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INTRODUCTION

This was the 5th meeting of the ICN Workforce Forum. It had been scheduled to take place in Ottawa, Canada in September, hosted by the Canadian Nurses Association. The tragic events of 11 September in the United States led to a postponement, and the Forum was rescheduled for December in Geneva. The Canadian Nurses Association agreed to co-chair the Forum with ICN.

Participants were welcomed to the ICN offices, and thanks were expressed to ICN for the preparations and for the hosting arrangements. The Overview Paper, prepared by the Canadian Nurses Association and the Canadian Federation of Nurses Unions, provided a useful framework within which to start the discussions at this meeting (See Annex I).

As it was on previous occasions, it was agreed that this would be an informal exchange of ideas and a discussion of trends affecting the nursing workforce. The objective was to stimulate thinking, enhance learning and develop strategies for addressing the emerging challenges.

Appreciation was expressed for the quality of the country reports, which were well focused and stimulated new thinking. ICN said that it would like to disseminate the Overview Paper more widely. The paper is viewed as a useful summary of current trends as well as country-specific information. This was agreed by consensus.
ENVIRONMENTAL SCAN

Developments and trends reported during the Environmental Scan can usefully be clustered under several headings:

1. NURSES / NURSING
   - **NURSING SHORTAGES** – In some countries, the shortage of nurses is being addressed by increasing use of temporary agency staff and by overseas recruitment. To examine the issue of overseas recruitment, ICN has drafted a document entitled “Nurse Recruitment Principles: Ethical Framework” to guide the way international recruitment is carried out.
   - In many countries, dealing with the nursing shortage depends on encouraging staff to work as long as they can, and not to change to part-time work or take an early retirement. But keeping full-time staff is only possible if there is a healthy working environment for everyone. The shortage problem is made worse by the fact that enrolment in nursing schools is reducing in many countries, and there is concern about the competence of new graduates.
   - **WORKING CONDITIONS** – Nurses in many countries face heavy workloads, and overtime is widely practiced. Both of these conditions are related to the inadequate numbers of nurses in the workforce. In the US, the introduction of mandatory overtime is widespread and being energetically opposed by the American Nurses Association. It has been learned that by improving the public image of nursing as a valued profession, one can better recruit and retain nurses. Flexibility of scheduling, better nurse-patient or nurse-bed ratios, and “family-friendly” working hours are key retention issues. Protecting salary levels in the face of regulated reductions in working hours is another. Some countries have been able to report improvements in working conditions.
   - A lot of effort is currently aimed at achieving equal pay scales between the public and the private sectors. In some countries, the government has imposed new pay scales, but there is little recourse if the right to strike has been taken away from nurses. Globally, however, industrial action among nurses seems to be on the increase.
   - Cost-cutting to address the high cost of health services may lead to reducing hospital income, and this may have serious implications for nursing. Hospital mergers also tend to enhance the power of the employer in determining the working conditions of staff.
- Health and safety issues are prominent in negotiation on socio-economic welfare. The fact is that nurses are the sickest of any major occupational group, and adverse working conditions contribute directly to this situation.

- Recent research on nursing life shows that the workload for most nurses is still too heavy, and there is an increase in the violence faced by nurses. Poor working conditions can lead to sub-optimum care, and dissatisfaction with care means that more patients are being treated in the private sector or going to other countries for care.

- **LEADERSHIP** – Nurses are moving into important management positions in some health care institutions, but they often live with a sense of tension or “competition” with medical and administrative staff. Clinical leadership is a big issue. Recent research has again shown the need for better preparation for leadership. Some have been able to report a new partnership developing between nurses and doctors in the matter of negotiations for socio-economic welfare. They are now looking at shortages and how job descriptions can or cannot influence that situation.

- With devolution and decentralisation, there is a need for nurses to be more politically active, both nationally and locally. Nurses need to participate in the national debate on issues related to private practice and privatisation, and to help shape the way to go from ideas to implementation. The introduction of the “magnet hospital” credentialing programme is one example that is showing results.

- **PRIVatisation** – One direction that many countries are exploring to address the high cost of health care is privatisation. Where this goes into effect, pay for nurses may be dealt with at the level of individual hospitals, and representative unions may no longer be able to participate in negotiations on socio-economic issues. Working conditions are deteriorating in some places where this has begun. Many are obliged to work overtime, especially community nurses and those working in homes for the elderly, and often they are not paid well enough.

- One additional problem with privatisation is that it tends to take funding away from the government and the public health care system. In some countries, however, nurses in “private practice” are still all paid by the State.
2. NATIONAL NURSES ASSOCIATIONS (NNAs)
   - New categories for membership – Some nurses’ associations are beginning to open up new categories for membership, such as health care assistants and specialist nurses. Student membership structures have been added in some places with positive results.
   - As the nursing workforce continues to age, implications for the long-term size of the nursing workforce and the priority membership needs make it increasingly important to focus on recruitment, retention issues and working conditions suited for the older nurse.

3. GOVERNMENT
   - There is a growing intrusion of government into regulation, entry requirements and examination standards. Many believe that this will have an impact on mobility. In some countries, negotiations for working conditions have been decentralised in the public sector, and this can weaken the negotiating position of nurses, although in certain Nordic countries this has been seen as a positive move. Nurses widely recognise their need to have training in negotiation skills.
   - Some are wondering what influence the European Union will have on health legislation and standards of care. The global trend in hospital mergers is stimulating questions whether this will decrease concern for health promotion, since many patients are discharged home still needing care.
   - New laws on maternity and paternity leave have been passed, and new retirement options are appearing in many countries. These developments should have a positive influence on employment benefits.
   - With the trend for increasing privatisation, the voices of nurses may need to be more insistent on protecting and improving working conditions and pay scales, particularly since nurses working in private offices often get less than those who work in public sector institutions.
   - Anti-terrorism legislation has been rushed through in many countries. In these circumstances, some are concerned that nurses who may be pursuing “illegal” strikes could be classed as terrorists. Others are concerned that domestic and human rights may be infringed upon by anti-terrorism legislation and what impact all this will have on society, health and health care.
4. SOCIETY

- Health issues are increasingly a critical dimension of current election campaigns.

- There is a new and widespread sense of personal, social and national vulnerability since 11 September 2001. Now more than ever, it is recognised that government must continue to play a key role in assuring water quality, maintaining security and setting standards. This may help nursing, especially with everyone’s increasing concern over emergency preparation.

- The dropping reproductive rate will have an increasing impact on the population pyramid. The growing number of aging persons, concerned about who will care for them, is having its impact on nursing. This changing face of the needs for care will become more and more important, particularly in these times of economic recession. Young people, too, have been deeply affected by the dramatic changes in society, and this may increase their interest in the caring professions.

