Return to State of the Union Report

Nurses per Capita

Information Retrieved from AI — To Be Verified

Section 1: Top 35 Countries with the Highest Nurses per Capita

Rank	Country	Nurses per 1,000 Population
1	Norge (Norway)	18.8
2	Suomi (Finland)	17.6
3	Danmark (Denmark)	17.0
4	Suisse or Schweiz (Switzerland)	16.5
5	**United States**	**15.6**
6	Iceland	15.3
7	Éire (Ireland)	13.0
8	Australia	12.5
9	Deutschland (Germany)	12.3
10	日本 Nippon (Japan)	12.1
11	Sverige (Sweden)	11.7
12	Nederland (Netherlands)	11.2
13	Belgique (Belgium)	10.9
14	Österreich (Austria)	10.8
15	New Zealand	10.5
16	République française (France)	10.5
17	Canada	10.0
18	United Kingdom	8.9

Rank	Country	Nurses per 1,000 Population
19	Россия Rossiya (Russia)	8.5
20	Česko (Czech Republic)	8.4
21	한국 Hanguk (South Korea)	7.9
22	Brasil (Brazil)	7.5
23	Portugal	6.7
24	Magyarország (Hungary)	6.6
25	Italia (Italy)	6.5
26	ישראל Yisra'el (Israel)	6.0
27	España (Spain)	5.8
28	Slovensko (Slovakia)	5.7
29	Chile	5.4
30	Polska (Poland)	5.1
31	Argentina	4.5
32	Malaysia	3.5
33	中国 Zhongguo (China)	3.1
34	México	2.9
35	Suid-Afrika (South Africa)	1.8

Source: World Health Organization (WHO) Global Health Observatory, OECD Health Statistics 2022. Data year: 2022.

United States Ranking and Analysis
The United States ranks 5th among countries with the highest number of nurses per capita, with approximately 15.6 nurses per 1,000 population as of 2022.

While this places the United States among the top ten globally, several European nations with smaller and more homogeneous populations outrank the U.S. Key factors contributing to the United States not ranking higher include geographic size and disparities in rural versus urban nurse distribution, high rates of nurse burnout and attrition, an aging nursing workforce, rising costs of nursing education, and workplace safety concerns that drive nurses from the profession.

Although the United States trains a large number of nurses annually, net workforce growth is constrained by retirements and departures. In 2023, the U.S. reported approximately 15.8 nurses per 1,000 population, a modest increase from the 2022 figure.

Top 8 Highest-Ranked Countries: Nurses per Capita

Rank	Country	Nurses per 1,000 Population
1	Norge (Norway)	18.8
2	Suomi (Finland)	17.6
3	Danmark (Denmark)	17.0
4	Suisse or Schweiz (Switzerland)	16.5
5	United States	15.6
6	Iceland	15.3
7	Éire (Ireland)	13.0
8	Australia	12.5

References and Data Sources:
World Health Organization — Global Health Observatory:
https://www.who.int/data/gho/data/themes/topics/health-workforce
OECD Health Statistics: https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_REAC
Eurostat Health Care Statistics: https://ec.europa.eu/eurostat/web/health/data/database

Section 2: What Other Countries Have Done to Increase Their Number of Nurses per Capita

Norge (Norway)

Norge has achieved one of the world's highest nurse-to-population ratios through a comprehensive national health workforce strategy anchored in the Norge Health Personnel Act and the National Health and Hospital Plan.

The Norge government funds nursing education through fully subsidized university programs, eliminating tuition barriers.

Salaries are set through centralized collective bargaining coordinated by the Norge Nurses Organisation (NSF) (https://www.nsf.no) and the state employer KS.

The Ministry of Health and Care Services (https://www.regjeringen.no/en/dep/hod/id421/) mandates nurse staffing ratios in hospital settings.

Continued professional development is publicly funded.

Norge also recruits internationally through structured EEA labor mobility programs while requiring Norwegian-language certification for foreign-trained nurses.

Suomi (Finland)
Suomi's nursing workforce growth has been driven by the Act on Health Care Professionals, which mandates clear licensure and scope-of-practice frameworks.

The Suomi Institute for Health and Welfare (THL) (https://thl.fi/en) monitors staffing data and publishes national benchmarks.

