The Global Emergence of the Nurse Practitioner Role

Madrean Schober

Introduction

As countries assess the efficacy of their healthcare services and strive to provide universal healthcare (UHC) to diverse populations, there is a need to identify solutions that enhance access to care and close existing gaps in provision of healthcare services. As a foundation for UHC, the World Health Organization (WHO) recommends reorienting healthcare systems toward primary healthcare (PHC). In addition, WHO emphasizes the central role of nurses in achieving UHC and the WHO Sustainable Development Goals (SDGs) by recommending that healthcare systems maximize the contributions of the nursing workforce in order to achieve UHC [2, 3]. The concept of advanced practice nursing and the advanced practice nurse (APN) is one option that is consistent with this perspective and is evolving globally. The nurse practitioner (NP) is one of the common APN roles that are emerging worldwide. Nurse practitioner initiatives have appeared in disparate regions internationally for over five decades.

This chapter provides the International Council of Nurses' (ICN) definition for an NP and identifies factors contributing to this global trend. The sensitive nature of country context is revealed along with how the local or national interpretation of who this nurse is determines what services this healthcare professional provides. Country and regional exemplars are described to underscore the variations in the promotion and development of nurse practitioners but are not intended to be an exhaustive list of nations implementing NP roles and advanced levels of nursing practice. Additional chapters in this book provide in-depth country and regional narratives of NP development and implementation.

M. Schober (✉)
Schober Global Healthcare Consulting, Indianapolis, IN, USA

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The International Council of Nurses' Nurse Practitioner Definition

The International Council of Nurses provides the following NP definition in the ICN Guidelines on Advanced Practice Nursing 2020 [1]:

> *A Nurse Practitioner is an Advanced Practice Nurse who integrates clinical skills associated with nursing and medicine in order to assess, diagnose and manage patients in primary healthcare (PHC) settings and acute care populations as well as ongoing care for populations with chronic illness*. (p. 6)

The ICN Guidelines on Advanced Practice Nursing 2020 goes on to describe a scope of practice for the NP [1]:

> The focus of NP practice is expert direct clinical care, managing healthcare needs of populations, individuals and families, in PHC or acute care settings with additional expertise in health promotion and disease prevention. As a licensed and credentialed clinician, the NP practices with a broader level of autonomy beyond that of a generalist nurse, [using] advanced in-depth critical decision-making and works in collaboration with other healthcare professionals. NP practice may include but is not limited to the direct referral of patients to other services and professionals. NP practice includes integration of education, research and leadership in conjunction with the emphasis on direct advanced clinical care. (p. 19)

The scope of practice for the NP differs from that of the generalist professional nurse in the level of accountability and responsibility required to practice. Establishment of a scope of practice is a way to inform the public, administrators, and other healthcare professionals about the services the NP can provide.

Factors Influencing Consideration of the Nurse Practitioner Concept

The NP concept often develops out of identified healthcare needs along with motivation by individual, practicing nurses who envision that healthcare services provided by NPs can enhance care to diverse populations. In addition, development of the NP concept forms part of the global reconceptualization of the current and future healthcare workforce as being at the forefront of meeting Sustainable Development Goals (SDGs) as defined by the United Nations (UN) and developed by the World Health Organization (WHO) [2]. In acknowledging that nurses and midwives are central to primary healthcare (PHC), WHO also acknowledges that achieving health for all will require investments in education and job creation for nurses who play a critical role in health promotion, disease prevention, and delivering PHC and community care. There is increasing acknowledgment that all nurses and those in advanced clinical roles such as NPs should be educated, recognized, and authorized to practice to their full potential [3–6]. Identifying NPs as a potential for

strengthening the healthcare workforce places these healthcare professionals at the forefront in the global plan to significantly diminish the complex factors that adversely affect health and access to healthcare.

