills to respond to the needs of a community, Bronte was engaged by the WHO EMTs Secretariat where she undertook a six-month secondment to develop and establish the Global Classification, Mentorship and Verification programme; ensuring validated, quality international emergency medical care is delivered in response to Sudden Onset Disasters.[42] Bronte is passionate about nursing and the leading role nurses play in the development of improved quality health outcomes. She believes that nurses are the core and frontline of the collective medical workforce, playing a critical role in contributing to national, regional and global emergency health response capacities.

GLOBAL HEALTH CHALLENGE 2
PRODUCT OF YOUR LIFESTYLE AND ENVIRONMENT – NON-COMMUNICABLE DISEASES

"NCD prevention and control should not be seen as competing with other development and health priorities, and solutions must be integrated with existing initiatives." HE Mr Joseph Deiss, President of the General Assembly

No matter where in the world, the evidence is clear the epidemic of NCDs is straining health systems budgets and diverting scarce resources away from other health and development priorities. As the Honourable Helen Clark once said, "NCDs hold back national and global economies and society".[34] NCDs rob people of their health, their wellbeing and their wealth. They create and further exacerbate vulnerable communities.

68% of Global Mortality
Is caused by either cancer, cardiovascular disease, chronic respiratory disease and/or diabetes.[35]

This is evident in the Pacific Region. As recently as the 1960s, diabetes was but a minor problem in the Pacific Islands. Today, every 1.3 days, a Tongan individual will lose part of his or her lower limbs to this debilitating condition.[36] This is not unique to Tonga, in fact the statistics are even worse in other Pacific Island such as Fiji where there are over 800 lower leg amputations every year.[37] This region faces some of the highest risks and percentage of population with NCDs in the world. WHO considers NCDs to be one of the biggest threats to health and development globally.[5]

In fact, WHO considers that the current Sustainable Development Goal target (3.4) of reducing mortality from NCDs by 30% by 2030 will not be achieved if the current situation continues.[5]

NCDs and the associated risk factors have strong correlation with the social condition in which people are born, grow, live, work and age. People living in poverty have a higher risk of dying prematurely from a non-communicable disease. Those living in low-middle income countries have twice the risk of dying prematurely from an NCD. The greatest burden of NCDs is from four main diseases – cardiovascular disease, cancers, chronicrespiratory diseases, and diabetes. Each of these diseases are largely preventable by addressing the following four risk factors: tobacco use, excessive alcohol, unhealthy eating habits and diets, and lack of physical activity.[5]

2/3 of NCD deaths are linked to
Tobacco use, harmful use of alcohol, unhealthy diets, and physical inactivity.[35]

Whilst the threat is real, action can be taken to stem the tide of NCDs. The good news is that in investing in evidenced based interventions provides a strong return on investment. WHO states that for every US$1 invested in an evidenced based strategy yields a US$7 return.[38] Therefore, not only will lives be saved and people's health improved, there will also be a major economic benefit, particularly to low-middle income countries.

Photo Credit – Melanie Rogers

Case Study

IMPROVING STROKE SERVICES
– Rita Melifonwu, Nigeria

According to the World Stroke Organisation, one in six people worldwide will have a stroke in their lifetime.[43] In Nigeria, stroke is now affecting more adults in their economically active lifespan, causing unemployment and poverty among stroke survivors. Stroke has reached epidemic proportions, affecting over 200,000 people a year, 46% of stroke survivors dying within three months and an additional 30% dying within 12 months.[44] Through a community-based service model, Stroke Action - a not-for-profit organisation working with stroke survivors, their carers, individuals and partner agencies to promote meaningful evidence-based and quality life after a stroke - provides a range of affordable and multidisciplinary stroke services to bridge the gap in stroke care and make basic stroke services available to the communities they care for.

Stroke Action is a nurse-led health care service and the only community-centred base rehabilitation in Nigeria, providing services to reduce the incidence, complications and the burden of strokes and to ensure stroke survivors and those at risk to get the help they need to be health and well.

As a nurse and patient advocate, Rita Melifonwu lobbied the Federal Ministry of Health to sign an MOU with Stroke Action Nigeria to implement a national Stop Strokes campaign incorporating a stroke assembly conference, stroke services development, a national stroke registry and a stroke strategy. Rita coached two stroke survivors

of working age to become Stroke Ambassadors, who have overcome social stigma and cultural barriers to engage in stroke advocacy and stroke policy decision making.

Patient Story

Onyinye, a 33-year-old graduate and former company manager, had a stroke and was dismissed from her employment due to her disability. Unemployed, she was unable to support herself, her widowed mother and younger siblings. She had limited mobility, was aphasic, had post stroke depression, and was socially isolated and marginalised. As a result of the support she received from Stroke Action, Onyinye successfully embraced her stroke recovery journey. She is now mobile, no longer depressed, a public stroke advocate, and is re-integrated back into her community. Onyinye is now a Stroke Ambassador Administrative Officer receiving above minimum wage income to improve her livelihood.

Figure 7: The value of preventing and controlling NCDs[38]
World Health Organisation, 2018
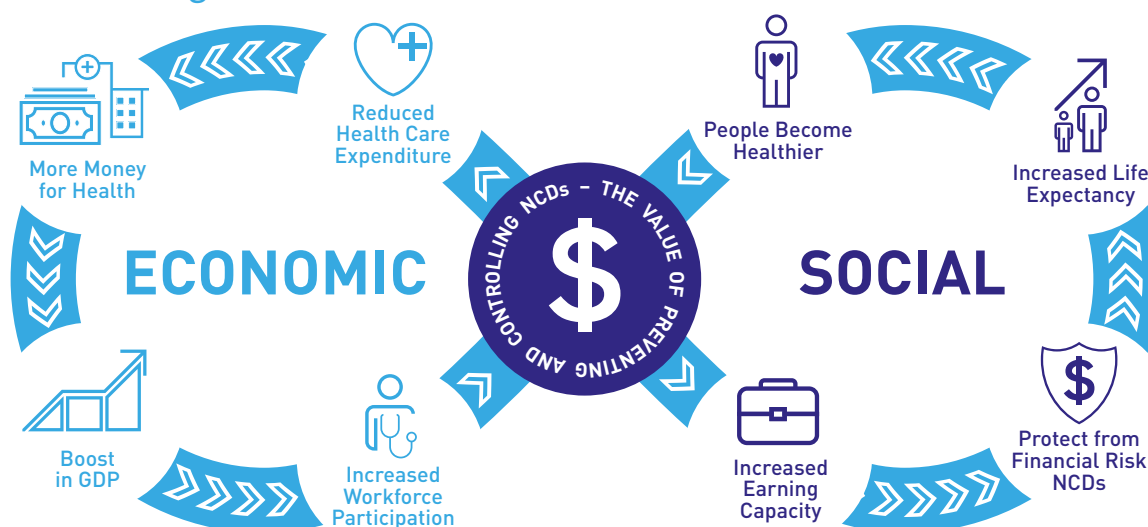
UHC and the health systems response to NCDs

One of the prime movers towards UHC has been dealing with the crises of infectious diseases and mitigating the risk of pandemics. But as NCDs have taken over communicable diseases as the leading cause of mortality, NCDs must be part of UHC frameworks. One of the core ways in which this could be achieved is the reorientation of PHC towards chronic disease management.

Primary care is for most patients the gateway to the health care system, yet in resource-limited settings most PHC is focused on acute episodic care delivered at secondary and tertiary centres. Models that do not focus on comprehensive Primary Health Care which are characterised by short term, episodic consultations will not meet the needs required to prevent and control the complexities of NCDs. These tend to focus on the diagnosis and immediate treatment of acute episodes or illnesses.[45]

Stronger primary care systems result in better health outcomes. Systems are stronger if they are more comprehensive, coordinated, community focused, universal, affordable and family oriented.[46] In order to achieve the best value and benefits out of PHC, it is essential that we move to a comprehensive model. The differences between a traditional approach to PHC and Comprehensive PHC are outlined in Figure 8.

We recognise that the best strategy to reduce the risk of NCDs is to address lifestyle and environmental factors which requires multi-sectoral action. However, for these efforts and opportunities to be realised, the health sector must be included as leaders. It is also crucial that NCDs are incorporated into UHC to close the NCD services gap and tackle the rates of unnecessary death and disability for those already suffering.

Figure 8: Moving towards a Comprehensive model of Primary Health Care[47]
Rogers & Veale, 2000

	TRADITIONAL PHC	COMPREHENSIVE PHC
View of Health	Absence of Disease	Positive Wellbeing
Locus of Control over Health	Medical Practitioners	Communities and Individuals
Major Focus	Disease Eradication through Medical Intervention	Health through Equity and Community Empowerment
Health Care Providers	Doctors	Multidisciplinary Teams
Strategies for Health	Medical Interventions	Multi-sectoral Collaboration

Five key features of a Health System organised to prevent, control and manage NCDs

1. Care Coordination
- Care coordination is any activity that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time.
- Care coordination is people-centred, team-based activity designed to assess and meet the needs of individuals and families, while helping them navigate effectively and efficiently through the health care system.[48]
- With the appropriate support, education and training, nurses are ideally placed to coordinate care, support and work across system boundaries and in close partnership with other team members and stakeholders, to ensure that individuals receive appropriate and timely care.

2. Multidisciplinary approach to care
- For people living with highly complex, ongoing problems, integrated and coordinated multidisciplinary care is required to address the broader range of personal, social and community challenges.
- Establish integrated relationships between health professionals so that practitioners can partner together as a team to treat patients. This would include joint involvement in developing treatment plans, joint monitoring of progress and jointly agreeing changes to treatment plans.[49]
- Processes and procedures must be established to manage competency of health professionals to ensure the quality of care
- Providing education and training for health professionals to assist in the transformational approach required for the delivery of appropriate health care for the prevention, promotion and control of NCDs[50]
- Standardisation of diagnosis and treatment to help ensure quality of standards for clinical care.

3. Working to the full scope of practice
- Providing access to quality education and training services at both undergraduate and post graduate levels to facilitate improved interventions in the prevention, promotion, early detection and control of NCDs.
- Support all registered nurses to include prevention of NCD in their practice and ensure nursing/clinical management roles are developed in Primary and Community Care.
- Strengthening the contribution of nursing leadership in policy and program decision making. This will require investment in nurse leadership and in nursing research related to NCDs, including efficacy and cost – effectiveness of interventions, and translation of knowledge into evidence-based practice.
- Increase the numbers of nurses specialising in NCDs to improve access to quality, cost effective and sustainable treatments.
- NCD supported self-management and nurse led clinical management maximises the use of technology. This will require Investment in sufficient numbers of registered nurses with skills and access to appropriate infrastructure and technologies within PHC to provide optimal care for the community.
- Harness the power of global nursing campaigns (i.e. Nursing Now) to lead the transformation and equipping of nurses across the world.

