INTERNATIONAL NURSES DAY 2026

Empowered Nurses Save Lives

International Council of Nurses

OUR NURSES.
OUR FUTURE.

International Nurses Day 2026

Empowered Nurses Save Lives

Lead authors:

David Stewart, ICN Director, Nursing Policy and Practice

Gillian Moore, ICN Communications Consultant

Contributors: Howard Catton, ICN Chief Executive Officer

Editor: Lindsey Williamson

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Foreword

This year's International Nurses Day theme, *Our Nurses. Our Future. Empowered Nurses Save Lives*, is both a celebration of nursing power and a call to invest in the conditions required to enable it. Every single day, across every single region, nurses save, improve, and transform lives. Nursing power is real, measurable, and high-impact — and it must be recognized and named. This report brings together clear evidence of the impact of nursing. It identifies seven distinct nursing powers that improve health outcomes, make health systems more resilient and accessible, and support social and economic progress. It also sets out what must be done to maximize the impact of nursing across all countries and contexts.

The 2026 IND report comes at a moment of extraordinary pressure for health systems and nurses, with severe workforce shortages, growing and increasingly complex health needs, and rising conflicts, climate crises, and inequalities. My Presidential watchword is "empowerment", because empowering nurses to reach their full impact is the surest way to meet these demands while protecting the quality and safety of care. As this report makes clear, "empowerment" means structural enablement. It means leaders making the deliberate choice to create the conditions that allow nursing to deliver at its highest impact, consistently and at scale. It means ensuring safe working conditions and fair pay; removing barriers that waste nursing expertise and time; and building systems that translate nursing capacity into measurable improvements in safety, access, continuity of care, and outcomes. And it means nurses having a strong voice at every level of leadership and decision making.

If we want stronger primary health care, safer hospitals, better chronic disease management, more equitable access to essential services, and more resilience to shocks, we must give nurses the authority, tools, data, resources, and fair and safe working conditions needed to deliver. This report sets out a clear framework for empowered nursing, based on the ICN Charter for Change and the World Health Organization Global Strategic Directions for Nursing and Midwifery.

ICN calls on governments, employers, regulators, educators, and partners to use this report as a practical agenda. The choices made now about staffing, education, scope of practice, safety, and investment will determine whether health systems can meet rising demands, stay resilient in the face of crises and changing health environments, and deliver Universal Health Coverage. The evidence demands action and the world's 30 million nurses are ready. It is time to harness the impact of the world's largest health workforce and empower nurses to save lives and save health systems.

Dr José Luis Cobos Serrano
President, International Council of Nurses

The power of the nursing profession to save and transform lives is clear. But power without recognition, without investment, becomes invisible.

When we don't name our power, we give it away. When leaders don't provide the structural support that enables nursing power, they leave billions of dollars and millions of lives on the table.

It is time for nurses to own our power to save and improve lives everywhere, with the support, recognition and empowerment the profession deserves.

José Luis Cobos Serrano, ICN President

Executive summary

Research demonstrates the immense power of the nursing profession to save and improve lives, drive economic growth, and transform health systems worldwide. Strengthening the health workforce could **prevent 189 million years of life lost to early death and disability** and **add USD 1.1 trillion to the global economy by 2030** (McKinsey, 2025). As the largest and most trusted part of that workforce, the closest to patients and communities, and the best positioned to deliver holistic, person-centred, primary, preventive care — nurses are the key to making this happen.

This report reframes disempowering and gendered narratives of nursing that emphasize only soft skills or caring instincts. It provides vital evidence that **nursing is a high-impact profession with measurable powers that transform health, social and economic outcomes**. It builds a strong case for **investing to unlock the impact of nursing's powers.** And it outlines decisive solutions to the challenges preventing us from mobilizing nursing power as the foundation of global health.

WHY NURSING POWER MATTERS NOW

The world faces **converging crises that make the impact of nursing more important than ever**. Rising geopolitical conflicts, climate change related disasters, cuts to health funding, and deepening inequalities are putting enormous pressures on health systems. Meanwhile, health demands are growing: chronic conditions are multiplying, mental health needs are soaring, and populations are ageing. Without urgent action, we will not achieve Universal Health Coverage and the Sustainable Development Goals to which all countries have committed to by 2030.

The only way forward is to transform health systems towards care that is preventive, continuous and community based rather than episodic — and **empowered nurses are uniquely positioned to lead this shift**. Recognizing the power of nursing also means recognizing the power of women. With women making up 85% of the nursing workforce (SOWN, 2025), the transformation this report calls for is inseparable from gender equity. Empowering nursing means empowering women as leaders, decision-makers, and agents of health system change.

This report focuses on **seven key nursing powers**, each of which has transformative, evidence-based impacts on health outcomes, equity, and economic prosperity.

The seven powers of empowered nurses

1

THE POWER OF TRUST

Nurses are consistently voted the public's most-trusted profession. Surveys of 100,000+ patients show that **high trust brings better health outcomes, and improved care experiences**. Nursing trust is vital to public health interventions such as vaccination, which has saved 154 million lives and 10.2 billion full health years globally over the past fifty years.

154 million lives saved

10.2 billion full health years globally preserved

2

THE POWER OF THE PROFESSIONAL

Nursing is based on strong ethics, clinical competence and rigorous education. Every 10% increase in bachelor's-degree-prepared nurses in hospitals reduces patient deaths by 7%. Using professional, registered nurses rather than substituting with less-skilled workers saves lives, prevents adverse events, and avoids costs.

Every **10%** increase in bachelor's-degree-prepared nurses in hospitals reduces patient deaths by **7%**

3

THE POWER OF NUMBERS

At almost 30 million strong, nurses are the world's largest health profession, yet we face a global shortage of 5.8 million nurses. Lessening health workforce gaps could save 189 million years of life lost to early death and disability and add $1.1 trillion to the global economy.

189 million years of life lost to early death and disability could be saved

1.1 trillion could be added to the global economy

4

THE POWER OF PRACTICE

When nurses work to their full scope, including Advanced Practice, access to high-quality care improves dramatically. Up to 77% of preventive care and 47% of chronic care could be provided by nurses and other non-physician roles.

77% of preventive care and **47%** of chronic care could be provided

5

THE POWER OF CARE

Nurses are key to person-centred, preventive and primary care, essential to bringing health to all and addressing the growing burden of non-communicable diseases. Scaling up primary health care could save 60 million lives by 2030 in low and middle-income countries — while investing in NCD prevention and management would save over 12 million lives globally and drive $1 trillion in gains.

60 million lives could be saved by 2030 in low and middle-income countries

Over **12** million lives could be saved globally and **$1** trillion could be driven in gains

6

THE POWER OF PROXIMITY

Nurses spend the most direct time with patients and have extensive reach into communities. Nursing proximity prevents care-related harm, which costs the world $606 billion annually. Nurses' reach brings essential care to underserved populations, advancing health equity and **Universal Health Coverage**.

Care-related harm costs the world **$606** billion annually

7

THE POWER OF PEACE

In conflict and humanitarian crises, nurses' care defends health, human rights, and peace. Nurses in conflict settings protect global health security by identifying and treating infectious disease risks: 80% of major infectious disease epidemics occur in fragile or conflict-affected countries.

80% of major infectious disease epidemics occur in fragile or conflict-affected countries

Sources: OECD 2025; WHO 2024; Aiken et al., 2014; Pence et al., 2005; Griffiths et al., 2018; McKinsey Health Institute, 2025; OECD, 2020; Aiken et al., 2021; Laurant et al., 2018; Butler et al., 2026; WHO, 2025; WHO 2025; Slawomirski & Klazinga, 2020; WHO, 2020.

A CALL TO *INVEST FOR IMPACT*

The kind of empowerment this report calls for is *structural*: it is about having the investment, policy, and fair and safe working conditions in place that enable nurses to use their powers to the fullest. This must include nurse leadership. Nurse leaders, national nursing associations, and Chief Nursing Officers all scale the profession's impact throughout organizations, nations, and the wider world.

A CLEAR HEALTH AND ECONOMIC CASE: *INVEST FOR IMPACT*

The value of empowered nursing clearly shows that **nurses should not be seen as a cost but as a high-return investment**. Every single USD 1 invested in better health can yield economic returns of USD 2-4, while poor health reduces global GDP by 15% each year (Remes et al., 2020). Research shows 1:14 returns on investment for preventive health interventions, where nurses are key (OECD, 2025). The evidence gathered in this report shows that investing in nurses prevents massive costs associated with patient harm and unnecessary hospital stays — and keeps populations healthy and productive, supporting better lives and economic growth.

Figure 1: The impacts of investing in empowered nursing

FROM CHARTER TO ACTION: *EMPOWERED NURSES SAVE LIVES*

Based on this evidence, this International Nurses Day, ICN brings a clear message to leaders: for empowered nurses to save lives, **we must invest for impact.** Empowered nursing is nursing that is structurally supported with safe, fair working conditions, leadership opportunities, and full scope of practice. At a time of collective uncertainty and stalled progress towards shared global health commitments, empowered nursing can catalyze health system transformations, advance Universal Health Coverage, global equity and development.

This report presents a roadmap of solutions designed to *maximize the impact of nurses' powers to save and transform lives,* all grounded in the ICN Charter for Change, which sets out the commitments needed to build health systems that value, protect and empower nurses, and aligned with the World Health Organization (WHO) Global Strategic Directions for Nursing and Midwifery, which ICN advocated strongly to extend and to which all WHO member states have committed.

This IND, we call for the following concrete actions to support the power and impact of nursing, based on each Charter for Change goal.

Figure 2: Actions for empowered nursing based on ICN's Charter for Change

ICN Charter for Change	Key actions to enable the power of nursing
Protect and invest in the nursing profession	• Commit to sustained, long-term investment in nursing to strengthen health systems • Ensure working environments that support and enable nurses • Invest in nursing professionals over substitution with less-qualified workers • Build absorption and equitable deployment so graduates become nurses in care • Redesign clinical workflows to return time to care
Ensure safe and healthy working conditions and respect nurses' rights	• Invest in fair and safe working conditions, including safe staffing and skill-mix • Prevent violence and protect nurse safety with zero-tolerance policies and clear protocols • Protect nurses' health and well-being with supports and conditions that prevent burnout • Uphold nurses' human rights and labour rights in every setting • Strengthen implementation of International Humanitarian Law and enforce legal protection to end attacks on health care • Guarantee occupational safety and health system infrastructure
Recruit and retain nurses by ensuring fair and decent pay and positive practice environments	• Invest in decent work and safe care environments that attract and retain nurses • Provide fair, competitive wages that address cost of living and gender pay inequity • Ensure positive working environments including early-career support • Provide clear career progression pathways
Develop, implement and finance national nursing workforce plans	• Develop and fund multi-year national nursing workforce plans that take a systems approach with measurable targets and sustained financing • Measure workforce deployment and returns and health outcomes • Ensure equitable distribution of nurses, with strategies for underserved areas • End dependency on health workers from fragile source countries and make all international recruitment ethical • Align health system funding with modern care models • Build workforce emergency capability and preparedness

Invest in high-quality, accredited nursing education programmes	• Invest in degree-level education as standard and strengthen regulations • Scale the education pipeline by addressing shortages of faculty and constraints • Align education and continuing professional development with contemporary health needs and people-centred, primary care • Support progression from general to specialist and advanced practice • Modernize information systems and embed digital technology in curricula
Enable nurses to work to their full scope of nursing practice	• Modernize legislation and remove outdated regulatory barriers that prevent nurses practising to their full education and competence • Invest in expanding advanced practice nursing roles and nurse-led care models • Invest in digital infrastructure and workflow reform to free time for people centred care
Recognize and value nurses' skills, knowledge, attributes and expertise	• Adopt the ICN Definitions of nursing and a nurse in policy to protect professional identity and ensure public understanding of nurses' impact and roles • Measure and use nurse-sensitive indicators to make nursing contributions to health outcomes visible and inform staffing • Align remuneration with nurses' level of expertise and responsibility • Build strong career pathways that support progression in clinical and education roles • Involve nurses as decision-makers
Actively and meaningfully engage national nursing associations	• Empower nursing associations to establish and advance professional standards • Ensure NNAs have a voice in health policy development and workforce planning • Recognize NNAs as crucial non-governmental organizations that can support health needs in crisis situations
Protect vulnerable populations, uphold and respect human rights, gender equity and social justice	• Recognize and promote nurses' trusted relationships with communities as an asset • Close equity gaps by removing barriers to accessing care • Ensure ethical, inclusive, and rights-based care for populations most at risk • Support nursing ethics and nurses' holistic, person-centred care that addresses social determinants of health and advocates for vulnerable patients
Appoint nurse leaders	• Ensure Chief Nursing Officer roles with authority at national level and at WHO • Involve nurses in health system design and decision-making at national and organizational levels • Invest in structured leadership development pathways for nurses

Our Nurses.

Our Future.

CHAPTER

1

The power of trust

Empowered Nurses Save Lives

Public trust in the nursing profession is exceptionally high, as empirically verified by decades of polling data from countries across the world. For over two decades, the annual U.S. Gallup Poll on Honesty and Ethics has consistently identified nursing as the public's most trusted profession (Gallup, 2026) — a distinction unmatched by any other field. Nurses also regularly top the Ipsos Veracity Index, which measures public trust across various professions in the UK (Ipsos, 2025). Nurses have achieved high (89%+) overall trust ratings in global studies of over 20 countries (GfK Verein, 2018).

According to one recent survey, 95% of respondents identify **professionalism and high engagement as the primary factors driving their trust in nursing** (Pawluk et al., 2024). This perception is rooted in the nurse's role as the lynchpin of the health system, providing evidence-based treatment and person-centred care that heals and supports patients.

ICN's updated Definitions highlight the importance of ***trust*** in nursing's unique blend of science-based competency, interpersonal closeness, and therapeutic human care.

"Nurses play a unique role in health and care for populations of all ages, and in all settings, **building trust with individuals, families and communities and gaining valuable insights into people's experiences of health and illness.**"

ICN, 2025

NURSES' POWER TO OVERCOME THE TRUST GAP

This trust is needed more than ever as we face a crisis of confidence in health institutions and systems, exacerbated by negative experiences during the pandemic, medical misinformation, marginalization, socioeconomic inequalities, and underinvestment in health (Kluge & Sikkut, 2023; WHO, 2023; The Health Policy Partnership, 2024; Sanofi, 2023).

The Organisation for Economic Co-operation and Development (OECD) Patient-Reported Indicator Surveys show a consistent trust gap: **almost four in five patients reported high trust in the last care professional they saw, while only a little over half trusted the health care system overall** (OECD, 2025). This gap matters: when institutional confidence is fragile, the health system's most credible interface with people is often the clinician in front of them.

> Nursing is widely recognized as a public trust profession due to its emphasis on professionalism, ethical standards, and patient-centred care. The profession demands adherence to legal regulations and ethical norms, fostering trust through its critical role in health care delivery.
>
> Pawluk et al., 2024

CASE STUDY

TAKING HEALTH CARE TO THE STREETS IN BALLINA, AUSTRALIA

In Ballina, Australia, a nurse-led outreach model demonstrates how trusted nursing relationships can reconnect people who have been pushed to the margins of the health system. Across Australia, there are people the health system rarely reaches. Some are sleeping rough, while others have lived through serious trauma and have stepped away from clinics and hospitals altogether. The result is unhealed wounds, escalating chronic conditions, untreated mental distress, and unsupported substance use needs.

Nurse Sonia Martin saw this gap up close, and decided the usual model wasn't enough. She left her hospital role and began taking nursing care to the streets, building a practical kit in the boot of her car so she could meet people where they were. What started as direct outreach grew into OneBridge, which has established a nurse-led clinic in Ballina, NSW, in partnership with Mary's Place (St Vincent de Paul Society NSW) and Healthy North Coast. The clinic provides primary health care for people experiencing homelessness, at risk of homelessness, or facing barriers to traditional services. Support ranges from wound care and general health checks to chronic condition education, mental health support, and connection into drug and alcohol care pathways.

The approach is designed around consistent, compassionate nursing care delivered in a familiar setting, with time to understand what sits underneath the symptoms. It improves access, going beyond geographic reach to ensure that care provides trust, safety, and support rather than judgement. For people who have been let down by systems — or who have learned to avoid them — this kind of care can be the difference between another crisis admission and a steady path back to health. People experiencing homelessness are more likely to develop chronic conditions earlier than the general population, and nurse-led services like OneBridge are built to interrupt that trajectory before preventable illness becomes permanent damage.

(HNC, 2025; ABC, 2025)

THE IMPACT OF TRUST

From crowded urban emergency rooms to remote village clinics, nurses are entrusted with people at their most vulnerable. Trust is exceptionally important for patients who may be uncertain, vulnerable, or at risk, and must rely on nurses' competence and ethics to act in their best interest (see Rowe & Calnan, 2006). Nursing professionals answer that trust with science and skill; with caring and with advocacy for the whole person.

Trust is the clinical multiplier that makes care work, converting investment in health care into measurable patient outcomes. Nurses' ability to build trust is not a peripheral "soft skill" but a core clinical competency with tangible, evidence-based impacts on individual patient outcomes and broader public health.

High levels of trust in health care providers increase patients' adherence to medication by

20–40%.

(Kanakubo et al., 2025; Kerse et al., 2004; Piette et al., 2005)

IMPACT 1

Trust improves patient health

The OECD's survey of over 100,000 patients across countries shows that **higher levels of trust** in health systems are associated with **better overall physical and mental health** (OECD, 2025). When patients trust their health care providers, they move from passive recipients of care to active partners in their own health management, directly influencing the trajectory of chronic disease and other health outcomes.

A review of 47 studies found that patient trust in health care professionals was associated with **increased patient satisfaction** and perceptions of **beneficial health behaviours, reduced symptom severity, and higher quality of life** (Birkhäuer et al., 2017).

The evidence shows that **trust has direct effects on treatment adherence**: studies report 20–40% improvements in adherence to medication regimens when trust in health providers is high (Kanakubo et al., 2025; Kerse et al., 2004; Piette et al., 2005). Non-compliance with prescribed medications is a huge problem, leading to almost 200,000 premature deaths and €125 billion in unnecessary costs every year in Europe alone (Khan & Dietrich, 2018). This means that trusted health care professionals improving treatment adherence have the potential for enormous impact, saving lives and reducing health expenditure. This matters because barriers are inevitable; trust determines whether patients remain engaged when care becomes difficult.

Trust is also associated with measurable differences in mental health treatment outcomes, where evidence suggests that trust explains around 5–10% of the variance in treatment outcomes (Flückiger et al., 2018; Probst et al., 2019).

