

Global nurse leader perspectives on health systems and workforce challenges

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Aim As part of the 2011 annual American Organization of Nurse Executives conference held in San Diego, California, a session was presented that focused on nursing workforce and health systems challenges from a global perspective. This article includes content addressed during the session representing nurse leader perspectives from the UK, Singapore and the USA.

Background Recent events in global economic markets have highlighted the interdependence of countries. There is now a global focus on health-care costs and quality as government leaders struggle to reduce budgets and remain solvent.

Evaluation Finding solutions to these complex problems requires that nurse leaders adopt more of a world view and network with one another as they look for best practices and creative strategies.

Key issues Nursing leadership challenges such as staffing, competency development, ageing populations, reduced health-care funding and maintaining quality are now common global problems.

Conclusion There is a need for innovation in nursing practice to accommodate the enormous challenges facing nursing's future.

Implications for nursing management Opportunities on an international scale for nurse leaders to have dialogue and network, such as the conference presentation discussed in this article, will become increasingly more important to facilitate the development of innovative leadership strategies.

Keywords: global nurse leadership, global nursing, global nursing challenges, nurse leadership, nurse workforce challenges

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Introduction

Recent events in global economic markets have highlighted the interdependence of countries (Lewis 2011).

Globalization has affected every industry including health care. Nursing leadership challenges such as staffing, competency development, ageing populations, reduced health-care funding and maintaining quality

are now common global problems (Parker & Hyratus 2011). Finding solutions to these complex problems requires that nurse leaders adopt more of a world view as they look for best practices and creative strategies (Huston 2008). As part of the 2011 annual American Organization of Nurse Executives conference held in San Diego, California, a session was presented that focused on nursing workforce and health-systems challenges from a global perspective. This article includes content addressed during the session representing nurse leader perspectives from the UK and Singapore. Initiatives in the USA developed by the American Organization of Nurse Executives and the Alliance for Ethical Recruitment in response to some of the challenges discussed are also presented.

Review of the literature

In reviewing the international nursing literature on current and future health systems and workforce challenges reported by nurse leaders, there are many similarities in the themes discussed. Huston (2008) noted that planning for the future is extremely difficult when environments are dynamic. Globally, few systems have been more unstable in the 21st century than health care. The World Health Organization (2007) has identified a framework composed of six building blocks to promote a common understanding of what a health system is and what constitutes health-systems strengthening. The six building blocks are: service delivery; health workforce; information, medical products; vaccines and technologies; financing and leadership and governance. It was noted in the report that there are great disparities between developed and developing countries in each of the six building blocks. Nurse leaders play a key role in responding to challenges and redesigning their health systems. In developing countries, access to basic care, child mortality, the migration of health professions and the lack of a health system infrastructure are pressing concerns. Populations in developed countries are ageing and chronic illness is more prevalent. Care delivery needs have expanded beyond primary and acute care environments to include more focus on long-term care. There is now a global focus on health-care costs and quality as government leaders struggle to reduce budgets and remain solvent.

In a 2008 issue of the *Journal of Clinical Nursing*, Clarke and Aiken reported that results from the International Hospital Outcomes Study (IHOS) indicate that the experience of being a nurse is remarkably similar across countries as is the organization of hospitals, despite cultural differences. Nakata *et al.* (2008) noted

that the critical challenges of getting the workforce numbers right, getting the skills right and getting the teamwork right are concerns that link leaders on all four continents. A recent RN4CAST (2011) project funded by the European commission projected a shortage of 600 000 nurses across Europe by 2020 with 44% of nurses in the UK, Poland and Ireland reporting that they intend to leave nursing. Indeed, the scarcity of qualified health personnel, including nurses, has been highlighted as one of the biggest obstacles globally to achieving health system effectiveness and this problem is expected to intensify over this decade (Buchan & Aiken 2008).

In the recently published collection of global leadership lessons for nurses (Gantz 2010), the universality in the challenges faced by nursing leadership is striking. Nurse authors from 34 countries shared their leadership lessons learned on topics such as the ageing workforce, conflict management, competency of staff, managing change and maintaining quality in practice. There are, however, some new emerging workforce challenges for developing countries. Lei *et al.* (2010) have noted that with the rise of international communication and interaction, the topic of the occupational role of the nurse across countries has become a new leadership challenge. In developed countries, nurses focus on assessment, consulting and evaluation in collaboration with other members of the health-care team. In developing countries such as China, nurses are still focused on non-professional nursing tasks. This has created dissatisfaction and burnout among younger staff that now have higher professional expectations. Nurse leaders in most developed countries are now faced with both the challenge of managing a multigenerational workforce and an ageing workforce. Manion (2009) outlined policy strategies for the International Centre for Human Resources in Nursing that included a focus on the workplace culture, a need for flexibility in workforce management and an international approach to nurse workforce planning. Even in some uniquely challenging international environments, nurse leaders are moving forward to create healthier work environments for nursing staff. Mouro *et al.* (2011) described the experience of becoming the first magnet hospital in the Middle East.

