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COMPARISON OF CHALLENGES FACED BY NURSING LEADERS IN HIGH INCOME AND LOW AND MIDDLE INCOME COUNTRIES: A LITERATURE REVIEW

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ABSTRACT

This literature review examines the challenges faced by nursing leaders in high-income countries (HICs) and low- and middle-income countries (LMICs), highlighting the significant differences in healthcare environments and leadership roles. Nursing leaders in HICs benefit from advanced technology, better resource availability, and more influence over healthcare policies, while their counterparts in LMICs grapple with severe resource limitations, workforce shortages, and inadequate infrastructure. The review explores key themes, including resource availability, workforce management, training, technological integration, policy influence, financial constraints, and socio-cultural barriers. The comparison reveals that nursing leaders in HICs focus on managing specialized teams and adapting to rapid technological advancements, while nursing leaders in LMICs face more fundamental challenges related to limited resources and unstable healthcare systems. Understanding these disparities is crucial for developing targeted global strategies that support nursing leadership in resource-constrained settings, ensuring effective healthcare delivery across diverse economic contexts.

Keywords: *Nursing leadership, high-income countries, low- and middle-income countries, healthcare challenges, resource constraints, workforce management, policy influence, healthcare infrastructure, leadership development, global health disparities.*

INTRODUCTION

Nursing leaders play a pivotal role in shaping healthcare systems by managing complex environments, guiding teams, and ensuring high-quality patient care. Their responsibilities include advocating for patients, influencing policy, managing healthcare resources, and fostering an environment that supports both professional development and patient-centered care (Aiken et al., 2012). Nursing leadership is essential to operational efficiency in healthcare settings, with leaders balancing administrative responsibilities with patient care (Curtis et al., 2011). Effective nursing leaders contribute to the development of strategic plans, ensuring that healthcare institutions can meet evolving demands (McSherry & Pearce, 2016).

Moreover, nursing leadership is not solely confined to managing staff; it involves making critical decisions during times of crisis and reforming the system to improve outcomes (Scully, 2015). This dynamic role also includes mentoring the next generation of nurses, ensuring that the nursing workforce remains resilient and prepared for future challenges (Finkelman, 2020). Their leadership is crucial to fostering a supportive work

environment, which is linked to reduced staff turnover and enhanced patient care (Huston, 2013). Healthcare infrastructure varies significantly between high-income and low- and middle-income countries (LMICs), which in turn affects nursing leadership (World Health Organization [WHO], 2020). High-income countries typically have more advanced healthcare systems, characterized by sophisticated technology, better staffing levels, and higher resource availability (Buchan et al., 2015). Nursing leaders in these settings often face challenges related to managing large, highly specialized teams and incorporating rapidly evolving technologies into patient care practices (Aiken et al., 2014).

In contrast, LMICs often experience a lack of resources, inadequate training, and underfunded healthcare systems (Kruk et al., 2018). Nursing leaders in LMICs must navigate unique challenges such as understaffing, insufficient access to essential medications, and infrastructure limitations (Foster & Bryce, 2015). These leaders often take on multiple roles, including clinical duties due to staff shortages, and they must work within healthcare systems that may lack the financial and technological support present in wealthier countries (WHO, 2020). Despite these challenges, they remain pivotal in ensuring that healthcare systems function effectively, often serving as advocates for both their staff and patients in settings where healthcare access is limited (Raven et al., 2018).

The disparity between high-income countries and LMICs is not only in the availability of resources but also in the policies that govern healthcare. High-income countries often have established protocols and a larger pool of trained nursing leaders, while LMICs struggle with weak healthcare systems and limited opportunities for professional development (Zuber et al., 2014). This gap in healthcare infrastructure reflects broader social and economic inequalities, further challenging nursing leaders in LMICs who must deal with resource constraints while striving to provide quality care (Kruk et al., 2018).