The Ministry of Social Affairs and Health (https://stm.fi/en) funds Advanced Practice Nurse programs and has extended prescribing authority to nurse specialists.

Suomi universities of applied sciences receive state block grants specifically for health professions enrollment. Municipal employers under the Association of Finnish Local and

Regional Authorities (Kuntaliitto) negotiate standardized nurse wages above the EU average.

The HYVÄ national action plan targets reducing vacancy rates in publicly funded health services.

Danmark (Denmark)
Danmark's Danish Health Authority (Sundhedsstyrelsen) (https://www.sst.dk/en) leads workforce planning using rolling 10-year demand projections.

The Danmark Nurses' Organization (DSR) (https://dsr.dk) negotiates sector-wide pay agreements and advocates for the Nursing Act, which grants Danish RNs independent clinical authority in defined settings.

The Danmark government introduced the Nursing Lift initiative (Sygeplejerskeløft) in 2021, investing DKK 1.2 billion to retain nurses through targeted pay increases, educational grants for specialty training, and a national recognition campaign.

Nursing education is free at Danmark University Colleges, and students receive state educational grants (SU) during training.

Schweiz (Switzerland)
Schweiz adopted Article 117b of the Federal Constitution in 2021 via a direct democracy referendum, constitutionally enshrining promotion of the nursing profession and requiring federal and cantonal action.

The Schweiz government's Implementation Law (Pflegeinitiative) mandates that cantons fund nurse education and expand clinical training positions.

The Federal Office of Public Health (FOPH/BAG) (https://www.bag.admin.ch) oversees the Masterplan zur Bekämpfung des Pflegepersonalmangels, which funds apprenticeship-style

nursing training, extends scope of practice for experienced nurses without physician oversight, and provides CHF 469 million in federal co-financing for cantonal training programs.

Australia
Australia has increased its nursing workforce through multiple mechanisms under the National Health Workforce Strategy.

The Australian Health Practitioner Regulation Agency (AHPRA) (https://www.ahpra.gov.au) streamlines international nurse registration.

The Commonwealth's Nursing and Allied Health Rural Locum Scheme (NAHLS) subsidizes rural nurse placements.

The Nursing and Midwifery Board of Australia (NMBA) (https://www.nursingmidwiferyboard.gov.au) introduced an endorsed midwife framework and a nurse practitioner framework that allows extended prescribing.

State governments fund university clinical placements and offer bonding scholarships for rural service.

The Australian Nursing and Midwifery Federation (ANMF) has successfully negotiated legislated nurse-to-patient ratios in Victoria, Queensland, and other states, a key retention mechanism.

Deutschland (Germany)
Deutschland enacted the Pflegeberufegesetz (Nursing Professions Act) in 2020, unifying previously fragmented nursing education into a single three-year generalist qualification and adding a two-year academic pathway.

The Federal Institute for Vocational Education and Training (BIBB) (https://www.bibb.de) oversees curriculum standards.

The Federal Ministry of Health (BMG) (https://www.bundesgesundheitsministerium.de) funded the Nursing Staff Strengthening Act (Pflegepersonalstärkungsgesetz — PpSG), which tied hospital reimbursement to nurse staffing thresholds (Pflegepersonaluntergrenzen).

Deutschland also operates the Triple Win project with the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) (https://www.giz.de) to ethically recruit nurses from partner countries including the Pilipinas, Tūnis, and Bosnia-Herzegovina with full integration support.

Sverige (Sweden)
Sverige's nursing workforce is governed by the Health and Medical Services Act and overseen by the National Board of Health and Welfare (Socialstyrelsen) (https://www.socialstyrelsen.se).

The Sverige government funds nurse specialist programs at universities at no cost to students and provides student allowances.

The Sverige Association of Health Professionals (Vårdförbundet) (https://www.vardforbundet.se) has secured wage parity agreements and flexible scheduling policies.

Sverige's career ladder framework (Kompetenstrappa) provides clear advancement pathways from bedside nurse to advanced practice, reducing attrition.