As we look toward the future, Kabene *et al.* (2006) observed that the globalization of goods and services may at some point inevitably include health care. At present, countries have different perspectives on health care that have influenced their delivery systems. This could change if health care becomes part of new trade agreements. It is likely with new technologies that multinational patients could be treated without leaving their homes by multinational teams of health professionals. Friedman and Mandelbaum (2011) discuss the

current interconnected environment where 23% of the global population now has internet access and two-thirds of the world's population have cell phones. They describe what is happening as the most important inflection point for communication, innovation and commerce since the Gutenberg printing press. These changes are having, and will continue to have, an impact on the profession of nursing. There is a need for innovation in nursing practice to accommodate the enormous challenges facing nursing's future (McSherry & Douglas 2011). Nichols *et al.* (2011) have suggested that globalization demands a recast of all leaders, including nursing leaders to expand their professional education and develop global competencies.

United Kingdom

This contribution is written by Dr Melanie Jasper, Professor of Nursing and Head of College of Human and Health Sciences at Swansea University in Wales, UK, and as the editor-in-chief for 10 years of the *Journal of Nursing Management*.

Health-care structure in the UK

The National Health Service (NHS) in the UK was created in 1948 from a post-war era socialist desire to tackle Beveridge's 'five giants' – want, disease, squalor, ignorance and idleness – in creating a fairer, more equitable society for UK citizens (Beveridge 1942). The NHS is a system of socialized medicine, founded on the principle of universal health-care for everyone, free at the point of delivery, funded from general taxation where access to good health-care is not dependent on ability to pay (<http://www.nhshistory.net/shorthistory.htm>). This remains the case across the UK, although the form and function that this takes, particularly given economic and demographic pressures, is constantly adapting. The NHS costs the UK taxpayer approximately 8.43% of gross domestic product in 2010 (uk-publicspending.co.uk 2010). This equates to about 100 billion pounds in current terms, roughly £2000 (US\$3000) per person, providing for all health-care needs. The topic of the NHS arouses passionate responses in the UK citizen, and is always a key issue at general electioneering; governments risk public outcry at any attempt to tinker with its founding principles.

All citizens are required to register with a general practitioner (GP) – a doctor qualified to deliver primary care medicine and who is contracted by the NHS to provide these services. A GP usually practices within groups, offering a range of both general and specialized

services that can be delivered from surgeries or clinics designed for that purpose. Some nurses, paid for by the practice, work as nurse practitioners or practice nurses in supporting primary care services delegated from the GP (such as immunizations, travel clinics, wound clinics, chronic disease, e.g. diabetes and deep vein thrombosis follow-up). In primary and community care, other nurses directly employed by the NHS, such as district (home) nurses, health visitors and midwives work with these general practices to deliver community based care. Primary care services are also tasked with health surveillance of vulnerable groups, and health education and illness prevention beyond the delivery of services on demand. There is a current trend within the NHS in all four countries in the UK to move many of the services currently provided in secondary care facilities out into the community; this is driven partly through finances, but also in the belief that care is better delivered closer to the patient's home. The GPs also act as the gatekeepers to secondary care services (usually located in hospitals or treatment centres) to whom referrals are made for specific services. Accident and Emergency services, within large hospitals, are the only self-referral opportunity to secondary care and these are also accessed via ambulance services run by the NHS. At no time will a citizen be denied health care; neither will they be asked to pay for a service (apart from drugs prescribed by a GP, which are subject to a standard charge per item in most of the UK, and general dental services).

There is a very small supplementary component of private medicine in the UK operating in small private hospitals, providing a limited range of services, for which citizens may have health-care insurance or pay per service. In addition, there is some charity-funded provision, such as the hospice movement, or long-term facilities for the elderly, or for those with chronic, long-term conditions or disabilities, which may be contracted by the NHS to provide services unavailable within the NHS. There has been a movement, over the last 30 years, away from long-stay bed service provision in the NHS, yet there is an awareness that some citizens require on-going health-care provision.

One challenge has been the constant redefining of what is perceived as 'social' as opposed to 'health' care need, as this has budgetary implications. Also, highly-specialized services are growing in certain areas, such as cancer services, or for military personnel returning from war theatres with multiple serious injuries, which require a degree of sophistication unable to be provided within most local hospital provision. The need for the NHS to contract out some service provision has led to accusations of 'privatization' of the NHS by various

different Governments – a move that is vigorously rejected by the UK population, who hold the NHS very dear to its heart. Creeping purchaser–provider relationships, where one part of the NHS commissions services from another part is seen as a market model that has no place in a NHS funded from general taxation. Another challenge, financially, has been the complication of different regional authorities ‘charging’ for provision of specialist services for people outside its geographical area. In addition, there is the issue of the so-called ‘postcode lottery’ where services or treatment available is defined by different providing authorities, with the result that a person living in one area may have access to, for example certain cancer drugs, while a person in a different authority may not. The changing political values of successive governments in the UK have changed the underpinning principles driving the NHS, and this has been compounded by the devolution of some Governmental functions to the regional governments/assemblies in Scotland, Wales and Northern Ireland which comprise the UK.

