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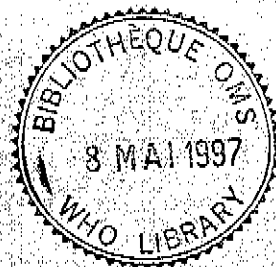
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WHO
**CONSULTATION
OF EUROPEAN
NURSE LEADERS
"HEALTH CARE
REFORMS,
PRIMARY HEALTH
CARE AND
NURSING"**

5th WHO MEETING OF GOVERNMENT
CHIEF NURSES OF THE EUROPEAN
REGION

Reykjavik, Iceland
11-13 April 1996

TARGET 30

COMMUNITY SERVICES TO MEET SPECIAL NEEDS

By the year 2000, people in all Member States needing long-term care and support should have access to appropriate services of a high quality.

ABSTRACT

Since the late 1980s an extensive movement for reform is emerging across Europe and elsewhere impacting the political, economic and social environment. As part of the broader process of change, health services are meeting fundamental challenges of cost containment, while increased demand for quality and choice, important demographic and social factors, and not least advancements in scientific technologies are influencing characteristics.

The challenge of the nursing profession is to understand the implications of this transitional process and be aware of how to maximize their contribution within the reformed health services while reaffirming the spirit of the Alma Ata Declaration (1978) and the Vienna Declaration (1988).

The aims of this 5th WHO Meeting of European Government Chief Nurses were three-fold: to review the guiding principles and strategies proposed in a Charter on European Health Care Reforms (to be adopted at the WHO Conference on European Health Care Reforms, Ljubljana, 17-20 June 1996); to produce a Statement on implications for nursing in the current health care reforms; and to develop a strategy for disseminating information to raise awareness of the new nursing contribution.

More implicitly, the meeting provided an opportunity to increase knowledge and vision of the nurse's role in health care reforms in Europe and to strengthen the network of nurse leaders. These aims were comprehensively met.

In seeking to bring to the attention of WHO European Member States the issues of concern about health care provision generally, and nursing related issues more specifically, a careful and longer term strategy will need to be devised consequent to the outcomes of the Ljubljana Conference.