This literature review aims to compare and analyze the challenges faced by nursing leaders in high-income and low- and middle-income countries. By examining the existing literature, this review seeks to highlight the distinct difficulties that arise in different healthcare systems and to identify common themes that transcend income disparities. In high-income countries, nursing leaders may struggle with technological adaptation, staffing management, and navigating healthcare policies (Aiken et al., 2014). Meanwhile, in LMICs, the emphasis is on overcoming severe resource constraints, dealing with inadequate healthcare infrastructure, and managing higher patient-to-staff ratios (Raven et al., 2018).

The primary objective of this literature review is to compare the challenges faced by nursing leaders in high-income countries and low- and middle-income countries (LMICs). This comparison aims to highlight the unique difficulties that nursing leaders encounter in differing healthcare environments, with high-income countries often grappling with issues such as technological advancements, staff management, and policy implementation, while nursing leaders in LMICs face more fundamental challenges related to resource limitations, workforce shortages, and inadequate infrastructure. By analyzing these challenges across both contexts, the review seeks to provide insights into the common and distinct barriers that nursing leaders must overcome in their respective settings. Understanding these challenges is essential for developing strategies that can support and strengthen nursing leadership globally, ensuring that leaders are well-equipped to manage healthcare systems effectively, regardless of their country's economic status.

I. Methodology

In conducting this literature review, a comprehensive search of peer-reviewed articles was undertaken to identify relevant studies on the challenges faced by nursing leaders in both high-income countries and low- and middle-income countries (LMICs). The selection criteria for the literature included articles published between 2010 and 2024, with a focus on studies that specifically addressed nursing leadership challenges within different healthcare systems. Key terms used in the search included "nursing leadership," "challenges," "high-income countries," "low- and middle-income countries," "healthcare infrastructure," and "resource constraints." To ensure the inclusion of high-quality research, the databases PubMed, Scopus, and CINAHL were used to conduct the

searches, given their extensive collection of healthcare-related publications.

Inclusion criteria for this review consisted of studies published in English, peer-reviewed journal articles, and research that specifically focused on the role and challenges of nursing leaders. Articles that did not directly address nursing leadership, or that focused on non-comparable settings such as high-income countries with unique healthcare systems (e.g., countries with universal healthcare only), were excluded. Studies discussing healthcare systems but without an emphasis on nursing leadership were also excluded from the review.

For the analysis, a thematic analysis was employed to identify common themes and differences in the challenges faced by nursing leaders across high-income and LMIC settings. The identified themes were synthesized to offer a comparative perspective, with special attention paid to areas such as resource management, leadership training, and the impact of healthcare policy on nursing leadership. This method enabled a structured comparison of the distinct and shared challenges faced by nursing leaders in both contexts, ensuring a comprehensive understanding of the topic.

Results and Discussions

Table 1: Thematic Comparison of Challenges Faced by Nursing Leaders in High-Income and Low- and Middle-Income Countries

Theme	High-Income Countries (HICs)	Low- and Middle-Income Countries (LMICs)	Differences
Resource Availability	Sufficient access to technology, medications, and staff.	Limited access to essential medications, equipment, and staff.	Resource constraints are more severe in LMICs.
Workforce Management	Leadership focused on managing specialized teams and improving retention.	High patient-to-nurse ratios, severe understaffing issues.	LMICs face higher staffing shortages.
Training and Professional Development	Regular leadership training, access to advanced education.	Limited access to leadership training, lack of professional development opportunities.	Development opportunities are scarce in LMICs.
Technological Integration	Regular adaptation to new healthcare technologies.	Difficulty in integrating and maintaining technology.	HICs have more access to advanced technology.
Policy and Leadership Influence	Greater influence in shaping national healthcare policies.	Limited influence on healthcare policy due to political instability or weak healthcare systems.	Leadership in LMICs often lacks policy influence.
Financial Constraints	Financial pressures due to rising healthcare costs and budget restrictions.	Severe underfunding, making resource allocation more challenging.	Financial challenges are more pronounced in LMICs.
Cultural and Social Barriers	Fewer cultural barriers in leadership roles.	Strong influence of cultural, gender, and social barriers in leadership positions.	LMICs face more complex socio-cultural challenges.