The population of the UK is approximately 61.8 million, divided into four nation states – England (57 million), Scotland (5.1 million), Wales (2.9 million) and Northern Ireland (1.8 million) – where there is some degree of devolved government. The whole of the UK is governed from the Parliament in London, with regional governments or assemblies in Edinburgh, Cardiff and Belfast. Each of these receives monies from Parliament for some functions, with health care being one of them. Different models of health-care provision exist within the NHS umbrella, dependent upon the political drivers in each of the four countries. All four countries, to some extent, have restructured and reorganized their health-care systems over the past decade, and change within the services is now a constant state. Wales, for example, restructured in 2009 to abandon the separation of commissioning from provision of services and reject the internal market model operated in England. This increasing diversity between models of delivery of provision is causing tension in both cross-boundary flow of patients and access to care, and in the provision and education of nursing staff to service its delivery.

The NHS in total employs 1.3 million people. There are roughly 680 000 nurses and midwives registered with the nursing and midwifery council (a UK-wide body), all of whom have completed at least a 3 year programme within a higher education institution (or the equivalent before 1990 when nurse education moved into higher education in the UK); 335 357 of those are currently working in the NHS (Williams 2011). Those others who are active will be working in independent health-care. All

nurse and midwife preparation will be at Baccalaureate level from 2012, although Wales moved to all-graduate preparation in 2004. Before wholesale degree preparation, there was a mixture of diploma and degrees in nursing or midwifery available. Post-qualification qualified practitioners can ‘top-up’ their diploma by taking honours level courses to acquire the appropriate credits they need to complete a degree. The UK has had more than 40 years of experience educating nurses in universities and, as a result, has a range of academic programmes at baccalaureate, masters and doctoral levels. One of the big challenges is preparing the work force without degrees to gain degrees to enable them to support students in practice who will be at degree standard. About 50% of the 3-year programme for undergraduate nurses is spent in the clinical environment. There is a 45-week teaching year in nurse education; 22.5 weeks of those 3 years is spent in practice placement. Thus, education is dependent on workplace mentorship and supervision provided by qualified nurses. Thus, there is a responsibility to ensure nurses feel confident in supporting those students. There is also a continuing professional development responsibility for those practitioners, in enabling them to understand evidence-based practice and developing practice and change in that way.

Initial undergraduate education is funded by the NHS, who commission places for students based on workforce development plans. Following registration the responsibility for continuing professional development lies with the employer or is self-funded by the nurse/midwife (although this latter proportion is very small). Most NHS employers have contracts with local universities to provide continuing professional development (CPD) opportunities.

Workforce challenges for nurse leaders

One of the biggest challenges for nurse leaders in the UK is meeting health-care needs and demands. Where the system is centrally funded, there is a fixed budget, resulting in a form of health-care rationing, that has an impact on nurses’ job satisfaction, working environment and ability to provide care of the quality and standard they would like to achieve. Linked to this is the target-driven approach to quality measurement currently employed in the UK to assess providers’ performance. Access to GPs is almost instant and by self-referral. However, the budgetary restrictions result in long waiting times for access to secondary care: for example, current referral-to-treatment time can be up to 26 weeks. Where there is an urgent need, people will be seen quicker. The consequences of this are that often a

person's condition will deteriorate during the time they are waiting for a consultation, resulting eventually in higher costs, which is somewhat of a paradox in terms of the efficient use of resources. Following the initial consultation the person may then be on another waiting list for treatment. Nurse leaders are therefore faced with the challenge of maintaining nursing and midwifery services with appropriate skill mixes where the demand is varied and fluid, and enabling nurses to function in working environments that may not be conducive to high job satisfaction or quality of care. Changing demographics of the ageing population, combined with higher levels of patient acuity, place extra demands on nurses' workload, with skill mix of vital importance for the delivery safe and effective care.

The current global financial situation, and the UK's strategies to manage its budget, has resulted in decreased funding in real terms to the NHS, despite a need to maintain and develop services; restructuring of services also makes extra demands on the resources available. Nurse leaders at executive levels are currently exploring opportunities for different skill mixes of staff, including reducing the number of registered nurses and replacing those with staff at lower grades that have appropriate training. This is despite the evidence that quality of nursing care received is in direct proportion to the number of qualified nurses within a clinical area: the more nurses there are, the higher the quality of care received, resulting in shorter bed-stay, less iatrogenic disease and better patient outcomes. Again, short-term expediency in terms of 'balancing the books' is likely to have long-term effects in the number of qualified nurses within the workforce, and the quality of patient care and outcomes achieved. The restructuring of the way that services are delivered is also affecting the way that nurse leaders deploy nursing staff. Care delivery outside hospital and closer to home requires a differently prepared workforce compared with that currently predominantly working in hospitals. Nurse leaders do not have the educational budget available to ensure the transition and development of skills that will be needed as the different health-care model is implemented.

