



Director-General

WHO Director-General addresses international conference of nurses

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Excellencies, members and executives of the International Council of Nurses, ladies and gentlemen,

It is said that a person who saves a life is a hero. A person who saves hundreds of lives is obviously a nurse.

That person is likely to be overworked, underpaid, and vastly under-appreciated, especially at the policy-making level. Yet that person is saving lives, all the same.

Through the auspices of a unifying federation like ICN, millions of nurses around the world speak with a single compelling voice. You are united by a shared vision, and guided by an international code of ethics that has been in place since 1953.

ICN has a much longer history than WHO, but has been in official relations with this Organization since 1948, when WHO was founded.

We have been close allies in the best of times, like during the health for all movement and the expansion of childhood immunization, but also in the worst of times, including the darkest years of the AIDS epidemic and during countless emergencies and humanitarian disasters.

I thank ICN and its members for their passionate commitment to the right to health, and to the provision of patient-centred, family-centred, and evidence-based primary health care. I appreciate the recent endorsement of universal health coverage as a route to achieving better health outcomes for all people.

The documentation prepared to commemorate this year's International Nurses Day includes a number of insightful observations. Let me mention just one. "The international community has given too little

attention to investments in health services in general and to the health workforce in particular.”

I could not agree more.

Prior to the outbreak of Ebola virus disease in West Africa, Guinea, Liberia, and Sierra Leone had only one to two physicians available per 100,000 population. WHO does not have estimates for the number of nurses working in any of these countries. But we do know how many nurses were infected, and how many died.

Last month, WHO issued its first report on Ebola infections in health care workers, including doctors and nurses, but also laboratory staff, ambulance drivers, burial teams, cleaners, and community-based workers. More than 800 health care workers have been infected and more than 500 of them died.

The report contains a startling statistic. Well over half of all those infected with Ebola were employed as nurses. Two-thirds of them died.

We also know that many of these nurses were not paid their salaries or promised hazard pay, sometime for months. Early on in the outbreak, when not enough personal protective equipment was available, nurses used plastic trash bags to fashion aprons and protect their hands and feet.

Yet despite no pay and no protection, they kept on working, kept on managing patients, putting their own lives at risk.

We must praise their courage and dedication. I doubt that any other statistics portray so dramatically the role of the nursing profession in providing front-line care. I can think of no other recent outbreak that portrays so dramatically the consequences of failing to invest in health services and the health workforce for so many decades.

Ladies and gentlemen,

We are global citizens in a world that has changed dramatically since the start of this century, when the Millennium Development Goals were put forward as an overarching framework for international cooperation.

These changes reveal the consequences of living in a world of radically increased interdependence. National affairs are intertwined as never before by the international systems that govern economies, financial markets, business relations, and trade.

Given the phenomenal increases in the volume and speed of international travel, there is no such thing as a local outbreak anymore. The definition of sovereign national autonomy no longer holds true.

Drug-resistant bacteria easily cross borders. Pollution is trans-national. Climate change is universal. The advertising of unhealthy products is beamed across borders by satellite. Social media propagate rumours like they were facts, clouding medical advice and sometimes undermining policies, like those for childhood immunization.

The distinctions between policy spheres have likewise become blurred. What looks like a good policy for one sector of government can be disastrous for another.

Biofuels can reduce the environmental damage caused by reliance on fossil fuels, but they can also endanger food security for millions. Trade agreements can open markets, but they can also shut down local livelihoods when heavily subsidized imports flood in.

All around the world, health is being shaped by the same powerful forces, like population ageing, rapid urbanization, and the globalized marketing of unhealthy products.

These universal trends have given the world a number of “firsts”.

For the first time in history, the population of people aged 60 years and older outnumbers the population of children under the age of five. In other words, being in the older age group has become the “new normal” in the world’s demographic profile.

The implications of this shift, in terms of the demands and costs of health care, are immense. The health workforce is also getting old.

For the first time in history, more than half of humanity lives in an urban setting. Living in a city brings many benefits, like more opportunities for employment, improved food security, educational and cultural advantages, and better access to better health care.

