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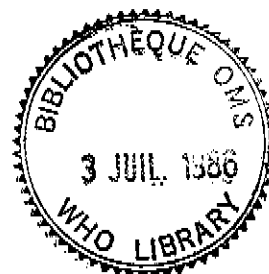
ORGANISATION MONDIALE DE LA SANTÉ
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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

NURSING AND MIDWIFERY IN THE CONTEXT OF HEALTH CARE DELIVERY SYSTEMS

Report on a Working Group

Brussels
4-7 December 1979



*Nursing
midwifery
Delivery of health care
Europe*

CONTENTS

	<u>Page</u>
1. Introduction	1
2. Background	1
3. The situation in the Region	2
3.1 Current subsystems of management of nursing services at national, regional and local levels	2
3.2 Levels and categories of nursing personnel within the subsystem	5
3.3 Education of nurses for senior posts in management	5
3.4 Some major problems	6
4. Descriptions and definitions which guide the WHO medium-term programme in nursing/midwifery in Europe	6
4.1 The position of nursing in relation to the patient and to other major health disciplines	8
5. Identification of some major desirable changes in the patterns of management of nursing services	8
5.1 National health policies in relation to primary health care	8
5.2 Clarifying what "nursing" is	9
5.3 Effective nursing subsystems	10
5.4 Nursing education and research	11
6. Recommendations	11
Annex 1 Summary of Symposium on Nursing Services, Stuttgart 1978	14
Annex 2 List of participants	15

1. Introduction

The Working Group on Nursing and Midwifery in the Context of Health Care Delivery Systems met in Brussels from 4 to 7 December 1979. It was convened by the WHO Regional Office for Europe in collaboration with the Government of Belgium and was composed of 26 temporary advisers and three WHO staff members.

The purposes of the Working Group were as follows:

- (a) to review the current subsystems of management of nursing^a services in the countries of the WHO European Region;
- (b) to formulate guidelines on the planned development of effective subsystems for the management of nursing services at national, regional and local levels;
- (c) to develop strategies for overcoming the major constraints in the introduction of desirable changes in current management systems; and
- (d) to make suggestions for the development of regional nursing subsystems and for the improvement of methods for determining the numbers and mix of nurses required to meet the needs of patients and families.

The meeting was the second in a series of three on nursing services and formed a continuation of the Symposium on Nursing Services, a meeting of national nursing advisers, held in Stuttgart, in November 1978.^b

Members of the Working Group were welcomed by Dr P. de Schouwer, Chef de Cabinet, on behalf of the Secretary-General of the Ministry of Public Health and Family Welfare, Professor S. Halter. The meeting was opened on behalf of the Regional Director by Dr Dorothy Hall, Regional Officer for Nursing.

2. Background

Nursing is a large, costly and important component of health services. Countries have long recognized its pivotal position in the health care provided in institutions. Now, with the upsurge of interest in primary health care, the extensive role of nursing in community health services is being studied and redefined. Moreover, a critical examination of the management of nursing services is being made in many countries. Fundamental questions about the discipline of nursing and about nurses and other categories of nursing personnel are being asked by many groups, including politicians and members of the community. It is in this perspective that the provision of nursing services must be viewed.

Few countries of the Region have a well-developed system of management of nursing services. Generally, the nursing component of national or regional health care systems, which now consumes 60% - 85% of most health manpower budgets, is managed in an unorganized and fragmented manner. Rational nursing personnel subsystems, with clearly defined levels and categories of workers, have been advocated by WHO since the early 1950s but few countries have implemented the recommendations. Nurses who are, or logically should be, the primary providers of nursing care, and thus the best source of reliable information about this care, are singularly absent from the decision-making groups dealing with health and nursing services. Few countries of the Region have nursing divisions, or units headed and staffed by nurses, and there appear to be no other arrangements for ensuring nursing input to management.

Reliable methods of determining the number and mix of nursing personnel required to provide care, in both institutional and primary health services are urgently needed. Current methods are barely effective and are being deservedly challenged. While resources are limited it is even more vital that those we have are used to the best possible advantage.

It is therefore a matter for serious consideration whether nursing personnel are making the greatest and most relevant contributions possible. Management systems should improve the use of manpower: but many are actually impeding, thwarting or misdirecting it.

^a Throughout this report the term "nursing" is used in its generic sense and, where applicable, includes midwifery.

^b A summary of that symposium is given as Annex 1.