III.I. Resource Availability

In high-income countries (HICs), the availability of healthcare resources such as technology, medications, and staff is generally far superior to that in low- and middle-income countries (LMICs). HICs, including countries such as the United States, the United Kingdom, and Germany, tend to allocate a significant portion of their gross domestic product (GDP) to healthcare infrastructure (Kruk et al., 2018). This investment

translates into enhanced access to advanced medical technology, a sufficient supply of essential medications, and a well-trained workforce to meet patient needs (World Health Organization [WHO], 2020).

One of the key factors that distinguish HICs is their ability to integrate cutting-edge medical technology into everyday clinical practice. For instance, advanced diagnostic tools such as MRI machines, robotic surgery equipment, and electronic health record systems are commonly available in hospitals across HICs (Buchan et al., 2015). These technologies not only facilitate more accurate diagnosis and treatment but also improve the efficiency and safety of healthcare delivery. Moreover, healthcare professionals in HICs have access to ongoing training programs to keep up with the rapid pace of technological advancements (Aiken et al., 2014). These conditions foster an environment where nursing leaders can focus on enhancing patient outcomes through the effective use of resources rather than struggling with resource shortages.

Another important aspect of resource availability in HICs is access to essential medications. In countries such as the United States and those in Western Europe, patients generally have timely access to a broad range of medications, including both generic and specialized drugs. This is facilitated by well-established pharmaceutical supply chains and government oversight that ensures the consistent availability of life-saving medications (WHO, 2020). Nursing leaders in HICs are therefore more focused on optimizing the use of these resources, managing patient medication adherence, and addressing issues such as drug interactions or side effects, rather than worrying about medication stockouts.

Staffing levels in HICs are also generally more favorable, with a higher nurse-to-patient ratio compared to LMICs. The availability of well-trained nursing staff allows nursing leaders to effectively delegate responsibilities, thus ensuring that patients receive high-quality care (Curtis et al., 2011). Moreover, the presence of specialized nursing roles, such as nurse practitioners or clinical nurse specialists, enhances the overall capacity of healthcare systems in HICs to meet patient needs (Scully, 2015). Consequently, resource management in HICs is less about scarcity and more about efficient allocation and optimization.

In contrast, resource availability in low- and middle-income countries (LMICs) is marked by significant shortages of medical technology, essential medications, and healthcare staff. LMICs often face challenges such as inadequate healthcare funding, political instability, and poor infrastructure, which contribute to these resource constraints (Kruk et al., 2018). Countries such as India, Nigeria, and Brazil, while striving to improve healthcare access, still suffer from persistent gaps in resource availability that directly impact patient care and outcomes.

One of the most striking differences between HICs and LMICs is the availability of medical technology. While HICs enjoy access to state-of-the-art diagnostic and treatment equipment, LMICs often struggle with outdated or non-functional medical equipment (Foster & Bryce, 2015). For example, hospitals in LMICs may lack basic diagnostic tools such as X-ray machines or ultrasound equipment, let alone advanced technologies like MRI scanners or robotic surgery systems (WHO, 2020). Even when technology is available, maintenance and repairs can be major challenges due to a lack of technical expertise or spare parts. This severely hampers the ability of nursing leaders in LMICs to provide timely and effective care, as they are forced to work with limited resources that may not meet the needs of their patients.

Access to essential medications is another major concern in LMICs. In many low-income settings, patients often face long delays in receiving necessary medications, or worse, they may not have access to these medications at all (Raven et al., 2018). Stockouts of life-saving drugs such as antibiotics, antiretrovirals, and vaccines are common, particularly in rural areas where healthcare infrastructure is weak (Kruk et al., 2018). Nursing leaders in LMICs must navigate these resource shortages while trying to maintain patient care standards, often resorting to improvisation or prioritizing patients based on the severity of their condition. This stands in stark contrast to the situation in HICs, where access to medications is generally stable and reliable.