IMPACT 2

Trust improves public health, crisis response and health security

In times of large-scale public health crises, like the Ebola, H1N1, and COVID-19 pandemics, public trust in health care professionals and institutions is a vital component of public health and national security. High levels of trust are essential to secure voluntary public compliance with crucial measures like vaccination, social distancing, and contact tracing.

> Strengthening **trust and transparency** are truly crucial if we are to absorb and implement the painful lessons of the COVID-19 pandemic and other emergencies as we prepare better for the future.
>
> Dr Hans Henri P. Kluge,
> WHO Regional Director for Europe

CASE STUDY

TRUSTED NURSE-LED IMMUNIZATION IN LEBANON

Nurses have played a central role in the immunization initiatives promoted by the Lebanese Ministry of Public Health in partnership with UNICEF and WHO since 2017, with a focus on strengthening childhood immunization efforts for the Inactivated Polio Vaccine (IPV) and Measles, Mumps, and Rubella (MMR) vaccines.

Quoted in a UNICEF report (2019), one mother said:
"Over the years we've seen how the nurses take care of our children, and we trust their advice on all medical issues – including the importance of vaccinations".

As trusted professionals, nurses work in collaboration with community health workers to screen children and identify those who have missed vaccinations. At nurse-led primary health care centres and in mobile vans, nurses administer missing vaccines, create plans for follow-up immunizations, conduct awareness and education sessions, and work to improve access and transportation.

Given additional challenges in Lebanon including ongoing conflict and lack of resources, the trusted role of nurses in promoting, delivering, and monitoring immunization is more important than ever.

(UNICEF 2019, 2021, 2024)

During the COVID-19 pandemic, societies with high levels of trust in health care experienced lower mortality rates **while mistrust was directly linked to negative public health outcomes, including higher rates of vaccine hesitancy, increased belief in conspiracy theories, and widespread non-compliance with public health mandates** (Souvatzi et al., 2024; Lenton et al., 2022; Jennings et al., 2021; Albæk, 2025). Research has found that people with greater trust in health care workers were less likely to have their children miss vaccine doses (Moucheraud, 2024).

Data shows a concerning trust deficit: on average, only 37% of people in OECD countries trusted COVID-19 information from government officials, highlighting a critical vulnerability in global health security (de Biennasis et al., 2023). Transparency and information integrity are essential for maintaining public trust. The risks of disinformation, which can lead to polarized societies and the spread of public health conspiracy theories, have a corrosive effect on trust and can undermine the acceptance of evidence-based treatment, including immunization. In 2021, WHO and UNICEF reported **the largest sustained drop in childhood vaccination rates for over 30 years** (WHO, 2022).

A one standard deviation increase in generalized trust reduced COVID-19 mortality by 43% (evidence from 42 European countries)

This equals ~588 fewer deaths per million at average mortality levels

60–90% of this effect is driven by greater public compliance with health measures

Higher trust also reduces the economic impact (4.4% reduction in GDP per 1000 COVID-19 deaths)

Albæk, 2025

Nurses have the power to improve vaccine uptake by leveraging their trusted relationships to share accurate health information, address concerns, and promote evidence-based interventions by reaching and educating communities. The impact of immunization is clear: over the past 50 years, **vaccination has saved 154 million lives and 10.2 billion full health years globally** (WHO, 2024). The power of nursing trust is indispensable for public health.

CASE STUDY

BUILDING COMMUNITY TRUST TO ACHIEVE HIGH CHILDHOOD IMMUNIZATION COVERAGE IN FIJI

Fiji provides a compelling example of how the power of trust and primary health care can sustain high childhood immunization coverage, even in socially diverse and geographically dispersed settings. With a population of approximately 937,000 people spread across multiple islands, Fiji delivers childhood immunization services through a nationwide network of 220 immunization sites. Since its establishment in 1988, Fiji's Expanded Programme on Immunization (EPI) has protected children against twelve vaccine-preventable diseases and remains a cornerstone of child health.

PROBLEM: VACCINE HESITANCY AND ACCESS BARRIERS

Despite strong infrastructure, vaccine hesitancy has been identified as a growing challenge, particularly in hard-to-reach communities and socially diverse communities.

RESPONSE: NURSE-LED FOLLOW-UP AND TRUST-BASED EDUCATION AND ENGAGEMENT

Nurses play a central role in a mixed-delivery approach that allows multiple opportunities for children to receive timely vaccinations. Nurses actively track children who miss scheduled immunization appointments, follow up with parents and caregivers and reschedule, update immunization records including for vaccinations received outside a child's usual catchment area, and coordinate care for families who travel between different divisions or communities. Nurses also organise outreach visits to underserved populations and use communication platforms, including vaccination update groups, to support real-time coordination across services.

To address vaccine hesitancy, nurses and other health care workers prioritized respectful, evidence-based engagement. They identified hesitant caregivers early, actively listened to their concerns, and provided clear, consistent information on vaccine safety, effectiveness, and the importance of completing the full immunization schedule, using tailored and culturally appropriate communication.

© Iliesa Ratuva, District Nurse serving the community of Viwa Island, Yasawa Islands, Fiji

Strengthening primary healthcare through community engagement was a key part of this strategy, including collaboration with trusted community figures—church pastors, village leaders, community health workers, and schoolteachers—to reinforce accurate information about immunization and increase community confidence in vaccination services.

RESULTS AND IMPACT

The combination of nurse-led counselling and community partnerships fostered trust, reduced misinformation, and encouraged caregivers to complete their children's immunization schedules.

In 2025, Fiji administered 16,032 doses of the measles, mumps, and rubella (MMR) vaccine, achieving a national coverage rate of 95.2%. This high level of coverage reflects proactive nurse follow-up, integrated service delivery, and sustained community trust and engagement.

Fiji's experience shows the power of trust-based, respectful communication, nurse-led integrated primary healthcare, and strong community integration.

Figure 3: Impact of trust

SUPPORTING THE PILLARS OF TRUST

Trust is the operational "glue" of safe and effective care. However, it is threatened by workload pressures, inadequate staffing, time constraints, and system inefficiencies that can prevent nurses from delivering personalized, relationship-driven care to their fullest potential.

To support high levels of trust in nursing and in health care, we must address systemic barriers that prevent health professionals from providing the kind of care that builds and maintains trust: adequate time with patients, personalized attention to individual needs, and reliably safe care environments.

64% of patients who felt their primary care professional spent enough time with them trusted the health system vs 34% of those who felt they lacked time — an almost

90%

relative difference.

(OECD, 2025)

PILLAR 1

Time as a clinical resource

Patients highly value having adequate time with primary care professionals as well as shorter waiting times. Patients who felt their primary care professional spent enough time with them were 30% more likely to trust the health system (64% compared to 34%), an almost 90% relative difference (OECD, 2025). The same large-scale survey found that people living with chronic conditions who have longer consultations are more likely to report better quality of care: scheduled consultations of more than 15 minutes increase the likelihood of trusting the professional by 12%.

Health systems must enable nurses with sufficient staffing and work environments that allow for this time. Patient relationship-building time is clinically productive work that drives trust, adherence, and health outcomes.

PILLAR 2

Personalized care

Trust flourishes when patients experience care as both professionally competent and personally meaningful. People are significantly more confident in managing their health when they are involved in their health decisions and receive strong self-management support from health professionals (OECD, 2025; Griffin et al., 2019).

With proper system support, the nursing profession's holistic, whole-person approach ensures this trusted, personalized care.

PILLAR 3

Safety culture

Patients need care that is safe and coordinated. Adverse events — not getting an appointment, receiving a wrong diagnosis, or experiencing communication problems — drastically erode trust. Only 45% of those who experienced an adverse event trusted the system, whilst 70% of those who did not experience an adverse event expressed trust in the system (OECD, 2025).

Nurse staffing must be prioritized as a critical driver of safety and trust for patients. When nurse staffing is perceived as adequate, 57% of patients rate their care as "excellent," compared to only 14% when staffing is insufficient (Aiken et al. 2021).

THE BLUEPRINT: POLICY ACTIONS FOR EMPOWERED TRUST

The power of nursing trust is a core mechanism of clinical effectiveness that strengthens adherence, supporting shared decision-making, and promoting accurate health information and public health, while also shaping the expectations that influence how people experience and respond to care.

ICN calls for the following actions to enable trust within nursing and health systems:

ACTION 1

Invest in working conditions that promote safe, time-rich care

Invest in safe staffing, supportive skill mix, professional regulation, ethical practice, and digitally-enabled models that extend access without weakening the nurse–patient relationship. Reorient workforce planning and performance models to protect nurse–patient time and ensure adequate resources for quality, person-centred care.

ACTION 2

Involve nurses in health system design and decisions

Close the gap between trust in the profession and trust in the system by embedding nurses' expertise everywhere decisions are made — service redesign, quality and safety, digital transformation, and workforce planning. This ensures that frontline realities shape policy and resources.

ACTION 3

Recognize and manage trust as a clinical asset

Treat public trust in nursing as a measurable driver of clinical effectiveness that converts nursing knowledge, skill and presence into improved health outcomes at scale.

ACTION 4

Protect professionalism to protect performance

Prevent erosion of trust by ensuring supportive environments that enable nurses to maintain their high professional standards of care. Ensure clear guidance and trust-critical standards that preserve confidentiality, informed consent, clear communication, and ethics across all settings. Prioritize registered nursing professionals in the skill mix to maintain the trusted expertise patients depend on.

ACTION 5

Target the equity-related trust gap with accountable action

Reduce disparities that can lower trust by removing barriers to access, communication and continuity for underserved groups. Require equity impact assessment, culturally safe care capability, and community-partnered delivery models as standard practice.

ACTION 6

Measure and publish trust as a board-level requirement

Collect trust data routinely and report it alongside safety, quality and access. Make trust a governance metric with clear ownership, transparent reporting, and improvement plans — so leaders manage trust with the same discipline as clinical risk.

To secure a healthier future, we must harness the power of nursing as the world's most trusted profession. Nursing trust not only saves lives and strengthens health systems, it protects global health safety and security. When trust is present, patients take their medication, families vaccinate their children, and whole populations comply with the public health measures that contain crises and health emergencies. We must now protect that trust through sustained investment in nursing.

Howard Catton, ICN Chief Executive Officer

CHAPTER

2

The power of the professional

Empowered Nurses Save Lives

Professional nursing education, regulation and standards are the cornerstone of patient safety and quality care. Nursing professionalism represents a social contract with the public based on rigorous academic preparation, strong skills and competence, binding ethical standards, and mandatory regulation that protects both patients and practitioners. The professional nurse is a safety-critical role that is vital to both saving and improving lives and health outcomes.

Recognizing and enabling the power of the nursing professional means overcoming stereotypes that focus only on nurses' caring vocation rather than their rigorous, regulated clinical expertise. ICN's new Definitions highlight nurses' role as **highly-skilled, highly-educated professionals who combine evidence-based care with the therapeutic relationships** that make that care timely, person-centred, and effective (ICN, 2025).

The power of professional education, standards, and regulations is critical to enabling the world's largest health workforce to address the escalating burden of chronic disease and the complexities of modern health care.

WHY THE POWER OF THE PROFESSIONAL MATTERS NOW

Three system pressures make the role of the nursing professional urgently important.

1. The complexity of care and health demands are increasing

Across the world, health care is becoming more complex. Care is shaped by interacting factors such as advancements in technology and treatments; growing multimorbidity, ageing populations, changing socio-economic conditions; system constraints and health care financing challenges. This complexity creates distinctive challenges for health care practitioners: many clinical situations do not follow linear cause-and-effect pathways and processes and outcomes are often shifting and difficult to predict (Katerndahl, 2005). Care is never about task completion alone. Professional nurses must make complex decisions, anticipate complications, and adapt in real-time in dynamic environments, all based on constantly evolving patient conditions and system constraints. Professional training, judgement, and ethics are vital.

2. Workforce value is being left on the table

In OECD countries, 79% of nurses reported being over-skilled for their day-to-day roles, signalling large-scale misalignment between educational investment and role design (Maeda & Socha-Dietrich, 2021). Systems cannot "train their way out" of gaps while simultaneously deploying qualified nurses into low-value work. We must design health systems that enable and utilize nursing professionals' full range of strategic skills, clinical judgement and expertise.

3. Health systems are tempted by "cheap capacity"

WHO projects an 11 million health care worker shortage by 2030 (WHO 2025). Health systems facing workforce shortages increasingly reach for quick fixes through substitution, shifting work to lower-cost, minimally trained, or unregulated roles. The International Labour Organization (ILO) notes a trend towards task-shifting that uses 'less skilled workers' in health care, which has led to 'an increase in the casualization of the regulated nursing workforce and the number of unregulated health care workers' (ILO, 2022).

While cadres such as community health workers and assistants can play valuable supportive roles as part of well-supervised teams, replacing professional nurses with unregulated or lower-trained workers can negatively impact patient safety and add strain to health systems and professionals (Pence et al., 2007; Aiken, 2017; Griffiths et al., 2018; Griffiths et al., 2023).

Nurse education saves lives

Every **10%** increase in bachelor's-degree-prepared nurses decreases patient mortality by **7%**.

(Aiken et al., 2014)

THE IMPACT AND FOUNDATION OF NURSING PROFESSIONALISM

The architecture of nursing professionalism rests on three interconnected pillars, each of which strengthens nurses' professional power by providing the structural foundation to convert advanced clinical knowledge into consistent, high-quality outcomes.

PILLAR 1

Rigorous education

Professional nurses complete extensive programmes covering anatomy, physiology, pharmacology, and pathophysiology in depth. This trains them to synthesize complex information, make accurate assessments, and develop evidence-based care plans. ICN advocates **competency-based education,** which focuses on the **acquisition of knowledge, skills and attitudes with measurable outcomes**, and through **supervised clinical practice** in real health care settings as well as simulation.

Accreditation ensures that education providers meet agreed standards, guaranteeing that graduates possess the knowledge and skills for safe, effective practice.

> The 2025 World Health Organization **State of the World's Nursing (SOWN) report**, co-chaired by ICN, shows positive progress in moving nursing to an all-graduate profession: **approximately 84% of nurses globally are now prepared with a minimum of three to four years of education.**
>
> We must now accelerate investment in high-quality nurse education and ensure it is accessible and equitable all around the world.
>
> Howard Catton, ICN Chief Executive Officer

Outcomes and impact

The impact of nurses' extensive education is clear: research has shown that every 10% increase in bachelor's-degree-prepared nurses on a hospital unit reduces patient deaths by 7% (Aiken et al., 2014). Studies show that clinical settings with higher proportions of bachelor's-educated nurses have lower risks of patient mortality and failure to rescue (Aiken et al., 2003; White et al., 2018; Haegdorens et al., 2019; Harrison et al., 2019). Research also suggests that a higher proportion of bachelor's-educated nurses significantly improves other outcomes, including decreased length of stay and lower hospital readmissions (Lasater et al., 2021).

Professional nurses also engage in continuous upskilling and professional development, which has been shown to be a strategic investment in health. One Europe-wide upskilling programme in ICUs across 24 countries **achieved a 478% return on investment, with costs recovered within days**, increasing patient throughput while protecting quality of care (Ebm et al., 2025).

CASE STUDY

THE IMPACT OF NEWBORN RESUSCITATION TRAINING IN GUINEA

Author
Céline Lomme, pediatric nurse and Master-educated clinician working with Souffle2vie

PROBLEM

Neonatal mortality in Guinea remains globally among the highest with >30 deaths per 1,000 live births representing 14,000 newborn deaths annually, mainly due to birth asphyxia, prematurity, and neonatal infections (UNICEF). The burden is highest in rural, low-resource areas, where understaffed maternity units with minimally trained staff and limited equipment struggle to provide skilled care. Strengthening education and clinical training for nurses and physicians is therefore critical.

NURSE-LED RESPONSE

Swiss NGO Souffle2vie closely collaborates with local health care professionals to support training and improve newborn survival. Our work to bridge bedside care, teaching, and research to strengthen health systems develops skills that are crucial where critically ill newborns lack access to basic resuscitation resources. Our projects also involve working alongside physicians trained in pediatrics, neonatology, and/or public health.

We delivered a twoday neonatal resuscitation training course to health care professionals from 13 peripheral clinics of Conakry, including theory and handson sessions covering newborn care, airway management, and team coordination. We also provided essential materials, including basic resuscitation equipment and woollen baby caps.

IMPACT

The intervention proved highly effective and sustainable, reducing very early neonatal mortality (within six hours after birth) by 82% and decreasing neonatal transfers to specialized facilities by 60% (Diallo et al., 2026).

This experience strengthened my conviction that nursing leadership extends beyond hospitals' walls. When nurses are empowered to teach, lead, and collaborate across borders, they help drive change that saves newborn lives.

> **Nurses have high moral authority and standing around the world… We have to stand and fight for what we know is important: pay equity, health equity, and addressing the economic, social, environmental, and commercial determinants of health and peace.**
>
> Helen Clark, former Prime Minister of New Zealand and global health leader, highlighted the ethical leadership and power of the nursing profession at ICN's Congress

PILLAR 2

Binding ethical standards

Professional nursing is marked by **adherence to rigorous ethical standards that govern every aspect of practice**. These standards are codified in the ICN Code of Ethics for Nurses, as well as national and regional codes (ICN, 2021). They establish fundamental ethical obligations for the profession that transcend personal preferences or institutional pressures, ensuring that nurses maintain patient confidentiality and safety, provide care without discrimination, and advocate for patients even when this conflicts with other interests.

Health care often involves complex ethical situations. In environments marked by rapidly changing technologies and increasingly complex health needs, ethical integrity is vitally important. Nurses are vital ethical actors who can ensure that health care remains person-centred, equitable, and focused on patients' needs. Nursing ethics is also critical in crisis or conflict situations, where professional standards guide decision-making under extreme pressure, resource constraints, and competing demands while maintaining dignity and human rights. ICN's Code of Ethics highlights how nurses' responsibilities go beyond individual care to address broader societal health and justice and advocate for vulnerable populations (ICN, 2021). This amplifies the impact of nursing: nurses' ethical leadership extends beyond bedside care to influence institutional policies and public health priorities at local, national, and global levels.

PILLAR 3

Regulation and accountability

Regulation of the nursing profession establishes and enforces standards for conduct, education and practice. Effective regulation protects the public with clear entry-to-practice requirements, licensure, ongoing competence expectations, and fair processes to address complaints and misconduct. These safeguards sustain the trust people place in nurses and make sure that "nurse" stands for verified preparation, accountability, and ethical responsibility.