3. The situation in the Region

3.1 Current subsystems of management of nursing services at national, regional and local levels

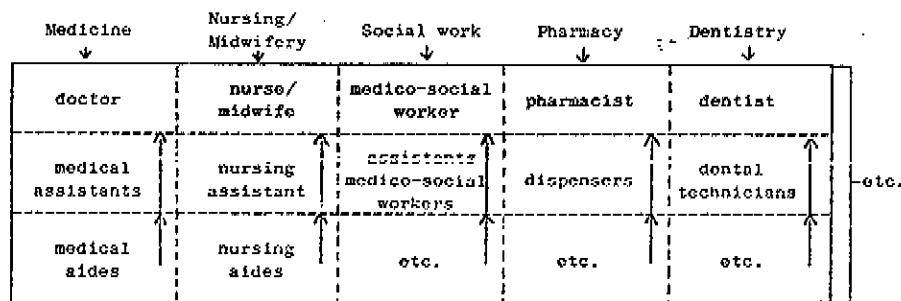
Many of the national systems of health services which have evolved over past decades, and of which nursing care subsystems are but one part, have developed on an expedient rather than a planned basis. Some have become so complex, expensive and unsatisfactory, both to the people they serve and to those who work within them, that they are now under attack from many sides. It is within this context that nursing personnel subsystems are viewed.

When nursing is considered within either health or medical personnel systems, two major patterns emerge. These can be described as the horizontal health personnel system and the "ladder" medical personnel system.

3.1.1 The horizontal health personnel system

In this system, nursing shares a relatively equal position on a lateral plane with other health disciplines, and the resulting health personnel system is set out on a horizontal axis as shown in Fig. 1. When seen in relation to the receivers of care, the system can be visualized as in Figs. 2 and 3 visualized on the following page.

Fig. 1. Horizontal health personnel system



In the pattern shown in Fig. 2, mobility and ranking are largely interdisciplinary in nature. The patient is the major focus of attention for all health workers and there is ample opportunity for both independent action and teamwork on either an inter- or an intra-disciplinary basis. This pattern applies largely to a number of the the developed countries, where highly qualified personnel such as physicians, nurses and dentists are available and generally accessible to the public. A number of less well-developed countries of the Region are seeking to employ a similar system but do not, as yet, have large numbers of highly trained health workers; Fig. 3 illustrates their position better.

In both instances each discipline forms a subsystem of the total health services system and each subsystem develops in parallel to the other and teaches and promotes its own members. While this vertical development is going on, there is also a horizontal exchange with students of other disciplines so that each acquires an understanding of the roles of others and is able to use knowledge and skills from related disciplines to improve practice in his own. Problems arise when one discipline seeks to use members from another as assistants. For example, one of the major problems in this system is the fact that the nurse/midwife, instead of working as a first-level nurse, frequently functions as a second-level medical worker. In this way first-level nurses, until recently, have not promoted the development of their discipline, and in many countries the medical subsystem has not developed its second-level medical assistant.

This horizontal system is a common pattern within the Region. It is one which leads to frequent overlaps of activity which could be reduced by closer collaboration between the professions and a clearer distinction between their areas of responsibility.

Fig. 2. Patient-centred health personnel systems with largely interdisciplinary mobility in developed countries

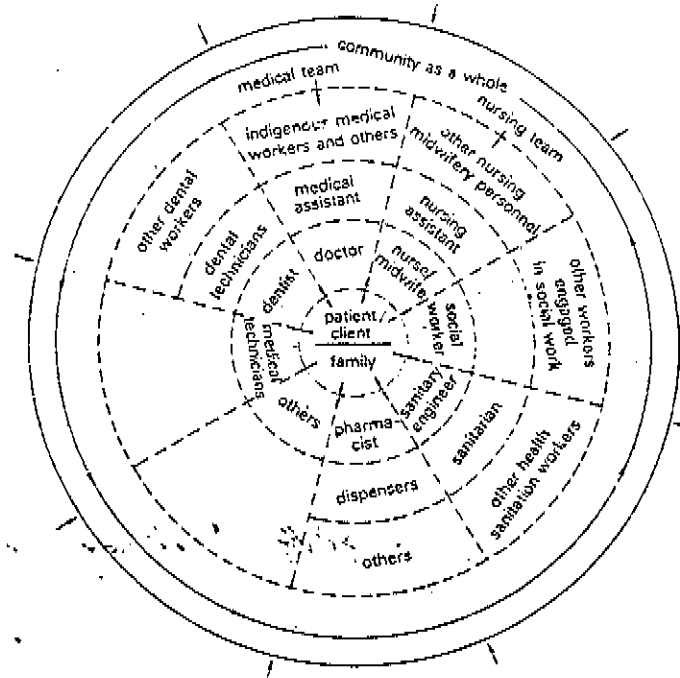
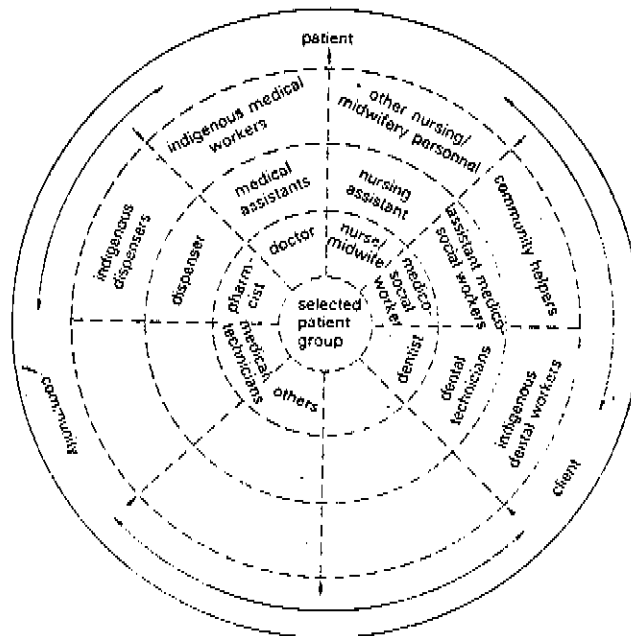