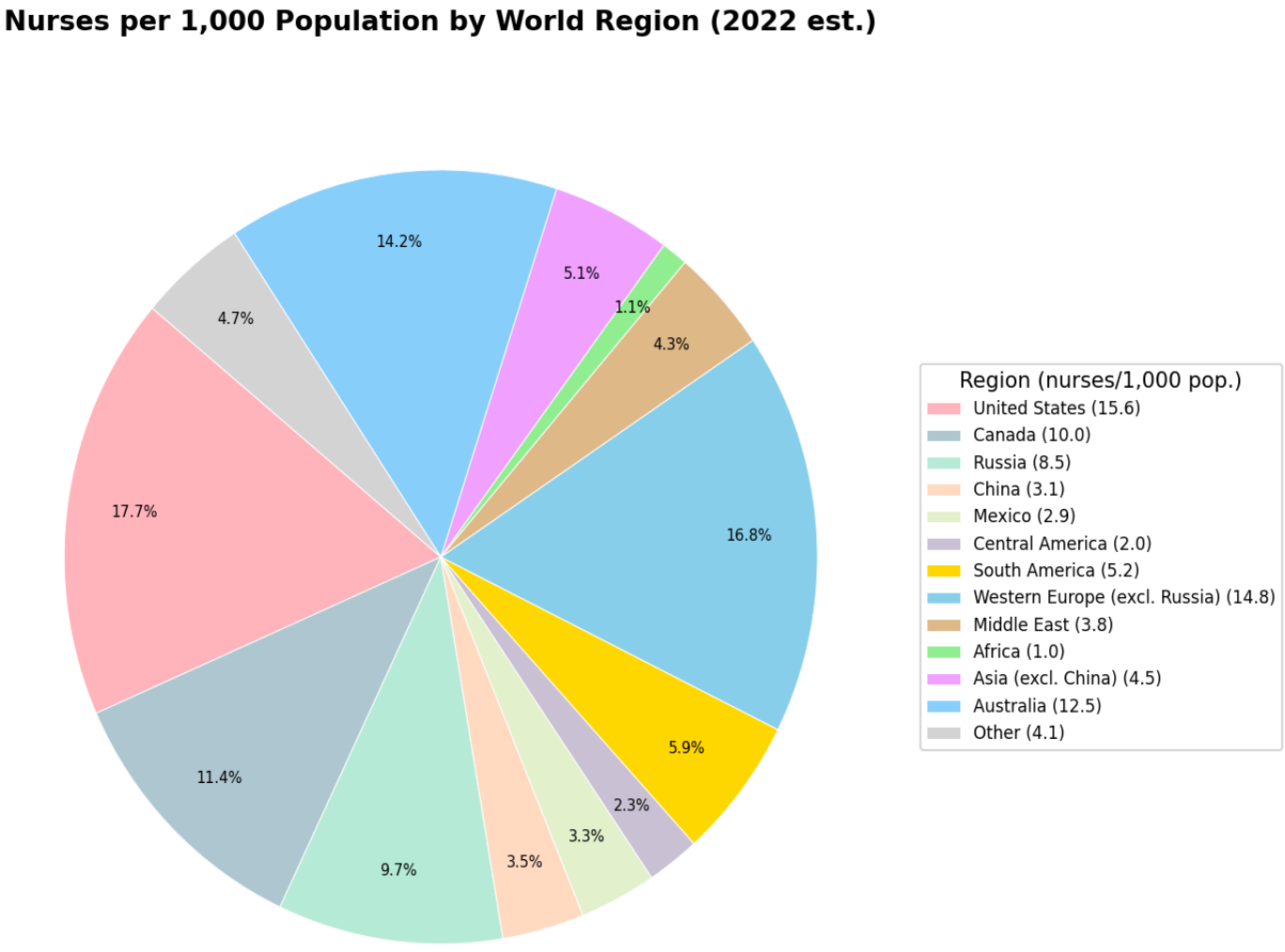
Regional health authorities fund simulation training centers attached to university hospitals.

Nederland (Netherlands)
The Nederland' program Waardigheid en Trots (Dignity and Pride) and the subsequent Waardigheid en Trots op Elke Locatie (WTiEL) invest in care quality and nursing capability in long-term care settings.

The Dutch Ministry of Health, Welfare and Sport (VWS) (https://www.government.nl/ministries/ministry-of-health-welfare-and-sport) has piloted nurse-led community care teams (Buurtzorg model) which have been adopted internationally.

The BIG Register (Big-register.nl) ensures licensure transparency.