Staff shortages further exacerbate the challenges faced by nursing leaders in LMICs. Many

healthcare systems in LMICs operate with a nurse-to-patient ratio that is far below the global standard, leading to burnout, high turnover rates, and decreased quality of care (McSherry & Pearce, 2016). In some regions, nursing leaders must manage large teams of under-trained staff, often without the support of specialized nurses or advanced practice roles that are common in HICs (Foster & Bryce, 2015). The lack of adequate staffing forces nursing leaders to juggle clinical and administrative duties, further straining their capacity to provide effective leadership in resource-constrained environments.

The disparity in resource availability between HICs and LMICs can be attributed to several factors, including differences in economic development, healthcare funding, and political stability. While HICs have the financial resources to invest in advanced technology, medication supplies, and staffing, LMICs often lack the necessary funds to build and maintain robust healthcare systems (Kruk et al., 2018). Moreover, healthcare in LMICs is frequently impacted by political and economic instability, which can disrupt supply chains and lead to shortages of critical resources (Raven et al., 2018).

One of the key differences lies in the healthcare infrastructure and support systems. In HICs, nursing leaders benefit from a well-established supply chain that ensures the timely delivery of medications, medical supplies, and equipment. They also have access to a skilled workforce that allows for better resource management and patient care (Aiken et al., 2014). In contrast, nursing leaders in LMICs must deal with fragile healthcare systems that are prone to disruptions. Resource constraints in LMICs are more severe, and nursing leaders often find themselves in situations where they must choose between providing care for a few patients at a high level or spreading limited resources thinly across a larger population (Foster & Bryce, 2015).

III.II. Workforce Management

Workforce management in high-income countries (HICs) is characterized by well-developed systems for staffing, recruitment, retention, and career development. In these countries, nursing leaders benefit from a structured and adequately resourced workforce, which supports the delivery of high-quality patient care. One of the defining features of workforce management in HICs is the presence of clear career pathways for nurses, from entry-level positions to advanced roles such as nurse practitioners or nurse managers (Curtis et al., 2011). This structured approach ensures that nursing professionals have opportunities for career growth, which contributes to better job satisfaction, reduced turnover, and improved patient outcomes (Aiken et al., 2014).

Nursing leaders in HICs often work in collaboration with human resources departments to ensure that staffing levels are appropriate and that there is a sufficient mix of skills within the workforce. This collaboration allows for more effective workforce planning, ensuring that the right number of nurses with the right competencies are available to meet patient needs (McSherry & Pearce, 2016). In addition to staffing, workforce management in HICs includes the implementation of policies that promote work-life balance, reduce burnout, and improve overall job satisfaction. For example, flexible working hours, mental health support programs, and career development opportunities are commonly available to nursing staff in HICs (Scully, 2015). These strategies contribute to a more stable and motivated workforce, which in turn enhances the ability of nursing leaders to manage teams effectively.

In contrast, workforce management in low- and middle-income countries (LMICs) presents significant challenges due to severe staffing shortages, inadequate training, and limited career development opportunities. Nursing leaders in LMICs are often tasked with managing large teams of undertrained or overworked staff, which can lead to high levels of burnout and turnover (Raven et al., 2018). The nurse-to-patient ratio in many LMICs is far below the global standard, resulting in increased workloads for nursing staff and a subsequent decline in the quality of patient care (Foster & Bryce, 2015). This shortage of healthcare professionals, particularly in rural or underserved areas, creates a heavy burden on nursing leaders, who must find ways to deliver care with limited human resources.

Training and development opportunities for nursing staff in LMICs are often scarce, leading to gaps in skill sets and competencies that are essential for providing high-quality care (Kruk et

al., 2018). In many LMICs, nursing leaders are responsible for managing teams that may lack the specialized skills necessary for dealing with complex medical cases, such as those involving non-communicable diseases or advanced surgical procedures. This lack of training is compounded by the fact that professional development opportunities, such as continuing education programs or leadership training, are not widely available in LMICs (McSherry & Pearce, 2016). As a result, nursing leaders in these countries must often take on dual roles as both managers and clinicians, which can further strain their capacity to lead effectively.