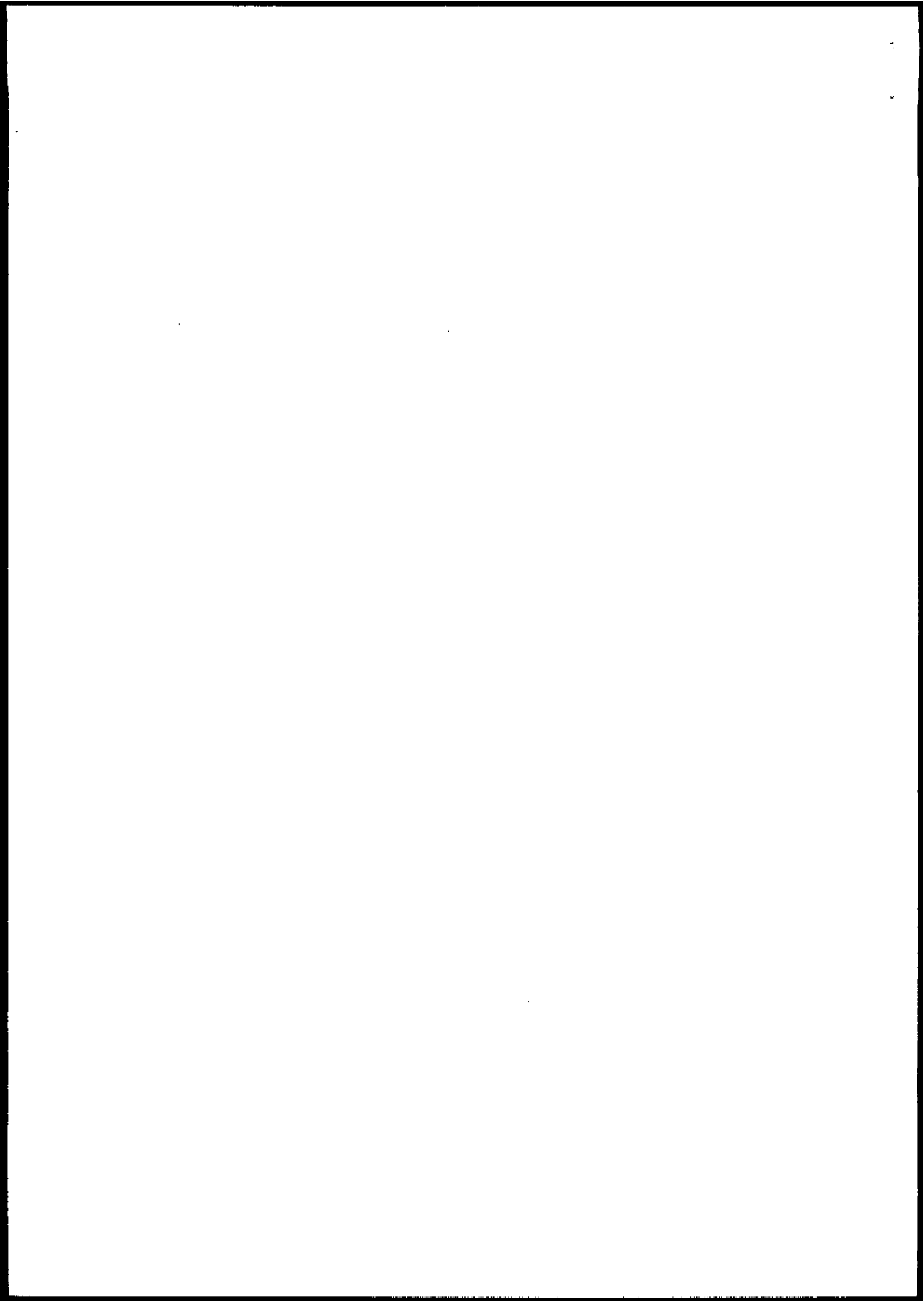
Keywords

NURSE ADMINISTRATORS
HEALTH CARE REFORM
PRIMARY HEALTH CARE
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EUROPE

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I. Introduction

A central theme in the European Health for All (HFA) policy is the balanced interaction of its main elements, whereby improved health status and well-being of individuals and populations are achieved through healthier lifestyles, a good environment and appropriate health care. The theme was stressed again in the Copenhagen Declaration, adopted at the European Health Policy Conference (1994).

Since the late 1980s an extensive and powerful movement for health care reform has emerged in Europe and elsewhere, as part of a broader process of change. As this movement has many important implications for nursing, it was considered timely to hold a Consultation for Nurse Leaders to debate the many issues and challenges they were, or would be, facing.

The Consultation of European Nurse Leaders "Health care reform, primary health care and nursing (Fifth WHO Meeting of Government Chief Nurses of the European Region) was convened therefore by the WHO Regional Office for Europe (WHO/EURO) in collaboration with the Ministry of Health of Iceland. A group of 26 participants from as many WHO/EURO Member State, three observers, one WHO Temporary Adviser, and five staff from WHO/EURO met in Reykjavik, from 11-13 April 1996. The Chief Scientist for Nursing from the WHO Headquarters Office joined them for the last two days (Annex III).

The opening session was attended by Mr David Gunnerson, Secretary General, Ministry of Health of Iceland, who acting for his Minister of Health, welcomed the Government Chief Nurses to Iceland. Ms Ragnheidur Haroldsdottir, Chief of Department, Ministry of Health and Social Security, also welcomed the participants on behalf of the 2500 nurses in Iceland.

Ms Ainna Fawcett-Henesy, Acting Regional Adviser for Nursing at WHO/EURO, opened the meeting on behalf of Dr J.E. Asvall, Regional Director of WHO/EURO. The agenda of the meeting, she said, had been drawn up by a small group of nurse leaders meeting in Copenhagen earlier in the year. It was designed to help participants to build on past nursing/midwifery activities of the Region (Annex II).

Outlining these previous activities, Ms Fawcett-Henesy reminded participants that the first European Government Chief Nurses Meeting was held in Sweden in 1989. A parallel group for Russian-speaking Government Chief Nurses was established in 1993. Both groups had met at regular intervals to share similar agendas.

The Alma-Ata Declaration (1978) and the Vienna Declaration for Nursing (1988) had been the guiding principles for both groups. Explicit aims of each meeting had been (i) sharing of experiences and information; (ii) development of leadership skills; and (iii) networking.

Recurring themes emerging at the meetings included health care reforms, cost containment, equity, efficiency and effectiveness, maximizing the potential of nursing, education, recruitment and retention. Statements with recommendations had been published following each meeting.

This latest consultation provided Government Chief Nurses with a unique opportunity to make an input to the milestone WHO Conference on European Health Care Reforms, to be held in Ljubljana in June 1996. In seeking to bring to the attention of WHO European Member States the issues of concern about health care provision generally, and nursing related issues, more specifically, a careful and longer term strategy would need to be devised either alternatively or in addition to a Statement.

Objectives of the Consultation

1. To provide an opportunity for Government Chief Nurses to debate:
 - how to maximize the contribution of the nursing profession within the reformed health services in the spirit of the Alma Ata Declaration (1978) and the Vienna Declaration (1988);
 - how to ensure that nursing practice is outcome orientated, based on the best available evidence and is underpinned by appropriate educational curricula which take account of new delivery systems;
 - the changes that may be required of the nursing profession to meet new demands and expectations.
2. To provide an opportunity for Government Chief Nurses to identify:
 - changes necessary within nursing leadership, management and education if such new roles are to be developed.

Expected outcomes of the Consultation

1. To produce a Statement on implications for nursing in the current health care reforms as input to the WHO Conference on Health Care Reforms in Europe (Ljubljana, June 1996).
2. To develop a strategy for disseminating information to raise awareness of the new nursing contribution.
3. Implicitly, (a) to increase knowledge and vision of the nurse's role in health care reforms in Europe; (b) to strengthen networks for nurse leaders.