- Other trends in society are also having their impact on nursing. The quality of childcare has an influence on the nursing workforce. We live in increasingly multi-cultural societies, and racism is being experienced for the first time in some countries, particularly since 11 September. The number of older persons is also increasing, a population group with greater purchasing power and greater demands for good health services.

- There is growing concern about the impact of globalisation on nurses – shareholder values and economic issues seem to be pushing aside human values.

- The competition between retirement funds encourages the introduction of exclusion practices for persons at risk.

5. HEALTH

- Nursing is going through changes as a result of scientific and health care technology, information technology, public attention to privacy issues, ethics, and questions about the future of technologies like genetic engineering in health-related issues.

- New financing systems also generate concern. Some countries are making efforts to get more funds going into the health sector, but they are not sure
where those funds will come from. All over the world, the debate continues about how best to spend funds available to have the best impact on health. In present circumstances, there is concern about reduced investment in community services, in the social determinants of health and illness or in primary health care.

- There is a new concern for bio-terrorism and the need for disaster training. With a greater emphasis right now on occupational health, nursing leadership is watching to see if this also changes the emphasis on primary health care.
- With many patients discharged home still needing care, it is increasingly important to look at what can be done to support the caregivers in the home.
- The rise in unemployment risks a deterioration of the general health status of the population.
- Attacks on a public health service providing equitable care are reported with greater frequency.
- The expanding dominance of pharmaceutical companies in health sector decision-making raises serious concern.
- Increasing efforts towards multi-disciplinary cooperation were reported.
- The introduction of male “midwives” was noted.
REVIEW OF DATA FROM THE PROFILE QUESTIONNAIRE

The compilation of the data received was reviewed:

- Years of pre-nursing education = 10-14 years.
- Years of nursing education = 3-5 years.
- Many qualified nurses not working as nurses, thus contributing to the shortage.
- Males comprise 1-19% of the nursing workforce, but there are more males in the recent groups of new graduates in Norway and Sweden.
- 25-60% of nurses are working part-time, but there is little data on overtime work.
- Most countries report new graduates find work within 3 months.
- Average age profile = 42-44 years of age
- Retirement age by contract is usually 65, by law it is 65-70, in practice it is 62-65, with early retirement possible 55-62.
- There is little data on average professional life in nursing.
- Most nurses are employed in the public sector, most in hospitals, most in acute care.
- National unemployment rate ranges 1.3 to 9 %, and for nurses it seems to be 0-2% (although data on unemployment among nurses is limited).
- On supply and demand, Germany is now in balance but expects to be in shortage by the end of 2001. Beyond this year, all countries will be experiencing shortage of nurses.
- Turnover rate is between 3 and 26%. The question comes up – how can one get useful data from a question on this matter?
- On migration, the situation is constantly changing and seems to be in relative balance between those leaving and those immigrating.
- Language competence and the recognition of foreign qualifications are the two most common barriers to recruitment.

- There were no problems using the survey electronic version. It was found to be useful for analysis as well. All agreed that the data could be more widely distributed, and should be kept up-to-date as much as possible.
- The Asia Workforce Forum felt that data questions were relevant for them as well. All the information gathered will eventually be put on the Internet.
It was AGREED that the questionnaire should be sent out on an annual basis, with each association providing changes/updates from its previous response.

COMMENTS ON THE VALUE OF THE DATA REQUESTED IN THE PROFILE QUESTIONNAIRE

Countries agreed that this is the best set of data of this type available anywhere. Since it is credible information, it is a crucial tool for negotiating working conditions, improving the quality of the work environment, and tracking the global picture on nursing shortages. While some improvements in the gathering of such data may be expected in the future, it may now be useful to formally request countries to collect such information.

It was recommended that a glossary be included in the document.

Certain limitations on the data collected are already recognized. Information on the average professional life in nursing is still rather difficult to secure, and much of what exists is rather old. Pay scales and benefits are difficult to use and interpret. Salary levels are not very useful for comparative purposes among responding countries, although comparative salary data across the professions in a given country can be very revealing information.

Much more informative data is found in the lists of benefits offered, how much choice of benefits is in a package, and overall amounts set aside for benefits.

Some countries are beginning to look at data on clinical errors and fatigue factors as they relate to overall working conditions, and this would be very useful data to begin to compile.

It would also be very helpful to have firm data on several other matters – so far not included – with a criterion for requesting new information being the benefit that may be realized in influencing policy and working legislation:
  o Occupation-related injuries – this should not be difficult since reporting injuries is mandatory in most countries. It should be disaggregated to show the proportion of injuries in nurses as opposed to other health care personnel.
  o Illness among nurses
  o Abuse and violence against nurses
Benefits:
- Flexible working hours
- Availability of childcare and “family-friendly working hours”.
- Access to continuing education and study leaves
- Health insurance, disability insurance, pension schemes available

**REVIEW OF INTERNATIONAL ORGANIZATIONS**

Attached as Annex IV is a document prepared by ICN summarising the Mission, Objectives, Membership, Structure, Budget, Personnel, ICN Status, Nursing Policy, Recent Cooperation with ICN, and Website of:
- World Health Organization (WHO)
- International Labour Organization (ILO)
- United Nations Conference on Trade and Development (UNCTAD)
- World Trade Organization (WTO)
- Public Services International (PSI)

The document was reviewed, and a few selected comments are noted here:
- In May 2001, the **World Health Assembly** passed a Resolution on Strengthening Nursing and Midwifery, recognising the contribution of nurses and noting the worldwide shortage of nurses. There will be a progress report on issues highlighted in the Resolution. The Secretariat of **WHO** will elaborate a plan of action on the key issues in follow up to the Resolution, but this plan is not yet available. **WHO/EURO** has restructured and the Human Resources Unit has moved to Barcelona, Spain. The vacant Nursing Adviser position causes great concern. It was noted that Primary Health Care as a guiding policy, as well as nursing, seem to be less emphasized in the work of WHO than in the past.
- **ILO** is somewhat special in the UN system in that it is tri-partite, working with governments, employers’ organizations and workers’ organizations. ICN is playing an increasing role in several sectors in which ILO’s work has a direct bearing on nurses and nursing.
A number of ILO Conventions are of interest:

- Nursing personnel
- Occupational Health Services – here ICN was successful in having the role of nurses in occupational health recognized
- Child labour issue – here there is concern about providing for alternative activities, household income, educational opportunities, family subsidies
- ICN Initiative on Workplace Violence in the Health Sector
- Recent workshop on the security of caregivers
- Impact of privatisation on health care in Eastern Europe

Trade in Services is getting more attention in the WTO at this time. ICN will monitor trade agreements to ensure information dissemination to NNAs who will need to lobby their national governments. ICN continues to work on establishing its most useful and functional entry into the working of WTO.