These two main challenges are global issues and are not dependent on the funding mechanisms used for health-care delivery (i.e. not just local to the UK). Certainly as editor of the *Journal of Nursing Management*, I see these themes recurring in the papers submitted from across the world. Papers generated from outside the UK account for between 50% and 75% of the papers we publish (8 × 12–15 papers per issue). These themes are reinforced by nurse authors across the globe and seem to be the predominant concerns facing

nurse managers and leaders globally. The third big challenge identified by nurse director colleagues in Wales is maintaining, developing and improving quality and safety within the shrinking budgets and particularly when there are continual media attacks or patient safety reports and terrible stories of poor-quality patient care. Related, and integral to the quality issue is that of skill mix (discussed above) of staff in all environments, including the community, where care is delivered. Implicit within this issue is the need for on-going professional development and education as roles change, yet the educational budgets are often the first to be attacked when savings need to be made and front-line services are threatened. This is going to be a huge challenge for nurse leaders in the UK from this time forth, and balancing the needs of care delivery with quality of service, and having the right nurse in the right place at the right time is a mantra constantly being chanted in Wales.

This brief snapshot of nursing leaders' life in the UK has, I hope, summarized the key challenges facing health-care delivery from a nursing perspective. The challenges are complex and multifaceted, and there are no quick-fix solutions apparent for a health-care system that copes with extraordinary demands and clearly cannot continue to function in its current form. Despite constant change and redesign from its beginnings in 1948, the optimal and long-lasting strategy for a universal system of care delivery, funded from the public purse and intended to cover all health-care needs for its population has not yet evolved. Nurse leaders continue to be central and integral to ensuring health-care services metamorphose with changing patient needs and with satisfying the employment needs of the largest workforce in the UK, and the NHS's greatest resource.

Singapore

This contribution is written by Chua Gek Choo, the Deputy Director (Nursing), Khoo Teck Puat Hospital, in Singapore. Gek Choo has been in leadership roles since 1986 and is a lecturer at a Nursing Polytechnic programme. She is also an Executive Member and Chairperson, Education Committee in Singapore Nurses' Association.

Health-care structure in Singapore

Singapore is a small island nation situated at the southern tip of the Malayan Peninsula. It has a land area of 660 km² (255 square miles). The Singapore healthcare philosophy is to build a healthy population through a preventive healthcare programme (Ministry

of Health Singapore 2011). It also aims to provide good, affordable basic health-care to Singaporeans through subsidized medical services at public hospitals and clinics. The Singapore health-care delivery system is an integrated system that consists of public and private health-care. Primary and intermediate long-term care consists of polyclinics, GPs and nursing homes. Secondary care has public hospitals and regional centres such as The Heart Institute. Tertiary care consists of two designated hospitals where transplant surgery is performed and national centres such as the National Cancer Centre. Primary health-care (public system) consists of 21% polyclinics and 79% GPs (private system). The public system is financed by the government but the private health-care delivery system receives no public funding. For acute hospital care, 80% of the care is delivered in the public hospitals and 20% from the private hospitals whose focus is on wealthy Singaporeans and medical tourism. Public hospitals are spread with six clusters over whole country. The purpose is to provide affordable care that is easy to access and provides a hassle-free experience for patients and their loved ones.

The health-care financing system in Singapore is anchored on two philosophies: that of individual responsibility and affordable health-care for all. Through a mixed financing system, the national health-care expenditures are below 4% of the gross domestic product (Ministry of Health Singapore 2011). The mixed financing system has multiple tiers of protection to ensure that no Singaporeans are denied access to basic health-care. The first tier of protection is provided by government subsidies of up to 80% of the total bill in acute hospital wards. The second tier of protection is provided by Medisave, a compulsory individual medical savings account scheme that allows all Singaporeans to pay their share of medical treatment without financial difficulty. Working Singaporeans and their employers contribute a part of their monthly wages into the account to save for future medical needs. The third level of protection is provided by Medishield, a low-cost catastrophic medical insurance scheme for major illnesses. Medifund is a medical endowment fund set up by the Government to help needy Singaporeans who are unable to pay for their medical expenses. This fund acts as a safety net for those who cannot afford the subsidized bill charges despite the Medisave and Medishield coverage (Ministry of Health Singapore 2011).

Workforce challenges for nurse leaders

Singapore has 19 733 Registered Nurses and 6765 enrolled nurses (Singapore Nursing Board 2009). The

nursing workforce is younger than in most developed countries. Thirty-one per cent of registered nurses are under the age of 30 years and another 30% are between 30 and 39 years old. Forty-six per cent of our enrolled nurses are under 30 years of age and 22% are between 30 and 39 years old (Singapore Nursing Board 2009).

More than half (65%) of registered nurses are baccalaureate prepared and 5% are prepared at master's or PhD level (Singapore Nursing Board 2009). Nurses must be registered at the Singapore Nursing Board (SNB) in order to practice. Foreign nurses need to have a firm offer of appointment before applying to sit for the SNB licensure examination. They are also required to pass the competency assessment as well as being proficient in English language before being accepted to practice. Currently, the nurse to patient population ratio is 1:200 (Singapore Nursing Board 2009). By the end of 2009, there were 26 792 nurses and midwives, reflecting a 10.7% increase in nursing manpower over the preceding year (Singapore Nursing Board 2009). These achievements have been made possible by government support. Major workforce challenges are discussed below.