II. Health Care Reforms in the European Region

At the first plenary session, Dr Serdar Savas, WHO/EURO Regional Adviser for Health Care Policy and Systems, gave a brief overview of the current position of health care reforms in the European Region.

Although the majority of the Member States were reviewing their health care systems, reforms were taking place at varying paces and by different processes. In all countries, however, common external and internal factors were causing health care reform to become a high priority.

Demographic and social trends and a reduction in overall Gross Domestic Product (GP) had led to economic recessions. Some countries were involved in armed conflicts and the vast

majority were experiencing problems of unemployment, poverty, homelessness, migration and social exclusions. Attempts to meet the increased demands of the public (well informed by the media of developments in medical technology, new pharmaceutical products and innovative surgical procedures) had also greatly increased health budget deficits. Internal factors which made review and reform imperative, included the search for improved effectiveness, equity and quality of health care.

The main health problems Europe as facing at the present time were cardiovascular diseases, external causes of death (accidents, homicide and suicide), resurgence of tuberculosis, diphtheria and poliomyelitis, the pandemic of AIDS and infant mortality.

Main challenges to the health sector therefore were those related to current limitations in health gain; increasing inequities in health care; inadequate cost-effectiveness, inefficient health system performances; service quality; citizens' choice and participation; and the accountability of health professionals.

Health care reforms had to deal with all these challenges, especially their organizational, financial and service delivery aspects. These, in turn, gave rise to many and diverse issues, ranging from the macro-economic situation to the responsibilities of local stakeholders (citizens, professionals, elitists and special interest groups).

Lessons had already been learned from a two-year survey of health care reforms undertaken by WHO/EURO. These included the importance of certain elements: timing; financial sustainability; political will and leadership; strategic alliances; public support; and good management of the reform process itself. Above all, said Dr Savas, the Charter was centred on the principle that health care reform is first and foremost about attaining "better health for people: this must be the primary yardstick against which every country's health care reform is measured".

To consider the current position of health care reforms in Europe and to identify the support WHO/EURO can give to its Member States in bringing these about, the Regional Office was convening a WHO Conference on European Health Care Reforms, in Ljubljana, Slovenia, 17-20 June 1996. A draft Charter, setting out a set of principles and strategies would be the subject for consultation by Ministers of Health and their representatives attending the Conference.

Dr Savas then presented the draft Charter to the Government Chief Nurses.

III. Implications for Nursing under Health Care Reforms

The WHO European Conference on Nursing, held in Vienna in 1988, recommended that in keeping with European HFA policies, nursing practice should be based mainly on the principles inherent in the primary care approach. Consequently, the focus would be on:

- promoting and maintaining health and preventing diseases;
- involving individuals, families and communities in care and making it possible for them to take more responsibility for their health;

- working actively to reduce inequalities in access to health care and services and to satisfy the needs of entire populations, especially the underserved;
- multidisciplinary and multisectoral collaboration;
- assurance of its quality of care and the appropriate use of technology.

In the second plenary session, Ms Karenlene Ravn, Chief Government Nurse, National Board of Health, Denmark, suggested that in their leadership positions, government chief nurses had to plan a coherent system or a nursing universe (of education, practice, research and leadership) which responded to, and influenced the health care services of their countries while bearing these five principles in mind.

She reminded participants that at a previous meeting (Glasgow, 1994) they had committed themselves:

- to influence reforms towards equity and social justice;
- to support trends towards nurses working in partnerships;
- to encourage individual and community responsibility for health;
- to develop national action plans for nurses;
- to link nursing input and outcome;
- to promote dialogue with the public;
- to provide effective leaderships; and
- to use all sources of influence, networking and relevant alliances.

The four main functions of a government chief nurse, Ms Ravn said, were those of advising; leadership, intelligence gathering and liaising among and between professions, sectors and the public.

The future would see an increased emphasis on healthy lifestyles and self care. Nurses therefore must be prepared to be educators, communicators, enablers, facilitators and coordinators. Flexibility would be crucial as change was likely to increase at an even faster rate than at present. It was necessary to foresee changes and plan how to meet them. Response must be rapid and this meant the development of appropriate mechanisms and indicators so that all nursing activities could be reviewed and evaluated equally.

Meanwhile, nurses in many countries of the Region were still battling against a legacy of under-development, domination by the medical profession, and gender discrimination. If the nursing contribution to health care reforms was to be realized fully, it was vitally necessary for nurses to strengthen their position in policy-making and management at all levels. This change could not be accomplished without effective leadership, strong professional organizations, sound educational policies, and pan-European methods for disseminating information for good practice, research-based evidence on effective interventions and nursing inputs and better ways of collecting and using relevant data for monitoring and evaluation.

As the largest single group of health care professionals and as front-line workers in the Region, nursing could make a significant contribution to health care reforms. However, new, relevant and supportive legislation was needed to allow nurses to realize their full potential and to practice comprehensively.