ICN has good working relations with PSI on several issues, most of which include cooperation with WHO and/or ILO, namely child labour, violence issues and public sector reform as it impacts on health personnel. A recent development of interest in PSI is a change in the constitution so that those who do not work in the public sector, but who provide public service, can be represented by PSI. EPSU, created within PSI and representing unions in the EU, is emerging as a social force in European issues. RCN has recently become a member. Sweden has left PSI but has decided to remain in EPSU.

INTERNATIONAL RECRUITMENT

International recruitment has become a lively issue due, in part, to the fact that most countries worldwide are experiencing shortages in nursing staff. Much debate has ensued in relation to aggressive recruitment from countries already experiencing shortages themselves. The proposal has been put forward that some means be explored to “protect” developing countries that are already short of nurses, or even imposing a ban on such recruitment. However, there is real concern that it is not possible to enforce such an approach, nor is it possible to assure an equitable application of the principle. Participants were informed that this initiative was discussed and rejected by
the ICN Board. The recommendation of certain WFF members was however noted, and will be passed on to the ICN leadership.

- The ICN draft paper, **Nurse Recruitment Principles: Ethical Framework**, was approved by the ICN Board. The draft paper has been reviewed and endorsed by the PCN. It will be disseminated by the PCN with the addition of an Introduction that contains region-specific information.

- The Commonwealth drafted a Code of Practice in this respect, after a review of the ICN Draft Framework. It will be discussed at the Commonwealth Health Ministers Meeting in June 2002.

- A basic principle is emerging – that countries should try to solve their staffing problems locally before relying on international recruitment.

- In this context of recruitment, it is recognised that rights and values must be protected as nurses exercise their profession, and also as countries seek to address staffing shortages. These rights and values would include:
  - The right of all to live and work where they want
  - Freedom of movement and the right to migrate
  - Freedom of association

- There is the concern that aggressive recruitment may have an adverse or negative impact on the countries from which nurses are recruited. It should be possible to minimise the negative impact through active dialogue between industrialised and developing countries, working cooperatively to create the best conditions in all countries for reaching local solutions where possible, and for reaching agreements on oversight of international recruitment.

- It was emphasized that student nurses and nurses engaged in educational exchange programmes are particularly vulnerable, and that they need to be protected from inappropriate work assignments imposed during their training.

- Difficulties being experienced by nursing services as a consequence of international recruitment include:
  - Language adaptation
  - Certification – recognition of qualifications
  - Quality of care
  - Exploitation of those recruited

- ICN should facilitate dialogue between importing and exporting countries, mainly through the NNAs.
Dual NNA membership was considered a worthwhile initiative (importing and exporting country NNAs).

**MONITORING WORKFORCE UTILIZATION**

- Models to review workforce utilization include methods of **workload measurements**. These may be useful, but the results are often after the fact and therefore not good forecasting tools.

- **Patient classification systems** are used in a few countries to examine workforce utilisation, but these are not without their own difficulties. One system that showed more nurses were needed simply led to the system being eliminated. In other cases, a recognition of the need to increase nursing staff where more nurses can not be found may simply open the door for alternative care providers to be established.

- Applying one or another **Diagnosis Related Groups** (DRG) system may offer a better approach. Using **clinical pathways** may add more elements to the DRG and contribute to identifying the nursing components that are required. The **International Classification for Nursing Practice** (ICNP) also offers the means to discover the real needs of the nursing workforce. There are certainly multiple models and assessment tools available, and efforts to standardize these tools may be helpful in the decisions that must be made in meeting care needs.

- In practice, nursing input is often less influential than it should be in workforce utilization assessment, and mechanisms do not always exist to identify inappropriate staffing assignments in the light of the needs and concerns for patient care. One country is trying to assess what nurses bring to decision-making in relation to skill mix, leadership capacity and cultural factors. Clearly, the political dimension plays a strong role in determining the outcome in workload issues. At the moment, one over-riding political rule seems to be a per capita allowance.

- There is some real concern that lawmakers, decision-makers and funders do not fully appreciate the developed observation skills and knowledge base that nurses bring to health care.
Until decision-makers come to value the preservation of nursing in this time of increasing patient complexity, they will not be able to take the steps that are needed to fully address workforce utilization issues.

It was agreed that present tools measure tasks and not nurses’ clinical judgement.

**RATIOS**

Few countries have established nurse-patient or nurse-bed ratios to determine workload determinations. Those that have tried found that there are so many variables from place to place, and from institution to institution (and certainly from country to country), that applying such ratios is neither feasible nor helpful. Some institutions may find themselves below legislated emergency minimum coverage levels. The mix of part-time and full-time staff and the presence of novice workers add to the difficulty in applying a ratio. Funding, management and governance systems vary so much from institution to institution, and from country to country, and this imposes the need for different strategies, most of which can only be applied at a local level.

This has clearly shown the inter-dependence of SEW and professional and quality of care issues. Most countries feel that ratios are not a useful tool in collective agreement negotiations, and there is a search for better tools and arguments with which to approach the political decision-makers.

The application of the California and Victoria (Australia) legislated RN/patient ratios needs to be monitored closely in the coming year.

**ASSIGNMENT REFUSAL**

Overtime work has become the only way that many systems and institutions can assure coverage. Cost implications, the right of refusal, and the health, safety and security of the nursing workforce are the issues here. Proper care and safety become precarious with excessive overtime, but if the employer is within the law to make overtime mandatory, then refusal is not an option.
It is up to nurses to determine if they should be working overtime, extra shifts, double shifts and during days off. The regulatory and legal side is concerned when assignments are given that break the law. It is essential, therefore, to define and understand what is, and what is not, abandonment so that nurses know how to avoid the risk of serious legal jeopardy.

The legal system needs to protect workers from pressure by employers to work beyond the legal and physical limits, and from aggression or bullying when in fact the system is failing.

The European Court in Strasburg decided that the legal limit of work time is 48 hours per week. Some countries have a legal “opt-out” clause that permits a nurse to “voluntarily” work over 48 hours.

Information systems for documenting nursing activities

Many countries are using the International Classification for Nursing Practice (ICNP), or adaptations thereof, as a way to standardise management of the workforce and documenting nurse interventions.