4. Improving access to care
- Nurses are the health professionals closest to the community – the first and sometimes only health professional that many people will ever see.
- They are part of the local community and understand its culture.
- Nursing philosophy, values and practice mean that nurses take a holistic and long-term view of patients and a bio-psycho-social- environmental perspective on health that encompasses the determinants of health as well as the care of patients.
- There are more than 20 million nurses' worldwide.

5. Empowering individuals and the community
Research shows that empowered, engaged patients have better health outcomes. WHO defines patient empowerment as "A process in which patients understand their role, are given the knowledge and skills by their health-care provider to perform a task in an environment that recognizes community and cultural differences and encourages patient participation."[51] Empowerment leads patients to increase their capacity to draw on their personal resources in order to live well and to navigate the health care environment.

Case Study

NURSE PRACTITIONERS PROVIDING HIGH QUALITY, COST EFFECTIVE CARE FOR WOMEN'S HEALTH
– Georgina McPherson, New Zealand

Advanced nursing practice in women's health has been well established internationally for more than 30 years. Georgina McPherson, a Nurse Practitioner (NP), developed the first nurse colposcopist training programme in New Zealand with Professor Ron Jones at the National Women's Hospital. She has been practising as a colposcopist for 18 years and in 2006 was endorsed as New Zealand's first NP in Women's health and first nurse of Pacific descent to gain NP endorsement. Her practice has spanned both primary and secondary care services, providing colposcopy and a well women's clinic in the community to improve access to care for Maori and Pacific women.

In New Zealand. NPs have been clinical experts within teams and are now becoming clinical leaders of teams. Through this recognition of the quality of service provision by NPs, Georgina was appointed as the clinical lead in 2016 with the approval of the Ministry of Health, a role previously reserved for medical practitioners.

Georgina is well recognised as a leader in her field providing frontline clinical care services that are excelling above the Colposcopy Quality Improvement Program standards and providing exceptionally high quality of care. Seeing some of the issues with access to services in her community, Georgina established a new clinical pathway. A laboratory utilisation project saw evidence-based guidelines implemented and a significant and sustained change in laboratory testing which has resulted in savings of close to NZ$100,000 over a 12-month period. It has also reduced unnecessary testing for women.

The benefits of an NP-led model of care has demonstrated NPs can provide a clinically and cost-effective care. There has been a reduction in cancelled Site Management Organization clinics due to the flexibility of NP to cover, and it has enabled the development of NPs into other areas of the gynaecology service. The development of a NP as a clinical lead has shown NPs can provide excellent clinical leadership and lead clinical services to improve quality of care and service provision.

GLOBAL HEALTH CHALLENGE 3
DELIVERING HEALTH OUTCOMES THAT MATTER TO PATIENTS AT A PRICE THAT COUNTRIES CAN AFFORD

Photo Credit – Karen Kasmauski

"For billions of people, universal health coverage will be an empty vessel unless quality improvement becomes as central an agenda as universal health coverage itself."

Sania Nishtar, Co-chair of the WHO Independent High-Level Commission on Non-Communicable Diseases.[52]

People-centred care has been a powerful movement over the last few years. But it is difficult to conceive how large and complex health systems that are striving for efficiency with busy professionals can incorporate this cost effectively as a central ethos. With such high demand combined with activity-based payment models, health care provision has tended to focus on scientific analysis and treatment with high volume turnover rather than the consideration of the patient as a person. Despite the acknowledgment of people-centred care as important, there are practical challenges to its implementation. However, achieving cost efficient care with improved health outcomes with people-centred care are not divergent philosophies.

The goal of health care is not more treatment, it is better health

Value based health care aims to achieve better health outcomes at an efficient cost. According to The Economist,[53] the health care system should move away from the supply-driven health care system around what physicians do and towards a people-centred approach around what the patient needs. When health systems partner with patients and their families, the quality and safety of health care rise, costs decrease, provider satisfaction increases, and the patient care experience improves. People-centred care also improves the business metrics of finances, safety and market share.[54]
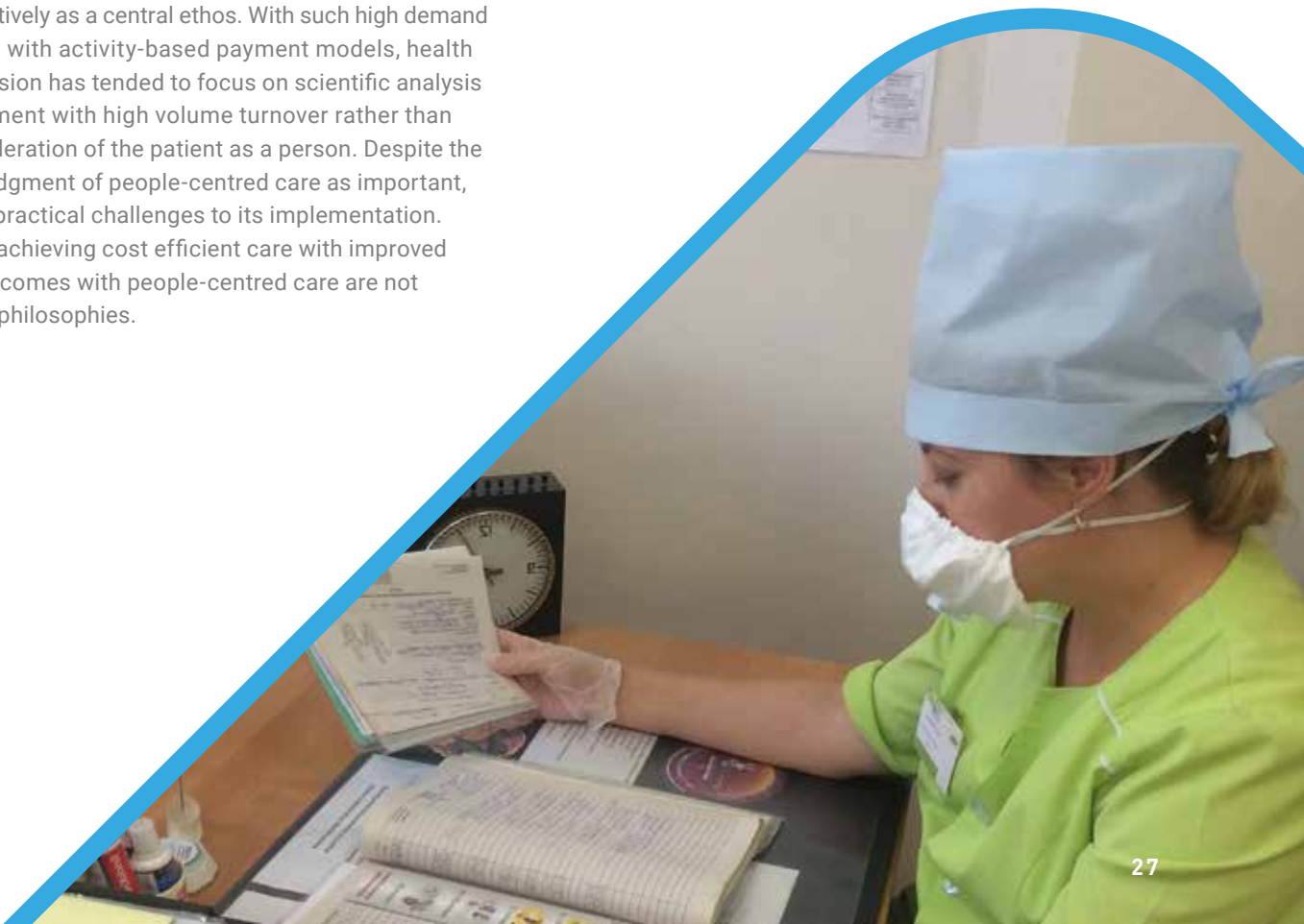
Case Study

NURSING AND END-OF-LIFE CARE
– Beke Jacobs, Germany

Demographics show that life expectancy of people worldwide is increasing. At the same time, options of medical treatment, particularly in western countries, are delivered at the highest of standards allowing for new treatments to the sick and dying. Often this raises the question of medical feasibility, considering the individual wishes of the patient. Consequently, there is a social mandate to reflect on the latter to what extent the individual wants to be medically treated in the case of illness, fragility and the end of life. This is especially important because therapeutic teams are frequently confronted with life –critical decisions in situations in which the patient can no longer express his or her will.

Beke Jacobs, a Registered Nurse and Head of the Patient Information Centre of the University Medical Centre of Schleswig Holstein Germany, provides a counselling services to support patients in the process of understanding the dimensions of end of life decisions decision and mandates.

There are many challenges that nurses face when managing patients who have moved into palliative treatment. Not only are there complicated legal requirements and aspects of wanted care regarding the precise and specific formulation of the advance directive, and empathising with the needs of the patient and their family members. Beke`s work is to inform and advise patients and their relatives in acute care situations in the hospital, public counselling on demand and during informative events, free of charge, organised by the hospital. With a written advance directive, patients can determine that certain medical measures are to be carried out or omitted, if they are no longer able to decide for themselves. This ensures that the patient's will is implemented, even if it can no longer be expressed autonomously in the current situation.

Nursing is a uniquely placed profession. It has the incredible responsibility of providing care and alleviating suffering, even in life's most vulnerable moments such as the process of dying. Experienced nurses have the training, skills and experience to empathise with patients, take into account medical interventions and their impact, the physical, cognitive, social and spiritual life situation, resulting in the ability to provide much care and support during the discussion of end of life care. Nurses provide a vital service in ensuring dignity and respect.

Value-based health care: is it the magic bullet?

At a recent health conference, the Health Minister opened the event with a speech that said that the Government had committed a further US$2 billion to the health system, a 15% increase over a three-year period. In this same speech, he committed to increasing the numbers of doctors, nurses and other staff within the health system. Whilst this may have been needed by the health system, the focus was not on delivering better health outcomes for the community but on the inputs that deliver health services. With increasing life expectancy, accompanied by the rise of chronic disease models, this business as usual approach is neither affordable nor sustainable. To continue to deliver accessible, high quality and people-centred care, governments and other policy makers will need to link health care costs with outcomes in order to improve value to patients, individuals and the community.