Demonstration projects and dynamic models should bridge the gap between the theoretical concept of primary health care and its implementation. They were likely to include alternative modes of nursing services e.g. health fairs and fetes, health educational theatres, occupational health clinics in the workplace, health "shops" in cities and towns, hospices to include outreach facilities and the mobilization of families and patients themselves into mutually supportive groups.

Reports of these should be evaluated and disseminated within and between Member States.

Following the two presentations and this general discussion, pertinent questions and issues were raised in relation to the participants own country situations and their own nursing challenges and obstacles. These, together with later group discussions on specific related topics, are the essence of this report.

1. Financing health care: the contract culture

In considering the funding of health care, the Group endorsed the Charter statement that the aim of all health care reforms must be "to create a broad consensus for a sustainable, long-term health care financing model".

It was reported that most countries across Europe were facing problems not only with the delivery but also with the financing of their health care systems. In a bid to contain costs and to encourage greater efficiency, new approaches to financing, using both private and public sector funding, were under consideration. The most radical changes had occurred in eastern Europe where, it was reported, centrally planned and funded services had been replaced by insurance-based care, and market forces had come into operation.

Participants were strongly of the opinion that the choices of taxation, social insurance and private insurance, must be guided by the principles shaping the reforms which they identified as being: equity; health gain (health status improvement) and quality of life; effective use of human, financial and other resources; quality development; and the participatory approach with reference to individuals, families, the community and local culture. Also to be taken into consideration, they agreed, was the larger socioeconomic context in which the health care system operated, the predictability and sustainability of those sources of funding; and the incentives (intended or unintended) which they created.

For financing to be economically sustainable, the total expenditure – private and public – must be seen as one package and must be controlled by the government. It must also be held at a level corresponding to the country's policy at any one time.

The Group agreed that public funding of health care – at all levels – must be evidence-based, outcome focused, built on a generally agreed ethical platform, transparent, and have clear priority-setting mechanisms.

The process of priority-setting and, in some instances, the rationing of services, must involve citizens, health and development professionals, financial or funding organizations (World Bank, International Monetary Fund, etc.) and government representatives. It should be carried out in the context of each country's economic development level, its socio-cultural structures

and its political status. Emphasis was also placed on the need for long-term effectiveness rather than short-term cost containment. To promote informed choices to be made indicators should be developed to provide information on costs and benefits.

The Contract culture must also be competition-based and compatible data on the quality of care developed and delivered should be published (without names) and disseminated to the public. A balance has to be kept between meeting society's health needs and the economic resources available. Although equity was a guiding principle, fragmentation of services, resulting in gaps or duplication, was a distinct danger. Governments must not be influenced by a changing value system but at their macro level, link the GNP with feasibility. They must ensure equitable distribution of resources, access of the entire population to health care and competition based on quality and price. Market mechanisms could be used to improve efficiency and effectiveness when, and as, appropriate.

Agreeing that the necessary legislative and regulatory framework and chain of accountability were also governmental responsibilities, the Group emphasized that the operational aspects of the service should be left to the actors. They also were guardians of equity, quality, observation of patients' rights and financial viability.

2. Orientation towards primary health care: the acute/primary care interface

The draft Charter on health care reforms also emphasized the need for a substantial shift in working capacity and resources from hospitals to primary health care, long-term care and community care, but what has been proven to be good should be kept. For example, the regionalized system of hospital organization is the most cost-effective allocation of scarce resources and the best framework for primary health care structures. While high priority has to be given to health promotion and disease prevention it is essential to keep a balance in relation to meeting needs at secondary and tertiary levels of the health system.

Discussion on the role of the nurse at all stages of an individual's life span and in relation to the broad spectrum of health services (promotive, preventive, diagnostic, curative, rehabilitative, long-term and terminal care) was led by Dr Miriam Hirschfeld. During this, the Group identified new groups of vulnerable people. Whereas hospitalized patients could be monitored, the identification and continuous care of scattered groups in the community (e.g. elderly, adolescents, substance addicts, homeless and unemployed people) has proved to be more difficult. Needs also change during stages of illness both within a community (e.g. an increase in mental health problems) and in individuals (e.g. elders improving after rehabilitation). Special attention should also be given to supporting carers in the community, usually women, and ways found to lessen their burden.

The development of a community-orientation must take account of the various social, ethnic and cultural strata and of the different ways in which members of those strata deal with their health problems. Nurses and midwives must help the community and its sub-groups (e.g. adolescents, refugees) not only to identify their special health care needs, but also to assess them, determine priorities and establish appropriate and realistic objectives.

Nurses must assume professional accountability in the primary health care team and evidence based nursing practice subject to audit is essential to ensure continuous quality development within a cost-driven process. It was recognized that efforts have to be made to develop teamwork, leadership and problem-solving skills, together with an ability to establish good

relationships with patients and citizens so that long-term trust is build and partnerships for health are productive.

At the macro level, the government of each country had a responsibility at the macro-level for raising value issues for public debate and ensuring an equitable distribution of resources and access to health services. At the micro level, the primary health care team members have a responsibility for equity, access and seamless continuity of care between levels of the system within a geographically circumscribed area.