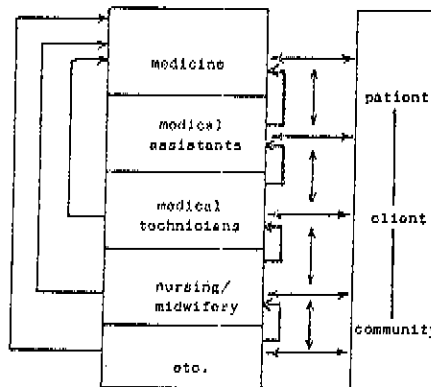
Fig. 3. Patient-centred health personnel systems in developing countries without large numbers of highly trained health workers



3.1.2 The "ladder" medical personnel system

The second of the two systems being used in the Region is a "medical" rather than a health personnel system. It is vertical in nature and presents a hierarchy of professions which are arranged one above the other according to their relationships with medicine which occupies the top rung of the ladder (Fig. 4).

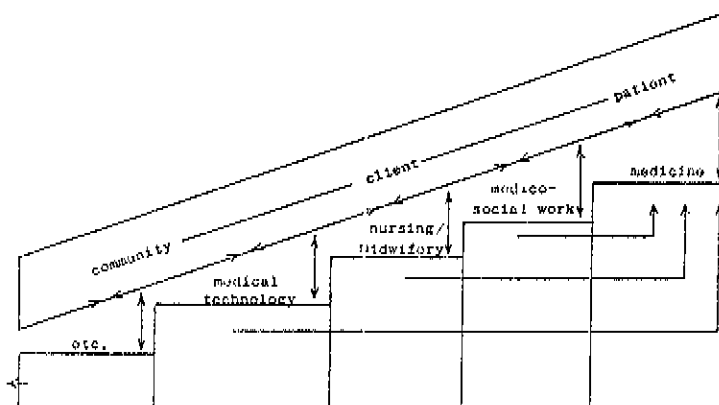
Fig. 4. The ladder medical personnel system



In this system the education as well as the management of all disciplines rests mainly with the medical profession. While the possibility of promotion is provided, its direction is towards medicine only. The various groups of workers have access to postbasic courses enabling them to climb from one category to the next. This system operates in several countries of the Region where approximately 15% of health workers move on to "higher level practice".

A third pattern appears to be emerging. This may be called the "staircase personnel system" and is illustrated in Fig. 5.

Fig. 5. The staircase personnel system



Mobility and ranking within the staircase pattern resembles that of the ladder system with the addition of somewhat greater interdisciplinary mobility. This pattern is a combination of a health and a medical personnel system.

The entry point for the patient into all these systems varies according to the amount of independence which custom and law allows to the patient and to health workers who are not doctors. Each pattern reflects the thinking of the society in which it operates. If society equates the level of health largely with the quality of medicine, and decisions regarding health services rest primarily in the hands of physicians, the ladder system usually predominates. If, on the other hand, good health care is seen to result from the services of a group of workers who have interdependent but discrete roles, and who work on a partnership basis with each other and the consumer, the horizontal pattern predominates. Since few societies are very knowledgeable about

health *per se* most, to date, have been content to surrender decision-making regarding organized health services to the doctor. With the development of patient associations, other "consumer" organizations and the emergence of health-service administration, this is changing. But up to now, patterns of health service have been structured to ensure the physician's place at the top. Within this setting, patterns of nursing service have developed to a great extent on an expediency basis and been directed largely by the needs of medicine rather than those of the patient/client, or indeed of nursing. As the hospital has become the major institution providing organized medical services, nursing has been largely hospital - and illness - oriented. Patterns for providing nursing care, therefore, have tended to be centred around serving the hospital and physicians within the hospital.

In many countries it is only in recent years that a distinction has been made between the nursing needs, and the medical needs of the individual and the family in the home, community and hospital.

As would be expected from such an *ad hoc* development, categories and of nurses and other nursing personnel are numerous, functions are unclear and the work of nursing personnel has been largely task - or procedure - oriented.

3.2 Levels and categories of nursing personnel within the subsystem

Members of the Group expressed concern about the increase in the levels of nursing personnel. Although the joint WHO/ILO meeting in 1973^a produced a pattern for a common form of nursing subsystem containing three levels, this did not mean that this was the best for all countries and should be adopted universally. While the exclusive use of professional nurses could be cost-effective in the long run, not all countries can afford the initial outlay to produce sufficient numbers. Consequently, many have recruited auxiliaries and in some Member States, it was reported, these workers are undertaking work for which they have no training, no competence and no supervision. The Group noted that the preparation and use of auxiliaries in the provision of nursing/midwifery services was to be the subject of the third meeting in this series.