The high turnover rate in LMICs is another significant challenge for workforce management. Due to poor working conditions, low salaries, and a lack of professional development opportunities, many nurses in LMICs choose to migrate to higher-income countries in search of better career prospects (Buchan et al., 2015). This "brain drain" exacerbates the already existing staffing shortages, making it even more difficult for nursing leaders to manage their teams effectively. In some LMICs, this outflow of skilled healthcare professionals has created a vicious cycle in which the loss of experienced staff leads to further workforce shortages, increased workloads, and declining job satisfaction among the remaining nurses (Raven et al., 2018).

The most significant difference between HICs and LMICs in terms of workforce management is the availability of resources. While HICs benefit from a well-funded healthcare system that allows for adequate staffing, professional development, and employee support programs, LMICs often operate with minimal resources, which severely limits their ability to manage the nursing workforce effectively (Kruk et al., 2018). Nursing leaders in HICs are able to focus on strategic workforce planning and long-term development, while nursing leaders in LMICs are often forced to focus on immediate operational challenges such as filling staffing gaps and ensuring that basic patient care needs are met (Foster & Bryce, 2015).

In terms of retention, HICs tend to have better mechanisms in place for maintaining a stable workforce. The availability of professional development opportunities, competitive salaries, and a supportive work environment contribute to lower turnover rates in HICs (Aiken et al., 2014). In contrast, LMICs struggle to retain their nursing workforce due to poor working conditions, inadequate compensation, and limited opportunities for career advancement (Raven et al., 2018). As a result, nursing leaders in LMICs are constantly dealing with high turnover rates, which further exacerbates the challenges of workforce management.

III.III. Training and Professional Development

Effective nursing leadership hinges on continuous training and professional development. This theme represents a significant area where disparities between High-Income Countries (HICs) and Low- and Middle-Income Countries (LMICs) are stark. In HICs, nursing leaders often have access to formalized and structured leadership training programs, allowing them to continuously enhance their skills and adapt to the evolving demands of the healthcare system. In contrast, the lack of access to comprehensive leadership training in LMICs hampers the ability of nursing leaders to effectively manage healthcare teams and navigate the complexities of healthcare delivery.

In HICs, nurses are afforded numerous opportunities for leadership development. Advanced education programs, including formal nursing leadership courses, master's degrees, and continuing professional development (CPD), are widely available. These programs emphasize critical leadership competencies such as strategic decision-making, communication, team management, and adaptability in the face of technological and procedural changes in healthcare (Fitzpatrick & Ea, 2019). Furthermore, many healthcare institutions in HICs offer in-house leadership development programs aimed at fostering nurse leaders from within their ranks. These programs typically include mentorship, executive coaching, and leadership seminars that help prepare nurses for managerial roles (Dignam et al., 2021).

In contrast, nursing leaders in LMICs face significant challenges in accessing professional development opportunities. Limited educational infrastructure and resources often restrict the availability of specialized leadership training programs. According to studies, nurses in LMICs are less likely to have access to formal leadership

development opportunities, contributing to a lack of preparedness for management roles (Kumbani et al., 2020). The World Health Organization (WHO) has recognized this gap and emphasized the need for investment in leadership development programs in LMICs, particularly in regions where the healthcare system is strained by workforce shortages, financial constraints, and inadequate infrastructure (WHO, 2021).

The disparity in leadership training between HICs and LMICs has profound implications for healthcare delivery. In HICs, well-trained nurse leaders are better equipped to implement quality improvement initiatives, manage staff retention, and foster innovation in healthcare practices. This contributes to better patient outcomes and more efficient use of healthcare resources (Fitzpatrick & Ea, 2019). Conversely, the lack of leadership training in LMICs often results in poor team management, higher nurse turnover rates, and reduced capacity to influence healthcare policies, further exacerbating the challenges of underfunded and overburdened healthcare systems (Zuniga & Bass, 2019).