Professional standards make care reliable and comparable, ensuring that all interventions are based on a globally recognized body of nursing science and practice. This consistency is a prerequisite for Universal Health Coverage, because it enables nursing roles to scale across settings — from primary health care to highly specialized acute services — without weakening safety or service integrity. Strong nursing regulation also helps to advance nursing education and practice quality and improve the mobility of nurses between countries.

Outcomes and impact

Regulated, registered nursing professionals deliver measurable safety benefits that directly save lives. Systematic reviews consistently find that a higher proportion of professional Registered Nurses (RNs) in the staffing mix is associated with better patient outcomes. **Higher RN staffing is linked to lower hospital mortality, reduced failure-to-rescue, and fewer hospital-acquired infections, patient falls, and pressure ulcers** (Griffiths et al. 2018; Drennan et al. 2024; Bourgon Labelle et al., 2019).

THE DANGERS OF UNSAFE SUBSTITUTION AND THE FALSE ECONOMY OF UNREGULATED LABOUR

Nursing professionalism is a primary mechanism that empowers nurses to save lives by giving them the authority, competence, and credibility to act effectively. It is not possible to safely replace the in-depth training and skills of nursing professionals with unregulated or less-skilled workers.

Substituting professional nurses with lower-trained workers can increase patient mortality, morbidity, and adverse events (Pence et al., 2007; Aiken, 2017; Griffiths et al., 2018; Griffiths et al., 2023). This means substitution is often a false economy. While the immediate labour cost of unregulated workers is lower, the resulting preventable harms transfer costs back to health budgets via longer hospital stays and readmissions.

Furthermore, over-reliance on untrained staff adds to the workload of professional nurses, who must provide constant supervision for teams exceeding their safe span of control.

The solution to workforce gaps and shortages is not unsafe substitution, but investing in a well-staffed, regulated workforce and engaging in safe and strategic *task-sharing* in professional-led teams. Community health workers and other cadres, such as assistant workers, are important complements to, not replacements for, professional nurses. By empowering nurses as professionals, enabling them to work to their full scope of practice, and establishing clear regulatory systems of supervision and accountability, we can safely expand access to care while upholding safety and public protection.

CASE STUDY

EXTENDING THE REACH OF CARE THROUGH NURSE-LED TEAMS

In the remote communities of French Guiana, nurse-led multidisciplinary teams demonstrate how geographic and relational proximity to patients can bring safe, high-quality care to settings removed from traditional health infrastructure.

In remote French Guiana, a Mobile Public Health Team (MPHT), established in 2019, pairs nurses with locally-recruited, multilingual community health mediators to bridge remote Amazonian communities and the formal health system. These nurse–mediator pairs are connected to Prevention and Care Remote Centres and receive ongoing training. They co-design outreach with village leaders, then travel — often by canoe — for door-to-door education, triage, and referral, translating across eight languages and cultures. During COVID-19, the MPHT successfully delivered targeted promotion, WASH education, and multilingual communications, and supported concurrent outbreaks (e.g. malaria, diphtheria, tuberculosis).

This shows that a linked service model, anchoring community workers to nursing health professionals, can expand primary care accessibility and accelerate epidemic response in places where people experience geographic and social barriers to care.

(Gaillet et al., 2025)

THE BLUEPRINT: POLICY ACTIONS FOR EMPOWERED PROFESSIONALS

Protecting and strengthening the power of the professional is essential for patient safety, public trust, and health system performance. ICN calls for the following coordinated actions:

ACTION 1

Invest in degree-level standards

Governments must prioritize investment in bachelor's-level nursing education as a high-yield safety strategy. Funding should target clinical career pathways that align advanced educational attainment with corresponding roles in managing complex disease burdens.

ACTION 2

Ensure safe staffing and skill-mix standards

Systems must adopt evidence-based staffing models that prioritize regulated professional nurses over unregulated substitutes for safety-critical tasks. Decision-makers must reject unsafe substitution as a quick fix for shortages.

ACTION 3

Reform regulatory frameworks for full scope of practice

Regulatory environments must be modernized to optimize scope of practice and eliminate over-skilling waste and inefficiencies. This reform ensures that health systems can operate effectively at cost while delivering higher-quality care through the full utilization of professional competence.

ACTION 4

Protect professional identity and regulatory boundaries

National legislation should formally adopt the ICN Definitions of 'nursing' and 'a nurse' to distinguish the regulated nurse from task-based unregulated workers (ICN, 2025). Protecting the professional title is essential for maintaining public trust and ensuring that legal and ethical accountability remains the foundation of all clinical interventions.

ACTION 5

Empower nursing organizations to establish and advance professional standards

National nursing associations (NNAs) and professional nursing organizations must be enabled to establish and advance the evidence-based standards, competency frameworks, and ethical codes to ensure, safe, high- quality and ethical patient care. Leaders must support NNAs in defining core competencies for nursing roles, influencing registration legislation, and improving continuing professional development to ensure a flexible, high-quality workforce.

ACTION 6

Track and report data

Regulatory information must be strengthened and standardized; and the collection of skill-mix and safety data needs to be mandated. Regulators and health systems must track the ratio of RNs to other staff and correlate it with patient outcomes (mortality, falls, infections, readmissions) and patient-reported experiences.

Patients need care that works — they need health professionals who are highly-educated, regulated, accountable, and bound by standards that put their welfare above all else. In a world facing complex health challenges, the power of the professional nurse is our strongest guarantee that clinical outcomes will be grounded in evidence, guided by ethics, and delivered with the competence and care that turns knowledge into healing.

José Luis Cobos Serrano, ICN President

© Jhpiego, Karen Kasmauski

Our Nurses.

Our Future.

CHAPTER

3

The power of numbers

Empowered Nurses Save Lives

> **Nursing numbers are the measure of whether health systems can deliver safe, responsive and equitable care to all who need it. Nursing is the multiplier of health: when we invest in nursing, every community, every health system, and every person benefits.**
>
> David Stewart, ICN Director of Nursing

Numbering **almost 30 million globally**, nurses represent the world's largest health workforce and the operational backbone of health systems everywhere. The **sheer scale of the nursing workforce means that strengthening nurse staffing, deployment, retention and recruitment has a massive global impact**.

When nursing numbers are sufficient, well distributed, and supported, countries expand access to care, improve quality and safety, and strengthen preparedness and resilience. When they are not, health systems ration care by default — through delays, reduced coverage, avoidable harm, and workforce collapse. Nursing workforce capacity determines whether health systems can achieve Universal Health Coverage, respond to health emergencies, and provide safe, quality care. The scale of the nursing workforce means that even modest improvements in retention, education throughput, and productivity translate into outsized gains for population health and national prosperity.

OVERCOMING WORKFORCE GAPS AND MALDISTRIBUTION

The huge potential of nursing workforce numbers is undermined by persistent underinvestment, shortages and maldistribution. The State of the World's Nursing (SOWN) 2025 report shows a continuing global shortfall of 5.8 million nurses (WHO, 2025). At the same time, the Institute for Health Metrics and Evaluation projects that health systems will require 30 million additional nurses to meet future needs and make care available to all (Haakenstad et al., 2022).

These numbers describe both:

- a capacity crisis (insufficient supply and failure to retain experienced workforce)
- an equity crisis (not enough nurses where needs are greatest).

The number of nurses available is strikingly unequal around the world. SOWN indicates that 80% of the world's nurses are concentrated in countries that account for just half of the world's population (WHO, 2025). Low-income countries bear the brunt of the health worker shortage, with estimates that the WHO African region, which represents ~15% of the world's population, will account for 52% of the global health workforce shortfall by 2030, (Boniol et al., 2022; Integrated African Health Observatory, 2022).

> **Communities in low-income countries face the highest burden of disease with the fewest nurses to respond and unethical international recruitment continues to pull skilled and specialist professionals towards wealthier health systems. Nurses have the right to migrate, but countries do not have the right to solve shortages by draining health systems that are already fragile. If we want nurses to use their full powers to save lives, we must enable them to flourish through equitable workforce practices and decent work, fair pay, safe practice environments, and real career progression in every setting.**
>
> Perpetual Ofori-Ampofo,
> ICN Third Vice President

The consequences of this capacity and equity crisis are severe, leaving health systems unable to scale access or quality fast enough to meet the growing pressures of ageing, chronic disease, and health emergencies, especially in lower-income countries where resources are most constrained.

THE IMPACT OF A STRONG NURSING WORKFORCE

The data indicates the scale of our current crisis but also the scale of the opportunity. Recent research by the McKinsey Health Institute shows that **closing the health workforce gap could prevent 189 million years of life lost to early death and disability and inject an enormous USD 1.1 trillion into the global economy by 2030** (McKinsey, 2025). As the largest segment of that workforce, nursing is the decisive factor in whether this value is realized.

Nurses are also central to preventive health, which shows massive returns: the Business at OECD (BIAC) Health Forum report notes a **1:14 return on investment (ROI) for general population prevention interventions and a 1:19 ROI for adult immunization** (BIAC, 2025).

The **economic analyses support the case that nursing should not be seen as a cost but as a high-return investment**. Investing in nursing generates value at every level, supporting the healthy, productive populations that drive economic growth while delivering human value through compassionate, skilled care that saves and transforms lives.

ADDRESSING THE MULTI-CRISIS DRIVING SHORTAGES

The global nursing shortage is a complex emergency with multiple contributing factors.

We are not only failing to educate nurses fast enough to meet growing demands (**a pipeline crisis),** we are also losing them faster than ever (**a retention crisis**) as nurses leave their jobs or the profession altogether due to burnout, unsafe working conditions and staffing, unacceptable workplace violence, and low pay. We are also underutilizing the nurses we have, preventing them from making full use of their expertise and overloading them with administrative burdens.

Addressing all of these issues together is essential.

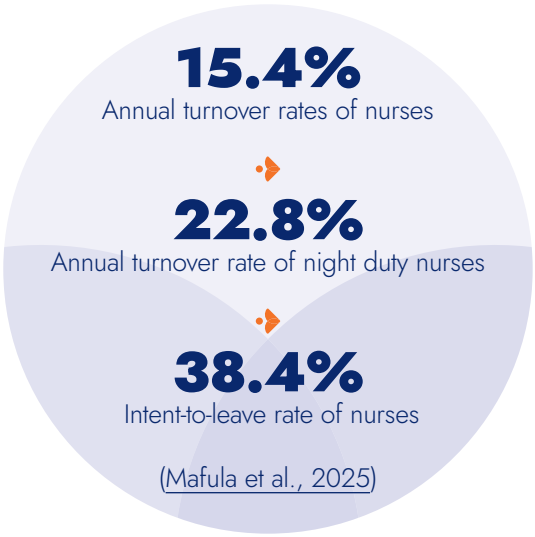
The McKinsey Health Institute has modelled a multifaceted approach to tackling health workforce shortages, based on simultaneously addressing crises in retention (stay), supply and education pipelines (grow), and inefficiencies (thrive) to close the gap (McKinsey, 2025). This chapter focuses on retention and pipeline issues and solutions.

1. The "retention-first" imperative

The fastest, most cost-effective way to increase nursing capacity is to *keep the nurses we have*. Retention is a strategic pathway to protect health system capacity and a prerequisite for safe care. **Failing to retain nurses represents a huge waste of skilled human capital and undermines health system capacity and population health**. Each departure is an enormous loss of clinical expertise and institutional knowledge that takes years to develop and cannot be quickly replaced.

What is driving nurses away: burnout, moral injury, unsafe work, violence, and pay

ICN's 2025 International Nurses Day report described a clear crisis in well-being and working conditions. The message from many nurses was: "I love my work – but hate my job." (ICN, 2025). Nurses remain deeply committed to patient care and their professional mission, but they are increasingly burned out and unable to tolerate the conditions under which they are expected to work, from chronic understaffing to continual overload and overtime (Azzelino et al., 2025). When poor work environments, chronic understaffing and overload prevent nurses from providing the quality of care their training and values demand, they experience not only stress but deep moral injury (Salari et al., 2022).



ICN's survey of 68 national nursing associations (Sharplin, Clarke & Eckert, 2025) shows accelerating strain:

- 48.4% reported a significant increase in nurses leaving the profession since 2021, and
- 61.7% documented growing workload demands making roles increasingly unsustainable.
- 38% rated national capacity to meet current health care needs as "poor" or "very poor".

Multiple sources show the same pattern:

- 61% of European nurses experience moderate to extreme job strain — double the rate across other occupations (OECD/European Commission, 2024).
- Over half of surveyed health workers regularly think about quitting, and 80% report working over capacity (Public Services International, 2023).
- Intent-to-leave and burnout thresholds are consistently linked to poor work environments, inadequate staffing, and lack of support, across settings including Ethiopia, Chile, the United Arab Emirates, Australia, France, Sweden, and the United States (APNA, 2022; Mulisa et al., 2022; Simonetti et al., 2021; Ahmad et al., 2025; Boyer et al., 2024; Muir et al., 2024; Lantz & Fageors, 2025).

Pay is a retention issue and a valuation signal

The 2025 SOWN report shows that median annual salaries range from just USD 4,320 in low-income countries to USD 27,624 in high-income nations (WHO, 2025). In short, nurses are often not paid fairly for the work they do.

The International Labour Organization found that nurses and midwives are paid **less than the average for high-skilled workers** in 34 out of the 49 countries they studied (ILO, 2023). This means that despite their advanced training and critical responsibilities, nurses consistently receive lower compensation than workers in other professions requiring similar levels of education and expertise. In almost half of the countries with available data**, nurses' salaries were also below the average among health sector workers** (ILO, 2023).

Even where nominal pay rises occurred, **when we account for inflation and rising cost of living, increases have often not translated into purchasing power**. OECD analysis indicates that between 2019 and 2023, nurses experienced "real" income increases in only around half of member countries, with real-term decreases in several nations including New Zealand, Chile, Italy, the Netherlands, and the United Kingdom (OECD, 2025). In the UK, nurse pay fell 25% in real terms between 2010 and 2024 (Royal College of Nursing/BBC, 2024).

In the ICN survey of national nursing association presidents, nursing associations in just 7 out of 68 countries described their members' salaries as "good" or "very good", with the overwhelming majority rating nursing compensation as "poor" or "very poor" (Sharplin, Clarke & Eckert, 2025).

Given that women comprise 85% of the global nursing workforce, undervaluation of nursing work intersects directly with gender inequity in the health sector. **Research shows women earn less than men in health care and are much less likely to hold leadership roles** (Women in Global Health, 2022, 2023).

Retention strategies must ensure equitable and competitive pay.

Workplace safety: a non-negotiable condition for staffing

> **Let me be blunt. The suffering of doctors and nurses is not inevitable. It is the result of political choices to underfund, to understaff, to look the other way when violence occurs, to view burn-out as dedication. These choices must end.**
>
> Dr Hans Henri P. Kluge,
> WHO Regional Director for Europe (2025)

Workplace violence is a growing threat to nurse well-being and staffing stability. 86% of nursing associations have reported that nurses have been attacked or threatened by patients or the public (Sharplin, Clarke & Eckert, 2025). SOWN 2025 reports 41% of countries lack measures to protect health workers from attacks and 58% lack provisions for mental health support and well-being (WHO, 2025). Violence prevention and well-being supports are therefore not optional add-ons but essential prerequisites for a sustainable workforce.

To rebuild and stabilize nursing workforce numbers, countries must act across all retention drivers: decent work conditions and support, fair pay, violence prevention, and leadership opportunities.

2.Building the pipeline: education and equitable supply

The nursing labour market exhibits structural characteristics that amplify the impacts of shortages. First, there is supply inelasticity: nursing education requires 3-4 years of training with clinical placement requirements, creating multi-year lags between demand signals and workforce availability (WHO, 2025). Second, we see patterns of geographic inequities: it is easier to attract health professionals to urban and high-income settings, resulting in persistent shortages in rural and low-income countries and regions even when there is growth in supply (Kharazmi et al., 2023). Third, there is retention volatility: annual turnover rates of 15.2% globally and 38.4% intent-to-leave rates create a "leaky bucket" dynamic where production gains are offset by attrition (Mafula et al., 2025). Fourth, recruitment into nursing is also under pressure. Approximately half of OECD countries saw decreased interest in nursing between 2018 and 2022 (OECD/European Commission, 2024; WHO, 2025). Finally, education constraints are also limiting the pipeline of new nurses entering the profession.

Education throughput is below what shortage contexts require

The Fifth Global Forum for Human Resources for Health recommended an 8–12% increase in graduates to double health worker stock in countries with severe shortages or high expected turnover (WHO, 2023; WHO, 2025). The workforce needs 8.3 new graduates per 100 active nurses, but the global average is far below this figure at just 6.4 graduates per 100 working

nurses (WHO, 2025). In some low- and lower middle-income regions, graduate ratios may be higher (8.3–8.7 per 100), but without employment opportunities this does not translate into effective nursing stock. Achieving the health targets of the Sustainable Development Goals requires at least 70% workforce uptake in low- and lower-middle income countries (Bruce & Mboya, 2022).

Faculty and clinical placements are binding constraints

SOWN 2025 also identifies widespread **shortages of qualified nursing faculty the world over**. For example, in the United States, over 80,000 qualified applications were turned away from nursing schools in 2024, due to insufficient faculty, clinical placements and supervisors, space constraints, and budget cuts (American Association of Colleges of Nursing, 2025).

Targeted investment in faculty — including advanced training and attractive pay — placements, and infrastructure is the only way to break this cycle and scale up education.

CASE STUDY

MAKING LEARNING AND PRACTICE SETTINGS SAFER IN CANADA

Author
Ankur Patel, ICN Student and Early Career Nurses Alliance Representative for the Canadian Nurses Association

The Canadian Nursing Students' Association (CNSA) is working to draw national attention to violence, bullying, and harassment in clinical learning environments through its ongoing research collaboration with the Canadian Nurses Association (CNA). By documenting student nurses' experiences at scale, they become impossible to ignore. The research provides powerful evidence for change, strengthens calls for safer, more respectful learning environments and makes clear that protecting student nurses is essential to the future of the profession.

Preliminary findings from this work reveal recurring patterns of verbal mistreatment, exclusion from learning opportunities and limited psychological safety in clinical settings. The consistency of these reports points to broader systemic issues that affect student well-being, professional development and the ability to provide compassionate, ethical, person-centred care.

This work builds on the 2024 Canadian Nursing Student Survey on financial needs and education, led by the CNSA in partnership with the Canadian Federation of Nurses Unions (CFNU), which engaged over 3,000 nursing students and shifted national policy priorities. Canadian nurses are using their power of numbers to create safer learning environments, stronger therapeutic relationships, and meaningful change in how they develop their professionals.