It was emphasized by the Group that countries should analyse their overall health manpower systems and identify the place and role of the nursing personnel system within them: thus each country should determine its own model according to the specific needs of its population. As far as nursing is concerned, responsibility for reorganization should be assumed by managers with first-hand experience of the discipline. Those countries without a well-structured management system in nursing should be encouraged to take the necessary steps to establish nursing divisions or units at national, regional and local levels.

3.3 Education of nurses for senior posts in management

Participants from Belgium, Poland, Spain, the United Kingdom and Yugoslavia presented reports on the educational systems of their countries, particularly as they relate to nursing management. From these and subsequent discussions, it appeared that educational systems often reflect the perception of nursing *per se* in the Region. It was noted particularly that, in the majority of those countries which like to believe that they follow the horizontal system, first-level workers in the nursing subsystem frequently work as second level workers in the medical subsystem. Indeed, in many Member States, a major part of postbasic education for nurses centres around subjects which clearly belong to medicine's supportive services, such as anaesthesiology and radiography.

Many countries have introduced management courses for first-level nursing personnel in their basic curricula, while a few have also considered it useful to teach management principles to auxiliaries. Although the Group regarded this as an encouraging trend, it was reported that in most countries management in this context was mainly relevant to personnel rather than to direct patient care.

In most countries those nurses who wish to move to administrative positions have access to complementary education either in the form of workshops, seminars, 1-2 week study periods, correspondence courses, etc. or through formal postbasic education of 1-2 years' duration in institutions of higher education or in universities. In many Member States, advanced education in management is not yet mandatory for access to high management positions, and most nurses in the Region are promoted to such posts on the basis of professional experience alone. Sometimes both systems of promotion (by experience and by further education) co-exist in the same country.

^a Joint Meeting on Conditions of Work and Life of Nursing Personnel, WHO/ILO Report, Geneva 1973.

The Group emphasized the necessity for countries to develop coherent programmes in management education which could be followed as nurses progress from basic through middle-level to top-level management positions.

3.4 Some major problems

In spite of some encouraging trends reported from a few countries, such as the modification of laws relating to nursing, and to the specific and independent functions and responsibilities of nurses (e.g. in Belgium, Arrêté-Loi concernant l'exercice de l'Art Infirmier, 1974 and in France, Loi du 31 mai 1978 sur l'exercice de la Profession d'Infirmier/ère), the Group agreed that a review of WHO reports on nursing, particularly those of the Expert Committees,^a, demonstrated very clearly that recommendations and conclusions initially made in the early 1950s, have still not been implemented today, for a variety of reasons.

(1) There is a tendency, on the part both of the public and of many health professionals, to confuse nursing with medicine, or with functions more suitable to second-level medical assistants.

(2) There is a tendency to confuse the profession with the discipline. There is a lack of understanding of nursing as a discipline with a body of knowledge and related skills specific to that discipline and requiring study and development in common with other disciplines.

(3) Researchers and others are of the opinion that nursing concerns activities being carried out in hospitals, or related institutions, by workers called "nurses" or sometimes more generally described as "nursing personnel". The proper study of nursing is the study of people's need for, and reaction to, care of a nursing nature.

(4) There is a pattern, common in Europe, of preparing first-level workers in nursing in educational programmes outside universities and/or institutes of higher education and directly attached to a hospital or another curative service institution. The inadequacies of these types of programme have been the subject of a number of WHO and national reports. Despite this fact, the majority of educational programmes remains unchanged. Content is frequently heavily weighted on medical rather than on nursing subjects and physicians are often appointed not only as principals, but also as teachers in such schools. The Group pointed out that many workers who have qualified in such programmes are neither educated in, nor employed to practise, "nursing".

(5) The profession itself has failed to identify what constitute the specialities of nursing and to organize educational programmes which prepare nurses at graduate level in those specialities. Most postbasic courses for nurses continue to be related to fields outside nursing, such as teaching and administration, or to medical subjects.

(6) Most countries have no rational nursing personnel subsystem with clearly defined levels and categories of nursing personnel. The fragmentation of nursing into a host of sub-specialities follows in most instances the specialities of medicine (psychiatry, paediatrics, obstetrics, etc.). Associated with this is the failure of the basic educational programme to prepare a well-qualified generalist in nursing. Because of this three or four types of nurses may be required to provide care for one family in the community, while, in hospitals, some nursing staff are limited to practising only in those departments of medical specialities towards which their education has been biased. The widening gap between midwifery and nursing was seen by the Group as being highly detrimental to both. Midwifery without nursing and nursing without maternity care were considered to be deficient disciplines.