A shortage of nurses

The addition of more public and private hospitals in recent years and the approved higher nurse–patient ratio have increased the need for more nurses in Singapore. However, the annual number of nurses graduated from the nursing teaching institutions is insufficient to meet the increasing demand. Foreign nurses from China, England, India, Malaysia, Myanmar and the Philippines have been recruited to Singapore to bridge the gap. The next 2–10 years will be challenging as planning is underway for two new public hospitals, two new community hospitals and at least two more private hospitals (Ministry of Health Singapore 2010). With the rapid expansion in health-care delivery, there is increased competition to recruit nurses within Singapore, particularly the more experienced ones to lead teams and provide optimal care for patients.

Recruitment and retention of the current workforce

Recruitment and retention of nurses are major challenges faced by nursing leaders. The Singapore nursing workforce is younger and the current generation of nurses more mobile. As they gain experience in their roles, they will often move to different work environments and are offered higher remuneration. There is competition for experienced nurses and retention of this group is challenging. The remuneration package for nurses, doctors and allied health-care professionals has been problematic for our human resource colleagues in

recent years. Rewards and recognition must be perceived as fair so as to ensure a more satisfied workforce that wants to serve the organization. As nursing leaders, we aspire to recruit, retain and develop quality nurses to assume leadership roles for the nursing profession.

Training and development

Training and development are major challenges because foreign nurses are a diverse group with different training background and practices. They need to be educated about different cultural beliefs and their practice needs to be aligned to evidence-based nursing practices in Singapore. We need to build the team, enhance the quality of care and reduce the theory and practice gap in the clinical work environment. Moreover, our nurses need to be educated to be more efficient and competent so as to meet the ever increasing health-care needs of the population.

Communication barriers

Singapore is a multiracial society with residents communicating in several languages and dialects. Although the national language is English, not everyone is able to communicate in English. Many elderly Chinese patients can only communicate in dialects, for example, Hokkien. Similarly, many elderly or older Malay patients can only speak and understand Malay language. Foreign nurses from the Philippines can only communicate in the English language. Nurses from India can communicate in English language and Tamil while those from China can only communicate in the English language and Mandarin. This leads to the need for interpreters during patient care. It has become overwhelming for nurses because in addition to caring for their assigned patients, they are often approached to be the interpreters. To overcome barriers in communication, language classes are regularly conducted for foreign nurses to enable them to learn the Malay and Chinese languages as well as some common dialects. This is to enable them to communicate more effectively with the patients and public. We also use pictorial charts for nurses' reference. We strive to ensure safety of care, patient as well as public satisfaction during the caring episode.

Manage rising expectations of the public

The population of Singapore has become more educated, and expectations about care have increased from both patients and their loved ones. Nurses are finding this stressful to manage and it has been a major reason for attrition and job dissatisfaction.

An ageing population

By 2030, 20% of Singapore citizens will be 60 years old and preparations are in place for the 'silver tsunami'

(Khalik 2011). Government agencies actively encourage a healthy lifestyle, such as encouraging the public to exercise regularly, eat wisely and stop smoking.

Health-care financing

At the present time, the government provides significant financial support for public sector health-care. As costs escalate, managing health-care financing is becoming more challenging. Nurse leaders are striving to be role models for the younger generation of nurses to manage health-care cost effectively and efficiently. Nurse leaders look for ways to spearhead nursing innovation, research and learn measures to enhance practices and achieve clinical excellence, improve processes and reduce waste. There is a need to continue to learn from the best and adopt/adapt quality practices for patient's safety and productivity.

Promotion of nursing values

Nurse leaders are challenged to promote the values of nursing to the younger generation. In Singapore, younger nurses now come from small, one- or two-child families. Many were cared for in their childhood by maids. Accepting responsibility for basic nursing tasks is a great challenge for this generation of nurses. Nurses are uniquely different from other profession. In addition to training and developing highly qualified nurses, nursing leaders work to instil nursing values such as compassion, diligence, humility, professionalism, respect, patience and integrity. The goal is to have our nurses recognized as highly qualified professionals who are able to care for the patients with the brain, heart and hands. Equipped with the art and science of nursing, nurse leaders hope to propel our next generation of nurses forward to a higher level.

Summary

Nurse leaders in Singapore recognize the need to have a vision for the profession and share this vision with our colleagues. The global shortage of nurses is felt by Singapore. With the shortage of nurses, it has been necessary to recruit foreign nurses to meet the needs of our patients. However, with foreign recruitment and our unique multiracial society, there are challenges in ensuring effective communication among the health-care professionals with our non-English speaking patients and public. The rapid expansion in the health-care arena has led to competition for experienced nurses between private and public hospitals. With the escalating health-care costs and an ageing population, nursing leaders will need to be more cost effective and

cost efficient. They also understand the need to be role models for the younger generation of nurses and provide relevant training and development programmes. As Singapore moves into the future, nurse leaders are working to ensure that the younger generations of nurses continue to uphold the values of nursing profession and consistently provide quality care and service to all the patients.