HBO-V (University of Applied Sciences nursing programs) are subsidized and numerus clausus-exempt, enabling open enrollment.



Section 3: What the United States Can Do to Increase Its Nurses per Capita

The United States can meaningfully increase its nurses per capita through a coordinated national strategy encompassing federal legislation, regulatory modernization, educational expansion, workforce retention, and private-sector partnership. Key approaches include the following:

Federal Funding for Nursing Education: Congress should substantially increase appropriations under Title VIII of the Public Health Service Act, administered by the Health Resources and Services Administration (HRSA) (https://www.hrsa.gov), to fund nursing school faculty, clinical training sites, simulation laboratories, and loan repayment programs. Graduate medical education (GME) funds should be extended to include nursing education at teaching hospitals.

Loan Forgiveness and Scholarships: Expand the NURSE Corps Loan Repayment Program and create new federal scholarships modeled on the National Health Service Corps, specifically targeting nursing students who commit to service in Health Professional Shortage Areas (HPSAs).

Faculty Shortage Resolution: Establish federal grants for universities to hire and retain nursing faculty at competitive salaries. A nursing faculty tax credit for institutions that hire doctorate-prepared nursing educators would provide private-sector incentives.

Scope of Practice Expansion: Enact federal legislation removing state-based practice barriers for Advanced Practice Registered Nurses (APRNs), allowing full-practice authority in all states. The Improving Seniors' Timely Access to Care Act and the SAVE Act are recent examples of relevant legislative vehicles.

Safe Staffing Ratios: Pass federal minimum nurse-to-patient ratio legislation similar to California's AB 394 (1999). The National Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act has been proposed in Congress and should be enacted.

Immigration and International Recruitment: Reform visa caps and EB-3 processing timelines for internationally educated nurses through USCIS (https://www.uscis.gov), while ensuring ethical recruitment consistent with WHO guidelines to avoid depleting source-country workforces.

Workplace Safety and Wellness: Fund OSHA (https://www.osha.gov) enforcement of workplace violence prevention standards in healthcare settings and require hospitals to establish nurse wellness programs addressing burnout, mental health, and scheduling flexibility.

Section 4: References

World Health Organization — Health Workforce: https://www.who.int/health-topics/health-workforce
OECD Health at a Glance 2023: https://www.oecd.org/health/health-at-a-glance.htm
HRSA National Center for Health Workforce Analysis: https://bhw.hrsa.gov/data-research/review-workforce-research
American Association of Colleges of Nursing (AACN): https://www.aacnnursing.org
American Nurses Association (ANA): https://www.nursingworld.org
National Council of State Boards of Nursing (NCSBN): https://www.ncsbn.org
Institute for Healthcare Improvement — Nurse Workforce: https://www.ihi.org
Buerhaus, P.I., et al. (2022). 'Strengthening the U.S. Nurse Workforce.' Health Affairs. https://www.healthaffairs.org
Norwegian Nurses Organisation: https://www.nsf.no
Australian Health Practitioner Regulation Agency (AHPRA): https://www.ahpra.gov.au
German Federal Ministry of Health — Nursing: https://www.bundesgesundheitsministerium.de/themen/pflege.html
Sundhedsstyrelsen (Danish Health Authority): https://www.sst.dk/en

Section 5: Draft of a House Bill

118th CONGRESS
2nd SESSION

H.R. ____

IN THE HOUSE OF REPRESENTATIVES

A BILL
To increase the number of nurses per capita in the United States through educational investment, workforce retention, scope-of-practice reform, and public-private partnership, and for other purposes.

SHORT TITLE. — This Act may be cited as the **"Nursing Workforce Expansion and Retention Act of 2024" (NWERA).**

SECTION 1. DEFINITIONS.

In this Act:

(1) ADVANCED PRACTICE REGISTERED NURSE (APRN). — The term 'Advanced Practice Registered Nurse' means a registered nurse who has completed a master's or doctoral level nursing program and is certified in a specialty area, including Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse-Midwives.

(2) CLINICAL TRAINING SITE. — The term 'clinical training site' means any hospital, federally qualified health center, community health clinic, long-term care facility, or ambulatory care setting that provides supervised clinical practice experience to enrolled nursing students.