It was suggested that if the concepts and descriptions of nursing, which are currently being used in the medium-term programme in nursing/midwifery in Europe could be accepted and applied in the countries of the Region, it would be a decisive step towards overcoming some of these difficulties.

4. Descriptions and definitions which guide the WHO medium-term programme in nursing/midwifery in Europe

Nursing is a fundamental human activity carried out by individuals, families and communities with or without the assistance of health workers specialized in the field.

^a WHO Technical Report Series, No. 24, 1950; No. 49, 1952; No. 91, 1954; No. 167, 1959; No. 347, 1966; No. 558, 1974.

In its organized form, nursing is an identifiable health discipline with a body of knowledge and skills which distinguishes it from other disciplines in the field of health. Its primary responsibility is to assist individuals and groups (families/communities) to optimize functions within varying states of health. This involves the practitioners of the discipline in caring functions which relate to health, as well as to illness and which stretch on a continuing or episodic basis from conception to death. Nursing is concerned with maintaining, promoting and protecting health, providing rehabilitation, and caring for the sick, injured and dying. It deals with the bio-psychosocial spheres of life as they affect all aspects of health.

Nursing is both an art and a science. Its practice requires the application of understanding, knowledge and skills specific to the discipline. In developing nursing, members of the discipline draw on knowledge and techniques from the physical, social, medical and biological sciences and from the humanities, and aim to add to and further develop the discipline's unique knowledge base.

The primary responsibility of the nurse, is to provide nursing direct to the individual, family or community. Nurses acquire the understanding, knowledge and skills to practise nursing through theory and practice in formal basic education, through experience in practice, and in continuing, supplementary and/or advanced education.

Nurses work on a partnership basis with workers from other health disciplines; when several disciplines are involved in providing health services, their functions should be complementary and their services jointly planned and given as an integrated whole rather than as a series of isolated activities.

In modern health services, nursing care is often best given by a team which usually consists of two or more categories of workers. The team should include at least one first-level (professional) nurse who is responsible for the assessment of the patient's needs for nursing care, the overall planning, provision and evaluation of the care given, and the associated management of the nursing care team.

When these concepts are translated into action, it is obvious that the nurse has a responsibility for the direct management of the patient/family care and of the teams providing that care. This is the first and most important management function. These concepts also help most effectively in defining the functions of the practitioner of nursing, and in determining whether "nursing personnel" are actually educated and/or employed to do work of a nursing nature.

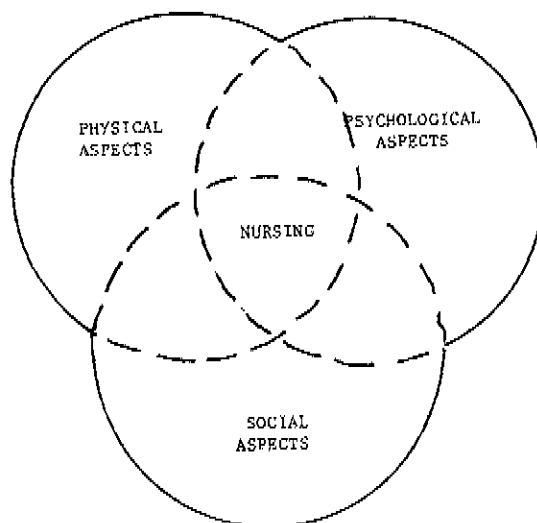
Further, these concepts serve as a basis for identifying areas in which the present management systems need to be re-organized and/or strengthened; and for determining areas in which appropriate management systems should be introduced so that nursing services can be planned and developed as an integral but discrete segment of the health service. Nursing education can then be reviewed, taking into account the needs of the population for nursing care, as well as for those interventions of a nursing nature which assist people to meet their needs themselves. Content of curricula at the basic level of education should focus on teaching the student how to assess needs and how to plan, manage, provide and evaluate nursing care. It should teach skills in both intra- and inter-disciplinary teamwork and should lay the foundation for specialized study in the discipline at graduate level. Use of the concepts for these purposes has been advocated in many previous WHO meetings.

Participants have also emphasized the necessity:

- to know the needs of the population in order to plan for nursing services;
- to have a structured nursing service to improve its coordination and utilization;
- to determine the need for nursing personnel and to promote their rational utilization; and
- for teamwork at all levels within the health team.

4.1 The position of nursing in relation to the patient and to other major health disciplines

The following model was considered helpful for a better understanding of the discipline:



Each of the three overlapping circles represents one of the three main aspects of life (physical, psychological and social) which shape the individual. Three major health disciplines (medicine, psychology, social work) are devoted to one or the other of these components. Nursing exists within the overlap area of these circles and is concerned with all three dimensions as they interact. The complexity of these interactions and their effect on the individual causing a need for support, comfort, counselling and caring, is the major reason the discipline has been so difficult to define. Good nursing deals with the whole individual, assisting him to maximize his physical, psychological and social functions within existing states of health. Such states include infancy, old age, dying, pregnancy, the preparation for or the aftermath of surgery, a remission period during the course of a chronic disease, permanent disability, and so on.

