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SYMPOSIUM ON NURSING SERVICES – A MEETING OF NATIONAL NURSING ADVISERS

Stuttgart, 20–23 November 1978

1. INTRODUCTION

The Symposium, convened by the WHO Regional Office for Europe in collaboration with the Federal Republic of Germany, was attended by 18 nursing advisers from 12 countries of the European Region and 2 members of the Regional Office staff. The list of participants is given as Annex III.

The purpose of the Symposium was to:

(1) introduce the members of the group to the WHO medium-term programme in nursing/midwifery in Europe;

(2) review the present situation in the European Region with regard to the organization and management of nursing services[a] at national, regional and local levels;

(3) review the methods used to determine the numbers and types of nursing personnel needed to provide safe and effective nursing care;

(4) discuss suitable ratios of professional to auxiliary personnel;

(5) formulate recommendations and strategies relating to short- and long-term planning for the medium-term programme in nursing/midwifery with regard to:

- alternative patterns of staffing for nursing care as determined by centres participating in standard studies;
- methods to determine numbers and types of nursing personnel;
- activities at national and regional levels which would provide more reliable information on which to assess needs for nursing personnel.

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

Dr D.C. Hall, Regional Officer for Nursing, opened the meeting on behalf of Dr Leo A. Kaprio, Director, WHO Regional Office for Europe. She pointed out that for over 30 years recommendations had been made in a variety of WHO reports regarding the need to employ well-qualified nurses to advise on and, where appropriate, be responsible for nursing services at national and regional levels of government. In the European Region only six countries currently had nursing personnel holding positions which required them to advise on nursing services at these levels. Many countries were now concerned to improve the management of their nursing services and were looking for more effective ways of involving appropriately qualified nurses in the overall planning of health services.

Professor G. Neumann welcomed the participants on behalf of the Mayor of Stuttgart and the Minister for Youth, Family Affairs and Health of the Federal Republic of Germany. He noted the interest taken by health administrators at all levels in the country in the deliberations of the Symposium.

Miss I. Witte was elected as Chairman of the Symposium, Miss E. Egebakken as Vice-Chairman and Miss M. Auld as Rapporteur.

2. GENERAL DISCUSSION

In the opening discussion the members of the Symposium were concerned to identify clearly the tasks they were facing. They stated that a problem common to all countries of the European Region was the development of improved methods to determine the numbers and categories of nursing staff required to meet the needs of patients[a] for nursing in a safe and effective manner. It also was recognized that a shortage of first-level nursing personnel is common to most countries, and that a rise in the number of auxiliary personnel is a matter of concern when this occurs without a corresponding rise in the number of nurses.

The recommendations of meetings convened by WHO headquarters or the Regional Office for Europe on themes related to nursing personnel and the management of nursing services were reviewed and summarized by the Secretariat. The summary (see Annex I) was made available to the members of the Symposium who noted that of the reports listed, six made reference to the important contribution of nursing to health services as a whole, and the need for countries to establish sound patterns of organization and management of nursing services at national and regional levels of government. Other

[a] In this report the term "patient" is used in the broad sense of the "patient/client", who is both the recipient of care and the consumer of a service.

reports emphasized that the title of "nurse" had been used indiscriminately to such a degree that it no longer described the first-level or professional nurse, and neither the health professions nor the public currently understood its significance. Adding the prefix "nurse" to the designations of staff such as aides, auxiliaries and assistants in nursing had helped to remove from the title the status which it merited. The report of the 1977 EC/WHO Meeting on Nursing Personnel Information Systems[a] stressed the need to restrict use of the title "nurse" to those categories of personnel who were first-level nurses and had passed the appropriate qualifying examinations.

The members of the Symposium recognized the urgent need to develop methods whereby the results of nursing interventions could be identified and evaluated in terms of patient/client outcomes. They welcomed the proposals made in the medium-term programme in nursing/midwifery to conduct multinational studies on the subject.

The participants also noted that the lack of a well-developed body of knowledge in nursing and a clear understanding of the functions of the discipline within organized health services presented major problems in planning, organizing and managing nursing services; many planners and managers were unfamiliar with the advances made in the discipline during the last few decades and thus were promoting services which had little relevance in the light of present-day developments. The contradiction between what was taught in many nursing schools and what was practised in nursing services as these reached the public was a case in point.

3. ORGANIZATION

3.1 Patterns of organization and management of services

3.1.1 *National and regional levels*

The participants from Belgium, Denmark, Poland and the United Kingdom described the present organization and management of nursing services at national and regional levels in their countries. In these countries, a nurse is in a position to advise on, or influence in other ways, policy relating to the provision of nursing services. There are, however, some differences in the management patterns as to the extent to which the nurse is involved in the planning of nursing services *per se* or of health services as a whole.

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[a] *European Communities/WHO Meeting on Nursing Personnel Information Systems: report.* Copenhagen, WHO Regional Office for Europe, 1977 (ICP/HSD 044).

In the presentations and the discussions which followed, three distinct patterns of management of nursing services at national and regional level emerged, namely:

Pattern No. 1

In this case a division or department of nursing has been established at the national and/or regional level of government. A qualified nurse with the appropriate experience heads the department, which is staffed largely by nurses drawn from a wide range of specialties within the discipline (e.g., nursing education, psychiatric nursing, nursing research, community nursing). The nurse in charge occupies a position established on an equal footing with those of medical and administrative colleagues heading similar departments in other fields. She has direct access to government officials such as the minister of health or the director of health services. There is a well-developed post description outlining her work.

This is the pattern which participants considered to be the most likely to provide for effective management of nursing services on a national or regional basis. The strength of the pattern, which also contains many of the better elements of the other two to be described subsequently, is that it ensures that appropriate nursing advice is available for policy-making, in relation to nursing services and to health care as a whole. It helps to prevent overlap and conflict in the provision of nursing services and facilitates the definition of priorities in the planning of services for various patient/client groups. It allows nurses prepared in the appropriate specialty to be attached to departments in other sectors such as mental health or maternal and child health, while providing them with the backing of a strong nursing department which defines overall nursing policy. It provides for close proximity of colleagues of the same discipline with whom nursing matters can be discussed, and technical information exchanged and whose expertise is readily available to solve nursing problems outside a particular specialist's area of competence.

This pattern has the additional advantage of ensuring the involvement of nurses in general policy-making which may not be directly related to the provision of nursing services but nevertheless impinges on these services. Also, the routine inclusion of competent nursing opinion in interdisciplinary advisory or decision-making groups can well improve the quality of their work.

The disadvantages of the pattern are minimal but should be recognized. When the pattern is first introduced, there is a danger of removing highly competent practising nurses from a situation where their expertise was having a major effect on direct patient care. In the long run the benefits of having this kind of nurse in a senior administrative post should far outweigh the

disruption caused. However, to ensure that this is so, the appointment of such nurses needs to be carefully planned so that their intimate knowledge of the service situation will be used to full advantage. Further, every effort should be made to see that nurses appointed to senior administrative posts maintain close links with nursing practice and education. The foregoing disadvantages apply also to members of the other health disciplines (e.g., medicine, pharmacy) who occupy posts in parallel divisions.

Pattern No. 2

In this case one or a number of nurses hold positions in the directorate of health services, but do not work in a division or department of nursing. The nurse acts as adviser either on nursing as a whole, or an aspect of the discipline, e.g., nursing services or education. She is usually directly responsible to a physician or an administrator, and has access to officers at higher levels in the system only through this supervisor. There may or may not be a well-developed post description.

Where several nurses hold posts, one of their number may be designated as "chief nurse" but this is often a title which carries little weight since the nurses are not in a single division or department, and have senior medical or administrative officers to whom they relate more closely than to the "chief nurse".