This section identifies international incentives and motivators that contribute to the consideration and promotion of APN initiatives, including the NP role and level of practice. The potential for considering the concept of advanced practice nursing is shaped by the country or regional context [1]. Four main themes are identified as providing momentum for launching a new initiative or continuing to sustain a system that is already in place [7–9]:

- Public demand for improved access to healthcare services and delivery
- An identified healthcare need for provision of healthcare services
- An answer to skill mix and healthcare workforce planning
- A desire for the advancement of nursing roles to enhance professional development

Additional factors that influence these four main themes and warrant discussion when developing a plan or framework for APN that includes NP development [1, 7–9]:

- Strong education programs for the generalist nurse that provide a robust foundation for advanced clinical education specific to the NP role
- Flexible and realistic education alternatives that not only educate the competent NP, but offer options when a country is in a transitional process to establish an NP presence
- Clinical career pathways for advanced clinical practice
- Effective mentorship and nursing leadership to support and promote the NP concept
- Links to governmental and nongovernmental agencies aligned with international expertise to establish a professional standard, credentialing process, and regulations

No single starting point is viewed as pivotal when launching a successful and sustainable NP initiative. In addition, global development in some countries follows parallel paths for other APN roles such as the CNS (clinical nurse specialist) or NA (nurse anesthetist). The sensitive nature of country or local context warrants advanced assessment of the specific setting(s) in which the NP will practice [1, 10]. Motivation and specific drivers alone do not fully describe the complexities involved when proceeding to integrate the NP concept into healthcare systems. However, identifying a driver or drivers provides a stronger foundation for launching and sustaining a successful NP initiative. Country and regional exemplars of NP initiatives are provided later in this chapter. These exemplars demonstrate factors that influenced the beginning development and promotion of an NP presence in select nations.

Approaching Global Nurse Practitioner Development

An NP scope of practice is built on the scope of practice defined for a generalist professional nurse and expands beyond that scope in terms of function, expertise, and accountability based on advanced education [1]. To be effective, NP practice must be anchored within the national and local healthcare system(s) and tailored to meet the needs of the population. This means that globally, NP practice, while sharing many similarities, also looks different in different parts of the world. Therefore, a range of approaches rather than a single prescriptive solution for defining an NP initiative ideally offers flexibility and a grounded process for development.

Discussions seek to define the NP focus on changes in boundaries of nursing practice. A country's stakeholders and decision-makers will likely see this as a paradigm shift from a more traditional view of nursing practice and collaborative practice with other healthcare professions [11].

NP practice often exists in settings where the NP provides primary healthcare services; thus prescriptive authority and the ability to make an initial and/or differential diagnosis as part of therapeutic management are seen as prerequisite for the NP to practice to the full potential of the role. Recognition of these elements of the role enables the NP to function at a level appropriate to their scope of practice under the professional standard and regulations of the country where they work. Even though these features are seen as central to NP practice, conversation related to nurse prescribing and diagnostic decision-making often stimulates lively debate when promoting new NP initiatives [10, 11]. It is the view of this author that NP prescriptive authority and use of a common diagnostic language are ways to attain consistency of care in provision of healthcare services as the world strives for universal healthcare.

Country Exemplars

The changes supportive of NP development and implementation take place over years, at times following decades of discussion and decision-making under diverse and complex circumstances. In this section, country exemplars have been selected to present illustrations of initial development as the NP concept emerged in a nation or region and to further highlight initiatives experiencing sustained success. The exemplars are not meant to be an exhaustive list of all countries with an NP presence, but to demonstrate similarities and yet diversity with which countries seek to integrate a new nursing role into their healthcare systems. Emphasis is on portraying country profiles that developed and integrated the NP concept tailored to country needs, healthcare context, and resource capabilities. In addition, country exemplars were chosen that clearly relate to the NP presence in primary care and PHC in communities and where the role is consistent with the ICN definition for the NP.

The global emergence of NPs is often attributed to the origins of the NP role in the USA in 1965 [12]. Where there is evidence of this association, country profiles include mention of adaptation of the USA NP model or collaboration with USA

mentors. The country illustrations demonstrate the somewhat simultaneous NP development that emerged in diverse regions globally from the 1960s over time. International surveys conducted from 2001 to 2014 found that anywhere from 25 to 60 countries were in various stages of exploring or implementing NP/APN roles [11]. Based on membership in the ICN NP/APN Network, over 100 nations indicate a level of interest in advanced nursing practice, although this does not necessarily mean an active presence of APNs or NPs (www.icnnpapnetwork.wildapricot.org).