VIOLENCE IN THE HEALTH SECTOR

Service sectors are the most vulnerable to violence directed against their workers. The health sector is the most vulnerable among them, and more nurses are subjected to violence than other staff in the health sector (three times more). There are suggestions that violence in the health sector is on the increase, and that it is becoming more severe as time passes. Some studies have shown that one in every five health workers has been involved in a violent incident. The violence may be carried out by patients, or their relatives, or by some other member of the health care team.

ICN will continue its efforts to secure “zero tolerance” for violence against health personnel, as well as abuse of the elderly. In a joint effort, ICN, together with ILO, WHO and PSI, commissioned a background review paper on Workplace Violence in the Health Sector. It is recognised that much work remains to be done on developing strategies to reduce this violence. Seven country case studies have been launched to look at this issue, addressing its
incidence, environment, possible causes, consequences and prevention strategies.

- In April 2002, there will be a Round Table in Geneva on this topic. A research protocol has been developed and is now in use on this topic. The protocol offers a useful framework for planning and conducting standardised country studies.

- This issue calls for careful monitoring of the situation, encouraging the consistent (or even mandatory) reporting of cases, and appropriate treatment. Further study and documenting of the situation may help to increase sensitivity to those circumstances that may lead to violence. The responsibilities of the employers must also be clear. When abuse of a health care worker by a client is repeated, a warning must be given, and discontinuing the care relationship may be one option when such abuse continues. Putting notes on the medical record of clients who are prone to giving abuse alerts future caregivers of the problem. Some feel that institutions may refuse care to those known to be prone to violence, but this raises ethical issues.

- One useful measure in addressing violence is the strengthening of links between nurses’ organizations and the police.

- The positive impact of training staff was questioned, and the need for mechanisms to deal with (and eliminate) violence between colleagues was stressed.

- It must be remembered that nurses can also be abusers, and that abuse can be directed to other health care staff or to their clients. Violence by nurses toward the elderly may actually be generated by very bad working conditions.

- Additional studies by the joint project will examine the links between stress in the workplace and violence, and to suggest ways for the management of victims. It is particularly important that appropriate arrangements are in place to deal with those who have been sexually harassed or attacked.

- The protection of the victims requires that there are places to which they can go to report such incidents and be cared for, places where they will be believed. They should further be assured that they would not be obliged to use their sick leave entitlement to deal with the effects of violence. One initiative appears to have a positive impact – the establishment of elected
women’s committees at district level that deal with gender issues, including sexual abuse.

- The accountability of psychiatric patients was raised.
- The use of contract language to impose zero-tolerance policies was considered useful. In addition, legislation with regard to working alone has been applied as a source of protection.
- The fact that nurses are sometimes unaware that abusive situations are not to be tolerated complicates their management.
- The prosecution of employers for failing to provide a safe work environment has had more success than the prosecution of perpetrators.

VULNERABLE NURSING GROUPS

- **Tele-practice and telenursing** – This is an emerging practice area, and guidelines to protect the practitioners are not yet clearly defined or widely established. This is crucial where the care given crosses international boundaries. Canada has set out five principles to guide this type of practice, and they may be found on their website. ICN has published a monograph on telenursing.

- **Disaster nursing and disaster preparedness** – Since the events of 11 September 2001, the issues have changed, and there is a renewed search for “best practices” in this area. The experience already gleaned in dealing with natural disasters is very useful. Additional best practice lessons may be gathered from the model of primary health care in developing countries, the work of the Red Cross in many countries, and occupational health nursing.

- One key question may be: What is health provider disaster preparedness? Assuring adequate supplies of personal protection and decontamination equipment is essential here, as well as assuring the availability of staff who are off duty. Field and community staff who are responsible for “pre-hospital care” are in particular need of preparedness training.

- ICN has a page on disaster preparedness on its web site. A useful link on the web is the Sphere Project ([www.sphereproject.org](http://www.sphereproject.org)), a coalition of agencies dealing with coordination in humanitarian relief and best practices.
Meeting of the ICN Workforce Forum in 2002

- It was agreed that this Forum is very useful and productive and that the next meeting should be scheduled in one year. This is a tumultuous time in health care and security, and it will be useful to look again at changes in nursing as well as issues related to the continuing shortage of nurses around the world.
- Two full days appears to be the most productive duration for the meeting.
- Iceland offered to host the ICN Workforce Forum next year, and this invitation was accepted.
- It was proposed that the next meeting take place on Monday and Tuesday, 16-17 September 2002.

Topics proposed for the Agenda of the Meeting of the ICN Workforce Forum 2002

1. Workforce utilisation and workload measurement
2. Wages and negotiations: the role of collective agreements on working conditions – the political dimension
3. WTO/Doha Meeting: trade in services
4. Workplace violence in the health sector – review of the draft guidelines and the data from the field and desk studies
5. Pensions and retirement: retention strategies for the older nurse
6. Environmental scan
7. Nursing workforce profile
8. One hour free-flow discussion
Annex I:

ICN Workforce Forum 2001 – Overview Paper

Geneva, Switzerland – 3-4 December 2001

This Overview was prepared by
The Canadian Nurses Association
and
The Canadian Federation of Nurses Unions
August 2001

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Acronyms:

DBfK.............German Nurses Association
CNA...............Canadian Nurses Association
CFNU ..............Canadian Federation of Nurses Unions
DNO ...............Danish Nurses’ Organization
ICD................International Classification of Disease
ICN ...............International Council of Nurses
ICNP .............International Classification for Nursing Practice
ILO...............International Labour Organization
NGO...............Non-governmental organization
NNA...............Norwegian Nurses Association
                 *(please note: the acronym NNA is not used in this document as an abbreviation for National Nursing Associations)*
NNF ...............Northern Nurses Federation
NZNO .............New Zealand Nurses Organisation
PCN...............Standing Committee of Nurses in the European Union
PSI...............Public Service International
RCN...............Royal College of Nursing
RIW ...............Resource Intensity Weights
SAHP .............Swedish Association of Health Professionals
SEW ...............Socio-economic welfare
UK................United Kingdom
UNCTD.........United Nations Conference on Trade and Development
WHO..............World Health Assembly
WTO ...........World Trade Organization
Introduction

This overview paper has been prepared to highlight the key trends and issues presented in the country reports submitted by the National Nursing Associations for the 7th International Council of Nurses (ICN) Workforce Forum in Ottawa, Canada. It is hoped that the identification of the main issues common to the majority of forum participants will assist the forum in meeting its stated objectives. These objectives are to:

- stimulate thinking, enhance learning and develop proactive strategies in addressing workplace concerns of nurses;
- identify trends in nurses’ remuneration and negotiation frameworks;
- determine nurses’ short, medium and long-term priorities in the area of socio-economic welfare; and
- support international partnerships for the advancement of nurses and nursing.