It is obvious, therefore, that the nurse has a responsibility for the management of patient/family nursing care and of the teams of nursing personnel providing that care. This provision of nursing care to individuals and groups and all the decisions surrounding it were seen by the Group as the most important management function of the nurse.

5. Identification of some major desirable changes in the patterns of management of nursing services

5.1 National health policies in relation to primary health care

Many national health policies require extensive reviewing in order to reach the actual health problems which exist.

The achievement of health for all requires a fundamental reorientation of priorities over the coming decades. This ambitious aim of WHO and all governments has major implications for research, manpower training, information systems and evaluation. The orientation necessary to achieve it will take place against a regional backdrop of an aging population, social instability, population movements, early retirements, unemployment and the promotion of desirable lifestyles.

While the least painful way of attempting to achieve health for all would be by allocating extra resources in the hope that they will fill the existing gaps, this is not economically feasible. Neither is it likely to be effective. On the other hand, present resources of skilled, knowledgeable and highly trained health personnel are often reluctant - and understandably so - to stop doing what they want to do, and what they have been taught to do, where they want to do it. What is necessary initially is planned and steady reorientation. Change can be slow, especially when it involves changing people's attitudes and way of life. Nevertheless, existing resources must be released or reorganized to do what is currently left undone. This has many implications for nursing, for example:

- less use of costly inpatient care by further development of outpatient facilities, development of day hospitals and early discharge policies will require the full support of home nursing as well as other domiciliary services;
- more cost-effective use of diagnostic tests is likely to result in an increased need for comprehensive assessment and health interviews by nurses;
- greater delegation of selected tasks is likely to include further delegation to nurses, auxiliaries and other primary health care workers (the latter categories will require teaching and supervision by nurses);
- greater use of generalist care will require support from nursing and other community services; and
- promotion of self-care and risk avoidance will require teaching, advisory and counselling services provided by nurses.

The proposed strategy to achieve health for all requires an organized system of primary health care to which all have access. This system of primary health care must:

- be built on the principle of community participation (the community will require motivating, and help with organizing, teaching and counselling);
- be staffed by multidisciplinary teams (which will include nurses, midwives and health visitors);
- be supported by an effective referral system (which will mean nurses must be available at every level and in a number of capacities including those of a teaching/supervisory nature for untrained staff and lay people);
- serve as a first point of contact with the national health system (which will require assessment/diagnostic ability on the part of every first contact, including nurses and other primary health care workers);
- maintain a continuity of relationship with every member of the population it serves;
- reach out into all homes and workplaces systematically to identify those at highest risk and/or dependency; and
- help people to assume greater responsibility for their own health.

These are the main principles underlying the Declaration on Primary Health Care agreed on at the international conference in Alma Ata and endorsed by all Member States at the World Health Assembly in 1979. All affect, and can be affected by, the existing networks of nursing personnel - accessible and acceptable to the vast majority of individuals, families and communities throughout the European Region.

5.2 Clarifying what "nursing" is

5.2.1 Functions and responsibilities

In recent years, nursing has been so extended, changed and challenged that it is little wonder that it is hard to define. Within the existing and medicalized health services, nurses have followed medical specialities both in education and practice and they have willingly taken over some of the more routine tasks from doctors. Many nurses have considered these jobs as more prestigious than giving assistance to patients and to prospective new mothers to meet basic physical, social and psychological health needs. Others have failed to see certain activities, such as feeding, rehabilitation and recreation, as components of the overall care of people and have allowed their take-over by dietitians, housekeepers, physiotherapists, occupational therapists and other health workers. Diverse traditional nursing activities have also been delegated, by nurses themselves, to auxiliaries and ancillary staff, because they seemed "unscientific" or "too simple" for them.

The functions of some of these other health professionals often overlap with those of nurses who still have to take them over for the so-called "non-social hours", during holidays and week-ends.

This gradual and insidious change has led nursing to dependence on, and subordination to, medicine, which has come to accept its dominance as both necessary and proper. The complementary and overlapping roles of physicians and nurses are an area which requires further study. The physician-nurse team is of major importance in the provision of health services and warrants far more detailed and frank discussion than has been entered into in the past. In many situations the work of the nurse as it relates to direct care has been reduced to a procedure/task-oriented job or has become divorced from the patient and focused instead on ward or departmental administration. This is particularly so in hospital, but it has also happened in some community nursing services. Several examples of such impoverished nursing were given by participants, e.g. midwives limiting their activities to assistance at delivery and neglecting pre- and post-natal care, and nurses organizing their work around a series of tasks (dressings, injections, medication distribution, etc.), while delegating direct and comprehensive patient care to auxiliary nursing personnel.

This type of practice was seen to have several corollaries, such as the frequent reluctance of nurses to assume responsibility at high levels, their laxity in maintaining and developing their level of competence after basic education; their lack of understanding of, or involvement in, the development of nursing; and their reluctance to accept the challenges inherent in their changing role and functions.