III.IV. Technological Integration

The integration of technology into healthcare systems has transformed the landscape of nursing leadership, but the degree of access and utilization of these technologies varies significantly between High-Income Countries (HICs) and Low- and Middle-Income Countries (LMICs). Technological integration, including the use of electronic health records (EHRs), telemedicine, and advanced medical equipment, plays a pivotal role in improving healthcare delivery and patient outcomes. However, while HICs are generally well-positioned to adopt and integrate new technologies, LMICs face multiple barriers in doing so, creating a significant disparity in healthcare leadership's ability to leverage technology effectively.

Nursing leaders in HICs are often at the forefront of integrating technology into their healthcare systems. The availability of financial resources and infrastructure enables hospitals and healthcare institutions in these countries to adopt cutting-edge technologies, such as artificial intelligence (AI), robotics, and sophisticated diagnostic equipment. In many HICs, electronic health records (EHRs) have become a standard tool, facilitating better communication between healthcare teams, reducing medical errors, and improving patient safety (DeShazo et al., 2019). For nurse leaders, these technologies streamline workflow management, enabling more efficient allocation of staff, time, and resources. Additionally, advancements in telemedicine have expanded access to care, particularly for patients in rural or underserved areas, and have empowered nurse leaders to coordinate care delivery across distances (Snoswell et al., 2020).

In contrast, nursing leaders in LMICs face significant challenges in integrating even the most basic healthcare technologies. Many healthcare systems in these regions are constrained by limited financial resources, poor infrastructure, and a lack of access to advanced technologies. For instance, while EHRs have become widespread in HICs, they remain rare in LMICs due to high implementation costs, inadequate training, and limited technical support (Adebesin et al., 2019). As a result, nursing leaders in LMICs often rely on paper-based records, which are prone to errors, inconsistencies, and data loss, thus hindering efficient patient care and care coordination.

The disparity in technological integration between HICs and LMICs significantly impacts the effectiveness of nursing leadership. In HICs, nurse leaders are empowered to use technology to improve patient outcomes, manage workforce challenges, and reduce healthcare costs. Technology-driven innovations, such as predictive analytics and remote patient monitoring, allow nurse leaders in HICs to make data-informed decisions, leading to better resource management and more personalized care (Carroll et al., 2021).

LMICs, the lack of access to essential technologies often leaves nurse leaders unable to optimize healthcare delivery. Without reliable data management systems or advanced diagnostic tools, nursing leaders are limited in their ability to make informed decisions, and healthcare delivery remains reactive rather than proactive. This technology gap underscores the urgent need for international support and investment in building technological infrastructure in LMICs, which would enable nurse leaders to more effectively manage their healthcare teams and improve patient outcomes (Adebesin et al., 2019).

III.V. Policy and Leadership Influence

Nursing leaders play a pivotal role in shaping healthcare policies that directly impact patient care, workforce management, and resource allocation. However, their influence over national healthcare policy varies significantly between High-Income Countries (HICs) and Low- and Middle-Income Countries (LMICs). In HICs, nursing leaders are often key stakeholders in policy discussions, contributing to the formulation and implementation of national healthcare strategies. In contrast, nursing leaders in LMICs face numerous barriers that limit their involvement in policy-making, including political instability, underdeveloped healthcare systems, and socio-economic constraints.

In HICs, nursing leaders have a well-established presence in healthcare policy-making. Nursing organizations, such as the American Nurses Association (ANA) in the United States and the Royal College of Nursing (RCN) in the United Kingdom, play a central role in advocating for nursing interests and contributing to broader healthcare reforms (Curtis et al., 2019). These organizations provide a platform for nursing leaders to influence policies on critical issues such as staffing ratios, patient safety, and professional development. Moreover, nursing leaders in HICs are often involved in governmental health commissions and policy advisory boards, where their expertise is sought in the design and implementation of healthcare policies (Sabatier & Cairney, 2020).