The author is aware of international collaboration between multiple countries other than the USA. As successful NP initiatives became more visible, representatives or delegates from countries with a thriving and effective NP presence are able to offer guidance to newly emerging projects and proposals worldwide. This intercountry collaboration speaks to the continued and heightened interest along with success of NPs globally.

Australia

The Australian health system is jointly coordinated by all levels of Australian government—federal, state, territory, and local. The aim is to provide health and wellbeing for all Australians through evidence-based policy, well-targeted programs, and best practice regulation. Medicare and the public hospital system provide free or low-cost access for all Australians to most of these health services. Private health insurance provides a choice outside of the public system. For private healthcare both in and out of hospital, the consumer contributes to the cost of their healthcare (www.health.gov.au/about-us/the-australian-health-system).

The prediction of a shortfall in medical graduates choosing primary care as their preferred option contributed to the consideration of APNs as one of the strategies in Australia to cope with this deficit. In October 1990 the first NP committee convened in New South Wales (NSW). This led to the formation of a steering group and the beginning of the NP movement at the NSW Nurses' Association Annual Conference [13, 14]. In January 1994, NP pilot projects were established to evaluate NP models in rural and remote areas, midwifery, well women's screening, emergency services, urban homeless men services, and general medical practice. The outcome of the evaluation found that NPs were effective in their roles and provided quality healthcare services [14–16]. The authorization process was formalized in 1999 paving the way for the first NP endorsement in 2000.

The Australian College of Nurse Practitioners (ACNP) is the national representative body for NPs and APNs in Australia (www.acnp.org.au). ACNP is active in advancing nursing practice and improving access to healthcare and defines NPs in Australia as registered nurses with the experience and expertise to diagnose and treat people of all ages with a variety of acute or chronic health conditions. Based on master's degree education, NPs practice autonomously and collaboratively with other healthcare professionals in a variety of locations [17]. The only regulated advanced practice role in Australia is the role of an NP. Registration for NPs is endorsed by the Nursing and Midwifery Board of Australia (NMBA) to enable the

NP to practice within their scope using the NP title, which is protected by law (www.health.act.gov.au).

As the NP initiative emerged in Australia, nursing leaders and regulators promoted a careful and strategic approach to development and implementation of NPs. As a result, the NP role and title are protected by legislation. Registration with the Nursing and Midwifery Board of Australia as an endorsed NP is a requirement to practice in this role. The first legally authorized NPs in Australia were recognized in 2000 and 2001. Within 9 years, following initial development in NSW, all Australian states and territories had achieved official recognition and a legislative framework for NP practice. The driver for this dramatic change in Australian healthcare, as envisioned by pioneer nursing leaders, was a commitment to patient-centered care and a patient-centered health service [13].

NPs in Australia are present in a variety of settings that include primary care, acute care, specialty medical services, and community care [14] with numbers increasing in response to identified gaps in service delivery. Even though there is evidence that NPs enhance quality of care and improve access to healthcare services, there continues to be a need for robust political support for NPs to practice to their full potential.

Refer to Chap. 23: The NP Role and Practice in Australia for an in-depth description of role development and implementation.

Botswana

Universal healthcare is offered to all citizens in Botswana through a public healthcare system, but privately run healthcare is also available. The government operates 98% of all medical facilities (www.moh.gov.bw). A nominal fee may be charged for some healthcare services in the public sector, but sexual reproductive health services and antiretroviral therapy services are free. The decentralized healthcare system in Botswana is comprised of 27 health districts, including mobile locations, clinics, and hospitals (www.borgenproject.org/healthcare-in-botswana).

Developments in provision of healthcare services were a result of societal needs and demand; in particular a shift of emphasis from hospital-based care to PHC in the late 1970s led to the establishment of the family nurse practitioner (FNP) program in Botswana [18]. Country independence from the UK in 1966, a need for healthcare reform, and a shortage of physicians triggered the need for nurses to accept increased responsibilities for PHC services. The nurses accepted these increased responsibilities but demanded further education to meet the healthcare needs of the country [19].