In spite of the efforts of some countries to reorganize their nursing services and revise their educational programmes, it still seems that nurses have not yet decided what should be understood by "nursing". Once a clarification of the functions of nursing has been made, nurses and nurse managers will be able to explain to other health professions, to politicians and to the public what contributions nursing can make to health. A code of practice from which standards of nursing care can be derived, will then need to be developed.

5.2.2 Teamwork and team leadership

Members of the Group discussed some of the problems surrounding the concept of teamwork and of team leadership. They were of the opinion that, as the roles of the different health disciplines were complementary, the traditional image of the physician as the sole leader of the team should not be perpetuated. The leadership role was seen instead as a coordinating one, rotating among members of the various health professions who were involved in the services provided to a patient/family. The leader of an interdisciplinary health care team should be the professional of the discipline which first had contact with the individual or family involved. Thus, for example, a surgeon would unquestionably be the leader when a surgical intervention was required, but the nurse would assume leadership in the long-term care of an elderly patient in his home. In hospitals, such coordinating roles could be most beneficial to patients who often have to receive everybody's "healing hands" because multiple professional care plans are used rather than a patient-centred one. The latter should include a time schedule, for one of the major current concerns is that patients often have no-one to manage their day.

5.3 Effective nursing subsystems

A rational nursing personnel subsystem should assist health service systems to provide effective nursing care to the public. It should clearly outline the types of nursing personnel required to deliver services, the approximate number of workers needed in each category and the opportunities for mobility within the system. Titles of the worker(s) should be precise and preferably distinct from each other; that is to say that they should not simply be made up of the title of another worker coupled with a descriptive adjective, e.g. assistant nurse. Over-use and misuse of the title "nurse" has led to much unnecessary confusion both within the profession and among the public.

The functions of the nursing subsystem should be determined according to the needs of the population. Nurses should therefore have the right to participate in those decision-making processes which affect not only nursing but the overall health services of a country. According to local administrative and political structures, they should be able to give documented advice so that politicians can make sound decisions on the health needs of society.

In the management of patient care, nurses should assume responsibility for ensuring quality care in hospitals and related institutions, as well as in the community. This requires a well-structured system of evaluation of care in which nursing research should play an important part. Nurse leaders should initiate research aimed at developing the body of knowledge and skills of nursing, and also use sound research findings as a basis for the establishment of standards of nursing care.

The management of patient care presupposes an appropriate management of the entire nursing personnel subsystem. Countries need to make optimal use of existing nursing personnel resources in the development of an adequate information system, including up-to-date statistics and the introduction of rational management systems. The pitfall of blindly applying to the provision of health care for people, those industrial management techniques which have been developed for machines, should be studiously avoided. The need for rational personnel systems in every country was never more urgent. It should be borne in mind that it is only when this kind of system has been developed that a correspondingly rational system for the education of nursing personnel can be designed.

5.4 Nursing education and research

A lack of investment in nursing education was considered by the Group to be a lack of foresight.

Research based on people's needs should be undertaken in order to reorientate and develop the body of knowledge and the skills to be taught in educational programmes for all levels of nursing personnel.

Efforts made by a few countries to introduce university education at the basic level should be encouraged and extended to others. Proof exists that university-educated nurses do not necessarily move away from direct patient care. Placing the nurse at the same educational level as other professions within the social and economic context of countries, raises the value of the service offered; this was seen by the participants as a factor which would, in the long run, reduce the instability and consequent shortage of nursing personnel. The reluctance to initiate university education for nurses is often based on unfounded doubts as to its value for improving the quality of nursing care. While it has not yet been ascertained that medicine taught at university level gives a guarantee of quality medical care, university education for nurses would at least ensure them a right to voice an opinion at an equal level with others, something which is difficult for them to achieve in many services and organizations at present.

Countries should develop an appropriate network of postbasic and/or university institutions accessible to all nurses holding, or about to hold, key management positions. In addition to the content already discussed, emphasis in these programmes should be placed upon communication skills and multidisciplinary teamwork.

The content of programmes was also discussed with reference to conclusions reached by a previous working group^a, which emphasized the need for "nursing management to be based on a philosophy reflecting the belief in the worth and dignity of the individual served" and to be "responsible for providing all persons who seek nursing services with the highest attainable quality of nursing care". Thus management of direct patient/family care was seen as the key responsibility of nurse managers. The image of the nurse either as the "doctor's assistant" or as an "auxiliary of the administration" had to give way to the image of the nurse as the "patient advocate". It was stressed therefore that nurse managers should at each successive level of their education continue to deepen their knowledge and skills in nursing and research. Positions for clinical specialists should be created so as to contribute directly to the improvement of nursing care. Nurses in regional and national management positions, should first be prepared in nursing with courses. Based on nursing research findings so as to enable them to ensure quality care, to give leadership to nursing, to develop nursing policies, to promote and maintain standards of care, and to initiate and/or supervise nursing research. According to the positions these nurse managers hold, they should be offered courses on the concepts of management of general health care systems (budgeting, planning, organization), including health economics, health statistics and epidemiology, systems analysis, industrial relations, social psychology and communication skills. Lastly, the Group emphasized the need for countries to prepare nurse/teachers at university level and/or at other related institutions for higher education. To avoid the frequent dichotomy between nursing education and nursing services, it was suggested that some joint appointments be made.