But not for everyone. WHO estimates that nearly a billion people live in urban slums, shantytowns, on sidewalks, under bridges, or along the railroad tracks. As this year’s State of the World’s Mothers, issued by Save the Children, shows, one of the worst places in the world to be a mother is in an urban slum.

For the first time in history, chronic noncommunicable diseases have overtaken infectious diseases as the leading cause of mortality worldwide. The burden of these diseases, long associated with affluent societies, has changed places.

Today, 80% of premature mortality caused by heart disease, cancer, diabetes, and chronic lung disease is concentrated in low- and middle-income countries, which have the least capacity to cope.

Most health systems in the developing world were built to manage brief

episodes of acute infections, in which the patient either survives or dies. These systems are ill-prepared to manage diseases requiring long-term if not life-long care.

For NCDs, all agree that prevention must be the cornerstone of the global response. Yet prevention is problematic, as the root causes of these diseases lie in non-health sectors.

Many of the risk factors for NCDs are amplified by the products and practices of corporations that are powerful economic operators, namely the tobacco, food, beverage, and alcohol industries. Market power readily translates into political power.

These corporations seldom interfered with efforts to reach the health-related Millennium Development Goals. No PR firms were hired to portray the delivery of medicines for HIV and TB as interference with personal liberties by the Nanny State, with WHO depicted as the Mother Superior of all Nannies.

No lawsuits were filed to stop countries from reducing the risks for child mortality. No research was funded by industry to cast doubt on the causes of maternal mortality. Mosquitoes do not have front groups, and mosquitoes do not have lobbies.

But the industries that contribute to the rise of NCDs do. When public health policies cross purposes with vested economic interests, we will face opposition, well-orchestrated opposition, and very well-funded opposition.

Taken together, these trends give us yet another “first” that calls into question the very way the world defines human progress.

Beginning in the 19th century, improvements in hygiene and living conditions were followed by vast improvements in health status and life-expectancy. These environmental improvements aided the control of infectious diseases, totally vanquishing many major killers from modern societies.

Today, the tables are turned. Instead of diseases vanishing as living conditions improve, socioeconomic progress is actually creating the conditions that favour the rise of NCDs. Economic growth, modernization, and urbanization have opened wide the entry point for the spread of unhealthy lifestyles.

This is a unique time in history where economic progress is actually increasing threats to health instead of reducing them.

In recent decades, China and India have lifted millions of their people out of poverty. This is one of the great achievements of economic development. But it has a clear down-side as well.

Two years ago, Chinese scientists published the results of a large national survey of diabetes prevalence. The authors estimated that China now has 114 million adults living with diabetes, representing a prevalence in the adult Chinese population of nearly 12%.

Less than a third of those surveyed were aware of their condition and only a quarter reported receiving treatment.

Think about what this debilitating disease, with all its costly complications, means in the world's second largest economy.

Will the rising incidence and costs of NCDs devour the benefits of economic gain? The demography of poverty has also shifted. Today, more than 70% of the poor live in middle-income countries.

If the economy is going well, what pressure will be placed on governments to take care of the poor? The world does not need any more rich countries full of poor people.

There is a final global trend that shapes the challenges ahead as health professionals, and most especially nurses, transition to the post-2015 development era.

This is the world's growing inequalities.

According to the Organization for Economic Cooperation and Development, or OECD, inequalities, in income levels and opportunities, have reached their most extreme levels seen in more than half a century.

Put another way, the Swiss bank, Credit Suisse, estimated last year that the combined wealth of the world's richest 85 people equals the combined wealth of the world's poorest 3.5 billion people.

A world that is so badly out of balance is neither stable nor secure.

I recall the statement from your ethical code: "The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services."

Again, I thank ICN for its commitment to universal health coverage. UHC is one of the most powerful social equalizers among all policy options.

Ladies and gentlemen,

The nursing profession is acutely aware of what these trends mean for health care, the costs, and the added demands on the daily practice of your work. The level of awareness is readily apparent in the agenda for this event.