The National Nursing Associations were requested to prepare written reports on the seven themes corresponding to the forum agenda topics. At the time of preparation of this overview paper, country reports had been received from the Canadian Nurses Association (CNA) and the Canadian Federation of Nurses Unions (CFNU), the Danish Nurses’ Organization (DNO), the German Nurses Association (DBfK), the New Zealand Nurses Organisation (NZNO), the Norwegian Nurses Association (NNA), the Swedish Association of Health Professionals (SAHP) and the Royal College of Nursing of the United Kingdom (RCN). Not all associations commented on all agenda topics.

1. SEW Nurse-Related Developments

There is evidence of a change in direction of employment legislation. New legislation in the UK and New Zealand aims to modernize employment relations and to encourage a new culture of fairness, understanding and cooperation between employers, employees and unions. As stated in the New Zealand legislation, the new framework is “based on the understanding that employment is a human relationship involving issues of mutual trust, confidence and fair dealing, and is not simply a contractual economic exchange.” Most unions in New Zealand believe that the new legislation will enhance their capabilities for organizing workers and their ability to negotiate better pay and working conditions.

The new partnership between employers, employees and unions is being demonstrated in Sweden. The foundation of wage formation and professional development is taking place in discussions where managers and staff talk about demands and expectations in the context of the goals of both the organization and the individual employee. In one of its contracts, SAHP has de-emphasized the importance of the central agreement and now focuses on the parts of health care where professionals provide services and outcomes are created.

CNA and CFNU noted that socio-economic issues are increasingly complex and are often linked to the growing trend toward globalization. Factors such as health sector reform, advances in technology, demographics and international trade agreements all affect the nursing workforce. In order to respond to local challenges, there is a growing need to understand and address global trends.
1.1 Pay
Recent reported pay settlements include increases ranging from 2.4% to 7%. The pay structure is an important factor in recruitment and retention of nurses. Some Nordic countries reported on new wage systems that allow for more individual and local input into nursing salaries.

1.2 Working conditions
Most National Nursing Associations expressed concern over the deterioration in working conditions related to such factors as increased workload, reduced time for patient contact and greater likelihood of being called back to work. The consequences for nurses arising from poorer physical and psychological work environments include increased overtime, difficulties in recruiting and retaining staff and absence due to illness.

According to a recent report prepared by the Canadian government, nurses face the highest level of stress across all health service provider groups. A Norwegian survey found that more than 33% of nurses regret that they chose nursing as a profession. The most important reasons given were poor pay and stress/low staffing. The findings from a Canadian study revealed that a high percentage of nurses (32.9%) are dissatisfied with their present jobs. Almost half said the quality of care in their workplace had deteriorated in the last year. These results are further validated by internal surveys by provincial nurses’ unions. In these surveys, nurses raised concerns about their ability to achieve professional standards of practice and about their fears related to their legal liability.

1.3 Career structure
In general, there is little uniformity at the country level in nursing career structures. Many different titles and career structures exist, resulting in confusion for the public and the profession. In the UK, the National Health Service, the dominant employer of nurses, has a national pay and career structure that comprises nine clinical grades.

Countries reported that, in the absence of formal career pathways, nurses advance within an informal structure of positions and through advanced education. There is some evidence that employers are beginning to introduce clinical career pathways with remuneration systems attached.

2. Nursing Workforce Data: Supply and Demand Trends

All countries are facing or will face nursing shortages. Projections vary in terms of the severity of the shortage and when the greatest impact of the shortage will be felt. Predictions about the nursing workforce are often uncertain because many factors influence supply and demand. Country reports did not deal in great detail with the demand for nursing services other than to emphasize that the demand will increase as the population ages and patient acuity rises. SAHP commented that greater demands on staff time arise from the desire of clients to be better informed about their health status.

On the supply side, several factors were identified that were common to all countries and that help explain the shortage of nurses. These include an increase in the number of nurses leaving the profession in mid-career or through
retirement (aging of workforce), a decrease in the number of young people entering and remaining in the profession and attrition from nursing education programs.

National nursing associations reported that the shortage of nurses is affecting both client care and the work life of nurses. Hospitals continue to close beds, surgery is being cancelled and the services provided to clients are deteriorating. Nurses are required to work more overtime. They may miss meals and breaks, be called back for work and have their vacations cancelled.

Most country reports stated that there has been a lack of national workforce planning to date; however, National Nursing Associations and governments are beginning to consider mechanisms for addressing the current and future need for nurses. The Canadian government, for example, is currently developing a demand projection model. Several country reports articulated measures to increase the supply of nurses similar to the range of measures put in place by the UK Government and RCN that include:

- high profile advertising campaigns to encourage health service careers
- expansion of the number of nursing student places available in higher education and an increase in student bursaries and grants
- ‘back to nursing’ initiatives, including increased funding for courses and payments for individuals
- delayed and phased retirement initiatives
- improved child care provision
- flexible working schedules
- targeted policies and payments in areas where the cost of living is high.

Other proposed recruitment and retention strategies include financial support to recognize and reward the continuing competence of diploma-prepared nurses and negotiation for both more full-time positions and benefits and pension for casual nurses (CNA and CFNU).

3. International Organizations

3.1 Previous Contact (positive/negative) with ILO, WHO, UNCTAD, PSI, WTO

Some National Nursing Associations are affiliated with several international organizations of particular relevance to SEW; others maintain affiliation only with ICN. Those affiliated with a number of different organizations, such as NNA, believe that these affiliations provide access to a broad range of useful information as well as the opportunity to input into decisions made at an international level that may have significance to national work and priorities. Other National Nursing Associations, for example, NZNO, have chosen to concentrate their international activities within ICN. As SAHP noted, "ICN is the information channel which is of greatest value to our Association since the questions are monitored and addressed from a platform that we share."

The contact of National Nursing Associations with the International Labour Organization (ILO) or other international trade union organizations is generally through their affiliation with a national trade union within the country. Other affiliations reported include Public Service International (PSI), the Standing Committee of Nurses in the European Union (PCN), the European Federation of Public Service Unions, the European Trade Union Conference,
the International Confederation of Free Trade Unions and the South Pacific and Oceania Council of Trade Unions. Several associations also have links with the World Health Organization (WHO) through membership in groups such as the European Forum of National Nursing and Midwifery Associations. Although few countries indicated whether their contact with these international organizations has been positive or negative, some National Nursing Associations have assessed their contact with ILO as generally satisfactory. Others have decided to reduce their involvement in some international organizations because of the costs or a perceived lack of relevance to their own work. Interestingly, the DNO reported on a decision from the ILO that directed the Danish government to consider alternatives to the right to strike in “life-important areas”. The DNO firmly indicated an unwillingness to forfeit the right to strike.