The Ministry of Health, through the then National Health Institute, responded by establishing the first family nurse practitioner (FNP) advanced diploma program in 1981. The 1-year post-basic program was established to educate nurses in advanced skills to provide comprehensive PHC services for common problems of the population in Botswana. In 1989 there were estimated to be 80 graduates identified as FNPs who were willing to work in the remotest communities [20]. In response to

the country's healthcare needs and consumers' demands, the length of the education program was extended to 18 months, and revisions to the curriculum for the diploma program took place in 1991 and 2001, and in 2007 a four-semester format was introduced. However, the program did not achieve identification resulting in a master's degree even though the education is comparable.

As of May 2020, the diploma program was at an advanced stage of revision at the Institute of Health Sciences (IHS) [formerly called the National Health Institute]. In addition, the University of Botswana offers a master's degree program for the FNP with discussions underway to determine possible options to matriculate the two FNP options so that the University of Botswana could recognize prior learning at the IHS diploma program [21].

Refer to Chap. 19: The NP Role and Practice in Botswana for an in-depth description of role development and implementation.

Canada

Canada has a universal healthcare system funded through taxes for medically necessary healthcare services provided on the basis of need, rather than the ability to pay. This means that any Canadian citizen or permanent resident can apply for public health insurance. Each province and territory has a different health plan that covers different services and products (www.canada.ca/en/services/health.html). The organization of Canada's healthcare system is largely determined by the Canadian constitution, in which roles and responsibilities are divided between the federal, provincial, and territorial governments.

The origins of advanced practice nursing in Canada can be traced to the efforts of outpost nurses who worked in isolated areas in the early 1890s but were largely unrecognized within the Canadian healthcare system. Since the 1960s, APN roles became more formalized [22]. To overcome a physician shortage in rural and remote areas, the primary healthcare NP (PHCNP) was introduced in the early 1970s, but by the 1990s the APN movement (NP and CNS) came to a standstill. The factors contributing to this included a greater availability of physicians, lack of a legislative framework or recognition in the nursing career structure, and poor public awareness of the APN concept.

As a result, NP educational programs were discontinued until the 1990s. The interest in NPs as cost-effective healthcare professionals in PHC was renewed in the 1990s by healthcare reform, an increased demand for access to PHC, and the need for integrated healthcare services. Formal legislation and regulation for NPs started in 1998 and all the provinces and territories now have it. NPs work across many settings and are well positioned to meet the ever-growing complexity and needs in Canada's healthcare system [23].

At the request of regulatory bodies in Canada, the core competencies for NPs were updated, resulting in the *Canadian Nurse Practitioner Core Competency Framework*. In 2016, the Canadian Council of Registered Nurse Regulators produced new *Entry-Level Competencies for NPs in Canada* as a result of the *Practice*

Analysis Study of Nurse Practitioners [23]. The study showed that NP practice is consistent across Canada, with NPs using the same competencies in all Canadian jurisdictions and across three streams of practice (family/all ages, adult, and pediatrics) included in the analysis. The Practice Analysis also indicated that the difference in NP practice in Canada lies in client population needs and context of practice, including age, developmental stage, health condition, and complexity of clients.

Refer to Chap. 11: The NP Role and Practice in Canada for an in-depth description of role development and implementation.

Republic of Ireland

The Republic of Ireland has a dual healthcare system, consisting of both private and public healthcare options. The public healthcare system is regulated by one government department, the Health Service Executive (HSE) (www.gov.ie/en/ & www.hse.ie/eng/). The mission of the Department of Health, which is made up of 12 divisions, is to improve health and well-being of people in Ireland by delivering high-quality health services and getting the best value from health system resources.

In 1996, the concept of an emergency NP was proposed in the James's Hospital Dublin. This initiative was intended to address a specific service need identified for patients with nonurgent clinical presentations to the emergency department. It was the first role of its kind in the Republic of Ireland and subsequently developed across a broad range of 30 nursing specialist areas [11].

A fundamental change experienced by the Irish nurses occurred with the publication of the Commission on Nursing, a blueprint for the future [24], and the subsequent development of the National Council for the Development of Nursing and Midwifery. The Commission on Nursing provided an opportunity for all Irish nurses to shape the future of clinical practice by outlining strategies to advance the nursing profession.