3. Multidisciplinary and multisectoral collaboration: partnerships and joint actions

Not all primary health care team members, participants recognized, are health professionals. Nurses have to assume focused responsibility not only for stimulating individual citizens and groups to become involved and vocal in decision-making and priority-setting process for their own community. They must also learn to work with all other health care stakeholders. These are likely to be staff members of other development sectors (.e.g. housing, education, environment and transport), financiers and politicians. It had to be recognized that not all might have the same goals. The inclusion of trained members of indigenous groups and support agencies can enrich, strengthen and enlarge the pool of health workers.

Nurses are equal members in primary health care teams which should be led according to the appropriateness of an individual's expertise. Such teamwork depends upon common intersectoral information flow and collaboration towards the mutual goals of equitable and quality-orientated care delivery. This calls for efficient health information systems. Professional "territorial" boundaries must give way to skill-mixes. The outstanding principle is to ensure that the individual/group/community needs are met by the right person/people for the job. Consumers have a responsibility not only for themselves and their families but also for the community in which they live. In order to participate they must be given the appropriate information and education.

It was recognized that teamwork is not necessary for every situation at the primary health care level. At times nurses (and others) will make independent decisions and take independent action, but they must know when to defer and when and to whom to refer.

Nurse education and training must be reoriented accordingly and relevant legislation and regulatory procedures reviewed and, where necessary, reformed, to enable an expanded scope of practice.

4. Expanding the scope of nursing action and ensuring quality control

In many Member States the legislation regulating health care is fragmented and, as it stands, could hinder health care reforms. While in some countries of the European Region, the scope of nursing and midwifery practice has been expanded, in others it has remained restricted – often because of legal barriers.

Medical Practice Acts frequently inhibit the expansion of the professions' respective functions, as do some Public Health Laws, licensing laws government hospitals and

legislation regulating payment for services. All such legal barriers express and maintain a restricted concept of the two professions.

It was reported from a number of Member States that there are no regulatory mechanisms for establishing, enforcing and maintaining standards of education and in the majority of countries there is no sound evaluation of educational programmes. The absence of these has important implications for expanded nursing practice, and the control of quality assurance.

Participants agreed that clinical information systems must be developed, whereby carefully selected indicators of the quality of care can be abstracted from the routine work and the resulting data fed back to the health care provider. They emphasized that such systems must be designed to be useful and acceptable, not only to the individual health professional or care-provider, but to all stakeholders. Appropriate mechanisms should be in place to ensure the active participation of all stakeholders at each stage of the quality development process. In this context, however, it was considered important to guard against the danger of consumer representatives becoming "institutionalized" themselves.

The group recommended that to promote quality in practice, nurses must be educated to appreciate science, use research findings, conduct research and evaluate the results. They must develop outcome indicators to assess health status, quality of life (understanding that there are different concepts of what that phrase means) and the provision of care. These indicators must be realistic yet challenging. They should be valid, objective, sensitive and specific. Indicators are also needed to provide information on costs and benefits.

Finally, it was agreed that the monitoring of outcomes is essential for assessing the achievement of quality development and that the development of a multidisciplinary ethical framework for dealing with quality issues has a high priority.

5. Effective and efficient use of appropriate resources

In relation to the effective and efficient use of human resources, participants recognized that it is essential to have an integrated process of planning, production and use within the framework of national health and human resources policies and the country's socioeconomic situation.

Many European countries have been unable to adopt this approach because of inadequate statistical information. An essential first step therefore is the development of an information system which allows for the monitoring of recruitment, retention, training, deployment and career development of human resources in health. From this it should be possible to summarize the information on the supply and education of health professionals as they relate to the health needs of the country. Analyses of the data would assist in helping to solve three frequently reported problems by:

- developing mechanisms to ensure a valid estimation of human resources essential to the planning and sound administration of the reformed health service, the disbursement of funds, the training and deployment of personnel and the evaluation of programme effectiveness;
- develop strategies to ensure equitable distribution of appropriate health professionals; and

- identify patterns of health work force migration.

Member States could then:

- take urgent and appropriate action to recruit, educate and retain nurses and midwives in their own countries;
- monitor and evaluate experiences;
- identify and promote education/training resource requirements;
- study, for cost-effectiveness, skill-mix exercises in hospitals and communities; and
- undertake decision-linked research.

Nurses and midwives themselves need to initiate and/or monitor research to obtain information on their colleagues' living and working conditions; access to continuing education programmes; career development opportunities and family-sensitive arrangements/facilities.

Finally, the Group agreed that the appropriateness of resource utilization must be scrutinized regularly in relation to its contribution to the improvement of health in society. All mechanisms for efficiency, effectiveness and cost-containment must be directly linked with health gain and the quality of life (as interpreted by the individual or group).

In this context, some chief nurses questioned the screening of well people where the procedure had been proven to be not cost-effective.

6. Realizing nursing's potential in health care reform: education and opportunity

The government chief nurses endorsed the following statement contained in the draft Charter, "At the primary health care level, most countries need to develop a far better outreach system of health service personnel, whereby broadly-trained nurses work to serve a limited number of families, delivering health producing, curative and caring services in peoples' homes, working in teams with family physicians, and promoting collaboration with other personnel from the many different community organizations that can help improve health in the local community".