3.2 Other international organizations that are of particular relevance in SEW
A number of National Nursing Associations have long-standing relationships with regional organizations that include a focus on socio-economic and workforce-related activities, such as the Northern Nurses Federation (NNF), a cooperative body for the six Nordic nursing associations. NNF provides a discussion forum for current issues regarding negotiations, salaries and working conditions.

4. Violence

Workplace violence is an emerging issue for many National Nursing Associations. In some countries, workplace violence is handled within a broad legislative framework of employment health and safety. It is a topic that is receiving public attention. ICN has included verbal abuse, sexual harassment and bullying as sub-topics under violence.

4.1 Working definitions
Some work on defining and classifying forms of violence is taking place. Examples of definitions or categories of violence (CNA and CFNU; DNO), sexual harassment (NZNO) and “unpleasant work situations” (NNA) are provided in the country reports.

4.2 Incidence
Countries generally do not collect national statistics on workplace violence. However, studies in several countries, including a recent postal survey of 6,000 nurses in the UK, have revealed a high incidence of workplace violence among nurses. Research findings have revealed that violence tends to be more prevalent in certain health care settings such as psychiatric and emergency departments, and with client groups such as the elderly and those with physical and psychological disabilities.

4.3 Elimination strategies: best practice
National Nursing Associations have been working to identify strategies to eliminate workplace violence and its consequences. These include:
- ensuring adequate staffing and permanently employed personnel with a high degree of professional competence
- developing workplace policies on management of violence incidents, including reporting and follow-up of incidents
• negotiating contract language to address violence issues
• identifying better ways to enforce safety standards rather than waiting and prosecuting after a significant event
• developing comprehensive educational programs.

These strategies need to be part of a broader initiative that is employee-centred and focused on organizational development and strong leadership. An observation of NZNO is of note: “Paradoxically the health sector performs very poorly in relation to health and safety and there has been very little systematic attention and co-ordinated activity devoted to this issue.”

5. Workforce Utilization

5.1 Political dimension
It is recognized by National Nursing Associations that addressing nursing workforce issues requires a multi-faceted approach. More collaborative and cooperative models for workforce planning are being established and the environment appears to be more optimistic. In the UK, the government has emphasized a new integrated approach to workforce planning that emphasizes the need for multidisciplinary approaches and changes to traditional professional boundaries. In New Zealand, there are some preliminary discussions between NZNO, employers and governments to try to establish a tripartite forum to properly address nursing workforce issues.

Some governments are developing action plans to deal with nursing workforce issues. Some of the features of these plans include:
• better utilization and distribution of nurses
• increased cooperation between providers
• better education for nurses
• development of guidelines for safe staffing.

5.2 Models, including workload measurement
Several countries supported the need for development and use of workload measurement systems. CNA and CFNU indicated that measuring nursing workload to determine nurse resource intensity is essential in a health care environment where there is:
• increased emphasis on accountability for resource use
• competition for scarce resources
• increased interest in accountability for results from investments or spending
• a desire to link resource decisions to outcomes.

Some countries have no standardized tools for data collection. Other countries that do use workload measurement systems collect and report data in some settings but not in others.

Currently, there is a proliferation of measurement methodologies. New Zealand and Germany have projects underway to assess the applicability of an Australian workload measurement model. In Canada, there has been extensive study of workload measurement systems. Research from the University of Toronto has demonstrated that there is little correlation
between nursing resource needs and resource intensity weights (RIWs), a measure of nursing performance that is currently used. The Canadian Institute for Health Information is planning to review issues related to nursing workload measurement systems and make recommendations for future development and implementation.

5.3 Nurse:patient ratios in collective agreements
According to the country reports, nurse:patient ratios have not been negotiated into collective agreements to date. NZNO reported that the best that has been achieved is securing an obligation to consult over adequate staffing numbers. CFNU noted that there is considerable interest in Canada in legislation in California and the Australian state of Victoria which incorporates nurse:patient ratios.

5.4 Nursing information systems
Common terminology and standards for documenting nursing activities are required. DBfK indicated that a nursing information system like the ICNP is urgently needed as medical information systems such as ICD 10 are being adapted for nursing needs. If this system becomes established, it will be more difficult to make changes.

5.5 Assignment refusal
There was variation in country responses to this issue. Two National Nursing Associations indicated that nurses must take part in all forms of nursing and patient care, provided that the situation involves activities that are ethical and meet professional standards. In Norway, the only activity nurses can refuse to take part in is induced abortion.

Under current law, nurses in New Zealand would place themselves at risk for disciplinary proceedings by refusing to work in a particular area because of either inadequate staffing or unfamiliarity with the particular practice area. On the other hand, there is legislative protection to enable a nurse to refuse work where the nurse believes that the environment is unsafe. The goal of this protection, however, is to provide protection for nurses and does not refer to the situation in which the nurse believes conditions are unsafe for the patient. CFNU provided an example of collective agreement language in Canada that defines situations such as an emergency circumstance in which nurses cannot refuse to work overtime or refuse to return to work.

6. Vulnerable Nursing Groups: SEW Challenges and Opportunities
ICN identified three nursing groups that might be vulnerable: disaster nursing, urban nursing and telenursing. For most countries that submitted reports, these are not areas that have received much focus to date. Several countries acknowledged that telenursing is expanding and that there is an increasing need to respond to challenges in this area and to issues related to protection of the public. In the areas of disaster and urban nursing, specific issues regarding collective agreements for nurses working in ambulances or on short-term contracts with the Red Cross and other NGOs were discussed.
CNA and CFNU warned that the experience in Canada suggests that the entire nursing community is vulnerable. This vulnerability is created by a nursing workforce that is shrinking in size, has an uneven age distribution and is composed of nurses with cultural backgrounds not reflective of the general population. The inadequate number of nursing leaders also contributes to this vulnerability. These factors have implications for nursing educators and recruiters.

7. International Recruitment: Principles and Ethical Considerations

The shortage of nurses is a common problem, and some countries are meeting their needs by recruiting nurses from other countries. National Nursing Associations view this strategy as a short-term solution to a long-term problem. CNA and CNFU identified three questions that policymakers must consider when using immigration to address shortages of health care providers:

- What, if any, responsibility does the nursing profession have to the public regarding the demands for nurses?
- Are there standards that can be defined to ensure that (real or perceived) unfair, discriminatory practices are avoided in the recruitment of foreign-trained nurses?
- What, if any, restrictions should be placed on facilitating the mobility of nursing professionals?