In this pattern the nurses act almost exclusively in an advisory capacity; while it demonstrates a recognition of the need for input from nurses at senior levels of management, the seeking and acceptance of that input are permissive rather than mandatory. In some settings the consultative process may be extended to include nurses or other personnel who lack the necessary education or experience to give informed advice on nursing. Moreover, the participation of nurses in planning for total health care, or planning of the extension of existing health services and facilities, is erratic and often depends on recognition by other health professionals of the need for nursing input.

Pattern No. 3

In this case one or several nurses work as members of interdisciplinary teams established at national or regional levels with responsibility for providing advice and managing services in specific areas of health care, e.g., education of health workers, mental health services. There is no "chief nurse" and no division or department of nursing.

The nurses thus employed have no corporate entity and the requirements of the nursing component of the team must often give way to the more dominant demands of the other disciplines involved. If the foregoing loss of

identity is avoided, however, this pattern does allow the establishment of close and beneficial collaboration between the nurses and other members of the team. It ensures that the nursing component of specialized services is developed and that all team members are informed about the contribution which the discipline can and should make to such services. Its major weakness lies in the fact that it provides no avenue for the establishment of a national or regional nursing policy *per se*. It can set one area of health services up against another and sow the seeds of intradisciplinary conflict.

The lack of an extensive body of knowledge in nursing makes the position of the nurse vulnerable within a team which often consists largely of physicians, other health workers and administrators. Information concerning the success or otherwise of such teamwork is still imprecise. The information that is available has been collected in situations which are themselves dynamic and changing. The concept of teamwork in this context requires further study.

There is also a need for the nurse involved in the organization and management of nursing services at national and regional levels to be politically conscious. Without appropriate political awareness, planning of nursing services could be ineffective. Nurses have tended in the past to remain apart from government policy-making in the belief that the policy did not influence nursing care. Nurses now recognize, however, that their care can be provided only in the context of total health care. They recognize that political decisions which affect the planning of health services in general may also either enhance or constrain the provision of safe and effective nursing care.

3.1.2 *Local level*

For purposes of the discussion, "local level" was taken to refer to an individual hospital or a group of hospitals, to a health centre or to the smallest geographical area recognized in the community health field. Descriptions of the current situation at local level were presented to the Symposium by participants from Finland, Iceland, Ireland and the Netherlands.

It emerged from the presentations that a nurse heads the nursing services in all institutions and communities discussed. There are, however, differences in the patterns of management. In some less frequent situations the nurse heads a nursing division in a hospital or community and is responsible to a senior nurse in a post on the next rung of the administrative ladder. In other more common situations, the nurse is responsible to a physician or administrator in the institution, health centre or community.

The contribution of the nurse to policy-making which affects either nursing services or health services as a whole varies, usually according to the pattern of management at national and regional levels. The participants discussed the part which should be played by the nurse manager at local level. They saw clearly the need for the manager to keep in touch with changing clinical and

other health care practices in order to determine priorities for the nursing services, while recognizing that she may not participate in direct patient care. She must be aware of the changing needs not only of patients but also of nurses themselves. She must also ensure that nurses work within the regulations pertaining to their welfare.

3.2 Involvement with other professions and services

An important point emerging from the discussion is the variation of the extent to which nurses are involved with services other than nursing and with related professional staff. In some situations, for example, nurses are responsible for the provision of domestic and catering services, while in others they work closely with the managers of those services who are not a part of the nursing subsystem. Physiotherapy and occupational therapy are part of the nursing services in some countries, while in others they are considered to be medical services under a physician or, more rarely, a senior member of their own profession. The participants considered that the nurse has a distinct function of management on behalf of the patient, in relation to planning and timing of direct care inputs from all professions including medicine. Current complaints from consumers of dehumanized services were seen in part to be the result of a failure among health professionals to plan care, keeping in mind the basic needs of the patient, such as those for rest, food, elimination, privacy and time to understand and adjust to an often threatening environment.

Participants were of the opinion that, as the person caring for the patient continuously over each 24-hour period, the nurse is the only professional in a position to plan and control the immediate environment of the patient. The needs of the patient for comfort, safety, understanding, etc., are in many instances as urgent as his requirements for interventions of a more technical nature. The growing tendency of hospitals to provide all services on a crisis intervention basis does not promote good care, and nurses therefore have a particular responsibility to create and maintain a climate conducive to healing in its broadest sense.

Many interventions are carried out at the convenience of the staff rather than the patient and while both must be considered, the patient should receive priority. To ensure effective control of health care on the patient's behalf, the authority of nurses over services having a direct influence on such care should be clearly defined.

The members noted the increase in the number of therapists in narrow specialized fields and concluded that the effect this could have on the provision of nursing care should not be minimized. It is possible to envisage nurses becoming solely the coordinators of services which others provide to the patient. However, while there is a coordinating factor in the nurse's role, this should be viewed as one element only and never as the entire contribution.

The nurse should be regarded as the major contributor to patient care on a continuing basis. The members stressed the need for the nurse to be in control of the situation in the interest of patient care. They believed that many therapists are perhaps inappropriately placed in the medical team and would serve patient needs better if they were made part of the nursing team and designated as assistants in nursing. This is an appropriate suggestion when one considers that professions such as physiotherapy and occupational therapy have their origins in nursing and that the skills of such professionals constantly overlap with those of nurses. However, the group was aware of the fact that in many countries there is already a distinct division between nursing and several of the major groups of therapists and it is not now realistic to suggest a return to the past. There is therefore a need to recognize the extent to which individual professionals are planning treatment without reference to the overall needs of the patient as a person and without discussion with other professionals. It was considered important to develop plans showing the contribution of all professional activities and focusing on care of the patient, which would be managed by the nurse on his behalf.

3.3 Determination of numbers and types of nursing personnel needed to provide safe and effective care in hospitals and community nursing services

3.3.1 *Current methods*

The members discussed the current methods used to determine the number of nursing personnel required in various situations. Three main methods are commonly employed, none of which is particularly sound.

The first common method is that of calculating staff needs according to the number of beds in the institution. The inadequacy of this method is apparent in that it takes no account of the patients' requirements nor of the fact that nurses are also required in outpatient departments, operating theatres, day care units, etc. In many countries a similar method has been applied in estimating needs for staff in community nursing services on a population per nurse basis. Such estimations do not take account of the age structure of the population or individual and family needs for nursing care.

The second common method is that of estimating the numbers of staff required according to the degree of dependency of patients, as determined by a special scale. The advantage of this method is that it gives an estimate of the minimal level of staff necessary to provide safe care. The disadvantage lies in its emphasis on physical dependency as compared with the need for psychological, emotional, social or educational support. It tends to emphasize the negative rather than the positive aspects of the health of patients.

The third common method of estimating staff numbers relies on observations of nursing activity. The current activity of nurses in different hospital or community health services is observed and recorded, and the staff

requirements are determined accordingly. This system has little validity since it assumes that current practices are meeting patient needs without any prior study to validate the assumption. It lays emphasis on the current activities of nurses without relating them to forecasts of future and changing needs and the consequent necessary alteration of staff numbers.

Two other methods currently employed for calculating nursing staff numbers were described by participants from the Federal Republic of Germany and the United Kingdom (Scotland).

Using the first of these methods it is possible to develop formulae to calculate the numbers of staff required in given clinical specialties, while allowing for factors such as study leave, sickness absence, holidays, a shorter working week.

The second method involves study of the needs of patients grouped into clinical categories. It is applicable to all specialties and can be used in situations of both health and sickness. It is not, however, sufficiently refined to enable an accurate determination of the appropriate grades of staff to meet patient needs. National formulae can be developed to assist nurse planners to forecast with some accuracy the results of various nursing manpower policies. Methods of calculating staff numbers on the basis of patient needs in daily living were discussed. It is interesting to note that in a few cases there has been a move towards thinking of the potential ability rather than the inability of the patient in relation to health functions.