EQUITY AND INTERNATIONAL MIGRATION: EXTRACTING FROM FRAGILE SYSTEMS IS NOT THE SOLUTION TO SHORTAGES

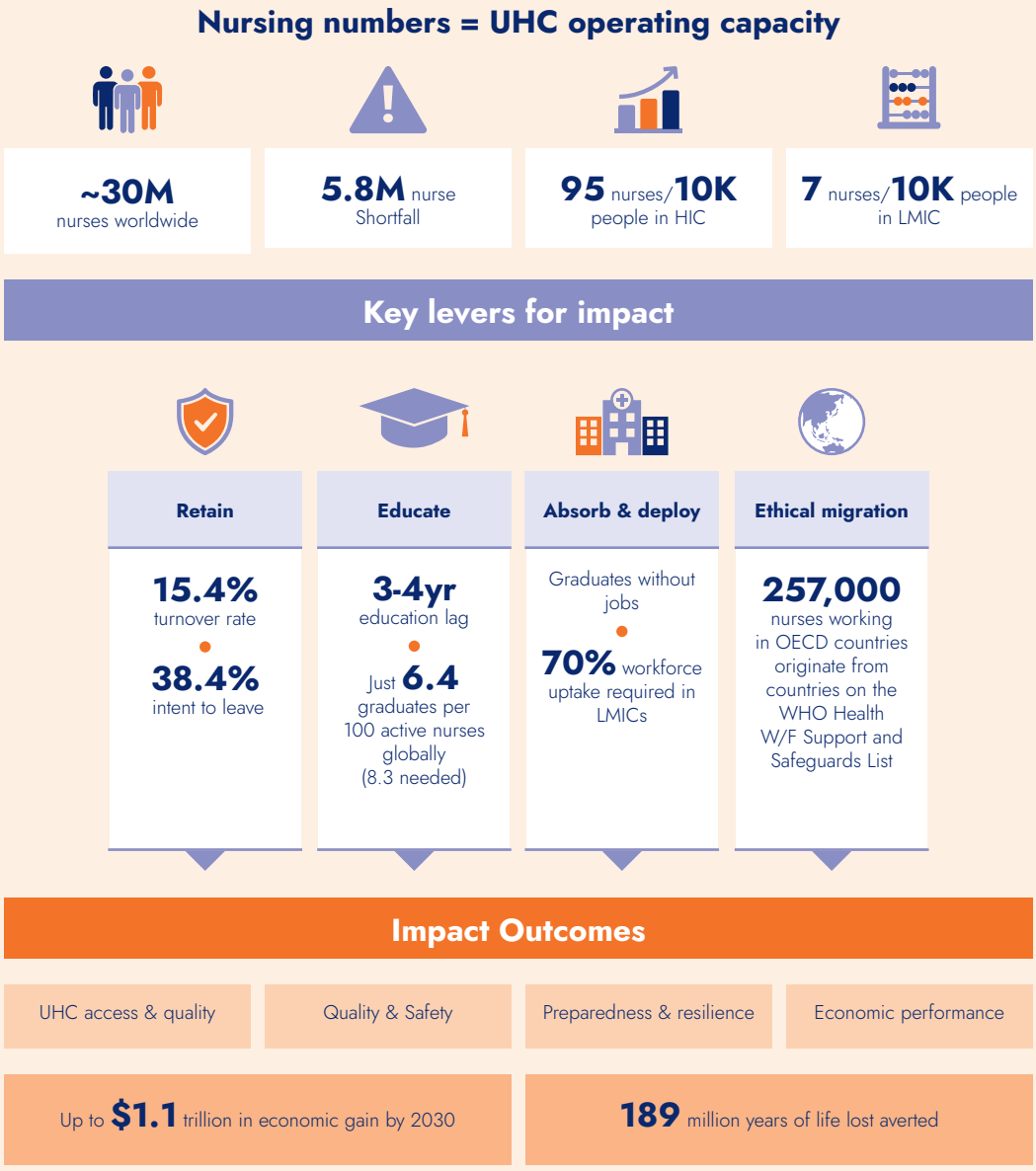
Global health inequities are worsened by recruitment patterns that systematically drain the world's poorest countries of their nursing pipeline. Many high-income countries are increasingly relying on international recruitment as a quick fix for their workforce shortages. This can result in what ICN has called a "great global nursing ripoff", where recruiting systems save on the costs of educating these nurses, while fragile source countries lose the nurses they have invested in training, generally without proportional compensation (ICN, 2025).

A recent report suggests migration of foreign-trained nurses to the WHO European region increased 67% between 2014 and 2023 (WHO, 2025). And 257,000 nurses working in OECD countries originate from countries on the WHO Health Workforce Support and Safeguards List ("red list") (OECD, 2025). For some countries, the loss is extreme - 15 countries have more nurses working in the OECD than at home; 90% of Jamaican nurses, 85% of Haitian nurses, and 66% of Somali nurses work abroad.

ICN supports the right of individual nurses to migrate. However, the policy failure is when destination countries substitute international recruitment for domestic planning and investment. Large-scale inequitable recruitment is a systemic issue with devastating consequences for nursing pipelines and health systems in fragile countries. Losing nurses can mean entire health departments shutting down, communities left without access to care, increased pressure on the nurses who remain, and a lack of nurse educators needed to train the next generation. Meanwhile, high-income recruiting countries save billions in training costs by recruiting health workers from abroad (UK All-Party Parliamentary Group, 2026; Evans et al., 2025). Source countries often do not receive meaningful, proportional compensation or investment in strengthening their health systems, sometimes even when bilateral agreements are in place (OECD & WHO, 2024).

> **ICN continually advocates for an end to inequitable and unfair recruitment practices, with the clear message: 'If you take, you must give back.'**
>
> **ICN calls on all recruiting countries to proportionally reinvest in the health systems they recruit from and we urge high-income countries to come together and take coordinated action, with shared standards and shared co-investment.**
>
> Howard Catton, ICN Chief Executive Officer

Figure 4: Nursing numbers improve health care access and quality



THE BLUEPRINT: POLICY ACTIONS FOR THE POWER OF NUMBERS

Closing the workforce gap is vital to maximize the power of nursing's numbers. Progress now depends on coordinated strategies to retain nurses through safe, decent work; scale education by removing faculty and placement bottlenecks; absorb and deploy graduates where needs are greatest; and make migration and international recruitment ethical.

ICN calls for the following policy actions:

ACTION 1

Retain nurses through decent work and safe care environments

Maintain safe staffing to prevent burnout and turnover while improving quality of care and health outcomes. Prevent violence and protect nurse safety with zero-tolerance policies, clear security protocols, de-escalation training, and reporting systems. Provide fair, market-competitive wages and benefits, accounting for regional labour market conditions and cost-of-living variations. Ensure positive work environments with supportive management, nurse autonomy, and collaborative physician-nurse relationships. Offer early-career support with structured transition-to-practice programmes, mentorship, and residency models to reduce early years attrition.

ACTION 2

Scale education by removing constraints

Address faculty shortages through competitive compensation, expanded advanced education programmes, and practice-to-academia transition pathways. Invest in expanding infrastructure including simulation laboratories, classroom capacity, and technology infrastructure to accommodate increased enrollment. Develop formal agreements with health care facilities to ensure clinical placement availability for expanded student cohorts. Provide financial aid, scholarships and stipend programmes to reduce financial barriers to nursing education and increase access, especially for underserved populations.

ACTION 3

Build absorption and equitable deployment so graduates become nurses in care

Increase health system nursing positions to absorb graduate supply. Attract nurses to rural and remote settings with financial incentives, housing support, and career development opportunities. Ensure that work environment quality, compensation, and career development opportunities retain graduates in clinical practice.

ACTION 4

Make international recruitment ethical and end structural dependency

Operationalize the WHO Global Code of Practice on the International Recruitment of Health Personnel and ensure no active recruitment from countries on the WHO health workforce support and safeguards list. Establish government-to-government bilateral agreements for international recruitment that provide fair and proportional reinvestment in source countries' health systems and health workforces. Ensure that destination countries prioritize domestic workforce development over international recruitment dependency and report on self-sufficiency indicators. Mobilize highrecruiting destination countries to act *collectively* through shared commitments, aligned ethical recruitment policies, and joint reinvestment mechanisms such as a global fund for nursing education in fragile source countries.

CHAPTER

4

The power of practice

Empowered Nurses Save Lives

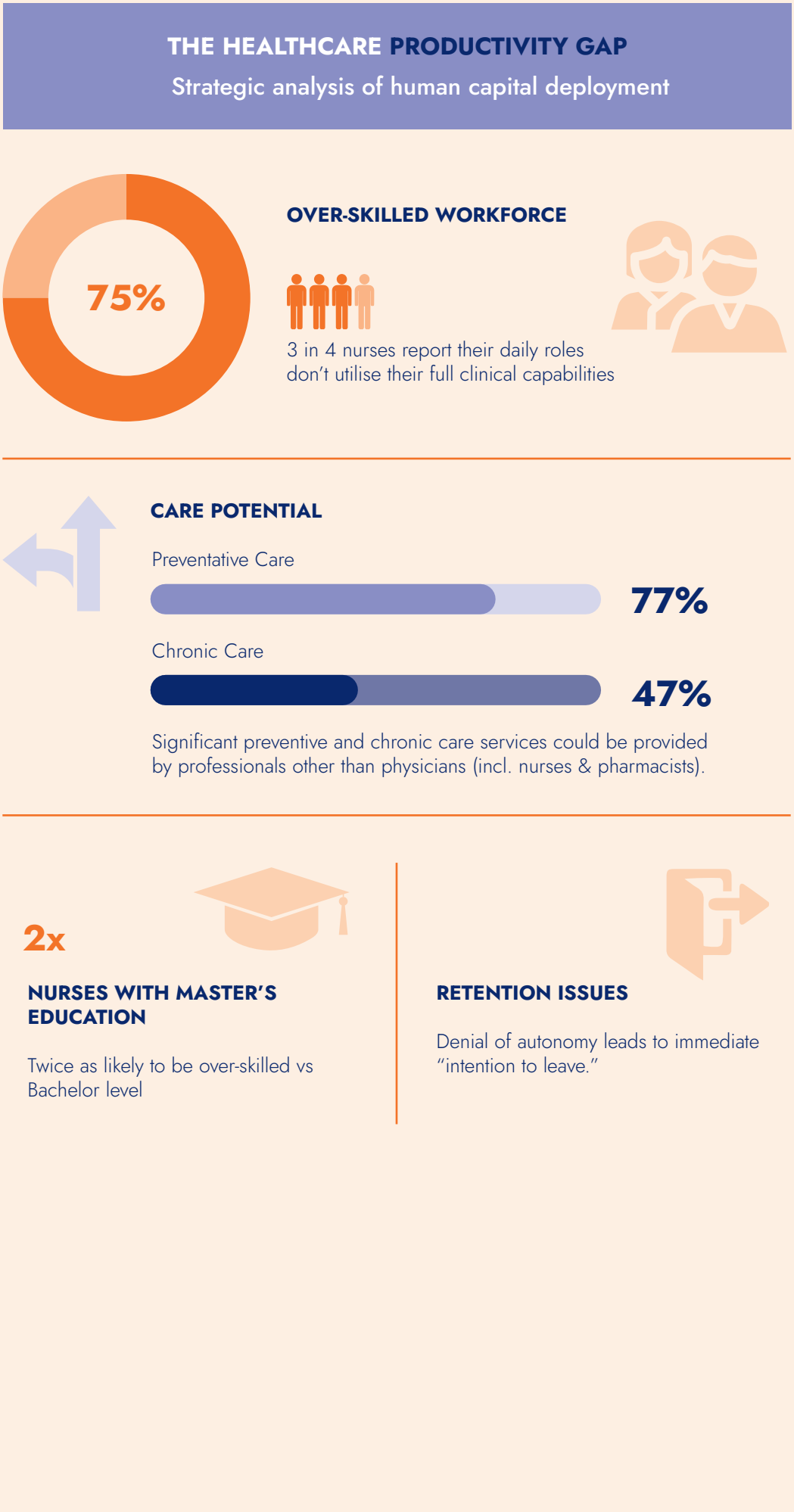
Health systems worldwide are under acute strain with deepening workforce shortages, rising chronic diseases, and entrenched inequalities. Yet one of the most practical, proven, and underused solutions is already in the system: **enabling nurses to practise to their full scope**. **More than three-quarters of nurses have reported being over-skilled for their daily work** (Maeda & Socha-Dietrich, 2021). Studies show that actual or "enacted" scope — the real work nurses perform — often falls short of their education and competencies, negatively impacting care access, quality, costs, and nurses' own job satisfaction (Déry et al., 2021). This represents a significant misalignment and waste of human resources and nursing potential and shows that many health systems are failing to capture full value from the professionals they educate and employ.

When nurses are able to work at their optimal scope of practice — with professional autonomy, clear clinical authority, and meaningful career progression — health systems convert underused capability into immediate clinical capacity. When that capability is constrained, highly educated nursing professionals are systematically underused and prevented from contributing fully, access is artificially constrained, and system capacity is weakened. **Underutilizing nurses leads to missed or delayed care, longer waits, and lower accessibility of care; it affects nurse motivation and retention; and it ultimately holds health systems back** (Déry et al., 2021; D'Amour et al., 2012).

With health systems under increasing pressure, the urgency of enabling the power of practice has never been greater. Empowering nurses including those in advanced practice roles to work to the full level of their training and competence is one of the fastest, most cost-effective ways to close the health care productivity gap and strengthen health systems.

> **When nurses are empowered to practise to the full extent of their education and competence, care reaches further, systems work harder, and patients are better served. The power of practice is the power of health systems that work, and we must invest in it.**
>
> Sineva Maria Ribeiro, ICN First Vice President

Figure 5: The health care productivity gap



> **Nursing's scope of practice is broad and encompasses individual care, community health, and organizational management and leadership, contributions to health care systems' design, innovation, education, advocacy and policy at the broadest level and much more.**
>
> ICN, 2025

SCOPE OF PRACTICE AND PROFESSIONAL IDENTITY

Scope of practice defines what a nurse is educated, competent, and authorized to do, within law and regulation. ICN's renewed Definitions of 'nursing' and 'a nurse' clearly show the full capability of professional nursing: a strong professional identity grounded in these definitions is essential to ensuring that scope of practice keeps pace with what nurses are educated and competent to do (ICN, 2025).

ICN's Position Statement on the scope of nursing practice calls for nursing scope of practice to be clearly defined but also "dynamic and responsive to changing health needs, knowledge development, and technological advances" (ICN, 2013).

THE IMPACT OF THE POWER OF PRACTICE

Optimizing the scope of nursing practice is a core mechanism for improving health care access, effectiveness, and productivity. Nurses in *all* roles, including advanced practice roles such as nurse practitioners and Clinical Nurse Specialists, must be supported to use their full education, skills, and clinical authority to deliver safe, effective, and accessible care.

IMPACT 1

Transforming health systems towards primary health care

Nurses are vital to primary health care, a whole-of-society approach that moves beyond treating specific diseases to addressing full person needs: education, prevention, chronic disease management, community connection, and the social determinants that shape health long before patients enter a care setting. A recent WHO and OECD report highlights the importance of expanding nursing scope of practice as one of the "central features of primary care reforms" (WHO/OECD, 2025).

Nursing practice is inherently holistic, oriented not only to disease, but to the person, the family, and the context in which health is lived. When nurses work to full scope, they help close the gap between clinical care and social well-being and drive the shift to preventive, person-centred primary health care.

CASE STUDY

NURSE-LED PALLIATIVE CARE FOR MULTIDRUG-RESISTANT TUBERCULOSIS IN UGANDA

Author
Anna Peeler

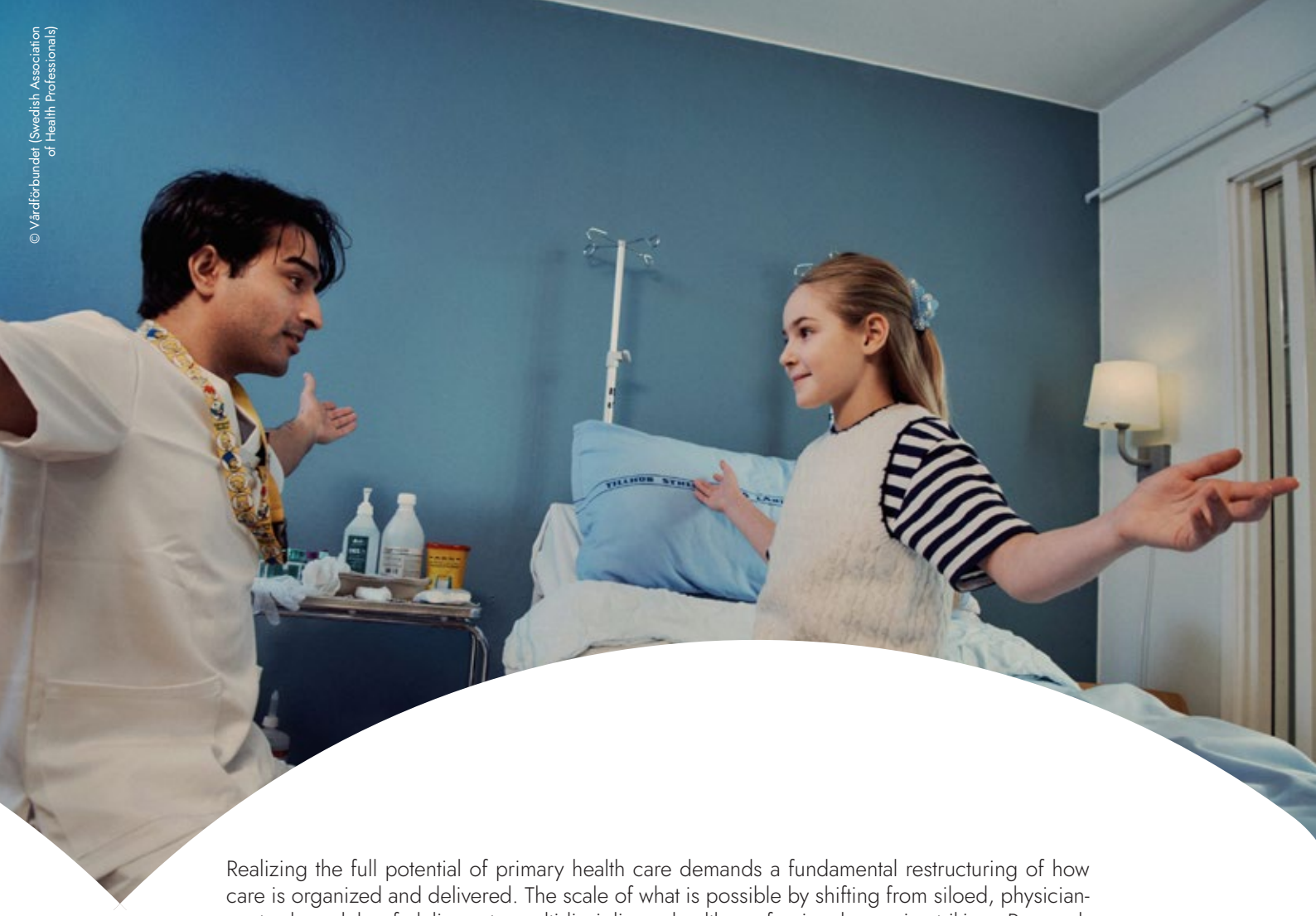
In Uganda, experiences of multidrug-resistant tuberculosis (MDR-TB) tell a story of pain, stigma, depression, and uncertainty. Many patients with this life-threatening infection endure severe physical symptoms, psychological distress, and show poor treatment adherence. Globally, TB remains one of the leading infectious killers and people with MDR-TB face especially high mortality and suffering. Yet palliative care, an essential service under Universal Health Coverage, is rarely integrated into TB treatment.