Health care reforms require nurses who have been trained to handle competently a number of new responsibilities, including:

- development of models for group/community needs assessments and teamwork;
- collation of information on cultural practices which affect health;
- development of databases on the health work force;
- effective use of modern communication techniques and educational technology;
- promotion of self-reliance in health care of individuals and families;

- collaboration with other health professionals, staff of all development sectors, members of relevant voluntary agencies and special interest groups in the promotion of health and the prevention of disease and disability;
- extension of health care coverage to all segments of the population.

(i) Basic nursing education

Nursing students therefore need to be prepared to:

- educate/inform people so that they are able to identify, express and, where appropriate, meet their own health care needs;
- stimulate and facilitate community self-reliance and the individual's responsibility in protecting health;
- recognize "hidden" health needs, especially in high risk groups such as mentally ill people and illegal migrants;
- extend health coverage to underserved, deprived and "outreach" individuals, families and groups;
- work in multidisciplinary and multisectoral teams;
- be actively involved in community action to identify and deal with local causes of ill health and reduce the effects of long-term chronic diseases and disabilities.

Such capabilities cannot be learned other than by means of a carefully planned series of practical learning experiences based on a representative range of health problems and in the settings in which they arise and are being dealt with by well-functioning practitioners.

This calls for the introduction of a separate innovative curricular track aimed at greater relevance to priority health needs and to use of the community, outside hospitals and the major learning environment.

The Group recognized that developing partnerships with the users of health services called for special attention in reorienting nurse education. It required:

- informing and mobilizing individuals, families and communities;
- encouraging them to improve their own health status and participate in health promotion and disease prevention campaigns (e.g. immunization programmes, etc.);
- involving them as partners in joint actions;
- monitoring joint ventures and innovative practices and disseminating information on successes and lessons learned not only locally but also between and among other European countries.

This coordination/communication to be undertaken by WHO/EURO's Nursing and Midwifery Programme.

(ii) Continuing education

The Government Chief Nurses also recognized the need for appropriate continuing education programmes (in institutes of higher education where providing service is not the main purpose) which include the development of managerial and teaching skills. They recognized they needed opportunities to study and apply the principles of health economics to take a major part in improving the financial structure and performance of the reformed health service and assist in the development of criteria by which the neglect of health needs as well as solutions to health problems, could be measured in cost-effective terms. They recommended a systematic approach to the development and evaluation of practice but believed this should not be in isolation. Also, if professionals were going to work together, the participants believed they should also learn together: the possibility of sharing a core curriculum or a number of common modules merited re-exploration.

Finally, it was agreed that countries will need to:

- reorient directors and teachers of education programmes;
- establish a system of education to ensure that teachers and managers acquire appropriate skills, knowledge and experience;
- use educational processes for all post-basic programme that are needs-based, practice-oriented, multiprofessional, team-focused and based on a common ethos.

Participants also thought that educators planning change in traditional schools of nursing and midwifery were likely to benefit by using the regional network to analyse strategies, experiences, successes and reasons for failure of others who have sought to bring about curricular changes.