The organization of nursing services through shift systems and more often on a task-oriented basis influences the numbers and mix of the personnel. The participants discussed the need for accurate forecasting of numbers and types of personnel to meet patient needs, both now and in the future, and recognized the complications associated with the existence of a variety of grades and titles. It is important to have an understanding of the professional nomenclature used in the various countries, as well as a knowledge of the effects of the nursing interventions of various categories of personnel.

It is still difficult to determine with any degree of accuracy the number of nurses or the number of aides or assistants required in any situation. The members agreed that before definitive statements can be made about staff numbers and categories, better methods must be developed for evaluating the results of nursing interventions in terms of patient outcomes. It was pointed out that many hospitals in Europe are run as nonprofit institutions supported largely by insurance schemes which could influence the pattern of nurse employment. The need to develop a system of cost-benefit analysis of nursing input was recognized by all members. A sound factual basis on which to support requests for additional nursing personnel must also be developed. The lack of accurate data concerning such personnel made manpower forecasting unreliable. Appropriate data collection methods were discussed including the use of pay-roll records.

3.3.2 *Discussion*

From the discussion it emerged clearly that there is a need for more and better information about nursing personnel, which is currently lacking in most of the countries. For this purpose it is essential that rational nursing personnel systems be developed. Accurate information about nursing personnel would include details of training, movement within the profession, and breaks in service for marriage, pregnancy or transfer to other occupations.

A registration system for all levels of nursing personnel, in which facts about the registrants are constantly updated, would provide accurate information with which to make manpower predictions. It is difficult at present to forecast long-term requirements with any degree of accuracy. Again, the large number of categories of personnel is a cause for concern. As a result of "splintering" of the profession, services have become demarcated to an extent that could be detrimental to the provision of personalized care, which is considered the ideal. Indiscriminate growth in the number of aides, assistants or auxiliaries should be stopped. When better information is available about patient needs, more realistic decisions can be made concerning the appropriate placing of such personnel in the nursing team. Also linked with this "splintering" is the confusion created in the minds of the public about nurses and nursing. Indiscriminate use of the terms "nurse" and "nursing" as prefixes in designating unqualified personnel has made it difficult for the public to differentiate between first-level (professional) nurses, second-level (qualified) nursing personnel, and others. "Nursing" apparently can be undertaken by anyone. There is a need for a clear definition of "professional nursing" and the activity of the professional nurse in terms of its consequences for the care of the patient. Lack of knowledge about "nursing" was seen by the participants as a major hindrance to the development of services and to accurate manpower forecasting. Nursing should be recognized as a discrete health discipline with a body of knowledge and technology clearly distinguishing it from other health disciplines.

Associated with the lack of knowledge of the discipline is a paucity of data on the nursing needs of patients in all countries. Until such data are collected and routinely updated through epidemiological-type studies, no realistic forecasting of nursing manpower needs can be made.

Other influences on nurse recruitment and deployment were discussed. Too often health services are established or extended without prior discussion with nurse managers. The consequences for nursing services and personnel are recognized too late to permit effective manpower planning. Nursing personnel resources are often stretched beyond the limit of safe practice. This is not only detrimental to patients and the personnel, but also creates dangerous situations in terms of the provision of services by other workers.

Some laws relating to nurses and nursing require review. Moreover, no law should be made which restricts the freedom to alter practice to meet the

changing needs of society. Nurses should be involved in the compilation of any legislation which affects nursing. Nurses should also participate in the enactment of any law which, although not directly related to nursing, might impinge on nursing education or practice.

The members recognized that nurses are often resistant to change, preferring an approach of "dynamic conservatism". The hope was expressed that monolithic oligarchies and established practices would not prevent changes if these are in the interest of improved patient care. Nurse managers should ensure that all staff under their supervision are aware of current thinking about nursing education and practice.

Ideally, manpower planning for nursing and the other health disciplines should be undertaken jointly by all health professionals. A joint planning scheme should be instituted in each country, but at the same time nurses need to refine their own system of manpower forecasting as a separate exercise.

4. RESEARCH

The members then discussed the part played by research in the effective organization and management of nursing services.

4.1 Need to improve knowledge of the discipline

The members were firmly of the belief that there must be better understanding about "nursing" before effective organization and management of nursing education and services can be ensured. In this respect three fundamental issues require clarification:

(*a*) the confusion between "nursing" and "doctoring" (medicine);

(*b*) the confusion, particularly in the mind of the public, regarding who nurses are and what nursing is;

(*c*) the confusion as to what is a discipline and what is a profession.

The role of nursing is too often defined by health personnel who have no real knowledge of the discipline but who, because they speak from positions of authority, are believed. Both educational programmes and service situations often fail to provide nurses with a clear image of the discipline or an understanding of their role as professional workers within it. The need for organized nursing care as part of overall health services is indisputable. What is required now is a concerted effort to develop, particularly through research, the body of knowledge and technology in the discipline to a level where it

can serve the public effectively. Nurses should see nursing as a research-based discipline and should view their profesisonal role as including responsibility to participate in and, where appropriate, to undertake nursing research.

It was felt that the following statements by Henderson and Hall regarding the functions of nursing are useful in understanding the discipline:

> "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible."[a]

> ". . . [the] primary responsibility [of nursing] is to assist individuals and groups (families/communities) to optimize function within varying states of health. . . . The primary responsibility of the practitioner of nursing (the nurse) is to provide care [of a nursing nature] direct to the individual, family or community."[b]

4.2 Need to establish standards of nursing practice

In every country nurses should come together to establish standards of nursing practice. These standards would not only protect them and the public but could be used as guidelines for the planning and management of nursing services.

The group endorsed the use of the nursing process method in the practice of nursing. They looked forward to the supply of material from collaborating centres associated with the medium-term programme in nursing/midwifery. These centres will develop study designs including assessment, planning, implementation and evaluation instruments and make suggestions regarding the procedures to be used by nurses to record nursing care and its outcomes.

There is an urgent need to establish methods to assess the continuing competency of nursing personnel. All personnel wishing to practise nursing at a given level should be required to provide evidence of competency at regular intervals throughout their professional career.

It was hoped that the nursing profession would not cling to traditional and sometimes inappropriate practices but would rather, with some imagination and vision, look at new patterns of care to meet the changing needs of society. Recording of nursing care in a personalized rather than task-oriented way could provide information which would help to alter traditional methods

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[a] **Henderson, V.** *Basic principles of nursing care.* Basel & New York, S. Karger, 1969.

[b] **Hall, D.C.** *A position paper on nursing.* Copenhagen, WHO Regional Office for Europe, 1979 (document EURO/NURS/75.1 Rev.l).

of organizing and managing nursing services. Use of the process method in the delivery of services will ensure personalized care. Nursing provided in this way should be studied in terms of structure, process and patient outcome.

4.3 Need to interest nurses in research

The group stressed the need to help make all nursing staff aware of the importance of research as a base for the development of nursing. In each country, depending on the pattern of nursing organization and management, the responsibilities for initiating and participating in research at different levels of the nursing hierarchy should be made explicit. Some staff would undertake research directly while others would participate in it, for example by data collection. All nursing staff should use the results of research. Informed advice should be available as to which nursing problems are amenable to research and which require the attention of nursing management.

The members hoped that eventually research would provide nurses with knowledge based on facts and enable the provision of nursing care resulting in predictable patient outcomes. Nursing staff numbers and categories could then be determined and costed accordingly. The value of such a development to nurse managers in the organization of care is evident.