In 2025, a nurse-led model changed that story. In three Ugandan referral hospitals, nurses partnered with hospice services to deliver person-centred palliative care alongside routine TB treatment. Nurses conducted holistic assessments, addressing physical, psychological, social, and spiritual needs, through home visits, clinic follow-ups, and telephone support. They managed pain and distressing symptoms, supported families, strengthened adherence counselling, and created safe spaces for patients to talk about fear and stigma.

The impact was transformative. Patients receiving nurse-led care showed significant improvements in symptom control and well-being, with a clinically meaningful increase in palliative outcome scores. Psychological distress dropped and quality of life improved across physical, social, and emotional domains. Most strikingly, 93% of patients in the nurse-led group adhered fully to treatment at four months, compared with 56% of those receiving standard care.

This is the power of empowered nurses using the full scope of their training and competence as well as their close proximity and trust to integrate compassionate, holistic care into infectious disease management. This advances Universal Health Coverage goals, strengthens health systems, and saves lives.

(Buzinya et al., 2025)



Realizing the full potential of primary health care demands a fundamental restructuring of how care is organized and delivered. The scale of what is possible by shifting from siloed, physician-centred models of delivery to multidisciplinary health professional care is striking. Research indicates that up to **77% of preventive care and 47% of chronic care could be provided by nurses and other** non-physician roles (OECD, 2020).

A **Cochrane review indicates that nurse-led models of primary health care**, particularly in chronic disease management, **deliver clinical outcomes equivalent or superior to physician-only models**. This nurse-led care likely **improved patient satisfaction while supporting treatment adherence and less need for unnecessary hospitalizations** when compared with treatment as usual (Laurant et al., 2018).

IMPACT 2

Closing access gaps and improving equity

Expanding full-scope nursing practice is one of the most practical ways to improve access to care, particularly in rural, remote, and underserved communities. Nurses, including advanced practice nurses, nurse practitioners and nurse-midwives, are often the health professionals most consistently present in areas where access is limited and need is high. Enabling them to practice fully helps close service gaps, extend essential care to excluded populations, and improve the fairness of health system delivery (OECD, 2020; Kilpatrick et al., 2024, Mackavey et al., 2025).

IMPACT 3

Positive outcomes and quality of care

Research consistently finds that nurse-led care leads to safe patient outcomes that are comparable to, or in some cases better than, usual physician-led care, in both primary health and hospital settings (Connolly & Cotter, 2023; Laurant et al., 2018; OECD, 2024; Kilpatrick et al., 2024). This evidence showed that patients under nurse-led care often report higher satisfaction, longer consultation times, and receive more follow-up, education, and counselling.

CASE STUDY

STANDARDIZED NURSING CARE GUIDELINES REDUCE MULTIDRUG RESISTANT ORGANISM INFECTIONS IN TAICHUNG CITY

When nurses are empowered to lead practice improvement using their full clinical expertise and authority, the results are strong — as this case study from a medical ward in China Medical University Hospital, Taichung City demonstrates.

ICN Congress 2025 Poster Presentation

Author
Lin Hsin Yi; Lin Miao Chen

PROBLEM

Older high-acuity medical ward patients at China Medical University Hospital faced ongoing health care-associated infections, with an average infection density of 2.77 per 1,000 patient days in 2023. More consistent infection prevention practice was needed to prevent transmission of multidrug resistant organism infections (MDROs), particularly in caring for vulnerable older patients.

NURSE-LED RESPONSE

Nurse practitioners led implementation of standardized MDRO care guidelines and education, supported by bedside reminders, patient and caregiver information, and clear isolation signage.

Key nursing interventions included:

- Education for nursing staff, patients, and caregivers, supported by bedside reminders, written materials, and clear isolation signage
- Strengthening central venous catheter (CVC) bundle care and hand hygiene through structured training and skills reinforcement
- Establishing routine review and monitoring of cleaning protocols

OUTCOMES AND IMPACT

From 1 January to 31 July 2024, infection density decreased from 2.77 to 2.56 per 1,000 patient days.

Practice indicators showed substantial improvement:

Correct CVC bundle implementation improved from 53% to 96%; hand hygiene adherence increased from 80% to 100%; protective measure accuracy rose from 49% to 91%, and cleaning protocol compliance increased from 52% to 94%.

This case study shows that systematic, nurse-led practice improvement can translate evidence into patient safety. By coordinating and reinforcing best practice and education, nurses improved safety and quality of care with measurable infection reduction.

IMPACT 4

Health system efficiency

Stronger health systems rely on multidisciplinary teams in which each professional is enabled to contribute fully. When nurses work according to their education, competence, and authority, care becomes more coordinated, more preventive, and more responsive. This reduces fragmentation, limits duplication, and strengthens continuity across the wider health and care system. The result is a model of care that is both more effective for patients and more efficient for providers (OECD, 2021).

Nurse-led clinics for conditions like heart failure, diabetes, and respiratory disease have been specifically shown to reduce avoidable hospital readmissions and emergency department use, with high levels of patient satisfaction, which improves efficiency and saves costs (Connolly & Cotter, 2023).

IMPACT 5

Improved retention and workforce satisfaction

Scope of practice is a workforce strategy as well as a service delivery issue. When nurses are restricted by arbitrary rules and spend their time performing tasks below their skill level, they experience lower work satisfaction (Déry et al., 2021). On the other hand, nurses who are able to use their education and skills fully are more likely to feel respected, purposeful, and professionally fulfilled. Enabling nurses to work to full scope is therefore one of the most effective non-financial levers available to improve retention, stabilize the workforce, and protect long-term system capacity (Mutsekwa, 2024).

The retention benefits of optimized scope are amplified when nurses can also see clear career development opportunities. For many nurses, especially in direct care settings, the availability of a visible pathway from generalist to specialist, Advanced Practice, or clinical leadership roles is central to the decision to stay. Without that architecture, the system behaves like a revolving door: talent is developed, but not retained (Thennakoon et al., 2025).

OVERCOMING CONSTRAINTS: WHAT IS HOLDING NURSING BACK

Understanding and dismantling the obstacles that constrain nursing scope is essential to unlocking the power of practice.

Structural barriers continue to suppress nursing value

Structural, financial, political, and cultural barriers mean that most nurses globally still do not work to their full scope (OECD, 2020; WHO, 2025).

Mismatches between nursing education and utilization are widespread

Across many systems, nurses hold knowledge and skills that are not matched by authority, service design, or job structure. The result is a large-scale waste of human capital. When master's-prepared nurses are substantially more likely to report being overqualified, the system is clearly failing to convert advanced education into advanced value (OECD, 2020).

Outdated regulatory restrictions often lag behind competence

In many jurisdictions, outdated legislation still requires unnecessary physician supervision or collaborative agreements for nurses — especially advanced practice nurses — to perform work for which they are already educated, competent, and accountable. These requirements create bottlenecks, increase costs, and reduce flexibility in where and how care can be delivered (Maier et al., 2017).

Funding models reward old delivery models

Even where regulation improves, reimbursement often remains tied to physician-led delivery. If financing arrangements do not support nurse-led clinics, advanced nursing services, or autonomous models of care, reform will stall (Maier et al., 2017).

Culture and hierarchy remain powerful constraints

Professional hierarchies, outdated assumptions about competence, and institutional turf protection can slow or block full scope practice. This risk is especially acute when nurses are absent from executive decision-making, policy design, and governance (Maier et al., 2017).

Implementation capacity is uneven

Reforming health systems to enable full scope of nursing practice requires education capacity, digital systems, clinical governance, public understanding, and workplace cultures that support interdisciplinary practice (OECD, 2020; ICN, 2024). We must match supportive policy with investment in the organizational conditions that maximize practice scope.

THE BLUEPRINT: POLICY ACTIONS FOR EMPOWERED PRACTICE

Optimizing scope of practice is one of the clearest pathways to strengthen health systems and deliver on the global health goals countries have committed to.

ICN calls for the following actions to unlock the power of nursing practice:

ACTION 1

Modernize legislation

Remove outdated regulatory barriers that do not enable full scope of practice, including advanced practice, or that require unnecessary physician supervision for work nurses are already educated and authorized to perform.

ACTION 2

Build credible clinical career pathways

Develop structured pathways that support nurses' progression from generalist to specialist, advanced practice, and clinical leadership roles. Growth must be visible, supported, and tied to real changes in responsibility.

ACTION 3

Redesign health system roles around capability

Organize service delivery around what professionals are educated, competent, and authorized to do. This means moving beyond inherited role boundaries and eliminating role paralysis.

ACTION 4

Strengthen implementation capability

Equip organizations with the governance, workforce planning, digital infrastructure, and leadership capacity needed to integrate expanded nursing roles effectively and safely.

ACTION 5

Embed multidisciplinary team-based care

Build cultures of respect and collaboration that recognize the complementary value of nursing, medical, pharmacy, and allied professions and enable multidisciplinary teams to work together.

ACTION 6

Align funding systems with modern care models

Reform financing so that reimbursement systems recognize nurse-led clinics, advanced nursing roles, prevention, chronic disease management, and community-based care.

ACTION 7

Measure workforce deployment and return

Track whether workforce capability is being used effectively and publish data on outcomes, access, efficiency, and economic return from scope-of-practice reform.

ACTION 8

Build the case publicly and politically

Use evidence on outcomes, workforce retention, and economics to support reform, educate the public, and build coalitions for change.

Our Nurses.

Our Future.

CHAPTER

5

The power of care

Empowered Nurses Save Lives

> **For health care and coverage to be truly universal, health services designed around diseases and health institutions must be transformed into health services designed for people, with people**
>
> (WHO, 2018)

Health is often defined by metrics: mortality rates, life expectancy, and disease prevalence. These numbers matter, but they do not fully capture what people experience as health. As the WHO Constitution articulates, health is "not merely the absence of disease or infirmity", but a state of physical, mental, and social well-being (WHO, 1946).

Person-centred, integrated, primary health care is the mechanism through which systems can address these multiple dimensions of health. The greatest gains come from combining high-quality clinical interventions with ongoing prevention, continuity, education, and sustained support that reflects the realities of people's lives (OECD, 2020). This approach is essential because the health challenges facing populations today — rising chronic disease, multimorbidity, ageing, and widening inequalities — cannot be met by systems designed principally for acute, episodic treatment.

Scaling up primary health care in low- and middle-income countries could **save**

60 million lives while **increasing average life expectancy by 3.7 years** by 2030.

WHO, 2018

WHO defines integrated people-centred care as a range of services that are "oriented around the needs of people and communities" and "managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector" (WHO, n.d.). It is grounded on trusted, long-term relationships and shared decision-making and empowers individuals as active partners in their own health.

Primary health care is the foundation on which integrated, people-centred services are built. It encompasses:

- integrated health services to meet people's health needs throughout their lives
- addressing the broader determinants of health through multisectoral policy and action
- empowering individuals, families and communities to take charge of their own health. (WHO, n.d.).

The impact of reorienting health systems toward primary, person-centred care is transformative. Scaling up **primary health care could save 60 million lives and increase average life expectancy** by 2030 in low and middle-income countries (WHO, 2018). Meanwhile, investing in non-communicable disease (NCD) prevention and management, which includes person-centred, primary care interventions delivered by nurses, could save over 12 million lives globally and drive USD 1 trillion in gains (WHO, 2025).

Nurses are the backbone of people-centred, primary health care models. They spend more time with patients than any other professional group, work across all settings and stages of care, and are often best placed to understand not only clinical needs, but also practical constraints, family dynamics, and the social factors that contribute to the health of individuals and communities

Non-communicable diseases now account for 74% of deaths around the world.

Investing in prevention and management of NCDs could save over 12 million lives globally and drive USD trillion in gains.

WHO, 2025

(ICN, 2025). They are vital to NCD prevention, screening, education, and long-term management.

The power of nurses' ability to deliver person-centred and primary health care is both a clinical and a systemic advantage. When care is organized around the whole person rather than around isolated conditions, procedures, or institutional boundaries, patients are better supported, resources are used more effectively, and trust in the health system strengthens (OECD, 2025; Yu et al., 2023).

CASE STUDY

BEYOND THE HOSPITAL — EMPOWERING HEALTH THROUGH CONTEXTUALIZED CARE

An early-career nurse from Argentina describes how person-centred care begins with understanding the realities of people's lives.

Author
Miranda Garcia Zeliz, ICN Student and Early Career Nurses Alliance Representative for Federación Argentina de Enfermeria

During my nursing clinical rotation at a community centre for homeless individuals and those recovering from addiction, my team and I moved beyond traditional clinical settings to provide person-centred care. We began by immersing ourselves in their environment, conducting interviews to understand each individual's daily challenges and health needs. We identified a high prevalence of non-communicable diseases, such as hypertension and obesity, alongside a lack of recreational activities.

Our intervention was designed to be sustainable, focusing on empowering the community with the resources already available. We organized a health workshop featuring interactive stations: nutritional education, recreational games, and physical activity circuits. We also provided personalized health records and mapped out the nearest health care facilities for emergencies.

This experience taught me that nursing is about more than clinical protocols: it is about deeply understanding a person's unique situation, whether in a hospital or on the street. To provide truly effective care, our interventions must be tailored to the individual's reality and their actual possibilities. That is what nurses actually do: we bridge the gap between health goals and the human context.

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OVERCOMING THE CARE GAP

Health care demands have shifted toward chronic disease, multimorbidity, population ageing, and long-term management of conditions. NCDs such as cardiovascular disease, diabetes, chronic respiratory conditions, and cancer now account for 74% of all deaths globally and represent a significant burden on health systems worldwide (WHO, 2025). Most of these conditions require not a single intervention but sustained, coordinated care over years or decades — precisely the kind of care that person-centred, primary care models deliver.

However, care delivery is often still designed around acute, episodic intervention. Many health services are fragmented, with high administrative burdens and care pathways designed around institutions rather than around patients (OECD, 2025; WHO, 2016). Chronic underinvestment in health systems and the nursing workforce has left many systems without the capacity to provide continuous, coordinated care where it is most needed.

The result is a widening care gap. For some, the gap is one of access: care is unavailable, unaffordable, or inconsistent. For others, the care that is available is not coordinated, continuous, or responsive to what people actually need to stay well and manage their health over time (WHO, 2025; OECD, 2025). This situation can leave patients struggling to access care or navigating disconnected providers, repeated assessments, and unclear treatment plans. Meanwhile, nurses are often pulled away from high-value care into paperwork, complex administrative processes and duplicated tasks. The end result is that patients feel unsupported, while nurses experience stress, moral distress, and burnout when they cannot deliver the standard of care they know is needed (OECD, 2021; Alotaibi et al., 2024).

To bridge this care gap, we must create the conditions that empower nurses to deliver holistic, person-centred care.

Figure 6: The power of care

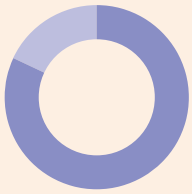
THE POWER OF CARE

Preventive, primary and person-centred care is a high-performing operating model to meet health demands

COMPLEXITY IS NOW THE NORM

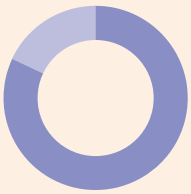
Among primary care users aged 45+, chronic disease and multimorbidity are the default, not the exception

3 in 4
Premature deaths from an NCD each year



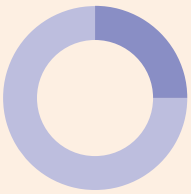
82%
of premature deaths related to NCDs occur in LMIC

81%
of years lived with a disability



82%
of people live with at least one chronic condition

52%
of people live with two or more chronic conditions



25%
of people state they have a care plan available

WHO, 2025; OECD, 2025; Grimshaw et al., 2025

INVESTING IN NCD PREVENTION AND MANAGEMENT CAN BRING ...

12M
lives saved by 2030

$1Tr
in gains.

THE IMPACT OF INTEGRATED, PERSON-CENTRED CARE

The person-centred care that nurses deliver is a high-performing care model as well as a commitment to health ethics and equity.

A substantial evidence base across different countries, health care systems, and patient populations shows that empowering patients and integrating care improve health care delivery and outcomes.

Better overall well-being and health outcomes

The OECD's Patient-Reported Indicator Surveys (PaRIS) draw on data from over 107,000 patients across more than 1,800 primary care practices in 19 countries, focusing on those who are over 45 years of age with chronic conditions - the largest and fastest-growing demographic of health care users and one with high complexity of care needs (OECD, 2025). This large-scale survey found that patients who report that their care is more person-centred and focused on their needs are more likely to report higher levels of well-being. Better experiences of care are also associated with positive health outcomes and higher trust in the health care system.

Better patient satisfaction and management of chronic diseases

A systematic review found that nursing interventions including psychosocial support, patient education, and pain control improve patient–nurse relationships and satisfaction scores, chronic disease management, and coping strategies (Alotaibi et al., 2024).

A review of randomized controlled trials found that general patient-centred care interventions for people with chronic conditions had benefits for patient satisfaction and perceived quality of care. Interventions included patient empowerment and education as well as training health care workers in delivering empowering care (McMillan et al., 2013).