Health is an important precursor to happiness and is one of the key foundations of a strong economy, but there are enormous challenges in promoting a healthier lifestyle and providing access to quality and affordable health care. There are significant challenges for governments and health care providers to contain costs whilst at the same time improve the health and wellbeing of populations. Value based health care is an approach to the health system where there is a drive to improve patient outcomes at a lower cost. It is an approach that attempts to unite both the interests of the health system and that of patients.[55]

Value needs to be achieved at all levels of the health system, not just the hospital, specialty intervention or primary care. Value is created when care is provided across a patient's medical condition over the care lifecycle. When outcomesare improved, this is the most important aspect for driving value and reducing costs.[55]

Figure 9: Value

VALUE =

Set of outcomes that matter to patients for the condition.

/

Total costs of delivering them over the full care cycle.

Therefore, at the very core of value-based health care is maximising value for patients – that is achieving the best health outcomes where costs and effort is affordable, and expectations are achieved. It moves away from supply driven healthcare system organised around physician activity toward a person-centred system organised on what is most needed for individuals and communities. It shifts the thinking from what's the matter with patients, to what matters to patients' As Sir Robert Francis highlighted in the Mid-Staffordshire public inquiry in England, "Quality of care is about patient experience as well as outcomes, and decisions made with an impact on quality need to consider the views of patients to understand this".[56]

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8 million

Deaths occur in LMIC countries due to poor quality healthcare[52]

Many countries are unable to provide even basic health care services that deliver safe and effective care to their entire populations. Even those countries with UHC are struggling to meet the health demands of ageing populations, growing burden of chronic diseases, increasing life expectancy, increasing consumer expectations and escalating health care costs associated with new technologies and treatments. The sustainability of UHC is at risk unless health systems change and adapt to the changing environment.

3rd Leading cause of death in the USA are medical errors[57]
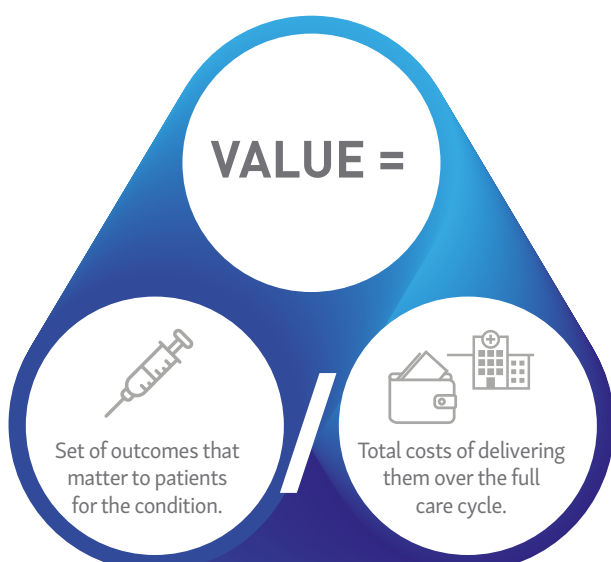
The premise of UHC is the provision of high-quality health care that is accessible to all at a price that is affordable to both the consumer and the country. This involves the right care provided at the right time and by the right provider whilst minimising harm and resource waste and leaving no one behind. Yet poor quality health care prevails in countries at all income levels. This includes inaccurate diagnosis, medication errors, inappropriate and unnecessary treatment, inadequate and unsafe clinical facilities or practices. For example, in low- and middle-income countries (LMIC), 10% of hospitalised patients can expect a hospital acquired infection during their stay (7% in high income).[58] According to some reports, in several LMIC,[59] health care providers could only make an accurate diagnosis 33-66% of the time with appropriate clinical guidelines followed 45% of the time. Some research has even suggested that even if access is improved around the world, the benefits to patients and communities will remain limited.[60]

A value-based health care approach can help implement a quality and affordable health system. Each country will require a different set of interventions depending on their need, but there are a number of basic and inexpensive interventions that are within reach for all countries. A value-based approach can help identify and fund services that will provide the greatest benefit to individuals and the community. Other benefits include:

- It puts the patient at the centre of the health care system.
- It orientates the health system to the entire continuum of health care rather than just treatment.
- It reorganises care around patient conditions, into integrated units.
- It measures outcomes and costs for patients, compares them, identifies areas of variations, and promotes excellence.
- It helps define success for the health care provider and the system.
- It drives multidisciplinary care and care innovation.
- It drives cost reduction that is truly value enhancing.
- It validates the areas for service line growth and affiliation.

"Even if the current movement toward universal health coverage succeeds, billions of people will have access to care of such low quality that it will not help them, and often will harm them"
Don Berwick, President Emeritus and senior fellow, Institute for Healthcare Improvement[52]

Value based health care and the role of nursing

Value-based health care is a driver of quality and affordable care and as such promotes PHC, effective population health management, improved patient and community engagement and interdisciplinary care and team collaboration. Progression towards these areas will increase the need for and elevate the role of registered nurses. For the health system to achieve the potential benefits offered by value-based health care, policy makers and health systems will need to ensure that the profession is equipped with appropriate education and tools and supported to work to their full scope of practice. An example of success in this area includes nurse-led chronic disease management where length of stay is reduced, health outcomes are improved, and emergency department admissions are reduced. Supporting nurses working to their full scope of practice and effectively utilising nursing leadership, health systems have and can transform health care delivery, achieving better health outcomes for individuals and communities at efficient levels of cost.[61]

The greatest area of advancement for the implementation and improvement of value-based healthcare is in the collection and analysis of nursing data. Information is pivotal to effective decision making and integral to the quality of health care and associated outcomes. Nurses work in an information intensive environment and there is much to gain by appropriately collecting it. This includes, but not limited to:

- Improved patient safety
- Improved understanding of patient health outcomes
- Efficient care coordination
- Enhanced performance analysis
- Timely access to more comprehensive patient information
- Improved utilisation of resources

Information technology systems that collect nursing data and information can revolutionise the health industry and assist in the development of a valued-based health system. Not only is efficiency improved, but there is improved experiences of staff, patients and families that will save countless lives and improve quality of life.

Case Study

IMPROVING THE TIMELINESS OF CARE WITHIN EMERGENCY DEPARTMENTS – Shirley Ingram, Ireland

Tallaght Hospital has the largest Emergency Department (ED) in Ireland, with 48,000 adult attendances per year. There is high-level use of ED use by residents in the direct catchment; with 40% of household's surveyed utilising adult ED in the previous 12 months. Chest pain is a principal presenting symptom of coronary heart disease.

48% of all people presenting with chest pains were admitted often remaining on a trolley in the ED for days whilst awaiting an in-patient bed. Along with the suffering of the patient, this presented a real problem. Tallaght is a low socio-economic area in southwest Dublin with a high level of cardiac risk factors such as smoking and obesity. The Tallaght Hospital ED is one of the busiest in the country.

The Cardiology Advanced Nurse Practitioner led Chest Pain Service has delivered remarkable patient benefits in the last three years with limited resource investment including the avoidance of almost 600 inpatient admissions per year.

The overall aim of this innovative service is to discharge appropriate patients from the ED to the nurse-led chest pain clinic for further assessment and testing. This provides a safe, competent service to the patient whilst avoiding admission.

Within the first-year of the Cardiology Advanced Nurse Practitioner led Chest Pain Service admissions to the ward reduced by 36%, and to ED trolleys by 60%, contributing to significant savings for the hospital. Patients also receive a timely diagnosis, health promotion and reassurance.

Case Study

NURSING'S ROLE WITHIN AN INTERDISCIPLINARY TEAM TREATING CHILDREN WITH ASTHMA
– Minna Miller, Canada

When nurses and nurse practitioners work to their full scope of practice in interdisciplinary teams, both patient and organisational outcomes improve. Research has shown that interdisciplinary team-based approach to paediatric asthma care reduces emergency department visits and hospital admissions and that asthma education improves outcomes.

Asthma is a chronic, inflammatory disease of the airways characterized by bronchial hyper-reactivity and variable airway obstruction, resulting in recurrent episodes of wheeze, cough, chest tightness and breathlessness. It affects nearly 300 million people worldwide, and is the most common chronic disease in the paediatric population.

The Children's Hospital interdisciplinary asthma clinic provides services to children in need of a diagnosis or already diagnosed with asthma, many of whom have multiple co-morbidities and vulnerabilities related to social determinants of health. The clinic may be one of a kind in Canada with nurse practitioners (NPs), certified asthma educator registered nurses, a respirologist, allergists, pediatricians, respiratory therapists, and allergy technicians all working together to provide comprehensive, family-focused, patient-centred asthma services to children. The aim is to improve access to comprehensive asthma services (diagnostics and diagnosis, management and education), and to improve patient outcomes (improve asthma control, reduce impairment and future exacerbations and related sequelae).

The NPs function autonomously and provide asthma diagnosis, management and education. As a result, paediatricians are able to focus their attention on asthmatic children with multiple, complex co-morbidities. Certified Asthma Educator Registered Nurses provide comprehensive asthma education to patients and families across all of the above tiers of service within the clinic.

The interdisciplinary asthma clinic is a "one-stop-shop" for comprehensive asthma diagnostics, diagnosis, management and education. Between 2012-16, 5,200 patient/family encounters (including telemedicine) have been delivered with over 60% of these being provided by NPs. The clinic is the provincial centre of excellence for paediatric asthma care. The team structure facilitates appropriate use of clinic resources and has resulted in significant reduction in wait times for new patient visits/consultations from 12-14 months to two-three months. Clinic data demonstrates a significant improvement in asthma control, reduction in emergency department visits and hospitalisations for those who have received care at the asthma clinic.

Case Study

INTRODUCING DISASTER PREPAREDNESS COURSES INTO THE SCHOOL OF NURSING CURRICULUM
– Manar Nabolsi, Jordan

Disaster preparedness education programmes have been introduced to the University of Jordan nursing programmes to assist with the training of nurses to participate in efforts to manage the impact that disasters have on the region.

Jordan is in a high-risk earthquake prone area that is also vulnerable to flash floods and landslides in both populated urban areas and rural regions. The impacts of climate change are felt heavily in this part of the world where hazards such as extreme drought devastates the region at regular intervals, Jordan has long been a nation of refuge for people fleeing violence in neighbouring countries. The recent influx of over 600,000 refugees has placed the country's essential services, such as health care, under significant strain.