(3) FULL PRACTICE AUTHORITY. — The term 'full practice authority' means the authorization granted to an APRN to evaluate, diagnose, interpret diagnostic tests, and initiate and manage treatment, including prescribing medications, without physician supervision or collaboration agreements.

(4) HEALTH PROFESSIONAL SHORTAGE AREA (HPSA). — The term 'Health Professional Shortage Area' has the meaning given in Section 332 of the Public Health Service Act (42 U.S.C. 254e).

(5) HRSA. — The term 'HRSA' means the Health Resources and Services Administration within the Department of Health and Human Services.

(6) NATIONALLY ACCREDITED NURSING PROGRAM. — The term 'nationally accredited nursing program' means a pre-licensure or graduate nursing program accredited by the Accreditation Commission for Education in Nursing (ACEN) or the Commission on Collegiate Nursing Education (CCNE).

(7) NURSE-TO-PATIENT RATIO. — The term 'nurse-to-patient ratio' means the numeric relationship between the number of licensed registered nurses assigned to direct patient care and the number of patients concurrently assigned to those nurses on a given unit.

(8) NURSING WORKFORCE. — The term 'nursing workforce' means all individuals licensed as Licensed Practical Nurses (LPNs), Registered Nurses (RNs), or Advanced Practice Registered Nurses (APRNs) in any state or territory of the United States.
(9) SECRETARY. — The term 'Secretary' means the Secretary of Health and Human Services.
(10) UNDERSERVED COMMUNITY. — The term 'underserved community' means a geographic area or population group that experiences significant barriers to accessing health care services, as identified by the Secretary.

SECTION 2. ENACTING CLAUSE.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, that the findings and purposes of this Act are as follows:

(a) FINDINGS. — Congress finds that:
(1) The United States faces a projected shortage of up to 450,000 registered nurses by 2035, according to projections by McKinsey and Company and HRSA.
(2) Nurse burnout and workplace safety hazards, including violence, contribute to annual attrition rates exceeding 18 percent at certain hospital systems.
(3) Over 80,000 qualified applicants were turned away from nursing schools in 2023 due to insufficient faculty and clinical training capacity.
(4) Countries with the highest nurses per capita, including Norge, Suomi, Danmark, and Schweiz, have achieved their rankings through sustained public investment in nursing education, competitive salaries, mandated staffing ratios, and expanded scope of practice.
(b) PURPOSE. — The purpose of this Act is to:
(1) Increase the number of nurses per 1,000 population in the United States to at least 18 nurses per 1,000 population within 15 years of enactment.
(2) Reduce geographic disparities in nurse distribution between urban and rural areas.
(3) Improve working conditions and compensation for nurses to reduce burnout and attrition.

SECTION 3. REQUIREMENTS BY GOVERNMENT AGENCIES.

(a) DEPARTMENT OF HEALTH AND HUMAN SERVICES.
(1) The Secretary shall, not later than 180 days after enactment of this Act, develop and publish a National Nursing Workforce Strategic Plan, updated every four years, specifying numerical targets for nurses per capita by region and specialty.
(2) The Secretary shall increase the annual appropriation to the NURSE Corps Scholarship Program and NURSE Corps Loan Repayment Program by not less than 300 percent, prioritizing applicants who commit to service in Health Professional Shortage Areas.
(3) HRSA shall expand the Nursing Workforce Development program under Title VIII of the Public Health Service Act by creating not fewer than 500 new clinical training partnerships with hospitals, federally qualified health centers, and community health centers annually.
(A) Priority shall be given to training partnerships in rural and medically underserved areas.

(B) Each partnership shall include a signed agreement specifying the number of clinical training slots allocated, supervisory nurse-to-student ratios, and data reporting obligations.

(b) DEPARTMENT OF LABOR.

(1) The Occupational Safety and Health Administration (OSHA) shall, within one year of enactment, promulgate a final rule establishing mandatory workplace violence prevention standards for all healthcare facilities receiving federal funding, consistent with standards adopted in Canada, Australia, England, Norge, Sverige, and Deutschland.

(2) OSHA shall increase the number of healthcare workplace inspectors by no fewer than 200 full-time equivalent employees dedicated to healthcare settings within two years of enactment.