CASE STUDY

PATIENT-CENTRED EDUCATION IMPROVES SELF-MANAGEMENT IN CHRONIC KIDNEY DISEASE

ICN Congress 2025 Poster Presentation

Author
Tzu Jung Lee; Ching Yang Chen; Yi Che Lee; Min Yu Chang; Hsi Hao Wang; Shih Yuan Hung; Wei Li Liang Ta

PROBLEM

Hypertension accelerates the progression of chronic kidney disease, but many patients at E-DA Hospital, Kaohsiung City, showed low adherence to hypertension self-management, such as consistently monitoring blood pressure at home and maintaining recommended levels of exercise.

NURSE-LED RESPONSE

Using a Plan Do Check Act approach, a nurse-led team strengthened patient-centred education and follow up to support sustainable self-management.

Interventions focused on:

- Building patients awareness of risks associated with uncontrolled blood pressure and inactivity
- Standardizing referral and education on accurate home monitoring of blood pressure
- Reducing practical barriers by providing free blood pressure monitors and education on using mobile measurement tools

OUTCOMES AND IMPACT

Home blood pressure monitoring increased from 37.5% to 56.3%.
The proportion of patients completing at least 150 minutes of moderate exercise per week rose from 31.1% to 52.1%.

This case study demonstrates the power of holistic, patient-centred care: nurses who understand patients' daily realities and barriers to self-care can make self-management tools and education more effective and empower patients to become active participants in their care.

Reduced mortality and unplanned hospital visits

A systematic review examining care in serious illnesses including COPD, diabetes, and cancer found positive benefits from interventions involving self-management and shared decision-making, core person-centred nursing domains. The studies showed reduced risk of death, less hospital admissions, and improved quality of life from these person-centred care approaches (Bashan Nkhoma et al., 2022).

Cost effective and care effective

Health-economic modelling suggests that person-centred care for patients with acute coronary syndrome under the age of 65 is less costly and more effective than usual care over both 2-year and 5-year timeframes (Pirhonen et al., 2020). Making care cost-effective is a key pathway towards making care more accessible. Large-scale hospital research has also shown that high-quality person-centred care can reduce unnecessary tests, procedures, prescriptions, and readmissions, helping to cut waste while improving appropriateness of care (Yu et al., 2023).

EMPOWERING NURSES TO INTEGRATE AND PERSONALIZE CARE

The nursing workforce is one of the health system's most important assets in delivering care that is both person-centred and integrated. Nurses operate at the point where clinical care, patient behaviour, family support, and social reality meet. They are often the first to see the gap between a technically sound treatment plan and a plan that a patient can actually follow. They identify confusion, non-adherence risks, family strains, transport barriers, food insecurity, and the many practical constraints that determine whether care succeeds in real life.

A person-centred system depends on nurses having the resources and time available to use their trusted relationships to understand what matters to the patient, not only what is clinically wrong, and to co-produce care decisions through shared decision-making that respects patients' goals, values, and circumstances.

To deliver on this vision, nurses must be empowered to:

- deliver coordinated care across settings, replacing fragmented models with continuity
- address the broader context of health, including the social, emotional, and environmental realities that shape outcomes
- leverage supportive, human-centred technology that serves care rather than complicating it, improving coordination and decision-making and freeing up time for what matters most to patients.

1. Overcoming fragmentation: coordination is where care models succeed or fail

For patients with chronic and complex needs, the quality of care depends as much on what happens between health service encounters as on what happens within them. This is where many health systems remain weakest. When patients move between acute hospital care and primary health care or back into their home lives, for example, critical information can get lost or treatment plans can become difficult to follow.

Health systems lose between USD 25-45 billion every year due to preventable complications, avoidable readmissions, and patient deterioration all driven by poorly coordinated care.

Almost **40%** of patients do not report good care coordination.

Investing in integrated, coordinated care strengthens health systems and improves patient safety.

(Berwick & Hackbarth, 2012; OECD, 2025)

The OECD defines coordinated care as the extent to which patients experience a seamless and continuous journey through different health care settings and providers (OECD, 2025). Yet PaRIS data shows that, on average, almost 40% of patients do not report good care coordination (OECD, 2025). Only around one quarter of patients with chronic conditions report having a care plan available to them, despite far higher reported use by providers.

The human and economic costs of fragmented care are substantial. Poor care transitions are a major driver of medication errors, adverse events, avoidable emergency department use, and preventable readmissions (WHO, 2016; Russell et al., 2013). They can result in increased mortality, disability and diminished quality of life for patients. Research estimates that inadequate care coordination accounts for USD 25–45 billion in wasteful spending every year, mainly due to the cost of complications, readmissions, and deterioration (Berwick & Hackbarth, 2012). Fragmented care also creates a huge administrative burden for nurses, who find themselves managing duplicated tests and results, or spending time searching for information that is not readily available.

Given their holistic approach, nurses are ideally placed to lead the shift toward integrated, coordinated models of care. Evidence shows that nurse-led care coordination, case management, and transition planning improve clinical outcomes, access, safety, and quality of care (Karam et al., 2021). In practice, nurses often act as the connective tissue of the health system: aligning information, sequencing care, supporting patients to navigate health systems and complex care needs, and translating care plans into everyday self-management.

Thus, care-first models require explicit investment in coordination. That includes advanced nursing and nursing coordinator roles, protected time for transition planning, interoperable information systems, and shared care protocols that follow the patient across settings.

CASE STUDY

NURSE NAVIGATORS SPEED UP THE PATH FROM CANCER SCREENING TO TREATMENT

When people receive an abnormal cancer screening result or a new diagnosis, the next steps can be confusing and slow — especially when care involves multiple services and appointments. A systematic review and meta-analysis from Korea examined what changes when a nurse navigator is added during the transition from screening and diagnosis to the first treatment phase.

Across 16 studies, nurse navigators consistently performed practical "through-the-system" work: coordinating the care pathway, acting as a primary contact, following up to keep appointments on track, obtaining records and test results, identifying and addressing barriers (such as logistics, costs, fear, or communication issues), providing education and psychosocial support, and linking patients to relevant resources.

The review found that **nurse navigators were associated with faster access to care**.

On average, patients reached key milestones sooner: about 20 days faster from abnormal screening to first treatment visit; 30 days faster from screening to diagnosis; 18 days faster from diagnosis to first treatment; and 11 days faster from first consultation to first treatment (compared with usual care). Patient satisfaction with nurse navigation was reported as high in individual studies. Completion of diagnostic and treatment services tended to be higher in navigated groups (reported ranges 13% to 45% more likely), though pooled effects were not statistically significant.

A key takeaway was how nurse navigators work best: the largest reductions in waiting time occurred when navigators operated as core members of multidisciplinary cancer programs, actively linking the team and the patient across handoffs.

Oh & Ahn, 2021

80% of modifiable health outcomes are shaped outside of clinical settings (Hood et al., 2016).

Nurses are ideally placed to address these social, economic, environmental, and behavioural determinants of health through education, prevention, screening and management interventions.

2. Addressing social determinants: care extends beyond the clinic

Research shows that only around 20% of people's health outcomes can be attributed to direct clinical care (Hood et al., 2016). The majority is shaped by social determinants of health, defined by WHO as "the conditions in which people are born, grow, live, work, and age, and the wider forces that shape the conditions of daily life" (WHO, n.d.). In short, health is strongly influenced by factors like educational status; access to resources and nutritious food; housing and working conditions; racial, ethnic, or gendered discrimination; and social status and support. There is a clear social gradient: the greater the socioeconomic disadvantage, the fewer healthy years people can generally expect to live (WHO, 2025).

Nurses have long worked at this interface between health and daily life. Nurses build trust with patients and communities and are trained to treat patients holistically within their life contexts. This means they are often the first to identify the practical barriers undermining care: unstable housing, transport limitations, financial stress, low health literacy, unsafe work, or family caregiving strain. Nurses are **ideally positioned to screen for social needs, connect patients with community resources, and advocate for policy changes** that address the upstream determinants of health.

That role is recognized in professional ethics as well as practice. The ICN Code of Ethics for Nurses states that nurses contribute to and advocate for policies and programmes that address the social determinants of health (ICN, 2021). ICN's Position Statement on health inequities and discrimination describes how nurse-led care provides "solutions that not only effectively meet the needs of people but also address health inequities by being non-discriminatory, accessible, appropriate, and person-centred" (ICN, 2023).

Supporting the power of care must therefore equip nurses to identify social need, connect patients to community resources, and help shape upstream responses to the drivers of poor health.

3. Ensuring technology is nurse-led, patient-shaped, and care-focused

Digital tools, AI, telehealth, and automation create opportunities to make care more accessible and patient-centred while freeing health professionals from routine administrative burdens and empowering them with powerful data and tools. But this can only happen if technology is designed and deployed with a clear purpose: to expand the capacity for care, not displace it. Technologies must enable nurses by liberating more time for human care, improving coordination, and supporting better decision-making.

McKinsey estimates that up to 30% of current nursing tasks could be automated, particularly in scheduling, documentation, charting, and information retrieval (McKinsey, 2023). That creates an opportunity to redirect scarce clinical capacity toward activities that matter most: patient interaction, care planning, education, coordination, and early intervention.

The most promising use cases are practical. AI-assisted documentation can reduce time spent on note-taking and after-hours work (Duggan et al., 2025). Predictive tools can identify deterioration or risk earlier, including sepsis and falls (Duke Institute for Healthcare Innovation, 2018; Nanevski et al., 2025). Robotics can reduce time spent on transport, supply delivery, medication selection, and manual handling (Shaw & Chen, 2025;

Up to **30%** **of current nursing tasks** could be automated — particularly scheduling, documentation, charting, and information retrieval (McKinsey, 2023).

If it is well-designed and human-centred, technology can support the nursing workforce and free up time for patient-centred care.

Cheng et al., 2024). Telehealth can improve access, continuity, and convenience, particularly for rural and underserved populations, while reducing missed appointments and travel burden (Charalambous et al., 2023).

At system level, digital tools can also strengthen access to patient information, support real-time monitoring, improve workflow, generate performance visibility, and accelerate evidence-based practice (OECD, 2021; WHO, 2021).

But the record of digital transformation in health care is mixed. Too often, technology has been layered onto existing complexity rather than used to remove it. The test should be simple: does the technology create more time and better conditions for care? If it does not, it is not a care improvement. Many health care workers report technology rollouts that actually *increase* their administrative workload, create safety risks, or exacerbate existing health inequities (OECD, 2021). Technology implementations routinely underperform when the people expected to use them, especially nurses, are brought in too late or not at all. Research has documented electronic health record systems designed more for billing and reporting than for clinical workflow, as well as digital monitoring tools that generate excessive alerts and contribute to alert fatigue, cognitive overload, and stress (OECD, 2019; Lewandowska et al., 2020). Poorly designed technology is also associated with burnout and patient safety risks (Barnett et al., 2025; Bahr et al., 2023; Tawfik et al., 2021; Alobayli et al., 2023).

To make sure that digital tools fit clinical workflow, support safer decisions, and strengthen rather than disrupt person-centred care, nurses and patients need to be involved as design partners from the outset. Human-centred design is not optional (Tzimourta, 2025).

Capability also matters. Digital literacy, data use, telehealth, and AI oversight should be treated as core nursing competencies, supported both in pre-service education and through continuous professional development (OECD, 2021). This requires more than one-off training. It requires protected time, flexible upskilling, and leadership pathways that allow nurses to shape digital transformation.

Ethical technology use is fundamental, including strong regulatory safeguards for AI and other digital technologies in health care (WHO, 2024). Interoperability is also critical. Fragmented electronic health records create dangerous information gaps, duplicate work, and force nurses to spend time searching, reconciling, and re-entering information. Research suggests that interoperable EHR systems improve patient safety while reducing costs (Li et al., 2022). A care-first digital strategy requires records that follow the patient across the continuum, rather than remaining trapped within institutions.

Person-centred, integrated, primary health care is the key to meeting the challenges of chronic disease, ageing populations, and health inequality. To build health systems that truly serve people, we must invest in the nursing profession's power to make care continuous, coordinated, and human.

Megumi Yamaura-Teshima,
ICN Second Vice President

THE BLUEPRINT: POLICY ACTIONS FOR PERSON-CENTRED, INTEGRATED CARE

In systems shaped by chronic disease, complexity, and constraint, health system performance will depend on redesigning care delivery around people's real needs, with nursing as a core integrating capability and technology deployed to support time for human care. The evidence in this chapter demonstrates that person-centred, integrated care delivered by nurses saves lives, improves well-being, manages chronic disease more effectively, and uses resources more efficiently.

ICN calls for the following actions to translate these findings into the structural changes required to unlock the full power of nursing care:

ACTION 1

Redesign care models around people, not institutions

Establish integrated, person-centred care pathways anchored in primary health and community care, with seamless transitions across prevention, diagnosis, treatment, rehabilitation and palliative care, delivered in the most appropriate setting (including at home, such as hospital in the home) and supported by nurse-led models where they are safe, effective and cost-effective.

ACTION 2

Invest in nursing coordination capacity

Resource nurse-led care coordination (case management, transitions, navigation) for people with chronic and complex needs, with clear responsibilities across settings and protected capacity for handover, follow-up, and escalation.

ACTION 3

Shared care planning that is visible to the person and the team

Establish a norm that people with long-term conditions have an accessible care plan (goals, medicines, red flags, next steps), co-produced with the patient and updated across the continuum — reducing duplication and preventable deterioration.

ACTION 4

Regain time for care through staffing, workflow, and documentation reform

Rebalance nursing time away from low-value administrative load via streamlined documentation standards, role clarity, and technology that reduces duplication — so relational care, education, and early intervention become the default.

ACTION 5

Strengthen information systems and knowledge management

Improve information systems and build a data-using culture that supports monitoring and evaluation, knowledge sharing, and evidence-informed decision-making as foundations for transformational change. Invest in records and referral systems that support continuity across providers and sectors, including community and social care interfaces — reducing unsafe information gaps and repeated assessments.

ACTION 6

Align nursing education and CPD with people-centred care

Strengthen curricula and lifelong learning in communication, cultural safety, shared decision-making, chronic disease support, quality improvement, and digital capability — so person-centred care is consistently delivered, not left to individual goodwill.

ACTION 7

Improve funding and payment systems

Recalibrate health financing and payment arrangements to secure adequate funding for people-centred care, align incentives toward continuity and integrated care across providers and settings, and strengthen financial protection by reducing exposure to avoidable out-of-pocket costs — enabling nurses to deliver coordinated, high-value care.

ACTION 8

Strengthen leadership and management for change

Strengthen collaborative leadership for service reform by engaging clinicians and other stakeholders, working with local communities and supporting integrated care through a clear change management approach that can deliver complex process and service innovation.

ACTION 9

Increase the nursing voice in care reform governance

Position national nursing associations as formal partners in policy and delivery reform and strengthen executive nursing leadership so people-centred care design reflects real workflow and patient need.

CHAPTER

6

The power of proximity

Empowered Nurses Save Lives

> **Lives are changed not only by expertise, but by presence, and nurses are the professionals who remain closest when it matters most.**
>
> David Stewart, ICN Director of Nursing

Nurses are not only the largest health care workforce, but also the primary point of continuous patient contact; the professionals who remain with patients around the clock. Proximity — the closeness that allows for continuous observation, immediate response, sustained human connection — is at the heart of nursing. While other health professionals often interact with patients episodically for designated assessments or interventions, nurses are a constant presence, providing ongoing care and monitoring and responding to changing patient conditions at every stage of their health care journey. Nursing proximity extends beyond physical presence to encompass "nursing presence" — being emotionally and cognitively available to patients through behaviours such as eye contact, therapeutic touch, attentive listening, and treating patients as whole individuals rather than simply diagnoses. In hospital settings, nurses are present 24 hours a day, seven days a week, while in community settings, including in underserved areas, they reach homes, schools, and workplaces, often serving as the sole health care presence there.

Giving nurses enough direct care time with patients enables them to rapidly detect risks, provide timely, evidence-based interventions, and build the therapeutic relationships that support health. Research shows that when there are enough nurses to spend sufficient direct time with patients, mortality and hospital-acquired complications decrease; and readmissions drop (Dall'Ora et al., 2022; Griffiths et al., 2018; Dynan & Smith, 2022; Saville et al., 2025). Nursing proximity is also defined by geographic reach and closeness to communities, which serves as a critical pathway to Universal Health Coverage. Nurses extend quality care into homes, schools, and remote communities, saving costs and improving health outcomes while making care sustainable and accessible (ICN, 2024).

CASE STUDY

CLIMBING TO VACCINATE CHILDREN IN RURAL UGANDA

In eastern Uganda, nurse Agnes Nambozo works across a wide scope — supporting maternal and child health, treating basic conditions, and providing health education. A key part of her role is reaching children in remote mountain communities which cannot easily access a clinic. Some villages are connected by steep ladders used as routes between communities, but they are not safe for mothers carrying babies, so outreach becomes the only practical option.

On vaccination days, Agnes starts early, travelling by taxi and motorbike before continuing on foot to reach the ladder access points and then the villages. She carries vaccines in an insulated backpack with ice packs to maintain the cold chain and plans for roughly 50 patients a day, mainly children under five, vaccinating against diseases including polio, measles, tetanus, pneumonia, and others. Because health workers rarely reach these areas, she and colleagues also provide additional basic services such as deworming treatment, vitamin A supplementation, and general health advice.

The work is physically demanding and risky, especially in wet weather when ladders become slippery. It has also become harder as staffing at the local clinic reduced after USAID-supported roles were cut, affecting services including support for mothers and work on HIV and tuberculosis. Despite these pressures, Agnes continues outreach and has returned to study to build further skills.

This is the power of proximity in action: a nurse who climbs ladders and rides motorbikes to reach children no system would otherwise reach, ensuring no community is beyond the scope of care.

(Deutsche Welle, 2026; Gates Notes, 2025)

NURSING PROXIMITY IS DEFINED BY BOTH PATIENT TIME AND FREQUENCY

Nurses constitute the largest workforce in hospitals both in terms of numbers and hours of service, functioning as the primary continuous caregiver and providing care 24/7 (Setiawan et al., 2023; Sun et al., 2024).

One study documented an average of 3.6 hours of nursing care per patient per day for patients in medical units (Peršolja et al., 2018). The frequency of contact matters as well as its duration. Multiple studies document nurses' patient rounds every one to two hours as standard practice in clinical settings (Brosey et al., 2015; Meade et al., 2006; Adawi, 2023; Maria et al., 2024) and research has shown an average of nearly eight separate interactions per patient bed per nursing shift (Sun et al., 2020).

These regular touchpoints ensure continuity of assessment, monitoring, and patient safety throughout the day and night.