5. EDUCATION

5.1 University programmes

The influence of education on the performance of nurses and the delivery of nursing services was discussed. The need was stressed for nurses to be educated at the basic professional level in programmes which prepare them to function effectively as multipurpose workers in nursing.

The group considered the need to establish more university programmes for nurses at both undergraduate and graduate levels, in the belief that the better educated nurse is able to function more effectively in diverse service situations and to provide quality care to larger groups of people. In this respect it must be emphasized that, contrary to common belief, nurses qualified through university programmes tend after graduation to occupy positions which allow them to provide care direct to patients. Studies in the United Kingdom (Scotland) and the USA have produced evidence to this effect. The group further expressed the opinion that it is time that the protracted and frequently misinformed debate on whether nursing should be taught at academic level be closed: the pattern is now accepted as both necessary and desirable.

There is a need to improve the remuneration of nurses who remain in clinical nursing (including community nursing). A career in clinical nursing would thus become comparable to one in management or education, which now provides higher pay and status.

In recognition of the fact that registration as a professional nurse should not imply that no further education is needed the members agreed that continuing education should be available to all nursing personnel. Bearing in mind the often adverse effect on staffing manpower of the absence of personnel at courses, it was felt that all postgraduate and postregistration courses for such personnel should be reviewed in terms of their appropriateness. Also, in choosing a course, consideration should be given to its contribution to satisfactory patient care.

5.2 Management education

In view of the importance of good management for the effective functioning of nursing services, it is important that nurses be taught the techniques of personnel and financial management. This applies to all branches of nursing. An understanding of the principles of management needs to be inculcated early in the career of the nurse and be reinforced at various stages to enable her to organize services effectively. Some management education should be multidisciplinary so that by working together professionals would learn the methods of determination of priorities and allocation of scarce resources. Nurses would not only participate in such multidisciplinary programmes but also contribute to the management education of other professional staff.

6. TEAM APPROACH TO THE DELIVERY OF CARE

Much emphasis is now given to the necessity for teamwork and the importance of considering the total needs of the patient. The members recognized that such needs cannot be met by one profession working in isolation and that many other professions and agencies have contributions to make. The way in which the different contributions should be linked in attaining the objectives of patient-oriented care is a matter for local discussion and decision. Nevertheless, it is emphasized that the patient should remain the focal point of any health care plan and the nurse, as the one professional who provides care on a continuing basis, should control the plan on behalf of the patient. It was noted that the composition and functioning of the nursing team should alter to meet changing needs of patients and to conform to new patterns of care that might be introduced.

The members discussed the need to consider nursing within the context of the total social system. A paper was presented by Dr J. Asvall, underlining the importance of the team approach to the planning of health care (Annex II).

7. MEDIUM-TERM PROGRAMME IN NURSING/MIDWIFERY IN EUROPE

The members of the Symposium thought it important to emphasize the potential contribution of the programme to the organization and management of services. It was developed by the Regional Office in response to needs expressed by Member States and is gaining impetus because it clearly meets these needs, which include the development of a body of knowledge about nursing which is currently lacking. It is divided into four components: the nursing process; organization and management of nursing/midwifery services; education of nursing/midwifery personnel; and resource planning.

The interrelationship between the four components was fully understood by the members, particularly as regards the extent to which the nursing process component influences the other components. It is hoped that the programme, as it develops, will eventually provide knowledge enabling nurses to improve the organization and management of the services.

It was suggested that the programme, as it relates to the organization and management of nursing services, should emphasize the following:

- establishment at national level of standards of nursing care, which would be determined by the profession in relation to the society in which it operates;
- assessment of patient needs for nursing care using accurate measurement tools;
- estimation of the resources necessary to meet the needs at the minimum level of safety and effectiveness;
- appraisal of the financial implications of meeting the needs in a planned fashion.

8. CONCLUSIONS

In conclusion, the members of the Symposium felt that emphasis should be given to the following points in relation to the effective organization and management of nursing services:

(1) There is a need to establish a pattern of organization and management of nursing services at national and regional levels, which would ensure that appropriately qualified nurses are in a position to advise not only on the nursing services but also on health services as a whole. It was thought that a nurse should head a nursing division at national/regional level and in this position should have direct access to relevant government officials.

(2) Permanent posts should be established for nurse managers at hospital, health centre and community levels to ensure that nursing policies are well defined and implemented.

(3) If the proposals for the appointment of nurse managers at national, regional and local levels cannot be implemented, a system should be adopted making it mandatory and customary at each level to seek informed professional advice from nurses on matters relating to nursing education and services in particular and health services in general.

(4) Informed nursing advice should be sought when any extension of health services is planned. This would ensure that the consequences of the extension for nursing services are considered by nurses before the implementation phase is reached.

(5) The establishment of a rational nursing personnel system is imperative. Policies governing the operation of the system should include provisions to halt the unplanned proliferation of categories of nurses and other personnel engaged in nursing.

(6) There is a need to establish a "live" register of nursing personnel with an associated system of recurrent registration, which would provide up-to-date information on the personnel.

(7) Legal protection of the title of "nurse" is necessary to protect the public and the practitioner. As nursing is a dynamic process, there is also a need to review the legislation to ensure that it does not impede progress in nursing. Nurses should be involved in the review or compilation of any law which would affect nursing practice or education.

(8) It is important to ensure that nursing manpower is available to meet patient needs. Sound systems should be established to collect information on the needs of selected cohorts of patients. Numbers and categories of staff should be related to the predictable outcomes of nursing intervention in terms of patients, practitioners and services.

(9) Research should be conducted to ensure that nursing is identified as a discrete health discipline distinguishable from other disciplines.

(10) The part to be played by nurses at all levels of the hierarchy in initiating or participating in nursing research should be clearly specified, if nursing is to be recognized as a research-based profession.

(11) Research should be conducted to establish standards of care in nursing and to describe the attributes (knowledge, skills, attitudes) which ensure competency to practise the discipline.

(12) Alternative patterns of nursing care and their relation to patient outcomes should be defined. The relationship between the various patterns and their influence on nursing manpower should also be studied.

(13) To ensure the development of total care for patients, the nurse must control their immediate environment.

(14) There is a need to increase the number of university programmes in nursing and to evaluate the impact of the services of nurses educated in such programmes on patient outcomes.

(15) There is a need to decide on appropriate patterns of postgraduate and postregistration programmes in nursing and to evaluate the impact of the services of nurses educated in such programmes on patient outcomes.

(16) Management education should be an integral part of the preparation of nurses. Some of the education should be provided through multidisciplinary courses, in which nurses would not only participate but also teach management principles to other health professionals.

(17) The importance of the planning of nursing services should be recognized. Such planning should not be isolated, but should take into account the objectives of the health care team as a whole and its role within the total social system.

Annex I

SUMMARY OF RECOMMENDATIONS OF MEETINGS OF WHO EXPERT COMMITTEES ON NURSING AND GROUPS CONVENED BY THE REGIONAL OFFICE FOR EUROPE

A. WHO Expert Committees on Nursing[a]

1950	Nursing: first session	**2. Use of nursing personnel** The Committee recommends that WHO urge national health administrations to include among their administrative officers highly competent nurses with authority to assist in planning health services, to define the role of nursing in these services, and to determine the nursing personnel requirements. The Committee recommends that WHO urge each Member Government to undertake (or continue) a study of: (1) the existing supply of each type of nursing personnel (including midwives, feldshers and other specialized groups engaged in nursing duties), and of various types of auxiliary nursing personnel;

[a] The Expert Committee on Nursing met in 1950, 1951, 1954, 1958 and 1966. An Expert Committee on Psychiatric Nursing met in 1955, and an Expert Committee on Community Health Nursing in 1974.