The University of Jordan has introduced disaster preparedness into its Undergraduate and Postgraduate Nursing education programmes. The aim of these additional education programmes is to prepare nurses to participate in the national efforts to prevent, mitigate, manage and recover from natural and human made disasters. To date, 150 Bachelor degree nursing students, 50 Masters students and 10 PhD students have attended the course. This is the first of its kind for the region and is supporting nurses working for international organisation providing services for Syrian refugees.

GLOBAL HEALTH CHALLENGE 4
A MOVING WORLD

Populations have been on the move for at least the past 60,000 years. However, the nature and demography of migration has changed. Globalisation has facilitated modern migration causing an increase in the volume, diversity, geographical scope, and therefore complexity, of international migration.[97] People migrate for many reasons including conflict, poverty, disasters, urbanisation, lack of rights, discrimination, inequality, and lack of access to decent work.

Health challenges of migrants, refugees and displaced persons

Numbers of refugees and asylum-seekers from Central America have increased five-fold in only three years. Honduras is plagued by political, economic and social instability and has one of the highest violence rates in the world. Families are threatened, extorted, and murdered and boys and men are forced to join gangs. In the migrant shelter in Reynosa, Mexico, a border city that is often used as a passageway for asylum seekers to the USA, Médecins Sans Frontières (MSF) and its teams of nurses, doctors, psychologists and social workers are caring for the influx of individuals fleeing their home country. They tell stories of not eating for days and sleeping in bus stations. They are often victims of physical and sexual violence, malnourished, dehydrated and neglected.[98]

> ### 244 million
> Total number of migrants worldwide.[75]
>
> ### 175.5 million
> Number of migrants have moved voluntarily.[75]
>
> ### 68.5 million
> Migrants forcibly displaced due to risk of persecution, violent conflict, food insecurity or human rights violations.[75]

In just over one year, 723,000 Rohingya refugees have fled to Bangladesh from Myanmar and the rates are not slowing.[99] UNHCR reports that families arrive by foot having walked through jungles and over mountains for days with little food and suffering various illnesses. Once arrived, they join the existing 600,000 people living in the 13km^2 settlement. They face issues of access to basic health services, high levels of communicable diseases, particularly respiratory infections and diarrheal diseases, and the risk of landslides and floods.

> ### 44,400 people a day are forced to flee their homes because of conflict and persecution.[75]

These are just two of hundreds of examples of scenarios that migrants, refugees and displaced persons (MRDPs) often face. Migration affects several determinants of the health and wellbeing of people, families and communities as well as population health. The impact of migration on health and wellbeing is multidimensional and presents a complex set of challenges to the determinants of health.

It is often incorrectly assumed that the health care needs of MRDPs are similar and equal across groups. The physical, psychological, spiritual, cultural and social needs of families and individuals can vary markedly and are influenced by a number of factors.[100, 101] The health care needs of groups forcibly displaced from Syria will be vastly different than economic migrants landing in Australia.

Another assumption is that the health of MRDPs is poorer than that of the destination country's population. The conditions faced during the migration process can vary with factors such as the reason for migration, the conditions during transit and the destination. However, as many MRDPs are forcibly displaced, their health care needs may be aggravated by deprivation, physical hardship, and stress occurring throughout the migration process. More complexities evolve from legal, economic and social exclusion that may occur during transit and upon arrival to their destination. MRDPs may also experience discrimination, violence, exploitation, detention, limited or no access to education, human trafficking, malnutrition and limited or no access to preventative and/or essential health care services.[101]

But this is not always the case, many migrants move without incident and have high levels of health upon arrival to their destination. Differing health and cultural practices may have protective effects and have a more positive impact on health and wellbeing compared to common practices in the destination country. The 'healthy immigrant effect' is well-documented in the literature.[102] With the exception of some higher rates of infectious diseases, including TB and HIV, immigrants are often healthier than the population of the receiving country. As such, sweeping assumptions on the health status of MRDPs should not be made.

There are, however, certain priority health issues that must be focused on. Children, women, older persons, and people with disabilities have particular vulnerabilities and are often exposed to discrimination, exploitation, and physical, sexual and psychological abuse.[101] Sexual and reproductive health needs should be prioritised as the risk of sexual and gender-based violence (SGBV) is increased by the migration process. Furthermore, SGBV is commonplace in conflict situations and is increasingly being used as a weapon of war.

In 2017, 50% of refugees were children under 18 years of age.[75] Many have been separated from their families and are unaccompanied. Children are particularly vulnerable and focused efforts must be made to minimise the impact of migration on their health and wellbeing.

Over 40%
In the Kutupalong settlement in Bangladesh, over 40% of children are stunted.

Mental health should also receive top priority. The negative experiences of MRDPs noted above, coupled with potential pre-immigration factors and high levels of stress, lead to higher rates of mental distress. MRDPs are at a heightened risk for mental health disorders including PTSD, depression and psychosis which is further exacerbated by the often lack of social support and mental health care at the destination.[103]

Story of Joseph, oversees nursing in refugee camp in South Sudan.

Migrant health – a cornerstone of UHC

While MRDPs may face specific health challenges, the goal is to make quality health services accessible for all. No matter the location and setting, health care should be available. Migration will be key to achieving the SDGs and UHC. The importance of migration on development is clear – it is interconnected with at least eight of the SDGs including health, education, poverty, gender equality, decent work, sustainable cities, and climate action.

1 in 3
Syrian refugees suffers from depression, anxiety and symptoms of PTSD.

Equal access to health care is a human right. However, this right is all too often violated by the multiple barriers to accessing the level of health care needed by MRDPs. The changing patterns and increasing complexity of population migration increases the risk of the health needs of migrants going unmet. At the individual and family levels, factors affecting access include the ability to navigate the health system, previous experience with and expectations of health care, language and cultural barriers, shame/stigma, fear of deportation, lack of financial resources and health beliefs and attitudes.[104, 105]

The inability of some countries to respond appropriately is in part due to historical migration patterns which have formed the policies, programmes and strategies of health systems that are often still in place. Furthermore, health care provision is often within the context of legal or administrative status of individuals. Many MRDPs are irregular and undocumented and this poses a particular barrier to accessing health care services.[106] Health programmes are often based on the difference in health indicators between the migrant population and the general population of the country.[100] As migration patterns have changed, these programmes are no longer adequately addressing MRDP health needs. Often, MRDP health is not integrated into national and regional plans and countries are not prepared for the additional burden on their health and social systems.

The paper 'Health, Health Systems, and Global Health'[100] considers migration health as a unifying agenda, bringing together global health, sustainable development and social determinants of health (Figure 10). This model presents the phases of migration as integrated rather than limited to the arrival phase, where the focus is often placed. It also acknowledges both MRDP populations secondary to a crisis and structural population migration that occurs over time.

Figure 10: Developing an integrated and dynamic approach to improve the health of migrants Adapted from 100

MIGRATION HEALTH – A UNIFYING AGENDA

LARGE, CRISIS DRIVEN, ACUTE INFLUX OF REFUGEES AND MIGRANTS

STRUCTURAL,LONG TERM, ECONOMIC AND DISPARITY DRIVEN POPULATION FLOWS

VULNERABILITY & RESILIENCY

To reduce vulnerability and enchance resiliance of migrants, host communities and systems, calibrated along the **social determination of health model and equity in migrants health.**

GLOBAL HEALTH

To promote preventive and curative health approaches to reduce disease burden in migrants and affected host communities, calibrated along concepts:

Universal Health Coverage (UHC) Primary Health Care (PHC) Health System Strenthening (HSS)

DEVELOPMENT

To ensure health of migrants are made an integral part of human and sustainable economic development, calibrated along the:

Sustainable Development Goals (SDGs)

Monitoring Migrant Health, Evidence, Research and information dissemination

Advocacy for conductive, cross-sector. **Policy and Legal Framework Development**

Direct Services & Capacity Development to create **Migrant Sensitive Health Systems**

Strenthening multi-sector and inter-country **coordination and partnership**

ORIGIN

TRANSIT

DESTINATION

RETURN

SDH

Structural and policy factors

Contextual factors

Individual factors

Social factors

PHC / HSS / UHC

People Centered Health Services

Cross-border health

Global health goals

Health Systems

UNDERLYING PRINCIPLES

Rights besed
Gender
Equity
Multi-sectoral
Research based
UHC

SDG

Social and technological innovation

Health of migrants and their families

Migration health for development

Migration health in SDGs

There will be considerable differences in health services depending on national realities and capacities that are determined by laws, regulations, policies and priorities. However, migration must be tackled in a cooperative and comprehensive manner. The WHO Framework for the Health of MRDPs sets out the following guiding principles for the health of MRDPs:[104]

- The right to the enjoyment of the highest attainable standard of physical and mental health

- Equality and non-discrimination

- Equitable access to health services

- People-centred, refugee- and migrant- and gender-sensitive health systems

- Non-restrictive health practices based on health conditions

- Whole-of-government and whole-of-society approaches

- Participation and social inclusion of refugees and migrants

- Partnerships and cooperation.

Not only must we ensure the health and wellbeing of MRDPs, we must have strong public health systems that are effective at preventing and responding to large movements of people. Population movement threatens to increase the spread, potentially uncontrollably, of communicable diseases. In 2014, the world witnessed an Ebola outbreak that spread faster and further than it ever had before. It devastated the already fragile health systems of Sierra Leone, Liberia and Guinea who were not prepared to deal with an epidemic of this magnitude and medical complexity. Furthermore, the near collapse of the health systems of these countries led to a deterioration in education systems, public safety, and the economy. This and similar recent public health events have shone a spotlight on the importance of migration on global health security.[100]

The nursing role in ensuring access for one of the most vulnerable population groups

MRDPs are likely to encounter a nurse during the first interaction with the health care system. Nurses are proficient at providing ethical, culturally- and gender-sensitive and dignified care to MRDPs and their families that acknowledges the inter-connectedness of their physical, psychosocial, spiritual, cultural and social needs and challenges. This is essential to increasing and ensuring the acceptability of health services which is a key component of health care access. Nurses are encouraged to continuously develop and enhance their own cultural competence and ensure it is incorporated into care delivery.