Some countries, such as Norway, have recognized that, despite the high number of nursing vacancies, there is actually no shortage of nurses. Surveys in Norway confirmed that a considerable number of nurses working outside nursing or employed part-time are prepared to fill the gaps provided improvements in salaries and working conditions are forthcoming. Consequently, Norway is working to improve conditions to enable it to make use of its national nursing workforce rather than embarking on aggressive recruitment campaigns in other countries. CFNU noted that action on retention issues also assists in the recruitment of new individuals into the profession.

Governments are beginning to work on the development of national recruitment strategies. These strategies must be based on sound ethical principles that consider both the individual nurse and the health system. National Nursing Associations defend the principle of free movement of labour, including nurses. Nurses must be welcomed in their chosen country and receive support to integrate into the new work environment and culture.

International and National Nursing Associations have been working to articulate principles concerning international recruitment of nurses. The NNA, for example, believes that governments and employers must emphasize:

- adequate language skills and cultural understanding
- professional competence in line with national requirements
- a supportive working environment
- professional and social integration of recruits
- ethical behaviour towards countries in need of retaining their nurses, particularly the poorer countries.
Finally, CNA and CFNU noted that transfer of capacity and knowledge represents one approach to solving the global nursing shortage, while at the same time improving the quality of health services offered around the world. For example, transfer of knowledge strengthens the capacity of the professional infrastructure in developing countries. As a result, the infrastructure will be able to promote nursing as an occupation and support interested individuals to come in to the profession. While addressing the shortage of nurses in a particular country, this approach also builds the confidence and skills of individual nurses.

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### Annex II: List of participants

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Annex III: Workforce Forum Agenda

**3 December 2001**

09:00 - 10:00  Opening - Introductions

10:30 - 12:30  Environmental scan:
   - Developments in nurses’ pay and working conditions
   - Developments outside nursing

14:00 - 15:00  Nursing workforce data:
   - Data collection (i.e. ICN form)
   - Supply/demand

15:30 - 17:00  International organisations:
   - UN agencies: ILO, WHO, UNCTAD
   - NGO: PSI
   - International contract: WTO

**4 December 2001**

09:00 - 10:00  Violence:
   - Incidence
   - Elimination strategies: best practice

10:30 - 12:30  Workforce utilisation:
   - Models, including workload measurement
   - Political dimension
   - Collective agreement ratios (e.g. RN/patient)
   - Nursing information systems
   - Assignment refusal

14:00 - 15:00  Vulnerable nursing groups:
   - Disaster nursing
   - Urban nursing
   - Telenursing

15:30 - 16:30  International recruitment - ethical considerations:
   - Individual nurse
   - Health systems

16:30 - 17:00  Future options
## ANNEX IV: REVIEW OF INTERNATIONAL ORGANIZATIONS

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<th>WORLD HEALTH ORGANIZATION (WHO)</th>
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<td><strong>Mission</strong></td>
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| **Objectives** | Ø To give worldwide guidance in the field of health.  
Ø To set global standards for health.  
Ø To cooperate with governments in strengthening national health programmes.  
Ø To develop and transfer appropriate health technology, information and standards. |
| **Members** | All countries that are Members of the United Nations may become members of WHO by accepting its Constitution. Other countries may be admitted as members when their application has been approved by a simple majority vote of the World Health Assembly, e.g. Switzerland. Territories may be admitted as Associate Members. Presently there are 193 Member States. |
| **Structure** | The World Health Assembly (held yearly) is the supreme decision-making body and is attended by delegations from all Member States. Its main tasks are to approve the biennial programme budget, and to decide on major policy matters. The Executive Board is composed of 32 individuals technically qualified in the field of health, each one designated by a Member State elected to do so by the World Health Assembly (meetings held twice a year). The term of office of Board members is three years and each year one third of the members change. There are six regional offices and most countries have a WHO Representative full-time employed. The World Health Assembly on the nomination of the Executive Board appoints the Director General. WHO headquarters are in Geneva. NGOs apply and may be granted observer status. There are six official WHO languages. |
| **Budget** | The regular budget is made up of assessed contributions from Member States and Associate Members: US$ 842 million (2000-2001). The total budget is US$ 1.9 billion for 2000-2001. (The figures for 2002-2003 are US$ 842 million and US$ 2.2 billion respectively.) |
| **Personnel** | 3,800 professional and general service staff (46% of staff work in countries, 24% are in regional offices and 30% are at headquarters). |
| **ICN Status** | Observer status in formal meetings (i.e. limited right to speak, no vote). Expert representative of nurses and nursing. |
| **Nursing policy** | Ø Resolution on Strengthening Nursing and Midwifery (2001).  
Ø Nursing related working papers, e.g. regulation, community nursing, integration of primary health care in nursing education. |
| **Recent ICN/WHO cooperation** | Examples include:  
Ø HIV/AIDS fact sheets  
Ø Impact of public sector reform on health personnel  
Ø Global Health Workforce Strategy Group  
Ø Workplace Violence in the Health Sector project  
Ø Nurse migration research. |
| **Web site** | www.who.int |
# INTERNATIONAL LABOUR ORGANIZATION (ILO)

<table>
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<tr>
<th><strong>Mission</strong></th>
<th>ILO is the UN Specialised agency that seeks the promotion of social justice and internationally recognised human and labour rights.</th>
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| **Objectives** | ☐ Promote and realise standards and fundamental principles and rights at work.  
☐ Create greater opportunities for women and men to secure decent employment and income.  
☐ Enhance the coverage and effectiveness of social protection for all.  
☐ Strengthen tripartism and social dialogue. |
| **Members** | 175 Member States. |
| **Structure** | ILO has a unique tripartite structure with workers and employers participating as equal partners with governments in the work of its governing organs. Member States meet yearly for the International Labour Conference. It establishes and adopts international labour standards, acts as a forum where social and labour questions of importance to the entire work are discussed, adopts the budget and elects the Governing Body. The Governing Body is composed of 56 titular members (28 government members, 14 employer members and 14 worker members) and 66 deputy members. Ten of the titular government seats are permanently held by States of chief industrial importance (Brazil, China, France, Germany, India, Italy, Japan, Russian Federation, UK and the US). Representatives of other member countries are elected at the Conference every three years, taking into account geographical distribution. The employers and workers elect their own representatives respectively. The Governing Body is the executive council and meets three times a year in Geneva. It decides ILO’s policy, elects the Director-General, establishes the programme and the budget which is submitted to the Conference for adoption. The International Labour Office is the permanent secretariat and focal point for the overall activities. The Office also constitutes a research and documentation centre and a printing house. |
| **Personnel** | The Office employs some 1’900 officials of over 110 nationalities at the Geneva headquarters and in 40 field offices. In addition, some 600 experts undertake technical cooperation missions world-wide. |
| **ICN Status** | Observer status in formal meetings (i.e. limited right to speak, no vote). Expert representative of nurses and nursing. |
| **Nursing policy** | Convention 149 and Recommendation 157 on Nursing Personnel. |
| **Recent ICN/ILO cooperation** | Examples include:  
☐ Child labour (especially with regard to surgical instruments industry).  
☐ ICN secondment of staff member for 3 months.  
☐ Impact of public sector reform on health personnel.  
☐ Security of Carers workshop.  
☐ Workplace Violence in the Health Sector. |
| **Web site** | [www.ilo.org](http://www.ilo.org) |
**UNITED NATIONS CONFERENCE ON TRADE AND DEVELOPMENT (UNCTAD)**