United States

The American Organization of Nurse Executives

This contribution is written by Donna Herrin-Griffin is the senior vice president of Operations and Chief Nursing Officer for the Martin Memorial Health System in Stuart, Florida. She has also served as a clinical associate professor of nursing for the University of Alabama in Huntsville since 1996. Donna is known internationally for her nursing leadership work. She served as President of the American Organization of Nurse Executives (AONE) in 2009 and is the current chair of the AONE International Committee.

Introduction

The nursing workforce and health system challenges experienced in the UK and Singapore are similar to those experienced by countries globally including the USA. Recognizing this new reality, the AONE's international work is now broad-based and has grown over the last 5 years. The international plan incorporates a future agenda in positioning the AONE as the source for nursing leadership resources globally. In late 2009, the AONE's International Institute held a strategic planning session where goals were reinforced and a direction for the global work established.

The AONE has a rich history encompassing the first decade of this century. Several efforts of outreach have been undertaken and AONE leaders have responded to colleague calls from many parts of the world. The requests to AONE have primarily been calls for assistance related to nursing practice issues, care delivery system improvements and developing education programmes for nurses and nursing leadership. These efforts have reinforced the understanding that the profession and the common issues are ours as a global profession with many things shared; and in fact, more things shared than different.

AONE international outreach

The AONE's history includes presentations at the biannual International Council of Nurses (ICN) conference and hosting 'People-to-People' tours. During the

2009 ICN presentation regarding the AONE Nurse Executive Competencies (American Organization of Nurse Executives 2005), it became clear that the use of the competencies is becoming a global standard, guiding nurse executive practice and leadership education. Over the years, AONE leaders have presented at the ICN meetings in Japan, Denmark and England. The People-to-People delegations have visited with nurse leaders in Russia, India, South Africa and China.

The international work of the AONE has also included several very specific collaborative efforts regarding development of education systems and nurse leader development. Two efforts have been with the Croatian Nurses Association and more recently, efforts with nurse leaders in Mozambique. Additional requests for AONE expertise has come from countries in the Middle East, India, Cuba and Australia, primarily requesting information on how nurse leaders can benefit from AONE sources and relationships. While affiliation is frequently an information request, the AONE has determined that the relationship would be more beneficial to be flexible in nature.

The AONE international strategy plan

The AONE International Committee's charge is to provide guidance for activities that support the overall AONE strategic plan. As of spring 2011, the international membership in AONE was at 90 members. An official review of potential legal structures was undertaken and determination made that the most flexible structure to meet the needs of international members was to continue with memberships that would encourage leaders in each country to determine how the relationship would work best for that country, which in most cases was to use professional association structures already in place. These existing structures provide the best opportunity for membership and relationship building upon a structure that fits the culture, the finances, and specific needs for support. This structure has proven to be flexible but yet solid enough that AONE membership is offered at a fee appropriate for the particular country. There is an AONE schedule of fees-based internationally established compensation rates.

Understanding international nurse leader needs

To understand the needs of nurse leaders more specifically and formally, an international survey of nurse leaders was planned. Focus areas of this survey attempt to understand how nurses would like AONE to provide support. There have already been requests for some international conferences focused on leadership. Spe-

cific requests have come from the Middle East and Cuba. Within limited resources and global economic challenges, the requests remain under consideration.

Future plans

A long-term focus of AONE is to continue to grow the global reach of AONE to nurse leaders who could benefit from the knowledge, resources, and professional collegiality within AONE. During the International Committee's deliberations in 2010, discussion of the potential for an international coalition of nurse leaders was undertaken and agreed as a future direction. As AONE is an association of more than 8000 members as of this writing, should an international coalition develop and a virtual presence mature, it is realistic to see a future with over 100 000 nurse leader members. The potential of nurse leader collaboration in a more formalized structure is a tremendous opportunity to enhance nursing leadership practice and care delivery systems across the world.

The Alliance for Ethical International Recruitment Practices

This contribution is written by Kathy Harris who serves as vice president, Clinical Services for the Western Region of Banner Health in the USA. In her role, she supports, coaches and mentors the clinical leaders, particularly the CNOs, and acts as a consultant to the 12 facilities within the Western Region. Kathy is an active member of the AONE and has served on several national committees and task forces for the association. She currently represents Banner Healthcare and the American Hospital Association on the Alliance for Ethical International Recruitment Practices.

History

In 2006 the MacArthur Foundation launched an initiative to examine, and potentially respond to, the growing practice of recruiting to the USA foreign-educated nurses (FENs). This practice had grown substantially in response to an expanding shortage of nurses in the USA. A multi-stakeholder task force, representing more than 30 high-level representatives from the hospital, union, nurse education and licensure, foreign-educated nurse and recruiter sectors was convened and over the next 2 years discussed and evaluate guidelines for international recruitment. The result of their deliberations was the introduction of the Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Nurses to the United States

(Alliance for Ethical International Recruitment Practices 2008). To maximize the impact of the Code, to monitor adherence to its principles and to collect data on the state of international recruitment and the standards promulgated, the Alliance for Ethical International Recruitment Practices (the Alliance) was established.