PHC remains the most important tool for progressing UHC. It is often the first point of contact in the health system for MRDPs. Nurses are both leading PHC initiatives and are on the frontline of primary care. Nurses can build trust and establish supportive relationships at the initial encounter and thereafter which will facilitate future access. The nursing role is one of health care provider, educator, care coordinator and advocate. Nurses act as the professional maintaining crucial links between individuals, families and communities and all areas of health and social systems. High-levels of collaboration and service integration across these systems will help reduce barriers of access to care. Nurses play an important role in cooperative actions to address the immediate and long-term health and nursing care needs of MRDPs and work to prioritise sexual and reproductive health issues, age-related vulnerabilities, gender-based violence and mental health.

The WHO Framework sets out priorities to promote the health of MRDPs.[104] In their roles as clinicians, educators, researchers, policy influencers and executives, nurses can and are contributing to achieving these priorities. They include:

- Advocate mainstreaming MRDP health in the global, regional and country agenda and contingency planning

- Promote MRDP-sensitive health policies, legal and social protection and programme interventions

- Enhance capacity to address the social determinants of health

- Strengthen health monitoring and health information systems

- Accelerate progress towards achieving the SDGs including UHC

- Reduce mortality and morbidity amongst MRDPs through short- and long-term public health interventions

- Protect and improve the health and wellbeing of women, children and adolescents living in refugee and migrant settings

- Promote continuity and quality of care

- Develop, reinforce and implement occupational health safety measures

Philomena in Nigeria, cares for malnourished children.

• Promote gender equality and empower MRDP women and girls

• Support measures to improve communication and counter xenophobia

• Strengthen partnerships, intersectoral, intercountry and interagency coordination and collaboration mechanisms

Culturally competent care respects diversity in race, ethnicity, age, gender, sexual orientation, disability, social status, religious or spiritual beliefs, and nationality; recognises populations at risk of discrimination; and supports differences in health care needs that may result in disparities in health care services.

Promoting and protecting the health of migrants is essential in achieving UHC and should be an integral piece of any UHC strategy. Migration also heavily impacts Sustainable Development Goals and targets, not only those that are health-related but several others on the agenda. Ensuring high quality health services protects global population health and leads to social and economic development. Above all, equal access to quality health care is a human right. The impact of migration on the health and wellbeing of individuals, families and communities is complex and multifaceted. An integrated, collaborative whole-of-society approach is required if we are to address this situation and nurses are pivotal in the success of ensuring Health for All.

Photo Credit – ICN International Council of Nurses

Case Study

Photo Credit – Stephen Gerard Kelly

PROVIDING HEALTH CARE TO IMMIGRANTS
– Rebecca A. Bates, USA

Refugee populations in the US are often unable to access health care services because of policies and payment schemes that create barriers to care. Adams Compassionate Healthcare Network (ACHN) removes many of these barriers. A free clinic in suburban Virginia, ACHN seeks to provide high-quality, evidence-based health care to any person who is uninsured and lives in poverty. Most of their patients are immigrants and refugees from Muslim-majority countries, living with chronic conditions. They are often uninsured and have had little opportunity to access health care services in their countries of origin. Some individuals have barriers related to transportation which causes them to forgo health care services in deference to obtaining food, housing and jobs. This leads to missed work time and hospitalisations for uncontrolled diabetes, hypertension, cardiovascular disease and undiagnosed cancers. Most of ACHN's patients also have financial and literacy barriers.

As a primary care site, ACHN covers most of their patients' needs, including: primary care; referral to specialty care and social services; monitoring and evaluation of chronic diseases; impact assessment through chronic disease registry to help identify the highest-risk patients for targeted interventions; calculating the cost of care for all services provided; and advocating for Medicaid expansion and refugee-friendly policies. This model of care allows for holistic evaluation and treatment of all patients. Telehealth has been implemented as a tool to improve connection with patients and as a way to bring in translators as needed. Community partnerships with specialists and social services help address food, housing and job insecurity to ensure patients are able to access the services they need to optimize health and wellness.

Since the clinic started five years ago, nearly US$1 million in services has been provided to care for 1500 uninsured individuals. In the past year, patient visits have increased 31%, volunteer hours increased by 207%, and an on-site physical therapy, eye clinic and pain management started.

Patient Story

Asha*, a recent refugee from the Iraq, presented with a six-month history of a breast lump that she had been unable to have evaluated because of lack of access to services. ACHN provided the diagnostic workup and care navigation into the treatment she needed to treat her breast cancer. They helped her apply for charity care at the local hospital; coordinate her specialist appointments; and continued to provide primary care services throughout and after Asha's treatment.

*Not her real name

GLOBAL HEALTH CHALLENGE 5
OUR MENTAL HEALTH AND WELLBEING

Photo Credit – ICN International Council of Nurses

"The current approach that psychiatry takes almost ignores social worlds in which mental health problems arise and tries to become highly biomedical like other branches of medicine such as cardiology or oncology. But psychiatry has to be far more embedded in people's personal and social worlds." Dr Vikram Patel, Co-Director of the Centre for Control of Chronic Conditions at the Public Health Foundation of India

Undervalued and underinvested

Even in modern health systems around the world, the health system is failing to meet the needs of people presenting to hospitals in mental health crises. The system is failing to the extent that mental health patients are more likely to wait longer than other patients to be assessed and treated. As a result, many mental health patients leave the emergency department at their own risk and against advice.[62]

<2US$
The level of mental health expenditure in LMIC.[63]

Access to quality and affordable mental health services is currently at crisis levels. WHO estimates that nearly two-thirds of people with a known mental health problem never seek help from a health professional. Stigma, discrimination and neglect prevent care and treatment from reaching people with mental disorders.[64]

Mental Disorders
Represent the largest cause of disability and disease in the world.[63]

Where care is provided, human rights violations remain a common feature where people may be abused, forcibly detained or locked away. The quality of care is also inadequate – for example for those with depressive disorder, only one in five people in high income countries and one in 27 people in LMIC receive minimally adequate treatment.[65]

1.1 billion
People with any mental disorder or substance use disorder.[66]

These statistics highlight national and international shame. Action lies with our governments and they are in part responsible for the circumstances that we are in.

The Mental Health Atlas[63] shows that 40% of countries have no mental health policy and over 30% have no mental health programme. In addition, one in four countries have no legislation protecting and promoting the health and being of populations.

275 million
People suffering from anxiety disorder.[66]

This situation, by any standard, is a global tragedy. Urgent reform and investment are required to meet the health and wellbeing needs of people suffering from the world largest cause of disability and disease in the world – mental disorders.

Mental Health for All

Across the world, care for mental health and substance abuse disorders are poorly resourced. With the inclusion of targets and indicators within the SDGs, there is the possibility that many people if not millions will be able to receive the care they need. However, for this to be a reality, there must be mental health coverage for all

and social inclusion. A change in public attitude and inclusion within societies will be required so that barriers to the health care are removed and the determinants of mental health are addressed. It is well known that there are multiple social, psychological and biological factors that can determine the level of a person's mental health at any point of time. Action, therefore, will need to be taken across multiple levels, however first and foremost mental health must be better integrated into the public health agenda and within PHC.

Mental Health does not discriminate.

Recently an Australian Billionaire stood down from his board position from the region's largest Casino and Resort industry as a result of his on-going battle with depression and anxiety.

As an important step forward in addressing the problem, the WHO High-level Independent Commission on NCDs included mental health conditions as an NCD. Both NCDs and mental health are largely affected by the environment and the social circumstances in which people are born, raised, play, work and live. They also share many of the same features:[67]

- Mental conditions are often determined by the environment and social circumstances in which people live, and their exposure to risk factors (e.g. diet, exercise and use of alcohol and drugs)

- Mental conditions can occur at any time of life and are often long-lasting (chronic) and require long-term management and support rather than one-off treatment.

- Mental conditions often occur in conjunction with other physical NCDs. People with mental illness tend to have worse health outcomes than the general community.

10-25 year

Life expectancy reduction in patients with severe mental illness.[68]

The World Federation of Mental Health recommended six priorities to the WHO High Level Commission on NCDs to address mental health conditions. These are outlined in Figure 11.

"Waiting and waiting and waiting, and feeling like it would never end."

Mental health patient waiting for care in an Emergency Department[69]

Figure 11: Six priorities in addressing mental health challenges

PRIORITY 01

PUT PEOPLE FIRST

Need to listen and actively include people with these conditions as we prioritise mental health in policy and action

PRIORITY 02

BOOST NCD INVESTMENT

Invest in mental health. Allocating more funds for mental health. Funds dedicated to mental health have 4 fold return on investment

PRIORITY 06

IMPROVE ACCOUNTABILITY FOR PROGRESS, RESULTS AND RESOURCES

Track mental health progress and hold people to account, support scaling up of care

PRIORITY 03

STEP UP ACTION ON CHILDHOOD OBESITY

Approximately 1/2 of mental health conditions start in early childhood and risk factors should be addressed early. Promoting healthy lives, including lifelong healthy nutrition and exercise

PRIORITY 05

SAVE LIVES THROUGH EQUITABLE ACCESS TO NCD TREATMENT AND UHC

Combine delivery of care across mental health and NCDs and increase health coverage, especially in PHC

PRIORITY 04

ADAPT SMART FISICAL POLICIES THAT PROMOTE HEALTH

Implement policies that reduce tobacco and alcohol use, improve nutrition, implement population mental health strategies

In moving the NCD agenda forward, the United Nations General Assembly adopted a resolution[70] on 10 October 2018 entitled "Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases." ICN welcomes and supports the actions agreed in the resolutions, in particular:

- The 'whole of government' and 'health in all policies' course of actions

- The development of comprehensive services and treatment for people living with mental disorders and other mental health conditions

- Promote access to affordable diagnostics, screening, treatment and care.

Whilst we applaud these strategies, ICN is concerned about the lack of recognition of the health workforce role in the care, advocacy and leadership in dealing with mental health and NCDs. ICN is also concerned about the absence of consumers and the community in the development of policies, strategies or legislation related to mental health and NCDs. People-centred care and community engagement need to be front and centre in any future implementation plans.

4% of GDP

The cost of mental ill-health (OECD) estimates that costs equate to 4% of GDP. To put it another way, for every 10% gain in mental health, GDP would rise by 0.4%.

$10 billion

The cost of mental illness to business.

Key features of a health system designed to respond to the mental health challenge

There are no simple and one stop solutions to addressing the burden of mental illness. There needs to be a comprehensive and integrated approach that recognises the important role that health systems have in leading and coordinating the fight against NCDs. Strong and resilient health systems that is capable of responding to individual and community needs should have the following key features:[71]

1. The development of coherent, consistent legislation, policies and plans through engagement and consultation with consumers, health professionals (particularly nurses) and the community.