The nursing profession, that so-called “sleeping giant”, is actually wide awake and ready to race ahead in clearly defined strategic directions. You are waiting for the starting gun.

Even more so, you are waiting for someone to let up on the reins that hold you back, the constraints that keep you from performing with the full set of competencies for which you were educated, trained, and licensed.

Some constraints have historical roots, often in legislation. As far back as 1986, experts convened by WHO concluded that national and subnational regulations often prevent nurses from exercising their full knowledge and skills.

The report set out a strategy for strengthening the contribution of nurses to primary health care based on a reorientation of legislation.

The impact of that strategy has been disappointing. Much more recently the US Institute of Medicine’s 2010 report on “The future of nursing: leading change, advancing health” reached much the same conclusion.

Again, that report argued that nurses should be able to practice to the full extent of their education and training.

The conclusion is similar to the one made 24 years ago: regulatory and institutional obstacles, including limits on nurses’ scope of practice, should be removed so that health systems can reap the full benefit of their training, skills, and knowledge.

Other constraints are attitudinal, often entrenched in the views and policies of national medical associations. As bluntly stated by the IOM report, physicians are unwilling to embrace policy that expands the supply and roles of nurses.

My own view is this. Given the enormous complexity of health challenges faced as the world transitions to the post-2015 era, no one, including WHO, dares to ignore the full contribution that the nursing profession can make.

If for no other reason, we cannot afford to ignore you.

A recent study conducted in the US found that the majority of clinicians have no idea about the costs of the interventions they order or the procedures they perform. In contrast, nurses are trained to work in a context of cost constraints, especially when their job involves procurement of medicines and hospital supplies.

Nurses need to have a much more active role in the policy process, especially in decisions that influence the financing of health services.

For NCDs, we cannot afford to miss opportunities for prevention, for early diagnosis, for counselling aimed at behavioural change, or for community-based approaches that improve health literacy.

As I speak, many health systems are at a critical juncture in planning their health workforces. For several reasons, the supply of primary health care physicians is dwindling, precisely at a time when the need for primary care has never been greater.

In countries facing a shortage of primary care physicians, one way to fill the gap is to permit nurses with advanced degrees to practice without a doctor's oversight, order and interpret diagnostic tests, prescribe medicines, and administer treatment. Yet this obvious solution still faces opposition from the medical profession.

Physicians who continue to believe that expanding the scope of nursing practice will have an adverse effect on the quality of patient care have not looked at the evidence. Mounting evidence shows that this opposition is more about competition than competence.

Nor can we afford to ignore other lines of evidence. Hospitals with a higher ratio of nurses to patient have lower mortality rates.

Studies underscore the quality of care provided by nurses, including preventing medical errors and medication mistakes, reducing or eliminating infections, shortening hospital stays, and easing the transition of patients from hospital to home.

Nurses using new technologies to care for patients, including the elderly, in their homes have been shown to reduce the number of hospital readmissions and visits to emergency wards. All of this cuts costs, of course, but it also improves the quality of life for patients.

What is needed is a less rigid dichotomy between the autonomy of nurses and doctors, and more collaborative teamwork.

This emphasis is thought to be one reason for the effectiveness of the WHO Surgical Safety Checklist, which gives all members of the team, and most especially nurses, an equal voice in decisions about surgical care.

Studies conducted in eight countries showed that use of this simple 19-item checklist reduced the rate of deaths and surgical complications by more than one third.

Other studies have noted an increased likelihood of staff speaking up when a problem is noticed. In fact, WHO recommends that a nurse be put in charge of running the checklist.

Ladies and gentlemen,

The nursing profession can transform the way health services are organized and how health care is delivered.

The sleeping giant is wide awake. With health challenged by so many first-time events, the starting gun has sounded.

You know where the health of this world needs you to run, and you are fully competent to move in those directions.

As I said, no one can afford to ignore your potential to change things for the better.

More cost-effective and more care-effective services will be the result.

Thank you.

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