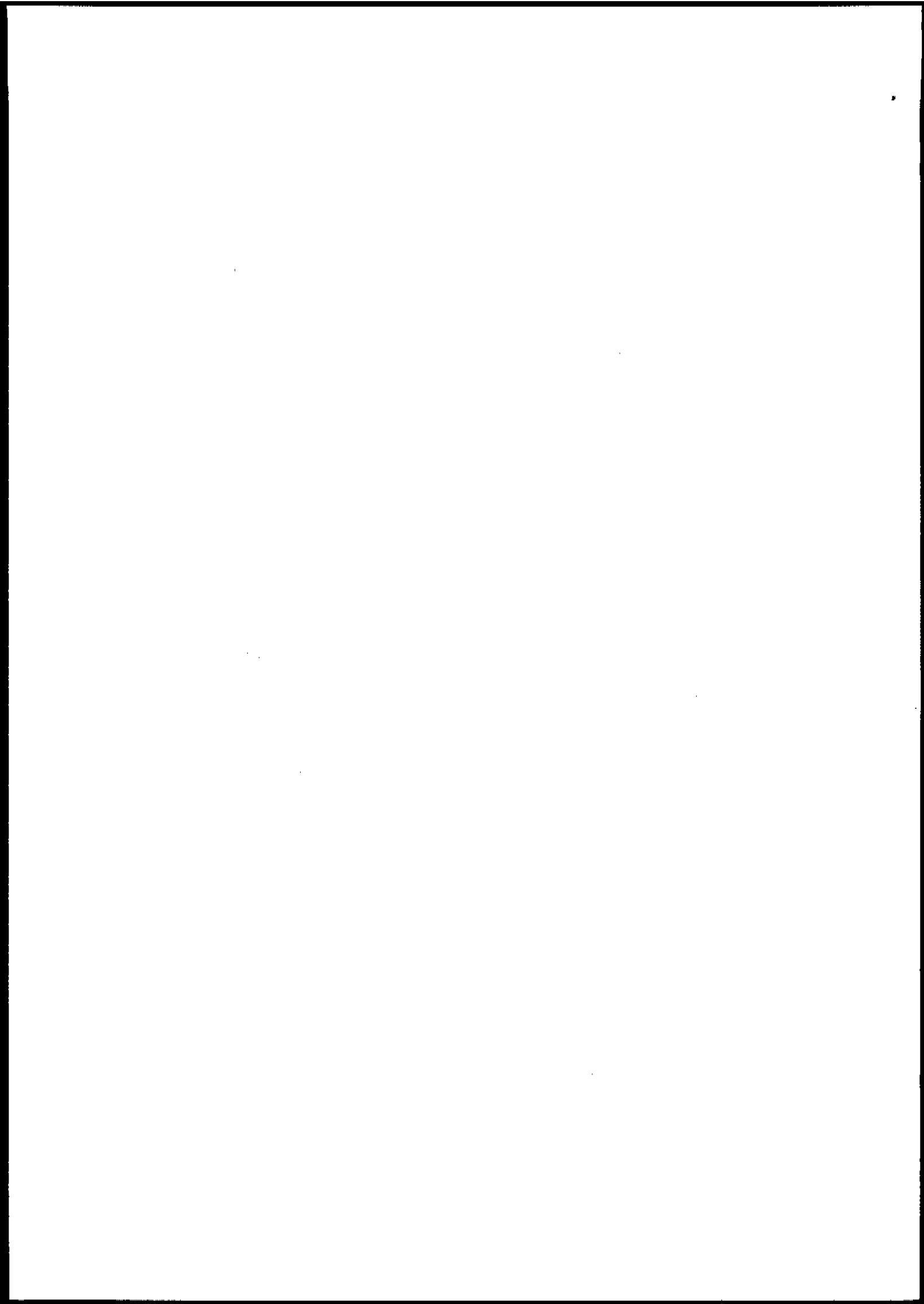
Such changes and "twinning" would need to be coordinated by the Nursing and Midwifery Unit at WHO's European Office.

(iii) Appointment opportunities

Turning to nursing appointments, it was suggested that joint posts such as research positions in clinical settings could contribute to evidence-based nursing practice.

Finally, the chief nurses emphasized the need for nurses to have access to experience and professional positions in order to develop and exercise their full potential in addressing the health care reform agenda in each Member State. They believed that countries should consider equally, appropriately experienced and relevantly qualified nurses and midwives who apply for leadership positions in reforming health care systems.

During the final plenary session, participants précised the outcome of the Consultation by drafting "Health care reforms: the nursing response" (Annex I), seeing this as the first step towards developing "A Charter for Nursing in Europe" in the coming months.



Annex 1

CONSULTATION OF EUROPEAN NURSE LEADERS
"HEALTH CARE REFORMS, PRIMARY HEALTH CARE AND NURSING"
5th WHO Meeting of Government Chief Nurses of the European Region
(Reykjavik, 11-13 April 1996)

HEALTH CARE REFORMS:
THE NURSING RESPONSE



WORLD HEALTH ORGANIZATION
Regional Office for Europe
COPENHAGEN

Government Chief Nurses of the European Region accept the challenge to play a key role in health care reforms. Together with other stake-holders in health, they are ready to take part in both the process of decision-making and the implementation of reform actions.

Guiding principles

For effective health care reforms, five guiding principles have been identified:

- equity
- health gain and quality of life
- effective use of human, financial and other resources
- quality development
- participatory approach with reference to individuals, families, the community and culture

The participants strongly urge the endorsement of these principles by WHO and its European Member States in the Charter on European Health Care Reforms.

Focus on Specific Reform Strategies

The following strategy areas have particular implications for the nursing contribution to health care reforms:

- ***Community based health care***

Health care systems must focus on society as a whole within specific geographical areas. Needs must be assessed on a population basis and take into account the specific requirements of vulnerable individuals and groups throughout all stages of the life span. Special attention must be given to supporting informal care givers in order to lessen the extra burden on women.

- ***Focus on primary health care***

As front-line professionals, nurses ensure a balance of care across the whole spectrum of health services, including health promotion and disease prevention. They must encourage self-reliance in health care and work in teams with other health professionals, staff of other sectors and members of relevant voluntary agencies and special interest groups.

- ***Quality development for outcome oriented care***

Care must be patient- and client-focused and be based on the best available evidence. Appropriate information systems must be in place to enable the use of comparable data on the quality of care developed and delivered.

- ***Competency based human resources development***

Education and training programmes must be responsive to identified population needs and be competency based. Skill mix exercises, in hospitals and the community, must be underpinned by adequate data and focused on issues of long-term cost-effectiveness, not short-term cost containment.

- ***Appropriate resources utilization***

The appropriateness of resource utilization must be scrutinized regularly in relation to its contribution to the improvement of health in society. All mechanisms for efficiency, effectiveness, and cost containment must be directly linked with health gain and the quality of life.