2. A well-resourced health system to cope with the demands across the entire continuum of care (with a focus on prevention and promotion) and applying universal proportionalism to drive equity of access. A well-resourced health system has a sufficient number of health professionals with appropriate skill mix. It also includes a safe working environment.

3. Integrated PHC that proactively manages community health and wellbeing. Case managers (or Nurse Navigators) and Credentialled Mental Health Nurses have shown to improve the patient journey and the integration of health services.

4. Adequately accessible specialist mental health services to provide efficient and timely care for acute conditions. Preferably, this specialist care should be given as part of a multidisciplinary approach to care.

5. The health system utilises a people-centred approach to care that upholds the rights of consumers.

6. There is a focus on value-based health care for mental health which means financing systems promote models of care that provide good health outcomes for a price that can be afforded. There needs to be a prioritisation of services with appropriate incentives to deliver the outcomes required.

7. Improved access to quality and affordable medicines.

8. Information solutions are used to support population health management condition management, coordination of activities, improved self-management and the monitoring of performance. Nursing informatics is particularly important as nurses are the frontline care providers in the community, clinic and hospital settings and this information can be used to support a high functioning and efficient workforce.

9. Fit-for-purpose health workforce that deliver people-centred interventions and services based on the best available evidence. This includes:

   a. The adoption and increased utilisation of Advanced Practice Nurses in mental health

   b. The development and implementation of appropriate governance and regulatory models to support health professionals working to their full scope of practice. In some circumstances this may mean the easing of restrictions placed on them through inappropriate regulatory environments.

   c. Appropriate financing and remuneration models are implemented. The uptake of innovation and practice is highly influenced by payment policies and reimbursements.

   d. Support the development of a highly skilled and competent workforce through the inclusion of mental health in undergraduate degrees and continuing professional education; specialist practice through post graduate education and increased value of nursing research.

Collaborative Care: An exemplar model for providing accessible, quality care at an affordable price

With the right targeted investments, improvements can be made in the quality and accessibility of health services and, in turn, an improvement in the mental health of the nation. The following example provides an evidenced based model that can provide excellent health outcomes and deliver additional economic and productivity gains for communities.

Collaborative care is a health care model that aims to improve patient outcomes through inter-professional cooperation. This includes the collaboration between PHC and specialist care working with a range of health professionals. The team is led by a care manager who is often a nurse. The reason for this is that nurses are the only clinical professionals who are specially educated and trained to understand the roles of other health care providers. This insight provides a strong foundation for successful collaboration.

A hallmark of collaborative care encourages the involvement of consumers and their families to be active participants in the treatment process. The case manager supports this involvement and is responsible for setting a structured care plan that involves the multidisciplinary team. It also ensures that communication flows to all associated professionals so that care can be provided for both physical and mental health.[72]

Effective communication is essential for the collaborative care model to work. Nurses are generally highly skilled to have adaptability, empathy and good communication skills and this is a powerful combination to lead as a case manager. In addition, educated nurses have the ability to understand and assess a patient's clinical, emotional and social needs and therefore call upon the available resources to create and implement a person-centred care plan.[73]

Analysis of collaborative care models demonstrate that not only do they save lives and improve health outcomes, they also have a strong return on investment. With every $1 invested, there is a return of $3.[72]

Case Study

Photo Credit – Stephen Gerard Kelly

IMPROVING THE PHYSICAL HEALTH OF PSYCHIATRIC INPATIENTS AT A MENTAL HEALTH FACILITY
– Amy Wallace, Australia

Statistics show that persons with a mental illness die up to 25 years younger than the general population due to preventable physical health conditions. Diagnostic overshadowing is proven to directly affect the physical health care mental health consumers receive and symptoms of physical illness are often disregarded as signs of their mental state. Preventable physical health conditions are contributing to this widening life expectancy gap.

The Graylands Wellness Clinic was established in 2016 to meet both the physical and mental health needs of patients. The Wellness clinic is an essential service to help reduce the life expectancy gap experienced by mental health patients' at Graylands Hospital, Western Australia's largest mental health hospital. Assessing and managing preventable physical health conditions and having targeted approaches to physical health care goes a long way to reducing this gap at Graylands Hospital. The Clinical Nurse Specialist in Primary Health Care (CNS PHC) drives the service and all the associated projects. Nursing staff are proactive in adopting the initiatives and volunteering to assist and be representatives on associated committees.

During the 12 months of this project, 101 referrals to the general practitioner were received (compared to just 25 in the 12 months prior to the launch) and a further 70 to the CNS PHC. The impact of this has meant that now the majority of consumers in the hospital have the opportunity to access physical health specific care at the hospital.

Patient Story

Beth*, a 55 year old woman, presented with mania with psychotic features and appeared to be in relapse of her bi-polar disorder. It was discovered that she had in fact been taking large doses of corticosteroids for a prolonged period and that her psychosis was steroid induced. While the team treated her mental illness symptoms, Beth identified her rheumatoid arthritis (RA) as the major concern in her life. Unable to have a walking stick on the ward, or steroids to reduce her inflammation and pain, and unable to see her normal general specialists, Beth's wellbeing was significantly affected. The CNS PHC was able to facilitate an urgent physiotherapy review and a wheeled frame was provided to assist Beth to walk. The GP contacted her RA consultant and discussed alternative anti-inflammatory options besides steroids and liaised with the Beth to help her decide what was best for her. Pain relief was charted and education around the safe use of this was given to the patient. The above measures helped dissipate Beth's anxiety, pain and inflammation and addressed her major concerns. Beth was so appreciative of having someone to speak with who understood her struggles and to give reassurance.

*Not her real name

GLOBAL HEALTH CHALLENGE 6
THE EFFECTS OF VIOLENCE ON HEALTH CARE AND ALL OF US

Photo Credit – Haiyan Bronte

"Injustice anywhere is a threat to justice everywhere."
Martin Luther King Jr

10 December 2018 marked the 70th anniversary of the United Nations General Assembly's Declaration on Human Rights, one of the most translated documents in the world having been translated to over 500 different languages.[74] Whilst it has been 70 years since a global war, the world is a long way off from achieving peace, justice and equality.

68.5 million
People who have been forcibly displaced.[75]

According to the Global Peace Index 2018, the world is becoming less peaceful.[76] As a result, it is now estimated that there are more people displaced from their homes than ever before.

Conflict has enormous consequences on health care. Conflict and violence disrupt and severely weaken health systems. The Red Cross states "One of the first victims of conflict and violence is the health care system itself.

4,200
People were victims of violence against healthcare between 2012-2014.[30]

The law states that hospitals, ambulances and health care professionals should never be targeted as they carry out their duties. This is often far from reality.
The lack of safe access to health care is causing untold suffering to millions of people worldwide."[30] People are unable to receive health care and vital services such maternity services, child care and vaccinations are cut off. Disruption to health services has immediate and long-term consequences. For example, the WHO estimates that more than half of Yemen's health facilities are non-functional.

This has led to deadly outbreaks of cholera and diphtheria and catastrophic levels of malnutrition.[77]

90%
Of current war casualties are civilians.[78]

Protracted conflict has weakened health and health systems to the point where old diseases (e.g. cholera), almost eradicated (e.g. polio) and newly emerging ones are growing and spreading across borders. If the world seeks to see the successful delivery of the SDGs, then they must ensure that its message of 'no one is left behind' is truly acted on.[79] Part of this is the successful delivery of UHC. The challenge exists however that UHC should be implemented by countries, but what happens when the state is in chaos or unwilling or complicit in human rights abuses?

23 countries
The number of countries in conflict where there have been attacks on health workers.[80]

How is it that even simple services such as maternity care, vaccination and outbreaks can be prevented/ managed. This is an exceedingly difficult issue with no easy answers, but the world's health is at stake and we are only 'as strong as our weakest link.'

Ahmed, gunshot wounds in the Gaza Strip

Figure 12: Strategies to progress UHC in conflict settings Adapted from 81

EQUITABLE ALLOCATION OF RESOURCES

Respect for international law

Healthcare in conflict settings is a human right

Independent assessment

Cooperation between govt, local providers and non state actors

Countries are responsible for the delivery of healthcare in conflict affected areas

This is a legal duty of a country to its citizens

Allocate additional resources

A responsive systems supplemented with sufficient / additional resourcing

Focus on high value areas with strong evidence base

Duty of care to health workers

All providers have a duty to provide healthcare without discrimination and equitably

This is a legal requirement and the basis of the UHC

UNIVERSAL HEALTH COVERAGE IN CONFLICT AREAS

Health for All

Ensure that no-one is left behind

Provision of health services to refugees

Safeguard non-discriminatory access to healthcare

People have the right to a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity

System for public reporting of violations

Documentation of attacks

Expand public awareness and education

Institution to protect human rights

Healthcare providers, systems and consumers are not targets during conflict

This is a legal requirement as healthcare is a global good

Support the establishment and functioning of national

A standard minimum package for UHC is essential in conflict areas

(eg. child care, NCD, women's health, nutrition, mental health, infectious diseases etc)

Harming those who care

Violence against health is not limited to areas of conflict and war. Violence is an everyday occurrence around the world for health workers. This includes violent physical, sexual and verbal assault from patients and potentially their families. The issue is so bad that across the world, nursing is considered more dangerous than being a police officer or a prison guard. In Spain, the problem has become so bad that a national observatory for violence against health workers has been established to collect information and develop strategies to combat the violence. In Pakistan, health workers are being shot at, kidnapped or killed.[82]

8-38%
of health workers suffer physical violence.[83]

Health workers do face particular risks because of the environment in which they work. They work on the frontline with stressful, unpredictable and potentially volatile situations which may be fuelled by drugs or other substances. The situation is such that health professionals and, in particular nurses, expect or even accept violence as part of their job. But violence takes its toll not just physically, but also psychologically and in the way that nurses interact with patients and their families. The psychological consequences resulting from violence may include fear, anxiety, sadness, mistrust and depression. As a result, research has shown that as a result of violence, nurses can feel less empathy and the quality of their care can suffer. There is a clear link between violence and subsequent adverse events.[84]

Violence against nurses can also have significant health and economic consequences on both nurses and the health system for which they work. The economic consequences on the health system potentially result from sick leave, legal action, diminished staff effectiveness and the recruitment and retention of staff. These add to the already high pressures that the health system faces in trying to meet community demand for health services.[85]

The impact of conflict and violence on UHC

Countries affected by health workforce shortages and/or maldistribution are highly unlikely to achieve UHC. The productivity, efficiency and quality of health care is highly dependent on the numbers, skills and competencies of the nursing workforce. Shortages and high turnover rates of nurses are therefore an important topic across the world. Whilst this is a complex topic, violence and conflict play a significant part in human resources for health.