In 1998, the establishment of a clinical career pathway leading from initial nursing registration to advanced practice was recommended by the Commission on Nursing. This career ladder was created to retain expert nurses in direct patient care and served to develop clinical nursing and midwifery expertise. The development of advanced nurse practitioner/advanced nurse midwife roles and services was part of the strategic development of the overall health service reform in the country [25].

The Republic of Ireland has established frameworks and standards for the expansion of nursing and midwifery roles including practice standards as established by the Nurse Midwifery Board of Ireland that have been essential to role development. It is envisioned that nurses, such as NPs, will acquire the knowledge and skills to provide better patient care along with the efficient use of resources. In addition, there is an expectation that positive clinical outcomes are demonstrated [11].

The Irish Association of Advanced Nurse/Midwife Practitioners (IAANMP) was established in 2004 to provide support to nurses and midwives practicing at an advanced level in the Republic of Ireland [26]. In addition to peer support for its members, the Association has been instrumental in ensuring progression of a vision

of advanced practice nursing at a national and international level by noting that APNs, such as NPs, are integral to healthcare solutions by providing safe and effective healthcare.

Refer to Chap. 16: The NP Role in Ireland for an in-depth description of role development and implementation.

Jamaica

Healthcare in Jamaica is free to all citizens and legal residents at government hospitals and clinics (www.jamaicans.com/health-care-in-jamaica/). This includes prescription drugs. Private physicians and clinics are widely available if the consumer has the funds or insurance to cover the cost. The introduction of free public health services to its citizens in 2008 to make healthcare accessible to all Jamaicans facilitated a dramatic increase in patients and resulted in an overload on the healthcare professionals. This situation along with scarcity of resources continues to challenge the Jamaican effort to provide UHC to its citizens (www.borgenproject.org/healthcare-in-jamaica/). Jamaica's medical infrastructures often do not match the demand of its patients. In 2019 the Minister of Health and Wellness announced an upgrade in public health facilities, in addition to developing more sophisticated healthcare technology.

In July 2017, the island of Jamaica celebrated 40 years of NPs providing healthcare services. Discussions on the expanded role of the nurse in Jamaica began in 1972. Twenty-five experienced nurses entered the first NP program in 1977. The NP program was established as a cooperative effort by personnel from the Ministry of Health (MOH), University of the West Indies (UWI), Pan American Health Organization (PAHO), and PROJECT Hope [7]. Throughout the early years Project Hope (USA) provided staff, equipment, and faculty in addition to textbooks, journals, and audiovisual equipment. The first group of NPs began practice in 1978. The MOH was the employer of the NPs with the nurses assigned mainly to provision of PHC services (personal communication H. McGrath 6/6/22).

Education of nurses as NPs was a response by the MOH to provide staff for the public health sector as the country was experiencing an acute shortage of physicians, especially in the rural areas. NP education began as an Advanced Nursing Education Unit based on the US NP concept. The first cohort consisted of 18 FNPs and 7 pediatric NPs with the course of study offered as a 1-year certificate. The pediatric specialty was discontinued in 1979, and mental health was introduced in 1997 (personal communication H. McGrath 6/6/22). In 2002, the NP program became fully university based at UWI and was upgraded to the master's level [7].

Desiring improved NP representation, especially for legislative issues, the Jamaica Association of Nurse Practitioners (JANP) was founded in 2009 to promote advanced nursing practice, advocate for access of affordable quality care for the population, as well as give NPs a voice internationally (https://www.facebook.com/JamaicaAssociationOfNursePractitioners). Even though Jamaica has been the

leader of NP education and practice in the Caribbean Region, the island nation continues to face challenges in gaining explicit legislation supportive of NP practice.

Refer to Chap. 12: The NP Role and Practice in Jamaica for an in-depth description of role development and implementation.

New Zealand

New Zealand's healthcare system is a universal public system. With the 1938 Social Security Act, New Zealand brought into law universal and free healthcare. The Act requires that all New Zealand citizens have equal access to the same standard of treatment in an integrated, preventative healthcare system. The government pays for the majority of healthcare costs using public tax money meaning that healthcare for citizens and permanent residents is either free or low-cost (www.internationalinsurance.com). There is also an option to choose medical insurance for private healthcare.