The Code

There are two components to the Code. The first is the minimum standards, which provide for recognition of those entities demonstrating adherence to the code, referred to as subscribers, and monitoring of recruitment practices of those and other organizations. The standards include the expectation that subscribers:

- Comply with the laws of any foreign country in which they operate.
- Communicate and make representations to applicants in an honest, forthright, and accurate manner based upon available information.
- Adhere to general principles of fair contract, immigration, and labour practices.
- Support the FENs' transition, after arrival in the USA States, into the workforce so that the FENs are free to concentrate on their work.

The second component is an aspirational one which identifies and suggests best practices. This includes:

- Working jointly with source country authorities to identify innovative and meaningful ways to ameliorate the impact of recruitment to local health-care organizations and ensure the sustainability of qualified healthcare professionals in those communities.
- Respecting agreements in which FENs have contractual obligations to serve their home country health system.
- Avoiding active overseas recruitment in those countries or areas within countries that are experiencing either a temporary health crisis or a chronic shortage of health workers.

The Alliance

The Alliance board today (Alliance for Ethical International Recruitment Practices 2011) comprises representatives of key stakeholder groups such as:

- Employers (e.g. American Hospital Association, Federation of American Hospitals, Johns Hopkins Health System)
- Professional associations (e.g. AONE, American Nurses Association, American Physical Therapy

Association, American Society for Clinical Laboratory Science),

- US-based associations of foreign-educated nurses (e.g. Philippine Nurses Association of America, National Association of Indian nurses of America),
- Unions (e.g. Service employees International Union, National Federation of Nursing, American Federation of Teachers, AFL-CIO)
- International recruiters (e.g. American Association of International Healthcare Recruitment, O'Grady Peyton International, GlobalCare, National Association of Health Care Recruitment)
- Others (e.g. National Council of State Boards of Nursing, Commission on Graduates of Foreign Nursing Schools)

The Alliance is a non-profit entity whose efforts are focused on promulgation of, and engagement around, the Code. A strategic priority is to collaborate with other parties and in aligned initiatives where the ethical treatment of migrating nurses and other health-care workers is an objective. There are ongoing efforts to publicize, educate and engage others in support of furthering the goals of the Code. The greatest accolade the Alliance can confer is to formally and publically recognize the practice of entities (recruiters, placement agencies and employers) whose processes are aligned and compliant with the principles of the Code. This recognition follows a rigorous application process designed to elicit supporting evidence of, and to reinforce those practices. The Alliance monitors adherence by the subscriber entities to the code and provides a repository for information provided by nurses concerning their own experiences while on the recruitment journey. Such information may or may not relate to subscriber entities. In either case the Alliance may act as a resource to individuals and entities when questions or concerns arise.

The nursing shortage

There are currently 57 countries considered by the World Health Organization (2010) to be in a crisis relative to their work force. The USA actively recruits 25.2% of our FENs from these countries. Clearly, there is work to be done.

A significant number of FENs who have come into this country say that they have experienced at least one problem that violates a principle of the Code. For example, they may not have been able to see the contract before they signed it, or they were given a contract and told 'Sign now' or perhaps they did not get a copy of the contract. The recruiter or the employer may have changed the contract without notifying the nurse. There

may be a requirement that the nurse being recruited has to provide some collateral to secure a visa or position. The nurse may have not known the position for which they were recruited or they may have thought, or been told that they were being recruited for one position and found subsequently that it was something completely different. There are also instances where nurses have been told that they will lose their green cards if they do not do whatever it is they are being asked to do – in other words, there is a threat hanging over their heads. The work of the Alliance is just beginning. It will continue until we can say with confidence and evidence that nurses can expect to be treated fairly if they are coming into the USA.

What to watch for

In an effort of its own to respond to global migration of health-care workers while also improving health care around the world, the World Health Organization (2010) has published its own code of standards to which all nations are expected to adhere. This code is very well aligned with the Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Nurses to the United States, which predates the World Health Organization Code, and each is synergistic with the other. As the economy of the USA improves it is expected that a nursing shortage will again appear. With the pipeline of new nurses diminished in the USA it is likely that the shortage will be severe. This will be compounded by a demand for nurses in new roles as health care adapts to a more continuum-based model of care delivery. As this occurs recruitment of FENs to the USA will once again gain momentum and the related recruitment activity will increase. If the Code is successful our record related to the ethical treatment of all nurses will be a good and strong one.

Conclusion

Nursing and health-care delivery systems are undergoing rapid change throughout the world. These changes have resulted in many common workforce challenges for nurse leaders globally. Opportunities on an international scale for nurse leaders to have dialogue and network, such as the conference presentations discussed in this article, will become increasingly more important to facilitate the development of innovative leadership strategies.