<table>
<thead>
<tr>
<th><strong>Mission</strong></th>
<th>Give developing countries and former socialist countries in transition to market economies the tools with which they can integrate successfully into the international trade and economic systems.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>Maximise the trade, investment and development opportunities of developing countries, helping them face challenges arising from globalisation and integrate into the world economy on an equitable basis.</td>
</tr>
<tr>
<td><strong>Members</strong></td>
<td>190 Member States.</td>
</tr>
<tr>
<td><strong>Structure</strong></td>
<td>UNCTAD is the principal organ of the United Nations General Assembly in the field of trade and development. The Conference is the organisation’s highest policy-making body. It normally meets every four years at Ministerial level to formulate major policy guidelines and decide on the programme of work. The Trade and Development Council is open to all UNCTAD members and presently includes 144. It analyses issues of interdependence and international economic trends with regard to trade and development, plans the programme of activities, monitors the coherence of UNCTAD activities, and assures coordination with other international organisations. It meets yearly. The Council has three committees which focus on trade of goods and services, investment, and entrepreneurship. They usually meet yearly. Headquarters are in Geneva.</td>
</tr>
<tr>
<td><strong>Budget</strong></td>
<td>Regular budget: US$ 50 million (from UN budget); Extra-budgetary funds: US$ 24 million.</td>
</tr>
<tr>
<td><strong>Personnel</strong></td>
<td>394</td>
</tr>
<tr>
<td><strong>ICN Status</strong></td>
<td>Observer status in formal meetings (i.e. limited right to speak, no vote). Expert representative of nurses and nursing.</td>
</tr>
<tr>
<td><strong>Nursing policy</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>Recent ICN/UNCTAD cooperation</strong></td>
<td>ICN participation in UNCTAD Board meetings.</td>
</tr>
<tr>
<td><strong>Web site</strong></td>
<td><a href="http://www.unctad.org">www.unctad.org</a></td>
</tr>
</tbody>
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## WORLD TRADE ORGANIZATION (WTO)

<table>
<thead>
<tr>
<th><strong>Mission</strong></th>
<th>WTO is the only international organisation dealing with the global rules of trade between nations. Its goals are a) to help producers of goods and services, exporters, and importers conduct their business, and b) improve the welfare of the peoples of the member countries.</th>
</tr>
</thead>
</table>
| **Objectives** | To ensure that trade flows as smoothly, predictably and freely as possible. It does this by:  
- Administering trade agreements  
- Acting as a forum for trade negotiations  
- Settling trade disputes  
- Reviewing national trade policies  
- Assisting developing countries in trade policy issues, through technical assistance and training programmes  
- Cooperating with other international organisations. |
| **Members** | 142 countries (accounting for over 90% of world trade). Over 30 others are negotiating membership. |
| **Structure** | WTO is run by its member governments. Decisions are made by the entire membership (typically by consensus although majority vote is also possible). The Ministerial Conference which meets at least once every two years is the top level decision-making body. The General Council (normally ambassadors and heads of delegation in Geneva) meets several times a year in Geneva headquarters. The General Council also meets as the Trade Policy Review Body and the Dispute Settlement Body. At the next level, the Goods Council, Services Council and Intellectual Property (TRIPS) Council report to the General Council. Numerous specialised committees, working groups and working parties deal with individual agreements, environment, development, membership applications, regional trade agreements, etc. |
| **Budget** | CHF 127 million (approx. US$ 73 million) |
| **Personnel** | 500 |
| **ICN Status** | Informal contacts |
| **Nursing policy** | Trade in Services Division will increasingly deal with the health sector and influence international nursing policies. |
| **Recent ICN/WTO cooperation** | WTO representative as ICN Congress speaker (2001). |
| **Web site** | [www.wto.org](http://www.wto.org) |
PUBLIC SERVICES INTERNATIONAL (PSI)

**Mission**
The PSI focus is on representing, promoting and defending the needs and interests of public sector workers. Recently, this work has been dominated by the new challenges of globalisation, the threats from ideological privatisation, commercialisation and contracting out of public services, the potential offered by public sector modernisation and quality services, the attacks on services through structural adjustment policies and the intrusion of transnational corporations into public services.

**Objectives**
1. To represent and defend the interests of affiliated organisations, strengthen the membership and promote cooperation amongst members.
2. To ensure freedom of association for public sector workers.
3. To campaign for the implementation of ILO Conventions, Recommendations, Resolutions and standards.
4. To work for equity in representation.
5. To promote and defend the creation and development of efficient public services.

**Members**
575 public service trade unions in 146 countries representing more than 20 million public sector workers.

**Structure**
PSI is an officially recognised non-governmental organisation and accredited by the United Nations Economic and Social Council (ECOSOC). It is the international trade secretariat representing the health sector within the International Labour Organization. PSI is governed by its five-yearly congress, which is made up of delegates from all PSI affiliates. Congress adopts policy documents, resolutions, statements and the programme of action, which form the basis of PSI policy. In addition, Congress elects the President, the General Secretary, the Executive Board and the Members’ Auditors. The Executive Board represents the four geographical regions (Africa, Asia and the Pacific, Europe, the Interamericas).

**Budget**
2000: Income CHF 8.7 million (US$ 5.05 million), Expenditure CHF 8.9 million (US$ 5.17 million).

**Personnel**
28 in headquarters (Ferney, France), with regional staff approx 50 workers.

**ICN Status**
Cooperation, exchange of information, invitations to meetings.

**Nursing policy**
- 

**Recent ICN/PSI cooperation**
Examples include:
- Child labour (especially with regard to surgical instruments industry).
- Impact of public sector reform on health personnel.
- ICN participation in PSI Health Task Force.
- Workplace Violence in the Health Sector.

**Web site**
www.world-psi.org