In New Zealand the shift to population-based and PHC services combined with a realization by the government that nurses do have untapped potential to provide a greater range of services ignited interest in introducing NPs into the healthcare workforce [27]. The APN concept was initially recognized in New Zealand in 1988 at two levels. The New Zealand Nurses' Organization's (NZN0) credentialing process certified nurses as nurse clinicians or nurse consultants (clinical) in an attempt to promote the concept of advanced practice in nursing; however, it was difficult to differentiate the difference between these two roles. The NP concept was then introduced in 2000 and the NZNO phased out its earlier certification process in 2006.

The government of New Zealand, while recognizing nurses were already providing some services at an advanced level, established a task force in 1998 to identify barriers to provision of optimal healthcare services by nurses. The Ministerial Taskforce on Nursing identified barriers to nursing practice and examined strategies to remove barriers and release the unused nursing potential. The task force recommended development of an APN model, and it was agreed that this role should be the NP. In addition, nursing leaders determined the title *nurse practitioner* should have a separate scope of practice that is regulated and the title should be endorsed by the national regulator, the Nursing Council of New Zealand. The New Zealand Gazette (the government's journal of constitutional record) published the first NP scope of practice in 2004 [28]. The presence of a supportive Chief Nursing Officer at the Ministry of Health was critical to the success achieved in obtaining government acknowledgment that regulation, formal recognition, and employment of NPs would improve health outcomes of the population [27, 28]. The first NP was endorsed in New Zealand in 2001 [21, 28]. In 2015, the Nursing Council of New Zealand (NCNZ) no longer restricted NPs to a specific area of practice and introduced a new more general scope of practice [28].

Refer to Chap. 22: The NP Role and Practice in New Zealand for an in-depth description of role development and implementation.

UK (England, Northern Ireland, Scotland, Wales)

The National Health Service (NHS) provides residents of the UK healthcare services based on clinical need, not ability to pay. There are different eligibility criteria across the nations of the UK. Since devolution in the late 1990s, the respective governments in England, Scotland, Wales, and Northern Ireland have been responsible for organizing and delivering healthcare services (www.euro-healthobservatory.who.int). The NHS budget is funded primarily through general taxation.

Dr. Barbara Stilwell is considered to be one of the first NPs in the UK as well as a trailblazer and influencer driving the UK NP initiative. Upon receiving an honorary doctorate at London South Bank University in 2016, Barbara Stilwell commented on her contribution to inspiring the UK NP movement:

> *The idea of nurse practitioners was inspired by my experiences as an inner-city health visitor… working in Birmingham, dealing with a lot of families from the Indian sub-continent. Women would come to the clinic wanting to talk about sensitive things like family planning, screening or childbirth and there were no female doctors to help them. It was also very clear to me that nurses' skills and knowledge were being under-used. I happened to read something about nurse practitioners in the US and thought, why don't we have something like that here? We set up a trial clinic and I wrote an article for the Journal of Advanced Nursing. Peggy Nuttall, one of the grandes dames of nursing, read it and offered me a scholarship to go and study in the nurse practitioner programme in North Carolina [USA]. It all started from there*. [29]

Dr. Stilwell practiced alongside physicians in an inner-city setting from 1982 to 1985 adapting the US model of examination, diagnosis, and treatment that included a focus on long-term health goals [30–34]. Her experiences and research informed the curriculum for the Royal of College of Nursing (RCN) NP diploma course. Dr. Stilwell's conclusion was that a NP is defined not merely by transference of tasks from other healthcare professionals, but by autonomy of practice involving case management.

The first education collaborations in the UK arose in the 1990s as a result of the implementation and franchise of the RCN "Nurse Practitioner" Diploma. The first cohort of NPs was educated in the UK in 1990–1992 (personal communication K Maclaine, 05/2022). This cohort subsequently traveled to NP conferences in the USA. Some remained in the USA to be mentored by US NPs. In 2000 the first NP course transferred from RCN to London South Bank University.