The reports issued on the meetings are as follows:

WHO Technical Report Series, No. 24, 1950 (First report of the Expert Committee on Nursing).

WHO Technical Report Series, No. 49, 1952 (Second report of the Expert Committee on Nursing).

WHO Technical Report Series, No. 91, 1954 (Third report of the Expert Committee on Nursing).

WHO Technical Report Series, No. 105, 1956 (First report of the Expert Committee on Psychiatric Nursing).

WHO Technical Report Series, No. 167, 1959 (*Public health nursing:* Fourth report of the Expert Committee).

WHO Technical Report Series, No. 347, 1966 (Fifth report of the Expert Committee on Nursing).

WHO Technical Report Series, No. 558, 1974 (*Community health nursing:* Report of the Expert Committee).

1950	Nursing: first session (contd)	(2) the estimated number of each type of personnel needed in all categories of employment, based on existing and prospective health programmes; (3) the factors which interfere with securing candidates for training of various types; (4) the effectiveness with which nursing resources are used. The Committee recommends that WHO invite the co-operation of ILO in a joint investigation of the employment conditions of nursing personnel, including salaries, hours, health conditions and personnel policies. The study would also include the qualifications of nursing personnel, adequacy of supervision, standards of service and problems of recruitment. The assistance of the International Council of Nurses and other appropriate groups should be sought. The investigation should include a pilot study undertaken in one country, or some division of a country, which exhibits the problems listed above. The Committee wishes to suggest the Federal District of Mexico for the pilot study.
1954	Nursing: third report	I. Having noted the recommendation of the Expert Committee on Nursing at its first session that "the World Health Organization urge national health administrations to include among their administrative officers highly competent nurses with authority to assist in planning health services, to define the role of nursing in these services, and to determine the nursing personnel requirements", The Committee recommends that those countries which have not made such appointments give consideration to the matter. II. Having considered the necessity of good administrative practice in nursing service, the Committee recommends: (3) that working conferences for the study of methods of improving nursing service administration be organized on a national and/or a regional basis; (5) that in an organization employing nursing personnel there be an established nursing service under the direction of a nurse who has had delegated to her the authority proportionate with her responsibility; (6) that in order to promote improvement in nursing service administration WHO continue to assist Member States: (*a*) in the establishment of nursing positions in national health administrations;

1954	Nursing: third report (contd)	(*b*) in the granting of fellowships for the study of nursing service administration; (*c*) by sponsoring working conferences on a regional and/or international basis; (*d*) by promoting the establishment of regional centres for the study of nursing service administration. III. The Committee draws attention to the sections of the report in which human relations and teamwork in administration are discussed, and recommends that methods of teamwork be applied at all levels of nursing service.
1955	Psychiatric nursing: first report	The Committee recommends: (1) that national health administrations include, among their administrative officers, nurses with responsibility for the overall planning of nursing service and nursing education, and that this planning includes consideration of the nursing needs of mental hospitals and other mental health programmes; (4) that an understanding of psychiatric nursing, mental health, and social and preventive aspects of nursing be extended through national and intercountry nursing seminars.
1958	Public health nursing: fourth report	(2) The Committee recognizes that the auxiliary worker has an important and almost certainly permanent place in public health nursing. The potentials and limits of auxiliary functions and the relation of auxiliary to professional workers are immediate and urgent problems. The Committee recommends that, after studies of actual practice have been carried out, WHO should consider the convening of an expert committee to discuss: (*a*) the role of the auxiliary worker in the health team, and its relation to the role of the professional worker; (*b*) the preparation of auxiliary workers.
1966	Nursing: fifth report	The Committee recommends: 1. that countries be supported in their efforts to meet legitimate quantitative demands for nursing services and at the same time develop a nucleus of qualified nurses capable of being prepared for positions of responsibility in nursing practice, teaching or administration; 2. that, in order to permit the optimum utilization of personnel and resources, the nursing personnel systems in each country be so designed as to prevent unwarranted proliferation of levels and types of workers in nursing;

1966	Nursing: fifth report (contd)	3. that organized programmes of in-service education and training for all nursing personnel be provided as a means of improving the quality of patient care; 4. that nursing be developed in relation to the needs of each country, and that each country be urged to designate a nurse or nurses to be responsible at national level for planning and coordinating nursing within the health services; 5. that in each country a body, the majority of whose members are nurses, be designated to advise the government on nursing.
1974	Community health nursing: report	The Committee recognized the urgency of the health needs and lack of health services in communities throughout the world and recommended that the following plans of action be made to bring about the necessary changes as rapidly as possible. (1) Decisions should be taken to initiate and further develop community health nursing services that are responsive to the needs of the community, encompass primary health coverage for all the population, and provide assurance of the safety and appropriateness of the services rendered. In order to implement this recommendation, it will be necessary to: (*a*) establish an organized nursing service within the context of community health with joint participation of community and health groups; (*b*) incorporate the primary health worker into the nursing and health care system; (*c*) develop the community health nurse as a provider of primary health care and as the first level of support of the primary health worker; (*d*) provide preventive, therapeutic, and rehabilitative care based on a family-centred approach; (*e*) organize a system of support that includes referral for specialized services and consultation, educational guidance of health workers at all levels, and administrative planning and evaluation; (*f*) coordinate community health nursing with the other community development programmes; (*g*) establish mechanisms to ensure the safety and appropriateness of health care, these mechanisms being based on community participation combined with technical health service judgements;

1964	Community health nursing: report (contd)	(*h*) make available the best-prepared community nursing personnel for service in the community. (3) Health manpower, of which nursing manpower is a part, should be developed within overall national development plans. These plans should reflect a rational distribution and utilization of personnel to provide community health coverage and essential support systems in the light of present and projected needs.

B. Groups convened by the Regional Office for Europe[a]

Study Group on Basic Nursing Curriculum in Europe, Brussels, 1955

Administration

In countries where there is no national nursing council or similar body recognized by the state, it is recommended that such a body be set up. It should have authority to establish minimum requirements for the basic curriculum and means for its continuous revision, to accredit schools of nursing and to evaluate the results they obtain in the light of the total needs of the country. The attention of ministries of health should be drawn to the importance of maintaining a department of nursing, with a nurse at its head having responsibility for nursing service.

Consideration, where appropriate, should be given to the feasibility of delegating responsibility for nursing education to the ministry of education. Liaison between the national nursing council and the two ministries would be necessary.

The role of the professional organization in fostering satisfactory nursing education and nursing service should be stressed. Good relationships between the medical and nursing professions should be fostered.

[a] The reports issued by the Regional Office on the meetings are as follows:

Study Group on Basic Nursing Curriculum in Europe, 1956 (EURO 86).

Working Group on Trends in European Nursing Services, 1972 (EURO 4405).

Symposium on Higher Education in Nursing, 1973 (EURO 4408).

Working Group on European Studies in Nursing/Midwifery, 1974 (EURO 4407(2)).

Working Group on the Role of Nursing in Psychiatric and Mental Health Care, 1976 (ICP/MNH 039).

Working Groups on the Definition of Parameters of Efficiency in Primary Care and the Role of Nursing in Primary Health Care, 1976 (ICP/SHS 039 & ICP/SHS 004).

Working Group on Trends in European Nursing Services, Bern, 1970

In view of the importance of nursing in health care, and since all plans leading to changed patterns of services, staffing and treatment have a direct effect on nursing personnel and services, nurses should be involved in national, regional and local health planning.

In the future, it will not be possible to provide nursing and health care with the traditional knowledge, skills and attitudes of today – much less on the basis of the isolated action of different members of the health team and the present fragmented clinical learning experiences. There is therefore an urgent need for a thorough study of education for the health professions, including nursing, with a view to orienting them to future health care needs.