9 million
estimated shortfall of nurses in 2013.[86]

Violence against nurses threatens the delivery of effective care and it violates their human rights. It damages their personal dignity and integrity. It is an assault on the health system itself.

Attacks, assaults and aggression against nurses pose a significant hazard to the strength of health systems and the development and sustainability of UHC. Protections must be instituted to ensure safe and respectful working environments. Workplace violence against health professionals is often a hidden social problem, with little recognition by governments and the community. This must be high on the agenda of the international community with actions by governments, policy makers, educators, researchers, health managers and most of all, combatants and communities. Nurses must be respected and valued, for they hold the frontline in maintaining and ensuring optimal health and wellbeing.[87] As one of its core principles, the WHO's Global Strategy for Human Resources for Health: Workforce 2030[88] states, actors must "Uphold the personal, employment and professional rights of all health workers, including safe and decent working environments and freedom from all kinds of discrimination, coercion and violence."

Photo Credit – ICN International Council of Nurses

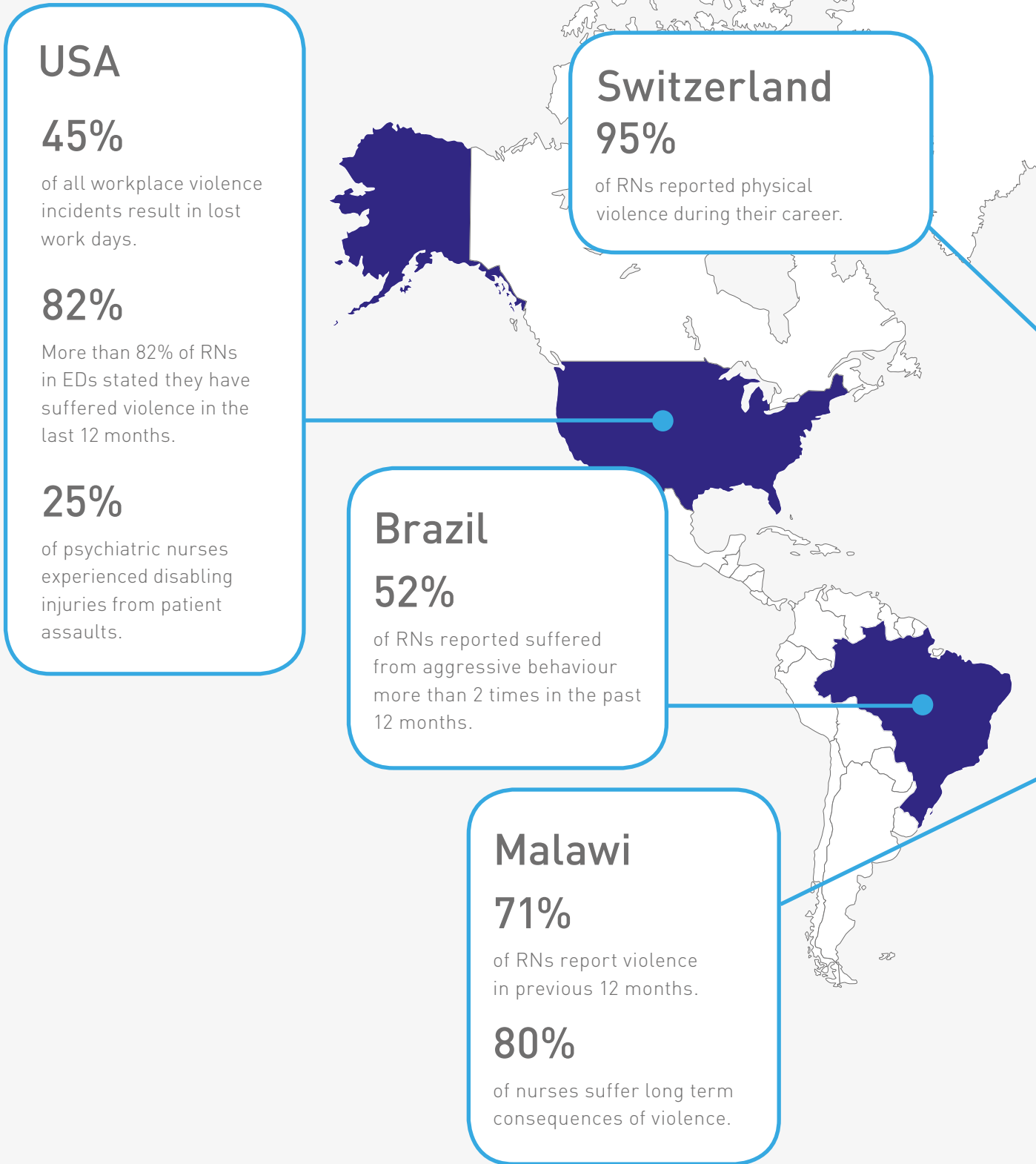## Figure 13: Strategies to reduce violence against nurses Adapted from 89

01 — SUPPORT THE HEALTH PROFESSIONAL

- Violence against health professionals violates human rights
- Support "Zero Tolerance" of workspace violence
- Provide access to legal, psychological and paid leave supports to nurses as appropriate
- Provide advocacy for improved education and on-going training in the prevention, recognition and management of violence

02 — EMPOWER THE COMMUNITY

- Raise the awareness of the public and the nursing community to the signs and symptoms of violence against healthcare workers
- Participate in the development and implementation of violence prevention and management strategies

03 — MANAGE THE SYSTEM

- Violence against health professionals weakens health systems and puts the safe delivery of care at risk
- Support the reporting of workplace violence
- Address workplace violence requires a system-wide approach
- Effective legal standards and protection in place
- Ensure appropriate and effective risk management systems, policies and procedures, and workplace safety plans are in place
- Share the experience of violence in the workplace to improve risk assessment of dangerous or potentially dangerous situations

04 — REPORT THE OUTCOMES

- Create or facilitate user-friendly, confidential and effective reporting mechanism
- Healthcare organisations to report to legal authorities any criminal act of violence
- Regular auditing to determine compliance
- Engage in research to continue to set of reliable data on violence in nursing and in the healthcare sector and support the development of consistent and comparable measure to compare findings and facilitate this research
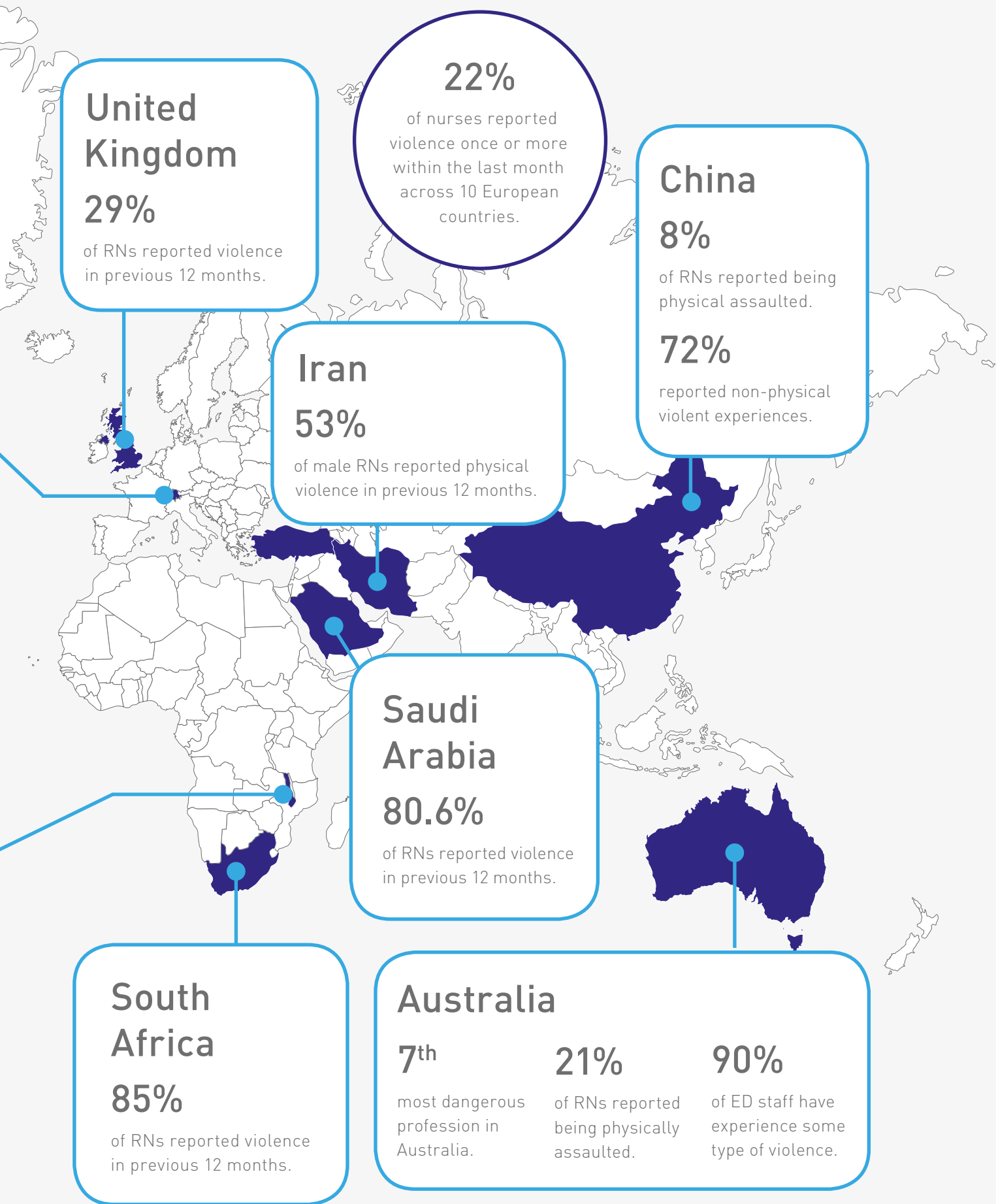
Call for Action

In 2002, the WHO, ILO, PSI and ICN developed the Framework Guidelines for Addressing Workplace Violence in the Health Sector.'[90] The framework was developed to support governments, employers, workers, trade unions, professional bodies or members of the publics. Over 16 years have passed since the release of this report. Whilst there is much that is still relevant to today, new research and evidence should be used to update the report and provide clearer guidelines to countries. ICN calls on the other partners to work with ICN to update these guidelines and develop metrics by which progress in this area can be measured.