- ***The role of Government as protector of values***

The role of Government includes raising value issues for public debate and decision. Governments must ensure equitable distribution of resources, access of the entire population to health services, and competition based on quality and price. To achieve this aim, the necessary legislative and regulatory framework must be in place. Market mechanisms can be used to improve efficiency and effectiveness when, and as, appropriate.

- ***The Nursing responsibility in addressing the health care reform agenda***

Taking the above strategies into account, the Government Chief Nurses of the European Region recognize the urgent need for them to have access to the appropriate education, training, experience and professional positions in order to develop and exercise their full potential in addressing the health care reform agenda in each Member State.

Annex 2



WORLD HEALTH ORGANIZATION
COPENHAGEN

WHO Consultation of European Nurse Leaders
"Health Care Reforms, Primary Health Care and Nursing"

DLVR02
English only
17 April 1996

Reykjavik, 11-13 April 1996

PROGRAMME

Thursday, 11 April 1996

- 09.00hrs. **Opening Session**
- *Minister of Health of Iceland*
 - *Ms R. Haraldsdottir, Government Chief Nurse of Iceland*
 - *Ms A. Fawcett-Henesy, WHO/EURO*
- 09.30hrs. **Introduction Session**
(Ms A. Fawcett-Henesy, WHO/EURO)
- **Background & objectives of the Consultation**
 - **Approval of the agenda and programme**
 - **Nomination of the Chairpersons & Rapporteur**
- 10.00hrs. **Overview of Health Care Reforms in Europe and
the WHO Conference on European Health Care Reforms**
(Dr S. Savas, WHO/EURO)
- 11.30hrs. **Implications for Nursing under Health Care Reforms**
(Ms K. Ravn, Government Chief Nurse of Denmark)
- (Followed by discussion on keynote addresses)
- 12.00hrs. ***Lunch and field visits to health centres, hospitals & nursing homes***
(1.5hrs.)
- 14.00hrs. **Introduction to Country Reports**
(Ms A. Beerling, WHO/EURO)
- 14.15hrs. **GROUP WORK: Country Reports**
16.000hrs.
- 17.00hrs. ***Social event hosted by the Ministry of Health of Iceland***

Coffee breaks: a.m. 11.00-11.30hrs; p.m. 15.30-16.00hrs
Lunch: 12.00-14.00hrs.

Friday, 12 April 1996

- 08.30hrs. **PLENARY**
Feedback from Day 1
(Rapporteur: Ms M. Skeet)
- 08.45hrs. **The draft European Charter on Health Care Reforms**
(Dr S. Savas, WHO/EURO)
- 09.30hrs. **Introduction to Parallel Workshops**
(Ms A. Fawcett-Henesy, WHO/EURO)
- 09.45hrs. **GROUP WORK**
1. **Contracting/financing for health care**
(Facilitator: Ms A. Jarvie, Government Chief Nurse of Scotland)
 2. **Teamwork in health care**
*(Facilitators: Ms G. Perfiljeva, Ministry Focal Person for Nursing in the Russian Federation
Ms G. Spinola, Ministry Focal Person for Nursing in Italy)*
 3. **Education and the Interface between primary and secondary care**
(Facilitator: Ms R Haraldsdottir, Government Chief Nurse of Iceland)
 4. **Quality of care & empowerment of services users**
*(Facilitator: Ms J. Oulton, ICN)
(Facilitator: Mr W. Zandbergen, Focal Person for Nursing in the Netherlands)*
- 11.30hrs. **PLENARY**
Feedback from working group rapporteurs
- 14.00hrs **PLENARY (continued)**
Feedback from working group rapporteurs
- 17.00hrs. **Reception & Dinner hosted by the Minister of Health at a small fishing village.**

Coffee breaks: a.m. 10.30-11.00hrs; Lunch: 12.00-13.00hrs.

Saturday, 13 April 1996

- 08.30hrs. **Feedback from Day 2**
(Ms M. Skeet, Rapporteur; and Day 2 p.m. Workshop rapporteurs)
- 09.30hrs. **“Pulling the pieces together”**
(Dr M. Hirschfeld, WHO/Geneva)
Followed by discussion.
- 13.00hrs. **The Statement on “The nursing contribution to health care reforms”**
(Chairperson)
- 14.30hrs. **Closure of the Consultation**
(Ms A. Fawcett-Henesy, WHO/EURO)

Coffee break: a.m. 10.30-11.00hrs; 14.30hrs.

BUSINESS MEETING

WHO's NURSING PROGRAMME

Saturday, 13 April 1996
14.30hrs. - 16.00hrs., Reykjavik

Dr M. Hirschfeld, WHO/Geneva
Ms A. Fawcett-Henesy, WHO/EURO

ANNEX 3



WORLD HEALTH ORGANIZATION
COPENHAGEN

WHO Consultation of European Nurse Leaders
"Health Care Reforms, Primary Health Care and Nursing

Reykjavik, 11-13 April 1996

DLVR02
English only
17 April 1996

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