Research and experimentation in new ways of organizing nursing services and educational programmes should form part of the planned development and improvement of health care systems.

Information on the organization of nursing services should be collected locally, regionally and nationally in order to provide a basis for planning.

Expert practitioners should be trained in the various clinical specialties and in community nursing.

Methods of studying decision-making in nursing and of analysing the roles of different categories of staff should be developed as a preliminary step towards improvement of health care.

Symposium on Higher Education in Nursing, The Hague, 1972

The Symposium took note of the recommendations of WHO expert committees on nursing, previous working groups and other international meetings concerning the need for nurses to be educated in and to have continuing access to the highest educational facilities in a country. In view of the time which has elapsed since many of these reports were published and their conclusions apparently accepted, it was considered to be urgent for each country to take active measures to establish, at undergraduate level, educational programmes for the preparation of the nurse as defined by the Symposium. A phased plan extending over a period of 5–10 years would provide for the gradual changeover from the conventional and currently inadequate hospital-based school.

Nursing helps to determine the quality of health care in a country and the participation of nurses in the planning of health services at all levels (national, regional, local) is indispensable to sound planning.

Working Group on European Studies in Nursing/Midwifery, Copenhagen, 1974

Information systems

If national health planning and the delivery of health services are to be effective, each country needs a nursing information subsystem. This subsystem

should, wherever possible, be an integral part of the overall health services information system. Registration of all types of nursing personnel, both practising and nonpractising, should form part of this subsystem.

The importance of readily available and accurate information for the development of quality nursing care is emphasized. The systematic documentation of the nursing process and the dissemination of the resulting information with a view to studying and improving nursing services of all kinds warrant concerted efforts in the immediate future.

An essential condition for the development of a satisfactory nursing information subsystem is that nurses should be able to state clearly their information needs and that such items should be included in the information collected at all levels, particularly at the point of delivery of nursing care. This would be possible if nursing staff were involved in the design and development of the information system from the beginning. It also implies that senior nursing staff should be trained in appropriate modern management techniques.

Working Group on the Role of Nursing in Psychiatric and Mental Health Care, Saarbrücken, 1975

Posts for nurses to advise and assist in the development of nursing within mental health services should be created and filled at national, regional and local levels of administration. Nurses should be prepared and appointed as directors of nursing in hospitals and community health care services.

Working Group on the Definition of Parameters of Efficiency in Primary Care and Working Group on the Role of Nursing in Primary Health Care, Reykjavik, 1975

Nurses should be involved at national, regional and local levels in the planning and decision taking process.

There is an urgent need for all countries to develop national health personnel systems and to establish, as an integral component of these, national nursing personnel systems which clearly define the categories of nursing personnel needed by the country. The titles of workers within the subsystems, including the title "nurse", should be protected by law and their use restricted to the categories of personnel to which they refer.

Annex II

PLANNING OF THE NURSING COMPONENT OF HEALTH SERVICES AS PART OF COUNTRY HEALTH PROGRAMMING (CHP)

J.E. Asvall[a]

Twenty-five years ago a WHO document stated: "nursing is an essential component of the total health programme and therefore any study of nursing and plans for developing nursing services are only one part of a broader health service plan" (*1*). Unfortunately, this simple statement has not yet been fully understood in many countries, where planning of nursing services often tends to be more a "numbers game" than a recognition of nursing as a health service in its own right. Or to put it more simply: planning of nursing services cannot, as is so often the case, remain a matter of health manpower planning only; instead, a thorough analysis of nursing care as a health service must determine that part of health manpower planning which concerns nursing. Acceptance of this simple, but basic principle is to me the crucial point in the planning of nursing services, as it is the only way to develop a type of health planning which forces us to concentrate on health problems and to search with an open mind for alternative solutions instead of being quickly lost in an endless fight over numbers of personnel and budgetary figures.

Historical development and present status of CHP

Country health programming (CHP) is an approach to health planning which is based on the above principles. In order to understand CHP today it may be useful to take a quick look at its past history and see where we stand now. At the beginning of the 1970s WHO reasoned that since the planning concept called "systems analysis" had been so effective in planning for industry, it ought to be equally useful for the health sector. A special development group was formed, which drew up a 300-page manual called "Health project management", describing in detail how to carry out planning based on systems analysis (*2*).

However, in the meantime WHO realized that there was a great need to develop a planning approach suitable for studying the totality of a country's

[a] Reproduced from the lecture by Dr Asvall, Regional Officer for Country Health Programming.

health problems and identifying priority programmes for health services development. The basic analytical steps of the health project management concept were therefore examined and modified to form a method called "country health programming". Provisional "Working guidelines for country health programming" were drawn up, field tested in Bangladesh in 1973, and issued the following year (*3*). Since then the method has been further developed, and at present more than 30 countries are using it or are engaged in training for the purpose. In the European Region CHP on a national level has been undertaken only in Algeria, where it was started in 1975 and has since been followed up with planning exercises. A regional CHP exercise is being conducted in the Province of Vizcaya in Spain. Finally, Portugal has just decided to take up CHP, starting with a regional pilot exercise in the north-east of the country. In all the countries where CHP has been introduced, WHO has been active in assisting in training for the purpose and also in practical introduction of the planning method.

These five years of work in many countries have provided broad experience in CHP, and WHO conducted three interregional meetings from 1976 to 1978 to discuss the experiences. Following the last meeting (Brazzaville, 1978), it was decided to revise the 1974 "Guidelines"; the new version has not yet been finalized by WHO headquarters, but I will describe below the main principles agreed upon in Brazzaville. You will also find that there are certain discrepancies between my presentation and the guidelines. Before proceeding I should like to give one word of caution. CHP is not an elaborate, detailed and rigid set of rules and planning tables covering all aspects of health planning and presenting ready-made solutions to all problems facing planners. Rather, it is a broad approach to health planning which is based on a specific health philosophy, provides a logical and step-by-step analytical technique for the formulation of plans and advocates certain principles with regard to the organization of planning. These basic principles are set out in the "Guidelines". In spite of the assistance often given by WHO to countries in adopting CHP, it is a fundamental principle that planning should remain a *national* responsibility. This implies not only that the planning must be undertaken by the national authorities and that there must be a full national commitment to this method before it is adopted, but also that each country must be willing to spend considerable time and effort in adapting the CHP guidelines to their own health problems and health care system.

So far such adaptation has been concerned almost exclusively with developing countries, so there has as yet been only limited experience in applying the method under European conditions. It is widely recognized that health care priorities in industrialized countries are quite different from those in developing countries, and evaluating the relevance and appropriateness of the sophisticated health services of many European countries poses a formidable challenge for any health planning system, including CHP. On the other hand, it is also clear that the basic principles of CHP – principles which

I will describe – are at the core of major issues in European health care. The Regional Office has therefore foreseen a number of development activities aimed at adapting CHP to European conditions, and this work will surely continue in the years ahead.

I mentioned before that CHP has three different aspects: a health philosophy, a health planning technology and some organizational principles. I will now take each of these aspects separately and mention some factors of particular relevance to planning of the nursing component of health services.

The health philosophy of CHP

In many countries, health planning is concerned almost exclusively with the planning of health services, its approach being mainly one of projecting past trends into the future and determining the corresponding needs of manpower and money. CHP rests on the philosophy that health problems to a large extent are caused by factors related to the development of other sectors of society, sectors which the health services can only rarely influence. Consequently, an effective health care strategy must go beyond the health services and actively involve the other sectors of society in a coordinated manner.