Figure 14: Harming those who care
Alarming Global Similarities[84, 87, 91-96]
(Koehn, 2017), (Gacki-Smith et al., 2009), (Nurses Notes, 2011),
(Locke, Bromley, & Federspiel, 2018)

USA

45%
of all workplace violence
incidents result in lost
work days.

82%
More than 82% of RNs
in EDs stated they have
suffered violence in the
last 12 months.

25%
of psychiatric nurses
experienced disabling
injuries from patient
assaults.

Switzerland
95%
of RNs reported physical
violence during their career.

Brazil
52%
of RNs reported suffered
from aggressive behaviour
more than 2 times in the past
12 months.

Malawi
71%
of RNs report violence
in previous 12 months.

80%
of nurses suffer long term
consequences of violence.

United Kingdom

29%

of RNs reported violence in previous 12 months.

22%

of nurses reported violence once or more within the last month across 10 European countries.

China

8%

of RNs reported being physical assaulted.

72%

reported non-physical violent experiences.

Iran

53%

of male RNs reported physical violence in previous 12 months.

Saudi Arabia

80.6%

of RNs reported violence in previous 12 months.

South Africa

85%

of RNs reported violence in previous 12 months.

Australia

7th

most dangerous profession in Australia.

21%

of RNs reported being physically assaulted.

90%

of ED staff have experience some type of violence.

PART THREE
LEADERSHIP (WITH A TWIST)

Photo Credit – Manar Nabolsi

THE ROOTS OF NURSING LEADERSHIP

Leadership is not foreign to nursing. Our history is replete with nurses whose leadership transformed societies and systems. Nurses in every country can likely think of their own examples of these leaders. Florence Nightingale is certainly one known to almost all nurses. While the nature of her leadership is somewhat obscured by the glossy, romantic rhetoric which has grown around her, she had a clear vision of what nursing leadership was and why it truly mattered. For her, education was a crucial foundation for this leadership. She also had a keen understanding of human suffering and the stories of the real people whose lives served as an anchor for her activism. Nightingale's leadership was purposeful and profound because she understood suffering through the lens of the forces beyond each individual. She saw that so often both the causes and the solutions for suffering were situated at systems and societal levels. Thus, these were the targets for her engagement as a leader.

Today, we sadly still encounter the kinds of stories that inspired and informed Nightingale's leadership. These stories are very important because they help us understand the actual problems that we can help to address. For Nightingale, these stories were what informed and inspired her work, yet she understood that the individual stories were the starting point for change, and that they alone were not enough to drive system level change. For this reason, she systematically documented these realities in ways that made them accessible and understandable to those who could make change at systems and societal levels.

Nightingale's leadership grew as she gained the trust of a wide circle of influential friends, but also those she represented – never forgetting the purpose of her leadership. While these were initially soldiers in the battlefields, their numbers grew to include British society's most vulnerable and poor. The leadership path that

Nightingale took was uphill and littered with barriers and the blindness of others to human suffering. Nonetheless, her approach to purposeful leading was successful and charts a route for nursing leadership to advance Health for All.

Nightingale's leadership reflects a powerful framework for gaining insight into the perspectives and positions of both allies and adversaries, while developing strategies that inform progress and counter the barriers along the way. She understood that successful, purpose-driven leadership requires leaders to:

- see the problem
- know the stories at the human-to-human level
- understand the issue at a broader systems level
- gain action through strongly articulating the issue, with evidence
- gain trust of those you speak for and those you speak to engage those with influence
- understand all stakeholders, their power and positions and be prepared to be persistent in your fight for what you know needs to be achieved.

Deceptively simple, these acts of exercising leadership are key to moving the injustices and inequities that nurses see every day into the changes that are required to realise health for everyone. Nurses around the world are perhaps the best positioned of all health professionals to give a voice to the most vulnerable and excluded. We know that in many countries nursing is considered the most trusted profession. What better starting point for leadership than this trust – and the privilege and responsibility to honour it? Now is the time – and we, nurses around the world, have the capacity to help transform the stories of those we serve into the policies and systems necessary to realise Health for All.

Case Study

NURSING AND POLITICS – FROM STRENGTH TO STRENGTH – Juliana Lunguzi, Malawi

Malawi faces a number of health care challenges including shortages in human resources, limited health and other infrastructure, shortages of essential medicines and other factors affecting the social determinants of health such as poverty. As such, the main health needs of the country are addressing child and maternal health, HIV/AIDS, malaria and tuberculosis.[107]

The Honourable Juliana Lunguzi is a Member of Malawi Parliament, representing Dedza East. As a Public Health Specialist and a State Registered Nurse, Juliana brings significant experience and knowledge to the committee and her role as Shadow Minister for Health. As a public health nurse, she has seen the first-hand effects of the determinants of health on her community. She uses this scientific knowledge of the disease process and the holistic needs of individuals within the community to advocate on their behalf.

Juliana provides advice to the direction of health in Malawi and holds the Government to account for the implementation of those policies. She brings a whole range of skills to the parliament, and has a comprehensive view of health. This is evident in the way that she advocates for the people in the policies being discussed in parliament.

Despite being a parliamentarian, Juliana says that she will always remain a nurse, particularly a public health nurse. She believes that her experience as a nurse has prepared her for her work as a politician and that she is well placed to enact change for the betterment of the people in Malawi. One of the reasons that Juliana moved into politics is that she wanted to make a difference 'particularly on a large scale.' Whilst working as a nurse she could see the issues that people faced on a daily basis. Instead of complaining about why things can't be different, and frustrated at the lack of action by politicians in addressing the issues, she decided to act and be a leader of change.

INNOVATIVE INROADS TO HEALTH FOR ALL: THE WORK OF NURSES AND NURSING

Nurses roles expand, twist and contract in creative and ingenious ways to address changing circumstances and needs of the health systems in which they work.

Vulnerable populations are found everywhere, and nurses have found ways to help address their needs. Examples include:

• underserved rural communities (the flying doctors service nurses who provide health checks at cattle sales in outback Australia or Nurse Practitioners in Inuit communities in Canada – see IND 2018)

• prisoners and inmates (where nurses look to provide the gamut of services often as a result of issues from social determinants of health)

• refugees and immigrants (both in camps waiting for resettlement and on arrival in a new country)

• individuals and families in conflict zones (through organisations like the ICRC, SOS or MSF)

• victims of natural or manmade disasters

• those threatened by disease outbreaks and epidemics (see p.16)

• individuals and families unable to access or adequately interact with the health care systems and services (Nurse Navigators, assisting families understand the need for hospitalisation and what happens there in and transitioning back to communities)

• high risk populations in which assistance is needed for a specific patient cohort (see Case study on p.6)

These examples can help to inform the work of others in similar situations. However, there are countless other examples that have not been documented and are lost to the shared knowledge that helps create progress. It is crucial that we work further on articulating the needs of the vulnerable; assessing and sharing the success of the programmes we devise, evaluating and publishing reports of the programmes we develop; and doing the work of scaling and mainstreaming those initiatives that we know work. Nightingale's leadership approach provides guidance in this. Additional insight can be gained from review of the 2018 IND resources (https://2018.icnvoicetolead.com/).

Nurses have also found that at times it is necessary to step out of practice to continue their "nursing" quest of Heath for All. They have found their influence can be better targeted at influencing the policy makers by being closer to policy decision-making. They do this by sitting on Boards, be they health related or other Boards whose actions influence health, such as School Boards, Local Councils, by becoming part of national or global health organisations, or indeed becoming part of the process of national government itself.

Throughout the world, nurses are realising that political influence is most effectively placed at the very heart of policy generation, when the problem is being defined and solutions sparked.

Global representation, leadership and advocacy for the International Federation of Red Cross and Red Crescent Societies was the job nurse Amanda McClelland found herself in after years of working on the Ebola Crisis in Africa. Based in Geneva, after years in the field, Amanda reflected on what it was that, as a nurse, she brought to these high-level global conversations.

My role was to be translator, bringing information from the field into these high-level meetings, explaining the complexities and difficulties of actually implementing programmes, and then interpreting the science or recommendations from these meetings back down to the field in a way that could be translated into action... I added a social mobilisation and community aspect to global strategy discussions, and gradually was asked to bring that viewpoint to public health conferences around the world. My message was always the same: The community needs to be at the centre of all health emergency planning. It's funny how often that common-sense advice came as a surprise.[104, pp. 274-5]

Advancing the leadership skills and policy influence of nurses is at the centre of ICN's work. Ensuring that nurses have a voice in the development and implementation of health policy is fundamental to ensuring these policies are effective and meet the real needs of patients, families and communities around the world. Nurses are the largest health profession across the world. We work in all areas where health care is provided. With investment in our profession, we have the potential to ensure the achievement of the vision of Health for All.

Case Study

NURSES ON BOARDS
– Kim Harper, USA

The Nurses on Boards Coalition (NOBC) aims to build health communities, not only in the US but across the globe, by ensuring the involvement of more nurses on corporate, health-related, and other boards, panels and commissions. Only by adding the nursing voice to these decisions can health care improve.

The NOBC represents 28 national nursing and other organisations working to build healthier communities by increasing nurses' presence on corporate, health-related, and other board, panels and commissions. The coalitions' goal is to improve the health of all citizens by ensuring that nurses are at the table where health care decisions are made. The key strategy is filling at least 10,000 board seats by 2020, as well as raising awareness that all boards would benefit from the unique perspective of nurses to achieve the goals of improved health an efficient and effective health care systems.

Made up of dozens of volunteers across all 50 states and the District of Columbia, NOBC provides resources for education related to self-assessment, development of board competencies and matching of individual nurses with potential board opportunities. Through research into the competencies needed for board service, NOBC has developed a Competency Model and a Board Readiness Model for nurses to use in preparation for board services and for building on competencies they already possess. It also partners with Boards who are looking to fill a board position to identify the best candidates for their needs.

This highly successful coalition of nursing organisations has created the ability for hundreds of thousands of nurses to work together toward one single goal: improving the health of populations through the voice of nurses at the tables where decisions regarding health care for communities are being made. The work of NOBC has become a movement in the United States and discussions ensue with other countries who share an interest in replication of the work.

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