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References

- Alliance for Ethical International Recruitment Practices. (2008) Voluntary code of ethical conduct for the recruitment of Foreign Educated Nurses to the United States. Available at: <http://www.fairinternationalrecruitment.org/images/uploads/Endorsement%20form.pdf>, accessed 12 December 2011.
- Alliance for Ethical International Recruitment Practices. (2011) About us. Available at: http://www.fairinternationalrecruitment.org/index.php/about_us/, accessed 12 December 2011.
- American Organization of Nurse Executives. (2005) Nurse executive competencies. Available at: http://www.aone.org/resources/leadership%20tools/PDFs/AONE_NEC.pdf, accessed 11 January 2012.
- Beveridge W.H. (1942) *Report of the Inter-Departmental Committee on Social Insurance and Allied Services*. CMND 6404. HMSO, London.
- Buchan J. & Aiken L. (2008) Solving nursing shortages: a common priority. *Journal of Clinical Nursing* 17, 3262–3268.
- Clarke S. & Aiken L. (2008) An international hospital outcomes research agenda focused on nursing: lessons from a decade of collaboration. *Journal of Clinical Nursing* 17, 3317–3323.
- Friedman T.L. & Mandelbaum M. (2011) *That Used to Be Us*. Farrar, Straus and Giroux, New York, NY.
- Gantz N.R. (2010) *101 Global Leadership Lessons for Nurses: Shared Legacies from Leaders and Their Mentors*. Sigma Theta Tau Inc., Indianapolis, IN.
- Huston C. (2008) Preparing nurse leaders for 2020. *Journal of Nursing Management* 16, 905–911.
- Kabene S.M., Orchard C., Howard J.M., Soriano M.A. & Leduc R. (2006) The importance of human resource management in health care: a global context. *Human Resources for Health* 20 (4), 102–111.
- Khalik S. (2011) Concerns over medical cost and ‘silver tsunami’. *The Straits Times*. Available at: http://www.straitstimes.com/BreakingNews/Singapore/Story/STIStory_635110.html, accessed 15 February 2011.
- Lei W., Hee K.Y. & Dong W. (2010) A review of research and strategies for burnout among Chinese nurses. *British Journal of Nursing* 19 (13), 844–850.
- Lewis M. (2011) *Boomerang*. W.W. Norton, New York, NY.
- Manion J. (2009) Managing the multi-generational nursing workforce: managerial and policy implications. Prepared for the International Centre for Human Resources in Nursing. Available at: http://www.ichrn.com/publications/policyresearch/Multigen_Nsg_Wkforce-EN.pdf, accessed 9 February 2012.
- McSherry R. & Douglas M. (2011) Innovation in nursing practice: a means to tackling the global challenges facing nurses, midwives and nurse leaders and managers in the future. *Journal of Nursing Management* 19, 165–169.
- Ministry of Health Singapore (2010) Hospital services. Available at: http://www.moh.gov.sg/content/moh_web/home/our_healthcare_system/Healthcare_Service/Hospitals.html, accessed 15 December 2011.
- Ministry of Health Singapore (2011) Healthcare finance overview. Available at: http://www.moh.gov.sg/content/moh_web/home/costs_and_financing.html, accessed 15 December 2011.
- Mouro G., Tasbjian H., Kozman K. & Shamoun A. (2011) On the scene: American University of Beirut Medical Center, Beirut, Lebanon. *Nursing Administration Quarterly* 35 (3), 219–226.
- Nakata Y., Yasukawa F. & Buchan J. (2008) Nursing workforce: global challenges and solutions. *Journal of Clinical Nursing* 17, 3261.
- Nichols B., Shaffer F.A. & Porter C. (2011) Global nursing leadership: a practical guide. *Nursing Administration Quarterly* 35 (4), 354–399.
- Parker S. & Hyratus K. (2011) Priorities in nursing management. *Journal of Nursing Management* 19, 567–571.
- RN4CAST (2011) RN4CAST: Registered Nurse forecast. Available at: http://www.rn4cast.eu/attachments/RN4CAST_ICN%20MALTA%202011%20-%20s210.pdf, accessed 9 February 2012.
- Singapore Nursing Board (2009) Annual report. Available at: <http://www.snb.gov.sg/html/1156329449883.html>, accessed 15 December 2011.
- ukpublicspending.co.uk (2010) *UK Public Spending since 1900*. Available at: http://www.ukpublicspending.co.uk/spending_brief.php, accessed 28 December 2011.
- Williams D. (2011) Nursing numbers fall, official figures show. *Nursing Times*. Available at: <http://www.nursingtimes.net/whats-new-in-nursing/news-topics/public-health/nhs-nurse-numbers-fall-official-figures-show/5027656.article>, accessed 14 December 2011.
- World Health Organization (2007) Strengthening health systems to improve health outcomes: WHO framework for action. Available at: http://www.who.int/healthsystems/strategy/everybodys_business.pdf, accessed 14 December 2011.
- World Health Organization (2010) Managing health workforce migration – the global code of practice. Available at: <http://www.who.int/hrh/migration/code/practice/en/>, accessed 15 December 2011.