Furthermore, the hectic search for even more sophisticated medical technology has led to a relative neglect of preventive strategies. Health planning therefore should be concerned much more actively with the development of preventive strategies, both within and outside the health services. Thus CHP encourages health planners to seek other, innovative and more relevant, ways to solve health problems than is often the case in current national health planning. It focuses on setting priorities in health care development as a fundamental requirement, in recognition of the fact that health plays a key part in social development and as such is at the core of a country's development in a wide sense.

This link between health and general development has long been recognized for developing countries where poor health has been associated with low socioeconomic development. More recent is the recognition that a high living standard has dangerous side effects which threaten the health of populations. Identifying such cause/effect relationships then becomes an important issue in CHP, which must therefore be a national process designed to stimulate more conscientious social development, with high priority given to the health status of the population.

Relevance of CHP to nursing programmes

The implication of the strategy described for planning the nursing component of health services is partly that planners must consider effective health promotive or disease preventive aspects of nursing and partly that they must see how nurses can be effective in encouraging those in other sectors to adopt

more health protective measures. The strategy poses formidable challenges with regard to creativity and innovation; it takes courage to look critically at one's own time-honoured conceptions and to face the entrenched conservative thinking of other groups in society. Already in 1966 the WHO Expert Committee on Nursing pinpointed the problem by stating that "minor modifications of existing nursing systems will be inadequate to meet new situations and demands in a rapidly changing society . . . nursing must break with some of its traditions as well as older existing stereotypes" (*4*). This means not only that professional nurses should be willing to face new tasks and problems, but also that they should have the wisdom to transfer some of their traditional tasks to other categories of personnel who are equally capable of performing them.

Such basic reassessment is needed in several aspects of nursing care, and indeed many ideas have emerged from discussions on these issues which have taken place in recent years, for example, those of a working group on nursing aspects in the care of the elderly (Berlin (West), 1976) (*5*). While recognizing the traditional role of the nurse in care of the acutely and chronically ill elderly population, the group called for a new role for nurses in conducting preventive and supportive programmes to help the elderly retain health and adapt to aging and to maintain or improve the quality of living. Furthermore, it was observed that the population at large should be educated to understand the normal physiological and psychological changes that come with advancing years and be helped to recognize and accept them as a part of life. Enjoyment of life, possibilities for social contact and independent mobility could be much improved by timely advice and assistance from nurses on such matters as foot care, hearing, eyesight, nutrition, prevention of accidents in the home, provision of household aids and so on. In care of the chronically ill, psychological as well as physical aspects should be included in the scope of nursing, with essential training also provided in the social, psychological, cultural and medical aspects of dying, death and bereavement.

In delivering such care, nurses should be trained and willing to detect not only physical but also social and psychological problems in the patient's family and social group, and to consider the involvement and solicit the cooperation of support groups outside the health services, such as voluntary organizations and cultural groups.

A working group on the role of nursing in primary health care (Reykjavik, 1975) drew up an extensive list of activities within the general framework of nursing (*6*). It was considered that the role of the nurse was to provide physical and mental health care in sickness and health, assess an individual's state of health, prevent illness and promote health, provide emotional support for the healthy, the sick and the dying, advise on the establishment and maintenance of a healthful environment, contribute to health education, participate with the physician in the implementation of medical services, advise on and provide rehabilitative care and, finally, coordinate and interpret to the client the health services provided.

This role of nursing may seem to be very wide and to represent a radical departure from the present role whereby the different categories of health personnel tend to be more and more sharply defined and restricted. However, in looking closer at this role we find that it describes functions which were in the past and are still in a number of countries carried out by public health nurses. This applies particularly in more remote communities where the nurse, through her direct patient care activities, wins understanding and support for an extended role as an adviser to individuals, families and communities on how to cope better with their functional disabilities, deal with risk factors and actively promote health through better nutrition, increased physical activity and improved interpersonal and social relationships.

In analysing the contribution of nursing to health our problem should therefore not be so much to seek out an unknown role for nursing, but rather to reinforce, strengthen and further develop long accepted practices which have proved their value. Needless to say, certain practical modifications are needed due to structural changes in society, like changing family patterns, increasing urbanization, etc. Also, the growth in the number of other health personnel working alongside nurses creates new challenges for teamwork, challenges which sometimes make painful adaptations necessary.

There is little doubt in my mind that if a role for nursing such as that described were actively promoted by national authorities, with a clear and realistic description of a comprehensive nursing programme within the health care plan, it would gain wide support by filling a deeply felt need in many countries.

However, it is clear that in many countries this step would necessitate a modification of the present system of nursing education in order to prepare nurses more effectively for the general preventive and health promotive aspects of their role in relation to individuals, family groups and communities. Just as now we have finally realized that we need to base physician services on one general practitioner for the community, I believe we should likewise rely on one type of well educated "general nurse" for a given community.

Health planning technology in CHP

As I mentioned previously the analytical steps followed in the CHP are based on systems analysis concepts. However, this does not mean that the planning is a highly technological process using complicated mathematical formulae. Rather, it is carried out using a systematic outline of a number of steps (20 in all) which one must take in developing health programmes, from preplanning to implementation and, finally, evaluation of the work done. The basic characteristic of the analytical pathway followed in CHP is that it focuses attention on analysis of the problems and takes these as the starting point for developing plans and for programming the services needed to carry out the health care strategy laid down in the plans. Furthermore, the planning

process does not stop with formulation of the document entitled "plan", but continues to the implementation stage and, as mentioned, to that of health programme evaluation. This overriding concern with focusing attention on problems is characteristic of systems based on "management by objectives". Similarly, the subsequent resource planning is based on a programme budgeting approach in contrast with many existing national systems, which are based on a resource planning philosophy whereby the expected outcomes and benefits to the populations are seen as implicit rather than explicit determinants of the health plan.

Thus it is quite clear that the CHP concept cannot be adopted without certain problems arising for many countries, in particular European countries which have long-standing extensive budgetary systems not essentially geared to this type of thinking. The issue in this Region will therefore be for each country to look at its own health planning system and to try and incorporate those CHP principles it is lacking, in such a way that a gradual improvement is effected over a period of time.

Central principles in this respect are the need for: study of a country's health problems in their totality through a more conscientious and comprehensive analysis of information on the health status of the different population groups; basic review of current health strategies in relation to present knowledge of preventive measures; systematic review of possible obstacles to the different health care strategies which are suggested, with active involvement of sectors other than health in the delivery of health care; and detailed programming of health care activities and use of resources on the basis of quantified and time-specific targets set in order to achieve the objectives of each health programme.

CHP can be divided into four stages:

- stage 1: policy basis, data collection and data analysis;
- stage 2: situation analysis and broad programming;
- stage 3: detailed health programme formulation;
- stage 4: implementation and evaluation.

First stage of CHP: policy basis, data collection and data analysis

Data collection and data analysis are shaped by the fact that in no country does planning start from zero, i.e., there already exist government directives, laws and regulations giving a frame of reference for the health care system and for socioeconomic development in general. The first stage of CHP includes collection of data on these aspects as well as information on the demographic, economic, financial and health situation, the health resources and the health organization.

