Investing in Nurses is a Prerequisite for Ensuring Universal Health Coverage

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Nurses and midwives constitute the majority of the global health workforce and the largest health care expenditure. Efficient production, successful deployment, and ongoing retention based on carefully constructed policies regarding the career opportunities of nurses, midwives, and other providers in health care systems are key to ensuring universal health coverage. Yet nurses are constrained by practice regulations, workplaces, and career ladder barriers from contributing to primary health care delivery. Evidence shows that quality HIV care, comparable to that of physicians, is provided by trained nurses and associate clinicians, but many African countries' health systems remain dependent on limited numbers of physicians and fail to meet the demand for treatment. The World Health Organization endorses task sharing to ensure universal health coverage in HIV and maternal health, which requires an investment in nursing education, retention, and professional growth opportunities. Exemplars from Haiti, Rwanda, Republic of Georgia, and multi-country efforts are described.

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The combined impact of endemic HIV, the growing burden of noncommunicable diseases in low- and middle-income countries (LMICs), and the shortfalls of millions of health care workers worldwide threaten the sustainability of health care systems and the possibility of achieving universal health care coverage. The World Health Organization (WHO) estimated in 2013 that 7.2 million nurses, midwives, physicians, and public health workers are needed to fill the human resources for health gap in "human resources

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for health crisis" countries with workforces below the minimum threshold of 2.28 skilled workers per 1,000 population, primarily those that are most impacted by HIV (WHO, 2013). An estimated 620,000 nurses and midwives are needed in sub-Saharan Africa alone, a region with 11% of the global population, 24% of overall disease burden, 67% of global HIV disease, 3% of all health care workers, and less than 1% of global health expenditures (WHO, 2006). This paper presents the argument that when developing, adjusting, or sustaining universal health coverage in a country, a failure to invest in the nursing and midwifery workforce as a key cadre will undermine universal health care coverage and result in poorer patient outcomes and increased health system costs.

Meeting the needs of universal health coverage effectively required nurses, nurse practitioners, and midwives to be trained and working at their fullest scope, including expanding schools of nursing, changing regulation and credentialing criteria, creating innovative retention measures in service delivery settings, adhering to international standards for nursing practice and education in order to maintain a quality workforce, and developing opportunities to include associate clinician practice options (Riegel, Sullivan-Marx, & Fairman, 2012) which are essential for meeting global health coverage. The WHO cadre of associate clinicians and advanced-level associate clinicians (formerly called nonphysician clinicians) include assistant medical officers, clinical officers, clinical associates, surgical technicians, physician assistants, and advanced practice nurses (WHO, 2012a). We describe a conceptual model for nursing and midwifery workforce development outlining core elements of education and capacity building, and provide examples from the field.

Nurses and midwives comprise up to 87% of all health professionals and provide primary care services for the majority of all health care systems, including those that are most resource constrained (WHO, 2006). Despite serious shortages and maldistributions in the nursing workforce, nurses, in terms of absolute numbers, remain the single largest category of available health workers. There is a strong and growing evidence base for the key role that nurses play in quality health care delivery in low-resource settings as well as in resource-rich environments such as the United States, the United Kingdom, and Australia (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Dall, Chen, Seifert, Maddox, & Hogan, 2009; Etchegaray, Sexton, Helmreich, & Thomas, 2010). The latest research from studies conducted in 12 European countries, China, and South Africa demonstrated that there was a significant relationship between nursing and patient safety, patient satisfaction, and the quality of nurses' work environments (Aiken, Sloane, Bruyneel, Van den Heede, & Sermeus, 2013; Bruyneel et al., 2013; Coetzee, Klopper, Ellis, & Aiken, 2013; Kirwan, Matthews, & Scott, 2013). These recent studies were significant because they highlighted universal organizational factors that promoted nurse retention and quality care, regardless of a country's income category. They also illustrated, consistently, that a satisfied nursing workforce created satisfied patients.

A sustainable health system that provides universal coverage and maximizes its use of nursing personnel requires the elements illustrated in a conceptual framework related to (a) preservice education, (b) targeted in-service training, and (c) capacity development (Table 1). Preservice interventions range from recruiting people to enter the nursing profession to updating the knowledge and skills of nursing faculty and placing emphasis on skill acquisition of both faculty and students through competency-based education. The most productive efforts at preservice capacity building can require working with schools of nursing and other training facilities on a long-term basis (on the order of decades, not months) to consistently produce competent health professionals. More common short-term efforts to turn out briefly trained (i.e., $<$6 months) health workers may prove to be less effective in the long run (Lehmann, Van Damme, Barten, & Sanders, 2009). Capacity development is divided into three types of interventions: policy, planning, and workplace policy. These can include preceptorship interventions built into preservice and early career training to support clinical competency attainment and creation of multidisciplinary care teams. Ideally, countries invest in all three areas simultaneously for system sustainability; more often, only one area receives emphasis.

Building from this framework, we provide case examples from Rwanda, Haiti, the Republic of Georgia,