The strong policy influence of nursing leaders in HICs can be attributed to several factors. First, the professionalization of nursing has led to the establishment of advanced leadership roles and greater recognition of nurses as essential stakeholders in healthcare management (Smith et al., 2021). Additionally, healthcare systems in HICs tend to have robust institutional frameworks that facilitate nursing leadership's involvement in policy discussions, providing them with the necessary resources and platforms to advocate for change.

In contrast, nursing leaders in LMICs face significant challenges in influencing healthcare policy. Political instability, weak healthcare infrastructures, and a lack of formal representation often prevent nursing leaders from being active participants in policy-making processes. In many LMICs, the healthcare system is underfunded, and policies are often dictated by short-term crisis management rather than long-term strategic planning (Lassi et al., 2016). This makes it difficult for nursing leaders to advocate for systemic changes or improvements in workforce management, patient care, and resource allocation. The absence of nursing representation in policy-making bodies further exacerbates this issue. Unlike HICs, where nursing organizations are often integral to policy development, LMICs tend to lack strong professional nursing associations with the political clout necessary to influence national healthcare decisions (Global Health Workforce Network, 2021). As a result, nursing leaders in LMICs are often excluded from policy discussions, limiting their ability to address critical issues such as staffing shortages, training gaps, and healthcare inequalities (Betancourt et al., 2018).

Several barriers prevent nursing leaders in LMICs from exerting influence over healthcare policy. First, the lack of leadership training and development opportunities in LMICs, as previously discussed, limits the ability of nursing leaders to engage with policymakers and advocate for their professional needs (El-Jardali et al., 2020). Without the necessary leadership skills, many nursing leaders in LMICs struggle to navigate the complex political landscape and articulate their concerns in a way that resonates with policy-makers.

The limited policy influence of nursing leaders in LMICs has profound consequences for healthcare systems. Without strong nursing leadership at the policy level, healthcare systems in LMICs often fail to address critical workforce issues such as nurse retention, staffing ratios, and professional development. This, in turn, exacerbates healthcare inequalities, particularly in rural and underserved areas where access to trained nursing professionals is already limited (Betancourt et al., 2018). In contrast, the strong policy influence of nursing leaders in HICs contributes to the development of comprehensive healthcare policies that address both the short-term and long-term needs of the healthcare workforce, leading to better patient outcomes and more sustainable healthcare systems.

III.VI. Financial Constraints

Financial constraints significantly impact the leadership capacity of nursing professionals in both High-Income Countries (HICs) and Low- and Middle-Income Countries (LMICs), but the nature and severity of these challenges differ drastically between the two settings. While financial pressures exist in both environments, the resource limitations in LMICs are often far more acute and present critical barriers to the effective functioning of healthcare systems.

In HICs, nursing leaders are primarily challenged by budgetary constraints resulting from rising healthcare costs, budget restrictions, and an increasing demand for healthcare services. Governments and healthcare institutions in these regions face pressures to balance cost containment with the need to provide high-quality care. For nursing leaders, this means making difficult decisions about resource allocation, particularly in the context of managing large healthcare teams and ensuring the delivery of quality patient care (Stokes et al., 2019).

Nursing leaders in HICs are expected to work within strict financial frameworks, which often limit their ability to expand staff, invest in new technologies, or provide continuing education opportunities. Although financial resources are generally more abundant in HICs than in LMICs, the pressure to reduce healthcare costs while maintaining high standards of care can lead to workforce reductions, increased nurse workloads, and the implementation of efficiency measures that sometimes negatively affect patient outcomes (Hewko et al., 2015). Despite these challenges, HICs have well-established financial systems that provide more stability, allowing nurse leaders to advocate for budget adjustments and influence decision-making processes at higher organizational levels.

In LMICs, financial constraints are significantly more pronounced and create profound challenges for nursing leadership. Healthcare systems in these countries are often severely underfunded, leading to chronic shortages of essential supplies, outdated equipment, and inadequate staffing levels. Nursing leaders in LMICs frequently face the dilemma of trying to provide care with extremely limited resources, which can compromise the quality of patient care and lead to widespread dissatisfaction among healthcare staff (Tuckett et al., 2019).