6. Recommendations

(1) Where countries are seeking to develop further existing subsystems or to introduce an effective subsystem for the management of nursing services, a nursing division, headed and staffed by appropriately qualified experts on nursing, should be established and integrated in the general health system at national level.

^a "Education of Managers in Health Services", report on a working group. Copenhagen, WHO Regional Office for Europe, 1978 (document ICP/HSD 043)

(2) Where there is a federal system in a country, or where decision-making has otherwise been decentralized, a nursing division should be established at regional level. Effective systems of communication and collaboration need to be developed and maintained, between nursing divisions at national and regional levels, as well as horizontally among all units in the services.

(3) Where nurses hold posts in a number of separate divisions in health departments and where no nursing division exists, some means of ensuring their effective communication and collaboration should be provided. Nurses should jointly develop a general nursing policy and adhere to that policy in their own work.

(4) A division of nursing at national, regional and local levels should have combined responsibility for the management of both institutional and community nursing services.

(5) Divisions of nursing at national, regional and local levels should include among their functions the following:

- participation in overall planning and policy making related to health services in collaboration with professional and related groups;
- planning for nursing services and, where appropriate, nursing education;
- stimulating, sponsoring, coordinating and conducting nursing research, and, where appropriate, participating in general and health service research;
- participating with recognized professional nursing associations in the establishment codes and standards of nursing practice;
- participating in the overall planning and management of nursing resources;
- establishing and maintaining information systems related to nursing services and, where appropriate, to nursing education;
- advising decision-makers at government level on all matters directly related to nursing.

(6) The management of nursing should use appropriate techniques from other disciplines, such as operational research, industrial management, etc., but it is important to recognize that the care of people cannot readily be compared to the care of inanimate objects such as machines, and that the above techniques may have only a limited application and need to be carefully adapted.

(7) Good management of patient/family nursing care is the keystone in the management of all nursing services. Teaching related to this field should therefore form an integral part of all basic nurse education and be reinforced and augmented at all other levels of education, thus preparing nurses for management of direct patient care (first-level management) and for middle and senior management positions within the nursing services. Management of nursing services should be carried out by nurses and, where appropriate, studies should be conducted to advance the management component of nursing services at all levels.

(8) Educational programmes in management of nursing services must be appropriate to nurses working at the various well-defined and interrelated levels of nursing service. Nursing education and nursing practice should be better related and both should be taught by appropriately qualified experts.

(9) Educational programmes for the preparation of nurses destined to hold senior positions which call for knowledge of management principles over a wide field at local, regional and national levels should be established within the framework of the health management system and with the assistance or cooperation of universities, specialized institutes and institutes of higher education. The content of these courses should be based on the concepts of management of general health care system (budgeting, planning, organization, etc.), including health economics, health statistics and epidemiology, systems analysis, industrial relations, social psychology and communication skills, as well as advanced nursing. Where possible, these management courses should be conducted on a multidisciplinary basis.

(10) There is an urgent need for nurses to recognize nursing as a discrete health-based and research-based discipline. Nurses should take steps to clarify, both among themselves and with members of other health professions, the concepts underlying the discipline and the body of knowledge and skills which characterizes the nature of nursing and distinguishes its role in overall health services.

(11) Studies should be undertaken by health professionals of the discrete functions of the various major health disciplines and overlapping functions should be identified, with the aim of informing the public and of producing an effective and more economical pattern of care for the population.

(12) Nurses should be encouraged and supported in efforts to write and speak in a comprehensible, cognizant and confident manner about all aspects of nursing, including the management of nursing services. Articles discussing the management of patient, family and community care as a shared responsibility should be prepared jointly by nurses, doctors and other health professionals, and their publication in professional medical and nursing journals should be promoted.

Annex 1

SUMMARY OF SYMPOSIUM ON NURSING SERVICES, STUTTGART 1978

The Symposium attempted to review and seek ways of improving the organization and management of nursing services in the context of the WHO medium-term programme in nursing/midwifery in Europe.

Its main conclusions were the following:

- nurses should be involved in the replanning of nursing services and health care and be able to occupy key management positions as heads of nursing divisions, and directors in hospitals, health centres and in the domiciliary services. If such managerial posts do not exist, the advice of professional nurses should nevertheless be sought;

- appropriate research and information must be used to assess nursing manpower requirements, nursing practices and the role of management. The most important reform in the nursing services must be in the definition and limitation of categories of nursing personnel, while keeping open the capacity for development according to changing needs. The university education of nurses should be encouraged and its effects on nursing monitored. Nursing care should be standardized within each country and the competence of nursing personnel should be testable in some way.

Annex 2

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^a Participation expenses not paid by WHO