WHY NURSE PROXIMITY MATTERS

While proximity begins with nurses' closeness to each individual patient, its effects ripple outward. Physically and emotionally present care can transform health systems, improve health outcomes, and bring essential, trusted health services to the communities that need them most.

Proximity has a measurable positive effect on (1) patient safety and quality of care (2) community and public health; and (3) the economic value of care.

1. Nursing proximity improves patient safety and quality of care

Nursing proximity is one of the clearest pathways to safer care. Its effects are visible in nursing-sensitive indicators, outcomes that depend directly on the quality and availability of nursing care (Afaneh et al., 2021). When nurses are able to stay close to patients, they identify risk earlier, respond faster, and prevent harm more effectively.

That proximity depends on staffing. Adequate nurse staffing and stronger nursing resources create the conditions for more direct patient time, while low registered nurse staffing weakens both the quality and quantity of nurse-patient interaction (Bridges et al., 2018). The evidence is consistent: safe nurse staffing reduces adverse events and improves patient outcomes across care settings (Dall'Ora et al., 2022).

Hospitals with stronger nursing resources deliver better results across the metrics that matter most — lower mortality, fewer readmissions, fewer falls, lower rates of hospital-acquired complications, and higher patient satisfaction (Lasater et al., 2020; Dynan & Smith, 2022; Assaye et al., 2021; Winter et al., 2021; Brosey et al., 2015).

Nurses' proximity means they are uniquely positioned to detect early signs of deterioration and intervene before a patient's condition becomes critical, protecting patients from preventable harm. Higher nurse staffing reduces mortality by 5–20% (Twigg et al., 2021; Griffiths et. al, 2016; Aiken et al., 2018) while every single additional hour per day of registered nurse care is associated with a 3% reduction in the risk of death (Griffiths et al., 2018). Sustained nursing presence is a critical safeguard against many hospital-acquired complications, such as pressure ulcers, falls, and infections. For example, increased nurse staffing brings a 68.5% drop in pressure ulcer rates (Dynan & Smith, 2022) while increasing care hours from professional nurses by 10% resulted in a 9% reduction in patient falls (Wieczorek-Wójcik et al., 2024).

2. Community and public health benefits of nursing proximity

Nursing proximity extends the reach of health systems beyond formal care settings. It connects individual care with population health by bringing continuous observation, early intervention, and trusted support into communities as well as hospitals. Nurses' geographic reach, sustained contact with patients, and understanding of local social conditions make them central to public health surveillance, screening, prevention, and response. In many remote, rural, and disadvantaged settings, nurses are the most consistent — and sometimes the only — health care presence. This community reach directly advances Universal Health Coverage by bringing essential health services to populations who might otherwise lack access (ICN 2024; OECD, 2020).

Public health and community nurses deliver key population-level interventions including screening, immunization, maternal and child health services, and community health education. But the public health value of proximity extends beyond specialist roles. The day-to-day practice of nursing — across hospitals, clinics, homes, schools, workplaces, and shelters — strengthens prevention, early detection, and continuity of care.

CASE STUDY

NURSE-FAMILY PARTNERSHIP MODEL

The Nurse-Family Partnership®(NFP) community health programme in the United States brings nursing home visits to first-time mothers affected by social and economic inequality and who face barriers to accessing health and wellness resources and supports.

45 years of research demonstrates that by addressing social determinants of health and making care accessible, the NFP programme brings significant improvements in the health and lives of mothers and their children.

Outcomes include:

- 48% reduction in child abuse and neglect
- 56% reduction in ER visits for accidents and poisonings
- 50% reduction in language delays of children aged 21 months
- 67% less child behavioural/intellectual problems at age 6
- 82% increase in months mothers were employed

The NFP programme shows a return on investment of up to $5.70 for every $1 spent, a clear demonstration that empowering nurses to deliver holistic, community-based care is one of the most effective investments a health system can make.

(Changent, 2025)

Nurses are often the health system's first point of visibility into emerging risk. Their continuous contact with patients and communities also enables them to act as the "eyes and ears" of the system: identifying deterioration early; preventing adverse events; detecting infectious and environmental threats; supporting contact tracing; reinforcing public health advice; and contributing to emergency response. In acute settings, that proximity helps prevent complications such as falls and medication errors. In the community, it helps detect risk sooner, intervene earlier, and extend the reach of health systems where access is weakest (ICN, 2019; Strasser & Strasser, 2020).

CASE STUDY

RIDING HORSEBACK TO REACH REMOTE COMMUNITIES IN FIJI

In Fiji's remote NadrogaNavosa Province, nurses remain committed to staying close to communities. Staff Nurse Rusiate Kuila Degei serves villages in the interior without transport support. To reach patients, he travels on horseback across rugged terrain, river crossings, ridges, and valleys.

Nurse Degei provides community health services to multiple remote villages and settlements, focusing on prevention, education, and followup care. Riding on horseback enables him to maintain regular contact with populations that would otherwise face significant barriers to care.

By going where systems cannot easily reach, nurses like Degei ensure that geography does not determine access to essential health services and show the power of sustained nursing presence, trusted relationships, and continuity of care.

Fjii Sun, 2026

3. The economic value of nursing proximity

When nurses have the time, capability, and continuity to stay close to patients and communities, health systems are better able to prevent harm, respond early, and avoid costly deterioration.

This matters economically as well as clinically. High-quality nursing care contributes to better population health, and better health is itself an economic multiplier through higher productivity, stronger workforce participation, and lower disease burden. Every USD 1 invested in better health can generate returns of USD 2-4, while poor health is estimated to reduce global GDP by 15% each year (Remes et al., 2020).

The cost of unsafe care remains immense. One in ten patients is harmed during care, with the global burden of patient harm estimated at 64 million disability-adjusted life years each year, comparable to HIV/AIDS (Slawomirski & Klazinga, 2022). The wider economic consequences are even larger. On a societal willingness-to-pay basis, unsafe care is estimated to cost between USD 1-2 trillion annually. From a human capital perspective, eliminating patient harm could increase global economic growth by more than 0.7% each year while the direct cost of treating patients harmed during care accounts for an estimated 13% of health spending globally, or approximately USD 606 billion each year (Slawomirski & Klazinga, 2022).

Nursing proximity is one of the clearest levers available to reduce this burden. Adequate staffing, stronger registered nurse skill mix, and more time in direct care improve surveillance, earlier recognition, and timely intervention. In turn, this reduces preventable complications, avoidable readmissions, unnecessary length of stay, and pressure on hospital capacity.

Seen in this light, investment in nursing proximity is a value-creating system strategy. Evidence shows that safe staffing standards, stronger RN skill mix, and deliberate efforts to maximize direct care time are associated with better outcomes and stronger financial performance (Wieczorek-Wójcik et al., 2024; Lasater et al., 2021; Needleman, 2016; Griffiths et al., 2020; Saville et al., 2025).

These investments help avoid high-cost adverse events, including hospital-acquired infections, medication errors, and missed care, while improving patient flow and the use of scarce hospital resources.

If health systems want to improve safety, productivity, and fiscal performance, they must treat nursing proximity as a strategic investment. The policy priority is therefore not only to increase staffing, but to direct nursing time, skill, and attention to the points in the system where they generate the greatest clinical and economic value.

CHALLENGES TO NURSE PROXIMITY

Despite clear evidence supporting the importance of nursing time with patients, nurses face significant "time poverty." Shift after shift, nurses are pulled away from patients by the demands of documentation, administrative and logistical processes, and task interruptions that fragment their attention and reduce the time available for direct care. For example, research in medical units found that only 36.8% of nursing activities involved direct patient contact (Peršolja et al., 2018).

Increasing nurses' well-deployed time with patients is a high-leverage intervention that improves health outcomes and strengthens the safety and efficiency of health systems.

Realizing this potential means tackling three interconnected obstacles that currently limit nurses' ability to be present with patients: insufficient staffing; administrative and technology demands; and working conditions characterized by constant interruption and task-switching.

1. Shortages and understaffing

The fundamental threat to nursing proximity is inadequate staffing that forces nurses to care for more patients than they can safely manage. When nurses are responsible for more patients, the time available for each individual necessarily decreases. Research shows that patient satisfaction decreases with the number of patients cared for daily, but increases with the amount of care hours spent per patient per day (Peršolja et al., 2018). Limited time has been identified as the most problematic barrier to nursing presence, leading to patient dissatisfaction due to lack of attention. Overcoming this challenge requires sustained investment in nursing workforce development and workplace improvements that support adequate staffing levels.

2. Administrative and technology burden

Administrative burden represents a significant challenge. Nurses want to spend less time on documentation and administrative tasks and more time with patients and growing as professionals. Models show that up to 30% of nurses' administrative burden could be automated or delegated, freeing up time for more meaningful work (McKinsey, 2023). Digital solutions can improve efficiency, but must be designed to support rather than hinder nurse-patient interactions. Some research has found that while nurses using electronic medical record point-of-care documentation had longer encounters with patients, they spent less time looking at and speaking to them (Duffy et al., 2010). This illustrates how technology intended to improve care can paradoxically reduce the quality of nurse-patient interaction if workflows and systems fail to prioritize nurse-patient time and relational care. The key is developing systems that save nurses time while preserving the human connection at the heart of care.

3. Fragmentation and task-switching

Nurses often deal with working conditions that require them to constantly switch tasks or interrupt their core activities, which also challenges sustained presence and proximity.

Research documented that nurses completed an average of 72.3 tasks per hour with a mean task length of 55 seconds, and an average of two interruptions every hour (Westbrook et al., 2011). Addressing this requires thoughtful workflow and organizational management that protects time for sustained, focused patient attention.

OVERCOMING THE BARRIERS TO NURSE PROXIMITY

When nurses have adequate time with patients, health outcomes improve and health systems save money. Nurse proximity advances Universal Health Coverage by bringing continuous, high-quality care to communities and populations. To tap into the power of proximity, we must urgently address the factors that limit nurses' ability to be present and close to patients. This will require systemic changes in how health care is organized and resourced.

We must create health care environments that prioritize and protect the time nurses spend with patients, recognizing this as the foundation for care quality, safety, and efficiency and wider public health. Health systems need evidence-based staffing standards, technology that enhances rather than disrupts human connection, organizational cultures that support nursing presence, and expanded nursing roles within communities.

THE BLUEPRINT: POLICY ACTIONS TO UNLOCK THE POWER OF PROXIMITY

Nursing proximity is one of the clearest levers for improving patient safety, health outcomes, and system efficiency. The greatest gains come from directing skilled nursing time to where it generates the most clinical and economic value.

ICN calls for the following actions to support the power of nursing proximity:

ACTION 1

Adopt safe staffing through acuity-based workforce planning

Implement staffing methodologies that calculate workforce requirements based on patient acuity and the time required for direct care. This shifts staffing from static ratios or roster compliance to a more precise assessment of clinical need and helps to protect both patient safety and workforce sustainability. This may include establishing unit-level, acuity-linked staffing standards for high-risk settings; defining clear escalation pathways (e.g. surge protocols, float capacity, and rapid redeployment arrangements) when staffing falls below planned coverage; and tracking hours below planned staffing levels as a core metric.

ACTION 2

Use RN skill mix as a clinical and productivity lever

Protect the level of registered nursing capability required for early recognition, timely intervention, and prevention of avoidable deterioration. This includes workforce targets that protect the proportion of registered nurses in high-acuity and high-turnover settings, and embedding skill-mix planning into workforce design so staffing models reflect clinical complexity, not only patient volumes.

ACTION 3

Redesign clinical workflows to return time to care

Systematically remove administrative bloat, duplication, and workflow fragmentation that pull nurses away from direct patient care. This includes simplifying workflows to reduce unnecessary task fragmentation and handoff complexity, delegating administrative to support staff, and redesigning team processes so nurses can spend more time in sustained, therapeutic, and clinically meaningful contact with patients.

ACTION 4

Invest in digital infrastructure that releases time to spend with patients

Deploy automation, interoperability, and digital health technologies that are designed with and for nurses and patients. Ensure that digital investment is directed towards reducing administrative burden and returning time to direct patient care. This may include implementing electronic health records, automated medication dispensing, and clinical decision support; improving interoperability so information can move across settings without manual re-entry or workarounds; and requiring digital investments to demonstrate measurable gains in nursing time, workflow efficiency, and care quality.

ACTION 5

Use nurse-sensitive indicators to steer staffing and improvement in real time

Make staffing and workflow decisions more adaptive, evidence-based, and outcomes-oriented by linking operational management to a focused set of nurse-sensitive indicators (including falls, pressure injuries, selected infection measures, medication-safety proxies, and missed-care signals, as well as staffing coverage and skill mix). Use this data to trigger targeted responses such as redeployment, surge staffing, workflow redesign, and focused prevention support.

ACTION 6

Expand nurse-led models in community and primary health care

Strengthen the role of nurses in primary health care and community settings to improve reach and continuity, support earlier intervention, and reduce avoidable hospital demand. This should include investment in primary health care models; integrating community, primary care, and facility-based data; and investing in digital early-warning capability to detect clinical decline and emerging disease outbreaks sooner.

ACTION 7

Target high-cost harm through nurse-enabled prevention bundles

Direct nursing capability toward the preventable events that drive the greatest clinical and financial burden, particularly falls, pressure injuries, and health care-associated infections.

This should include scaling nurse-led prevention programmes that reliably reduce falls, pressure injuries, and health care-associated infections, as well as supporting implementation with protected time in rosters, appropriate equipment, and targeted training.

CHAPTER

7

The power of peace

> **Health and peace are intimately connected: nurses are peacemakers as well as healthmakers. In times of crisis, nurses and health workers do not only respond, but also rebuild, recover, and deliver equitable care that supports social stability, the foundation for peace. Nurses prevent conflicts from devolving into permanent public health catastrophes and restore hope where it has been lost. It is time to recognize the power of nursing for peace.**
>
> Myrna Abi Abdallah Doumit,
> ICN Eastern Mediterranean representative

In fragile and conflict-affected settings, nurses serve as trusted guardians of health, often at great personal risk. Nurses' skills, dedication, and integration into communities gives them the power to promote health, peace and stability and defend human rights in settings where these values face their gravest threats.

Health system collapse in conflict settings is rarely the result of a single shock, but instead the consequence of repeated attacks on the infrastructure, workforce, and social conditions required to deliver care.

The world is seeing increasing attacks on health care facilities and professionals in conflicts, which are both morally abhorrent and illegal under International Humanitarian Law (IHL) (SHCC, 2025; WHO, 2026; ICN, 2025; MSF, 2026). These result in the tragic and unacceptable loss of nursing life and represents a pattern of violence that strips communities of care, weakens emergency response, and accelerates institutional breakdown. The normative frameworks are clear in IHL and the UN Security Council Resolution 2286, the first Security Council resolution focused specifically on attacks on health care in armed conflict, adopted in 2016. Yet a decade later, implementation remains weak and impunity remains widespread, evidenced by the continued number of attacks.

Through its humanitarian work and #NursesforPeace campaign, ICN continually advocates for protection of nurses and health personnel, raises awareness of the consequences of violence against health care in conflict, and calls for accountability and an immediate end to these horrific attacks.

THE IMPACT OF NURSING POWER IN CONFLICT

In the face of violence and instability, nurses demonstrate the power to preserve both health and hope: maintaining access to care when systems collapse, supporting humanitarian efforts through trusted community relationships, preventing epidemics that could destabilize entire regions, and rebuilding the social fabric that underpins lasting peace.

> **No nurse should ever be a target. Nurses have enormous power to bring health and peace to communities and they make enormous sacrifices to continue to provide care even in the most challenging circumstances. Violence against nurses and other health care workers has been normalized in conflicts, but this normalization is morally unacceptable and cannot be tolerated. Every attack on health care weakens the foundations of civilization itself. We need to support nurses as fundamental pillars of peace and security in our communities.**
>
> José Luis Cobos Serrano, ICN President

IMPACT 1

Nurses protect access to care in crisis conditions

When conflict destabilizes a country or region, populations experience what can be described as a double disadvantage. Health risks increase at the same time as the capacity of the health system to respond declines. People become more vulnerable to injury, infectious disease, maternal and neonatal complications, non-communicable disease deterioration, malnutrition, and mental ill health, precisely when the institutions designed to protect them are least able to function.

This breakdown is visible in the basic operating conditions of care. Globally, an estimated 1 billion people are served by health facilities with no or unreliable electricity, while 1.7 billion people are served by facilities lacking basic water services. These deficits are most acute in fragile and conflict-affected settings, where routine care, infection prevention, emergency surgery, and safe childbirth become harder to sustain (WHO, 2025)

In such environments, nurses become critical agents of continuity. They are the largest and often the most consistently available segment of the health workforce and, in many settings, they are the first, most frequent, and sometimes only health contact for patients and communities. Their role extends well beyond bedside care. They stabilize service delivery, maintain vaccination and primary care access, support infection control, coordinate teams, and preserve a thread of trust between communities and institutions when broader systems are fragmenting.

CASE STUDY

STAYING TO CARE IN ODESA

At a maternity and women's and children's hospital in Odesa, Ukraine, nurses were used to caring for women and children. After the war escalated, their work changed: they began receiving wounded men, including soldiers brought directly from the front. The nurses treated injuries they had not previously encountered in this setting and listened to what the soldiers shared about their experiences, while carrying their own personal worries about family members, many of whom were fighting.

Despite the strain and the ongoing risk, nurses have continued to report for duty and keep services running. When air raids required people to shelter, the nurses prepared the hospital basement so it felt less frightening for children, painting it with bright colours and cartoons. They moved as many patients as possible into the shelter and stayed with those who could not be moved, continuing care on the wards.

Many staff could have chosen to evacuate. They chose to stay, adapting quickly, protecting patients during alerts, and maintaining care under wartime conditions. This is a testament to the power of nursing to protect access to care when conflict transforms every aspect of daily work and life.

(ANMJ)

IMPACT 2

Nurses enable humanitarian efforts

Nurses and national nursing associations serve as indispensable humanitarian actors on the ground. Through their embedded presence in communities, nurses can identify the most vulnerable populations, assess evolving health needs, and adapt service delivery models to changing security conditions. As well as providing direct care, nurses can leverage their deep local knowledge of community needs and their trusted relationships to facilitate humanitarian aid efforts. As one example, ICN's #NursesforPeace partnership with Direct Relief has supported nursing associations to transfer emergency medical supplies to conflict-affected regions, ensuring resources get where they are most needed.