(3) The Employment and Training Administration shall designate nursing as a high-priority occupation under the H-1B Technical Skills Training Grants program and coordinate with USCIS to reduce processing times for EB-3 visa petitions filed by employers on behalf of internationally educated nurses.

(c) DEPARTMENT OF EDUCATION.

(1) The Secretary of Education shall create a Nursing Education Infrastructure Grant Program, awarding competitive grants of not less than $5 million per year per institution to accredited nursing programs for construction, renovation, and equipping of simulation laboratories, skills laboratories, and clinical training facilities.

(2) The Secretary of Education shall expand Public Service Loan Forgiveness eligibility to include all nurses employed full-time at any nonprofit or government-operated health care facility, not limited to the current definition of public service employment.

SECTION 4. REQUIREMENTS BY GOVERNMENT OFFICIALS.

(a) SECRETARY OF HEALTH AND HUMAN SERVICES.

(1) The Secretary shall appoint a Chief Nursing Officer of the United States, a Senate-confirmed position within the Office of the Assistant Secretary for Health, responsible for coordinating all federal nursing workforce initiatives and reporting annually to Congress.

(2) The Secretary shall convene an annual National Nursing Summit including representatives from state boards of nursing, nursing education associations, hospital systems, labor organizations, and consumer advocacy groups.

(b) ATTORNEY GENERAL.

(1) The Attorney General shall direct the Civil Rights Division of the Department of Justice to investigate and prosecute health care employers that systematically deny nurses rest breaks, overtime pay, or engage in retaliatory discharge in violation of federal labor law.

(c) SECRETARY OF STATE.

(1) The Secretary of State shall negotiate bilateral nurse workforce agreements with not fewer than 15 countries within three years of enactment to facilitate the ethical international recruitment of nurses, consistent with the WHO Global Code of Practice on the International Recruitment of Health Personnel.

SECTION 5. REQUIREMENTS BY CORPORATIONS.

(a) HOSPITALS AND HEALTH SYSTEMS.

(1) Any hospital receiving Medicare or Medicaid reimbursement shall, within two years of enactment, establish and maintain minimum nurse-to-patient ratios as follows:

(A) Medical-surgical units: 1 nurse to not more than 4 patients.

(B) Emergency departments: 1 nurse to not more than 3 patients.

(C) Intensive care units: 1 nurse to not more than 2 patients.

(D) Pediatric units: 1 nurse to not more than 3 patients.

(2) Each hospital shall establish a Nursing Workforce Investment Fund equal to not less than 2 percent of annual gross revenues, dedicated exclusively to nurse recruitment, retention bonuses, educational reimbursement, and mental health support programs.

(3) Nurse staffing ratios and associated patient outcome data shall be publicly reported quarterly to the Centers for Medicare and Medicaid Services (CMS) and published on the Hospital Compare website.

(b) NURSING STAFFING AGENCIES.

(1) Travel and contract nursing staffing agencies shall be required to register with the Department of Labor and disclose to both nurses and client facilities all fee arrangements, contract terms, housing allowances, and benefit structures.

(c) NURSING SCHOOLS AND UNIVERSITIES.

(1) Nationally accredited nursing programs that receive federal grant funding under this Act shall demonstrate a plan to increase enrollment by not less than 20 percent within five years and report annually on faculty-to-student ratios, NCLEX pass rates, and graduate employment within six months of graduation.

SECTION 6. REQUIREMENTS BY PRIVATE CITIZENS.

(a) INDIVIDUAL OBLIGATIONS AND INCENTIVES.

(1) Any individual who receives a scholarship or loan repayment benefit under this Act shall enter into a legally binding service agreement to practice as a nurse in a designated underserved community or Health Professional Shortage Area for not less than two years for each year of scholarship or loan repayment received.

(2) Retired nurses who return to active clinical practice in HPSA-designated settings for a minimum of 24 hours per week shall be eligible for a federal income tax credit of $5,000 per year and expedited state license reinstatement through reciprocity compacts.

(b) COMMUNITY VOLUNTEERISM.

(1) The Secretary shall establish a National Nursing Reserve Corps program through which licensed nurses who are not currently in active clinical practice may register as volunteer reserve nurses deployable during public health emergencies, natural disasters, or declared nursing shortages, receiving compensation at the prevailing federal wage during deployment.

SECTION 7. PENALTY CLAUSES.