In addition to RCN formulating initial NP education, the RCN Advanced Nurse Practitioner Forum began to hold annual NP conferences in the 1990s. These were primarily focused on the UK market with international representatives participating on an individual basis. The conferences rotated around the UK and facilitated discussions related to the global emergence of the NP concept that preceded and led to the launching of the ICN NP/APN Network.

The RCN franchise also brought together a small group of UK university representatives that began to meet on a regular basis to share their educational

experiences and expertise. A key part of the stimulus for NPs in the UK included setting up the UK NONPF (National Organization for NP Faculty) in 2001, based on the US NONPF. This helped support NP education which was a key grassroots driver for NPs in the UK in getting it off the ground and collectively lobbying for standards and high-level recognition. UK NONPF has evolved to become the Association of Advanced Practice Educators (AAPE UK) that represents a collaborative network of higher education institutions (HEI's) across the UK who are providers of advanced clinical practice programs of education for interprofessional/multiprofessional groups. AAPE UK includes representation of advanced nurse practitioners along with other advanced healthcare professionals (www.hallammedical.com/partners/appe/).

Development of the advanced nurse practitioner (ANP) in the UK is often described as a single approach in development; however, the ANP has emerged differently in the four nations of the UK (England, Northern Ireland, Scotland, Wales). Following devolution of the UK around 2005/2006, each country now has a separate government with the individual countries determining their own health policy and approaches. These differences are reflected in how ANP has progressed in each nation [11, 35].

Issues including inconsistent health policy, education, regulation, and lack of title protection have plagued the UK since the inception of the NP concept. Lack of regulation led to a decision by the RCN in 2012 to change the title to *advanced nurse practitioner* in order to bring clarity to the role. Unique to the UK, advanced practice as a whole has now moved, or is moving, toward a multiprofessional approach recognizing advanced practice as a level of practice rather than a specific role [35]. This multiprofessional approach indicates that educational programs for allied health professionals are considered to be multiprofessional with study programs leading to the title *advanced clinical practitioner*. However, many nurses who undertake these programs of study still use the title *advanced nurse practitioner* as advocated by RCN [25]. Ongoing challenges and the complexity of the context in the UK continue to impact NP development.

Refer to Chap. 14: The NP and Practice in the United Kingdom for an in-depth description of development.

International Influence

Visible support for the NP concept by international organizations can provide the authority and advocacy that an initiative may need to convince key stakeholders and healthcare decision-makers of the benefits of NPs. When a scheme is viewed as part of global advancement for universal healthcare services versus only a local or national directive, this backing offers an increased level of credibility for consideration of an NP proposal. Sections 2.5.1 and 2.5.2 provide examples of how international entities promote the advancement of nursing practice that includes NPs.

International Council of Nurses (ICN)

The launching of the ICN Nurse Practitioner/Advanced Practice Nursing (NP/APN) Network in 2000 signaled the advent of a new era in the recognition of the progression of the NP concept and advanced practice nursing worldwide. Representatives from 25 countries, displaying their national flags, gathered for this momentous event in San Diego, California, USA, to provide encouragement, inspiration, and energy for what was recognized as a global trend [11]. ICN sought organizational support to follow trends and new developments in this new field of nursing. Since that time, enthusiasm continues to grow, and interest in advanced practice nursing, including the NP concept, has progressed. This progression has been positively influenced by international organizations such as ICN and WHO (World Health Organization) [1, 2].

In 2000, although there was increased attention for advanced practice nursing, there was also uncertainty as to the intent and function of this classification of nurses. ICN had been observing the global growth of APNs since 1994 [7]. Subsequent to the launching of the NP/APN Network, along with recognition of this ambiguity, ICN took the first step in 2002 to recommend a definition, scope of practice, and characteristics for a nurse practicing in an advanced capacity and role [36]. At the time, the intent was to provide a benchmark to refer to and offer points for countries to discuss as they developed the APN concept sensitive to country context. Over time discussions have matured and research on the subject of advanced practice nursing has increased. It is worth noting that the recognition of this trend by ICN and the ICN NP/APN Network has had a lot to do with lending credibility and encouragement in support of the global emergence of NPs. Through the expertise of its NP/APN Network members, ICN continues to review the relevance of its official position on APN roles, including NPs, as well as to follow this global trend.