IMPACT 3

Nurses prevent epidemics and promote health security

In fragile settings, where disease surveillance systems are weakened and outbreak risks are elevated, nurses serve as the frontline of health security, detecting infectious diseases before they escalate into pandemics. This role is crucial to global health resilience, as over 80% of major infectious disease epidemics occur in fragile or conflict-affected countries (WHO, 2020). Through their clinical expertise, community presence, and surveillance capabilities, nurses in crisis zones provide early warning systems for emerging health threats while delivering high-quality care that improves outcomes for communities in crisis.

IMPACT 4

The peace–health–nursing nexus supports wider social stability and recovery

The stability of a society and the health of its people exist in a reinforcing cycle. Without peace, the right to health is systematically denied: mortality and morbidity rise, access to care deteriorates, and public health worsens. When health systems fail, social instability deepens, grievances intensify, and recovery becomes harder to sustain.

Nurses do not only respond in times of crisis. They actively contribute to recovery and rebuilding of health systems and societies. By providing equitable, compassionate care, nurses foster social stability and build pathways toward sustainable peace (UN & World Bank, 2018).

THE SYSTEMATIC DESTRUCTION OF HEALTH IN CONFLICT

Conflict destabilizes regions and destroys or weakens health care systems. When health care facilities are targeted, bombed or forced to close, entire populations are left without access to essential services. The scale of this violence is alarming: the Safeguarding Health in Conflict Coalition documented over 3,600 attacks on health care globally in 2024, averaging ten attacks per day — the highest number ever recorded (SHCC, 2025). WHO's surveillance system for attacks on health care recorded 1,348 attacks in 2025, resulting in 1,981 deaths, compared with 944 fatalities in 2024 (MSF, 2026).

The damage extends far beyond the immediate attack. Attacks lead to facility closure, reduced hours, staff withdrawals, medicine shortages, interrupted transport, delayed referrals, and suspended outreach services. Preventive and routine services are often the first to disappear, followed by specialist and emergency services. This has long-term consequences for maternal and newborn health, trauma care, vaccination coverage, chronic disease management, disability, and mental health (Lokulo-Sodipe, 2018).

Systematic attacks on health infrastructure can lead to a prolonged collapse of service capacity. Some statistics from recent conflicts illustrate the extent of this devastation. In Syria, following years of conflict, only 57% of hospitals and 37% of primary health care centres remain fully operational (WHO, 2025). The Gaza Strip has just 42% of health service points functioning, and 90% of these operating only partially (UN OCHA, 2026). Ongoing war in Sudan has left only 14% of hospitals operational (WHO, 2025).

Attacks on health care also increase health workers' exposure to not only physical danger but also moral distress and psychological trauma from witnessing violence against patients, families, and colleagues (Agbo et al., 2024). Repeated exposure to violence contributes to trauma, burnout, moral injury, absenteeism, resignation, and emigration (ICN, 2025; Rija et al., 2022; WHO, 2025). In already fragile settings, this can contribute to greater workforce shortages, more insecurity, lower service capacity, and deeper loss of public confidence.

The destruction of health infrastructure in crises has enormous human, social, and economic costs. Models estimate that health system shocks reducing primary health coverage in the Latin America and Caribbean region could lead to an additional 35,000–174,000 deaths (including neonatal deaths, child deaths, maternal deaths and deaths due to non-communicable diseases) and ultimately create USD 7–37 billion in societal economic costs per shock (Wickramaarachchi et al., 2025). The destruction of health infrastructure is a primary driver of long-term economic decay. Conflicts imply about a 15–20% drop in real GDP per capita over five years (IMF, 2019), and recovery can take decades, stalling development and public health progress.

The protection of nurses and other health personnel is an urgent strategic requirement to uphold the right to health, preserve institutional resilience, and prevent crisis situations from leading to permanent health system collapse. The nursing workforce keeps care accessible and human under the most difficult conditions. Protecting and empowering nurses is an investment in stability, recovery, and peace itself.

CASE STUDY

GRADUATING NURSES DESPITE CONFLICT IN MYANMAR

In Myanmar, the collapse of safe, formal health services after the 2021 coup created an urgent problem: patients needed care, but the pipeline for educating new nurses was being dismantled. Nurses and educators continued working in hiding and in conflict-affected areas, sustaining a parallel health system under constant risk.

To protect nursing education and standards, the Royal College of Nursing (RCN) supported Myanmar nurse educators and convened international nursing academics to design and deliver a full undergraduate degree: the Phoenix Bachelor of Nursing Science, aligned with International Council of Nurses' standards and Myanmar's pre-coup curriculum. Delivery combined recorded teaching, local facilitation, and supervised clinical learning in high-risk settings, while students trained around surveillance, insecurity, and communications disruptions. One graduate, Khun Sue Reh, summed up the operating reality: "Safety is never guaranteed."

By early 2026, the programme had delivered 58 modules, about 2,100 hours of recorded teaching, and around 1,500 hours of supervised clinical practice (about 3,600 hours over three years), and graduated its first class of nursing students.

This is the power of nursing for peace — continuing to educate nurses supports the infrastructure of care that *rebuilds societies*.

(The Guardian, 2026; RCN, 2026)

THE BLUEPRINT: POLICY ACTIONS FOR THE POWER OF PEACE

The current response remains too reactive, too fragmented, and too weakly enforced. What is needed is a peace-health compact that protects health workers and health services as a strategic priority for conflict prevention, crisis response, and sustainable recovery.

ICN calls for the following coordinated actions:

ACTION 1

Strengthen implementation of International Humanitarian Law and enforce legal protection for health care

States should fully embed International Humanitarian Law protections for health workers and health services into domestic law, including explicit criminalization of attacks, obstruction, intimidation, and interference with care. Legal frameworks should also protect nurses and other health professionals from prosecution for providing impartial, ethical care, including to wounded combatants or members of armed groups. These legal frameworks must be fully enforced and monitored.

ACTION 2

Ensure accountability and systematic reporting

Protection is weakened when attacks remain invisible. Countries and humanitarian actors should ensure comprehensive participation in surveillance systems such as the WHO Surveillance System for Attacks on Health Care in all conflict-affected settings. This should include trained focal points, confidential reporting channels, integration with national systems, and routine public reporting. Attacks on health care should be independently verified and linked to national and international accountability pathways so that attacks on health care are treated as prosecutable violations rather than inevitable by-products of conflict. Comprehensive accountability mechanisms must be established that end impunity for attacks.

ACTION 3

Fund a minimum protection package for facilities, transport, and staff movement

Every high-risk setting should have a baseline package of protective measures. This includes facility risk assessments, safe areas and shelter procedures, reliable communications, and safe movement protocols for staff and ambulances. These measures should be context specific and proportionate.

ACTION 4

Ensure occupational safety and system infrastructure

Governments and facility leaders must ensure the core operational inputs that keep care safe and functional: electricity, water, sanitation, ventilation, waste disposal, equipment, infection prevention systems, and availability of personal protective equipment. Occupational health programmes should include risk assessment, injury and exposure monitoring, hazard mitigation, and response plans for violence, infection, and psychological harm.

ACTION 5

Protect workforce well-being, rights, pay, and retention during crises

Crisis response must include confidential mental health and psychosocial support, peer support, trauma-informed supervision, enforced rest and leave arrangements, safe staffing protections where possible, and the right to refuse unreasonably unsafe work without retaliation. Hazard pay, life and disability insurance, and prompt compensation for injury or death should be standard components of crisis workforce policy.

ACTION 6

Enable ethical and inclusive care for populations most at risk

Nurses and other health workers must be protected and enabled when acting in accordance with medical ethics and the principles of impartial care. Service models must be deliberately designed to reach populations most likely to become invisible in crises: women, children, older people, survivors of sexual violence, people with disabilities, detainees, and people with mental health needs. Nurses must be supported as the backbone of care continuity and access for underserved populations.

ACTION 7

Build emergency capability across the workforce

Protection depends in part on preparedness. Health workers should receive practical training in mass casualty triage, trauma care, outbreak response, infection prevention and control, emergency communications, and personal security procedures. This should be reinforced by training on rights and obligations under international humanitarian law, medical neutrality, and ethical decision-making in high-risk settings. Continuing education is essential, particularly in settings where staff turnover is high and emergency care demands escalate rapidly.

ACTION 8

Invest in research, evaluation, and implementation learning

The evidence base on what best protects health workers and services remains too limited. Donors, academic institutions, and multilateral agencies should prioritize research on the effectiveness of protection measures, staffing and deployment models, mental health interventions, retention strategies, and the long-term impacts of attacks on service continuity and population health. Better evidence is needed not only to document harm, but to guide practical policy and investment decisions.

Conclusion: Invest for impact

This report has provided clear evidence that the power of nursing saves and transforms lives, strengthens health systems, and supports social stability and economic prosperity.

In the busiest urban hospitals and the most remote communities, in high-resourced clinics and conflict zones, nurses keep health systems functioning, populations healthy, and societies resilient.

Together, the seven powers of nursing represent an extraordinary concentration of impact. But power without investment is potential without effect. Chronic underfunding, shortages, restrictive regulations, and other challenges all hold back the impact of nursing care.

Turning the capability of nursing into the outcomes that populations need depends on whether systems invest in the conditions that allow these powers to operate at full strength.

Nursing power must be enabled through strategic investment.

THE CASE FOR INVESTMENT

The evidence across this report shows that nursing is not a cost to be managed — it is a high-return investment that converts health spending into healthier populations, stronger economies, and more resilient societies.

Every USD 1 invested in better health can generate economic returns of USD 2-4, while poor health reduces global GDP by an estimated 15% each year (Remes et al., 2020). Strengthening the health workforce — of which nurses are the largest and most critical segment — could prevent 189 million years of life lost to early death and disability and add USD 1.1 trillion to the global economy by 2030 (McKinsey, 2025). In low- and middle-income countries, returns on health workforce investment could reach as high as 10:1 (Asamani et al., 2022). Preventive health interventions, where nurses are central, yield a 1:14 return on investment, with adult immunization showing returns of 1:19 (BIAC, 2025). Eliminating patient harm — much of which adequate nurse staffing directly prevents — could increase global economic growth by more than 0.7% per year (Slawomirski & Klazinga, 2022). As a majority-female profession, investing in nursing also advances gender equity: empowering women through degree-level nursing education yields potential earning gains of over 300% in some regions (Wodon et al., 2018), and gender parity in the global labour market could unlock USD 28 trillion in societal value per year (McKinsey Global Institute, 2016).

INVESTING IN NURSE LEADERSHIP FOR BETTER DECISIONS, EXECUTION AND OUTCOMES

Nursing leadership at the point where services are designed and delivered is essential infrastructure that converts health investments into outcomes. This makes investing in nurse leadership a strategically important priority for all health system strengthening. Leadership improves workforce and health reform plans and converts them into action, ensuring they respond to the true scale and complexity of health challenges and adhere to the operational realities of care.

Nurses bring a unique vantage point that is vital in all health decisions because they sit at the interface between policy and practice more continuously than any other profession as the largest professional group in the health workforce and the most consistent presence across the care continuum. This is a strategic asset: nurses can see early and unfiltered how politics and policy shape the experience of patients, communities, and the workforce, and can translate that into practical design choice (Salvage and White, 2019). Policies developed without nursing insight are often impractical, expensive, unrealistic and therefore not followed; the discipline of asking "does this work at 2:00 a.m.?" is a governance test for real world viability (Disch, 2020).

When nursing perspectives are present in boardrooms and at policy tables, it strengthens patient and occupational safety, improves quality and risk awareness, and increases the efficiency of policy implementation by reducing blind spots (Arabi et al., 2014).

Investing in nurse leadership is also crucial to close the gender leadership gap in health systems. Globally, health care remains "delivered by women, led by men": women constitute around 70% of the health and social care workforce yet hold only about 25% of senior roles (WHO, 2019). This imbalance stalls gender equity and concentrates decision-making power away from the health workforce that most directly understands care delivery, flow and safety risk.

Closing this gap demands sustained and deliberate investment in women's leadership through nursing. This means funded pathways, sponsorship and succession planning, equitable pay and progression, and workplace cultures that remove structural barriers, including discrimination and harassment.

Other key actions needed to invest in nurse leadership include:

- strengthening the nursing voice in governance and high-level decisions
- ensuring senior nursing representation (e.g. Chief Nursing Officer posts with defined authority) in ministries of health, national health workforce councils, organizations such as WHO, hospital/health-system boards, and reform programmes (including digital/AI and emergency preparedness) — and ensuring that nurse leaders have sufficient authority and resources
- setting targets and publishing gender-disaggregated leadership metrics performance.

OVERCOMING INVESTMENT CHALLENGES: RISING DEMANDS AND FINANCING CONSTRAINTS

In the face of financing challenges, rising demands, and global unpredictability, the worst thing leaders can do is defer health care and health workforce spending or turn to quick fixes rather than sustainable investment.

Health systems everywhere face a structural double bind that makes the case for strategic investment both urgent and complex.

On one side, **demand and cost pressures are intensifying**. Demographic change — ageing populations and the growing burden of chronic and non-communicable disease — is driving demand for care that is continuous, complex, and long-term. Rising inequalities, natural disasters, conflicts and crises add layers of acute strain to health systems. New technologies, treatments, and rising expectations bring new possibilities, but also new costs.

On the other side, **public finance constraints are tightening.**

Government revenues are limited and health must compete for funding with education, defence, climate, infrastructure, and social protection. Meanwhile, the resilience gap remains large. OECD analysis estimates that countries would need additional spending of around 1.4% of GDP relative to pre-pandemic levels to be better prepared for future shocks, with roughly half directed to strengthening frontline health professionals (Morgan & James, 2023).

For many low- and middle-income countries, the picture is even harder: domestic fiscal pressures and sovereign debt are colliding with sharp contractions in external health aid. WHO reporting estimates more than a 30% reduction in total external aid for health in 2025 compared with 2023, and immediate service disruptions in approximately 70% of 108 low- and middle-income countries surveyed (WHO, 2025).

This is the clearest possible warning signal for policy makers: financing shocks translate rapidly into service shocks, and service shocks translate rapidly into declining health outcomes, especially for the most vulnerable, the poorest, for women and children, and for people living with chronic conditions.

Health spending has been volatile. OECD data shows that real health spending surged during COVID-19, then fell sharply in three-quarters of countries as emergency budgets were withdrawn — even as underlying demand continued to rise (OECD, 2024). This pattern reveals a structural weakness: systems oscillate between emergency expansion and post-shock contraction rather than building durable capacity.

OECD projections indicate that without major policy change, total health expenditure will continue to outpace economic growth, reaching around 11.2% of GDP by 2040 on average across OECD countries (OECD, 2024). Health systems cannot rely on growth alone to solve the problem, but must improve productivity and reduce waste.

The costs of underinvestment in health show up as service delays, avoidable complications, preventable mortality, stalled progress toward Universal Health Coverage, and the erosion of the public trust that holds health systems together. In fiscal terms, they show up as inefficient emergency spending, escalating long-run costs, and the loss of economic productivity when populations and workforces are less healthy. The question is no longer whether countries can afford to invest in the health and nursing workforce, but whether they can afford the consequences of failing to do so.

The practical challenge is to invest strategically in the levers with the highest proven returns, improving health systems and outcomes while defending fiscal sustainability and improving value for money.

> **In challenging and turbulent times, investing in nursing is vital for social, economic, and health security. The care nurses provide keeps populations alive, productive, and resilient against the shocks of pandemics, rising health needs, conflicts, and natural disasters. There is no national security without health security, and there is no health security without the nursing workforce. Countries have already committed to strengthening the nursing workforce under the Global Strategic Directions for Nursing and Midwifery. We now need the investment to deliver to turn these commitments into action.**
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> Howard Catton, ICN CEO

INVESTING IN SYSTEMIC CHANGE: THREE KEY LEVERS

The mistake most governments make is treating nursing investment as a single line item ("more staff"), rather than as a system with multiple return channels. When demand is rising and fiscal space is tightening, leaders must fund the interventions that most reliably protect system performance including access, quality, resilience and long-term affordability.

The evidence points to three proven strategic levers that can maximize the impact of investment and direct resources to where they generate the most sustainable value.

Figure 7: Invest for impact

First, prevention and healthier populations reduce avoidable demand. This is where health systems buy back capacity: fewer preventable admissions, better-controlled chronic disease, and earlier intervention. The effect is not only downstream cost reduction; it is immediate operational relief through core elements such as shorter waitlists, fewer crises, less pressure on staff (OECD, 2024). Nurses are the engine of this prevention at scale. Their trusted relationships drive vaccine uptake and treatment adherence; their holistic care model enables chronic disease education and self-management; and their proximity to communities reaches populations that are often underserved. Investing in nursing makes preventive and primary care a reality for populations.

Second, removing ineffective and wasteful spending creates headroom without undermining outcomes. The goal here is not marginal efficiency but rather systematic decommissioning of low-value activity, duplication and the freeing of human resources for what works (OECD, 2024). Health systems lose enormous resources through preventable patient harm, avoidable complications, care fragmentation, and uncoordinated service delivery.

As this report has shown, investing in professional nurses avoids the far greater cost of preventable harm. Investing in integrated, well-coordinated systems further multiplies these efficiency and patient safety gains.

The third lever focuses on optimizing performance and using technological transformation to improve productivity, throughput and consistency. One core example of this is maximizing nursing scope: when nurses work to their full scope of competence and education — including advanced practice roles — care reaches further, systems work harder, and patients are better served. This can be augmented and supported by the right equipment, including digital tools and responsible AI, provided that these are designed with and for nurses. Redesigning service delivery around what professionals are educated, competent, and authorized to do, with the right technological and organizational support, can reduce administrative load, improve coordination, support safer decisions, and enable care to be delivered in lower-cost settings.

Investing in these levers and enabling the power of nursing delivers the outcomes that matter most: expanded access and reach of care, improved quality and patient safety, more resilient health systems, more affordable care, and long-term fiscal sustainability.

ICN calls on all leaders to act decisively to mobilize nursing impact. The ICN Charter for Change and the corresponding policy priorities outlined in this report provide a clear roadmap for strengthening the nursing workforce and the health systems that protect populations. Investing in nursing means investing in the health, stability, and future of all people, everywhere.

> **This report leaves no room for doubt: the power of nursing is immense — and it is being systematically underused. What is required now is the political will to match evidence with action, by recognizing that investing in nursing is a high-return strategy that no health system can afford to forgo. This International Nurses' Day, ICN calls on leaders to invest for impact and empower nurses to save and transform lives. The evidence demands it, the economics support it, and humanity depends on it.**
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> José Luis Cobos Serrano, ICN President

International Council of Nurses
3, Place Jean-Marteau
1201 Geneva, Switzerland
+41229080100
icn@icn.ch
www.icn.ch