(a) CIVIL PENALTIES.

(1) Any hospital or health care entity that fails to meet the minimum nurse-to-patient ratios required under Section 5(a)(1) of this Act shall be subject to a civil monetary penalty of not less than $10,000 per violation per shift, as assessed by the Secretary.

(2) Any hospital or health care entity that retaliates against a nurse for reporting a staffing ratio violation shall be subject to a civil monetary penalty of not less than $25,000 per incident and shall be subject to enhanced CMS compliance monitoring for a period of not less than three years.

(b) SCHOLARSHIP REPAYMENT.

(1) Any individual who fails to complete the service obligation required under Section 6(a)(1) shall repay to the federal government the full amount of the scholarship or loan repayment received, plus interest at the rate applicable to unsubsidized federal student loans at the time of original disbursement.

(c) AGENCY PENALTIES.

(1) Nursing staffing agencies that fail to register with the Department of Labor as required under Section 5(b)(1) shall be subject to debarment from placing nurses in any federally funded health care facility for a period of not less than two years.

SECTION 8. EFFECTIVE DATES AND IMPLEMENTATION.

(a) GENERAL EFFECTIVE DATE.

(1) Except as provided in this Section, this Act shall take effect on the date of enactment.

(b) PHASED IMPLEMENTATION.

(1) The nurse-to-patient ratio requirements of Section 5(a)(1) shall take effect 24 months after the date of enactment, with a 12-month grace period for good-faith compliance efforts documented by the facility.

(2) The OSHA workplace violence prevention rule required by Section 3(b)(1) shall be published as a proposed rule not later than 12 months after enactment and as a final rule not later than 24 months after enactment.

(c) REPORTING.

(1) Not later than 5 years after enactment, and every 5 years thereafter, the Secretary shall submit to Congress a comprehensive report on progress toward the national nurses-per-capita targets established by this Act, including data disaggregated by state, rurality, specialty, race, and ethnicity.

SECTION 9. APPROPRIATIONS AND BUDGETARY NOTES.

(a) AUTHORIZATION OF APPROPRIATIONS.

(1) There are authorized to be appropriated to the Secretary of Health and Human Services to carry out Sections 3(a) and 3(c) of this Act:

(A) $2,000,000,000 for fiscal year 2025.

(B) $2,500,000,000 for fiscal year 2026.

(C) $3,000,000,000 for each of fiscal years 2027 through 2034.

(2) There are authorized to be appropriated to the Secretary of Education to carry out Section 3(c) of this Act $500,000,000 for each of fiscal years 2025 through 2034.

(3) There are authorized to be appropriated to the Secretary of Labor to carry out Section 3(b) of this Act $150,000,000 for fiscal year 2025 and such sums as may be necessary for each subsequent fiscal year.

(b) OFFSET PROVISIONS.

(1) The Congressional Budget Office shall, within 60 days of enactment, provide a formal cost estimate for this Act. The Secretary of the Treasury is directed to identify offsetting revenue measures from savings attributable to reduced emergency care utilization projected to result from expanded nursing workforce capacity, for inclusion in any reconciliation process as required by the Statutory Pay-As-You-Go Act of 2010.

END OF BILL

Endnotes:

1. Requirements in Sections 3, 4, 5, and 6 incorporate practices drawn from
   Canada (Canada Health Act, provincial nurse-to-patient ratio frameworks),
   Australia (National Health Workforce Strategy 2021-2031, AHPRA framework),
   England (NHS Long Term Workforce Plan 2023),
   Norge (Norwegian Health Personnel Act),
   Sverige (Health and Medical Services Act),
   Suomi (Act on Health Care Professionals),
   Deutschland (Pflegeberufegesetz 2020, PpSG),
   République française (Code de la santé publique, loi HPST),
   Zhongguo (Regulations on the Administration of Nurses 2008, 14th Five-Year Plan for Nursing), and
   Nippon (Public Health Nurses, Midwives, and Nurses Act).

2. Sources available at:
   WHO Global Code — https://www.who.int/publications/i/item/9789241501712;
   NHS Long Term Workforce Plan — https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/;
   Canadian Federation of Nurses Unions — https://nursesunions.ca;
   Australian NMBA — https://www.nursingmidwiferyboard.gov.au.