World Health Organization (WHO)

As an agency of the United Nations, WHO emphasizes international cooperation aimed at improving and providing universal healthcare worldwide. Although its emphasis is not specific to nursing, WHO can influence the extent of attention given to the advancement of nursing/midwifery and the contributions nursing professionals can make in achieving SDGs [2]. Working in collaboration with ICN, in addition to an array of other partners, WHO efforts have the potential to strengthen support for nursing/midwifery and further ensure that NPs are visible in discussions of effective and quality healthcare.

The WHO Global Strategic Directions for Nursing and Midwifery 2021–2025 presents evidence-based practices and an interrelated set of policy priorities that can help countries ensure that midwives and nurses optimally contribute to achieving universal health coverage and other population health goals [2]. This document

includes a strategic direction to establish and strengthen nursing leadership and service delivery that acknowledges the influence and effectiveness of advanced practice nurses. The policy priority emphasizes adaptation of workplaces to enable midwives and nurses to maximally contribute to service delivery in multidisciplinary teams. In addition, it is noted that laws and regulations can intentionally restrict midwives and nurses from practicing to the full potential of their education, sometimes due to "turf" issues with other groups of healthcare professionals. Recognition of this issue includes a call to action to update legislation and regulations in order to optimize these roles in practice settings.

In addition, WHO regional offices have provided support to strengthen acceptance of advancing expanded roles for nurses. The WHO Eastern Mediterranean Regional Office (WHO-EMRO), aware that advanced nursing practice and nurse prescribing was a growing trend, held a meeting of country representatives in Pakistan in 2001 to discuss these topics and identified strategies for progress in the region [27].

The World Health Organization-South East Asia Region (WHO-SEAR) [27] in making the case for a more flexible global nursing and midwifery workforce provided a conceptual framework in 2003 to assist countries to develop strategies to strengthen coordination between education and practice with service needs. The emphasis was on developing skills and competencies for nurses that correspond with service requirements and health priorities for the region.

In 2013, members of the Pan American Health Organization (PAHO), the Americas' regional office of WHO, passed a resolution to increase access to qualified healthcare workers in PHC-based health systems, urging education and implementation of APNs. In 2014 the WHO-PAHO regional leaders established a working plan to support the expansion and professionalization of advanced practice nursing. The plan included goals for education, regulation, and scope of practice of the APN role. Through prioritizing the preparation and professionalization of APNs in Latin America, there is an expectation that the presence of APNs will enhance the quality of PHC and offer a solution to disparities in universal healthcare in the region. In order to move this agenda forward, the Universal Access to Health and Universal Health Coverage: Advanced Practice Nursing Summit in 2015 hosted by PAHO/WHO fostered collaboration between nursing leaders and institutions in North America with those in Latin America and the Caribbean in order to outline priorities for APN implementation [11, 37].

When effective, influence by international organizations provides the capacity to strengthen support for a heightened NP presence by facilitating discussion forums, providing workshops or webinars and conferences, as well as offering consultancy expertise. In addition, publications and resources arising from the international community can incentivize healthcare planners and key decision-makers to consider integration of NPs in enhancing PHC and universal healthcare services.

Conclusion

The NP concept emerged in the USA in 1965 with the collaboration of a nurse and a physician (Dr. Loretta Ford and Dr. Henry Silver) responding to an identified need to improve healthcare services for underserved children. Country profiles in this chapter demonstrate global emergence of the NP role in disparate regions of the world. Motivation for new initiatives was driven at times by individual nurses who identified a healthcare need and saw the potential for nurses to enhance healthcare services. In addition, nongovernmental and governmental agencies pursued innovative solutions to pressing healthcare needs as their countries sought to provide PHC in community settings. Nurses with advanced education and skills have been repeatedly identified as an effective option. This trend and the growth of the NP phenomenon continue to increase worldwide undoubtedly based on a foundation of the international successes of early NP initiatives. In addition, increased global visibility of a growing NP presence has added to the discussion that these nurses are a valuable option for provision of diverse healthcare services and universal healthcare.

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