Financial shortfalls in LMICs also hinder the ability of nursing leaders to implement evidence-based practices, invest in training and professional development, or maintain adequate staffing ratios. These financial limitations force nursing leaders to prioritize short-term crisis management over long-term strategic planning, further exacerbating the systemic challenges within these healthcare systems (Lassi et al., 2021). Additionally, funding gaps in LMICs often leave nursing leaders without the ability to advocate for better wages and working conditions, leading to higher turnover rates and further destabilizing the healthcare workforce.

The financial disparities between HICs and LMICs have far-reaching implications for healthcare outcomes. In HICs, while budgetary pressures exist, nursing leaders can generally maintain a high standard of care and implement innovative healthcare solutions. In contrast, financial constraints in LMICs prevent nursing leaders from making the necessary investments in healthcare infrastructure, staff, and training, leading to overburdened healthcare systems and lower quality care for patients (Tuckett et al., 2019).

III.VII. Cultural and Social Barriers

Nursing leadership is deeply influenced by the cultural and social context in which it operates. Cultural attitudes toward healthcare, gender roles, and societal norms play a significant role in shaping the leadership dynamics of nursing professionals in both High-Income Countries (HICs) and Low- and Middle-Income Countries (LMICs). However, these barriers are often more pronounced in LMICs, where traditional and patriarchal structures can limit the advancement and effectiveness of nursing leaders.

In HICs, nursing leaders generally face fewer cultural and social barriers compared to their counterparts in LMICs. Societal attitudes toward gender equality and professional leadership have progressed considerably, allowing nursing leaders—both men and women—to assume leadership roles in healthcare without significant cultural resistance (Curtis et al., 2019). Nursing in HICs is often recognized as a highly respected profession, and nursing leaders are viewed as key

contributors to healthcare management and policy development.

Nevertheless, some challenges persist in the form of gendered perceptions of leadership. While nursing is a predominantly female profession, leadership positions in healthcare are often still male-dominated, particularly at the executive level (Sabatier & Cairney, 2020). Nursing leaders in HICs may encounter subtle forms of discrimination or bias, which can hinder their influence in healthcare decision-making processes. However, robust legal frameworks and social policies in HICs generally provide avenues for addressing these issues and promoting gender equality in leadership roles.

In LMICs, cultural and social barriers pose a much greater challenge for nursing leaders, particularly for women. Many LMICs are characterized by deeply entrenched patriarchal systems, where leadership roles are predominantly held by men, and women are often excluded from decision-making processes. In many of these regions, nursing leadership is not recognized as a legitimate or influential role, which limits the capacity of nursing professionals to advocate for policy changes or improved working conditions (El-Jardali et al., 2020).

The socio-cultural barriers in LMICs limit the ability of nursing leaders to advocate for improvements in healthcare systems. In regions where women are culturally constrained from taking on leadership roles, the nursing profession suffers from a lack of representation in policy-making bodies and a lack of influence in healthcare management decisions. This contributes to the underdevelopment of healthcare systems and exacerbates inequalities in healthcare access and delivery (Betancourt et al., 2018).

II. **Conclusion**

This literature review highlights the distinct challenges nursing leaders face in high-income countries (HICs) and low- and middle-income countries (LMICs). In HICs, nursing leaders navigate advanced healthcare systems, with challenges focused on workforce management, technological integration, and policy influence. In contrast, LMICs face more fundamental obstacles, including resource limitations, workforce shortages, and inadequate infrastructure, compounded by socio-cultural barriers and limited policy influence.

Addressing these disparities requires targeted global efforts, such as investing in leadership development, improving healthcare funding, and enhancing technological infrastructure in LMICs. Additionally, fostering gender equality and empowering nursing leaders to influence healthcare policies will be critical for strengthening healthcare systems worldwide. By supporting nursing leadership in both settings, we can improve healthcare delivery and outcomes globally.

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