For the nursing component this stage includes compilation of nursing legislation and information on nursing activities and their use of resources. The WHO document "Planning and progamming for nursing services" (7) reviews the type of information which should be collected for analysis of the nursing situation in a country, i.e., information on:

(*a*) the system, both public and private, through which health services are delivered;

(*b*) the organization of health services having a nursing component, i.e., the types or categories of services, the number, size and geographical distribution of each category of service, the programmes of each category and the nursing functions undertaken in each programme;

(*c*) the organization of nursing within the health sector;

(*d*) legislation on nursing practice, nursing education and general education;

(*e*) the structure of the nursing personnel system, i.e., categories of nursing personnel;

(*f*) the nursing manpower available according to category, sex, level of training, type of function (care, management, teaching, research) and type of service;

(*g*) the deployment of nursing manpower;

(*h*) the adequacy of education and training, i.e., the extent to which nursing personnel in each category have been prepared for the functions they are performing and the number and types of in-service training programmes available;

(*i*) the utilization of nursing personnel, i.e., the types of nursing activities and tasks being carried out in each service and in the various programmes of each service, and the approximate amount of time being spent on each;

(*j*) the number of vacant positions existing in the services and the personnel policies of employing institutions;

(*k*) other purveyors of nursing care, i.e., the extent to which families can undertake nursing functions, the approximate numbers and distribution of nursing and midwifery workers lacking formal training, etc.;

(*l*) education and training programmes in nursing and their capacity;

(*m*) the potential nursing manpower supply, i.e., as influenced by factors like the level of general education, socioeconomic conditions, the reemployment of inactive married nurses, and the mobility of each category of nursing personnel.

Second stage of CHP: situation analysis and broad programming

This comprises several steps. The first, and in many ways the most important, is the definition of priority health problems in the country. This requires an overview of all the major health problems through an analysis of statistics on mortality, morbidity, temporary and permanent disability and economic effects of diseases, and an analysis of risk factors in the physical or social environment or in the behaviour of individuals which affect the health of the population.

The next step is the assessment of problems relating to current activities and use of resources for the solution of health problems. With regard to nursing this step would include determining what type of nursing care is available in a country and what problems are apparent with regard to delivery, organization, use of resources, coordination and education. In this matter, extensive use should be made of existing health services research performed in a field of nursing, as well as sampling or expert opinion through delphi technique surveys.

Following these two steps of analysis of problems comes that of setting of objectives. This unfortunately is often undertaken rather lightly as a kind of ritual exercise. However, as CHP is based on the principle of management by objectives, enough time and effort should be spent in choosing objectives which reflect the main problems that have been identified and which give clear guidelines on the direction that future development should take. Only then can objectives become effective tools of planning and serve as guiding principles for subsequent decision-making.

After the setting of objectives comes the definition of health strategies. This is the step which poses the most serious challenge to the health planner, and here the need for critical analysis, innovative thinking and creative synthesis is most evident. On the basis of the problem analysis, the planner must identify all possible ways to improve the health situation and design clear-cut alternatives for solving the problems. In so doing the planner must have in the forefront of his thinking possibilities for preventive and health promotive activities in the health and other sectors. With regard to the nursing component, alternative strategies will evolve around issues mentioned previously, i.e., whether the nursing role in primary health care will comprise only isolated tasks of care for the acutely or chronically ill or whether it is to include the broader aspects of rehabilitation, prevention and health promotion; and whether this function is to be performed by one nursing practitioner or a series of specialized nurses, as at present in many countries where there are separate school health, home care, occupational health, maternal and child health and public health nursing services.

An important requirement in selecting a strategy as outlined above is to make a systematic review of the obstacles which could be met in implementing the different strategies. As mentioned, such obstacles could be of a technical,

political, financial, cultural or administrative nature. Failure to recognize obstacles and to learn how to overcome them has been the cause for failure in many health planning exercises, and CHP therefore puts particular emphasis on the analysis of obstacles. With regard to nursing, possible obstacles would be resistance from nurses, other health professionals, the public or politicians to accept the nursing role suggested; lack of appropriate training of nursing personnel to take on advisory functions in regard to health prevention and promotion for individuals or communities; lack of a legislative basis for improving nurses' access to planning or decision-making bodies, etc.

Setting quantified and time-specific targets to meet defined health objectives is the next step. Such targets should include measurement of the care to be provided to population groups through nursing activities undertaken in accordance with the broad strategies outlined in the previous step.

On the basis of the analysis done so far, proposals for broad priority health programmes are drawn up for a medium-term period (usually 4–5 years). For each programme, they present specific objectives and targets, a list of activities necessary for its implementation, a broad statement of the human, material and financial resources to be allocated and a general time sequence over the medium-term period for carrying out the activities.

In my opinion it would be appropriate to see nursing services as a single health care programme – not of course as a separate programme, but rather as one which has extensive input in many fields of health care as well as health manpower development. Such a nursing programme should specify the number of patients requiring care, the categories of care required (intensive, partial, promotional), the productivity of nursing personnel, the nursing activities performed by non-nurses (including patients and families), the standard of care to be provided, etc.

The degree of detail which should be given in this "broad programme" would differ according to local conditions. However, the guiding principle is that the broad programming should stop at a level which is sufficient to give top decision-makers a clear understanding of the policy to be adopted, the benefits to be expected, the resources required and the organizational changes needed in order to carry out the different alternatives of the plan.

At this stage the planning document is submitted to the high level policy-makers for consideration and choice among the alternatives proposed.

Third stage of CHP: detailed health programme formulation

This stage comprises a more detailed review of the different health activities which have already been identified and for which broad programming has been carried out. The planner's task is to analyse and define, in operational terms, the activities to be undertaken, their spatial distribution, the information support needed, the training programmes to be developed, the services required and resources to be provided, the assignment of functions and

responsibilities for carrying out specific activities at central, intermediate and community level, etc. Again, the question of detail in planning arises. The document "Planning and programming for nursing services" (*7*) gives good advice on this point, as follows:

> "Comprehensive health planning does not mean planning down to the last detail or presenting all conceivable alternatives. The law of diminishing returns would make such a process uneconomic. Comprehensive health planning should:
>
> (*a*) take into account *all* important aspects of the health situation;
>
> (*b*) focus on those health problems where the greatest improvements can be achieved with the limited resources available; and
>
> (*c*) systematically expand in scope and effectiveness as planners gain in experience and understanding."

This programming should also include a constraint analysis, with an examination of possible obstacles to the detailed plan of action which has been elaborated.

The CHP document is then submitted for final approval by the administrative and political decision-makers.

Fourth stage of CHP: implementation and evaluation

Since in many countries the budgetary system is not fully coordinated with the health planning system, it is imperative that the policy, activities and resource allocation specified in the health plan produced by the CHP exercise be reflected in the budgets of all those public and private bodies which are supposed to contribute to its implementation. Likewise, steps must be taken to ensure that the health manpower planning and educational programmes are modified to suit the requirements of the health plan. In nursing these considerations are of particular importance since the services are often administered independently by many bodies (state, district or municipality authorities, voluntary organizations, professional associations, corporations, etc.). The foregoing applies equally to educational programmes.

CHP should include designing of the managerial process necessary to ensure that the health plan is carried out in practice, with monitoring of implementation of activities and use of resources. Closely linked to this requirement is the need for a review of the programme management information system to ensure that it is capable of delivering information at the times needed and at the appropriate level of management.

Finally, CHP should include specification, by programme area, of the criteria to be used for routine evaluation of the activities. The evaluation should relate not only to process (time used, number of activities provided,

resources spent) but also to outcome in terms of effectiveness and wider health impact of programmes.[a] For the nursing programme, evaluation criteria should be proposed for application at the local and central levels of management.

Organizational aspects of CHP

The third characteristic of CHP is that certain organizational principles are laid down. Underlying these principles is the belief that health problems can no longer be solved by the health services alone and also the conviction that if sectors other than health will be contributing actively to the solution of the problems, they must be actively involved in the planning process at top level. The CHP model therefore advocates that the planning exercise should be done under the supervision of a steering committee. A leading official in the ministry of health (e.g., director-general of health or state secretary for health) should be chairman of the committee, which should also include senior representatives of the different health sectors as well as the ministries of planning, education, housing, agriculture, environment, etc., depending on which are found to be crucial in influencing health status in the country.

The committee would, however, not have the time or expertise for the practical aspects of planning, which should be carried out by a special planning group. This group would work under the committee and have attached to it a number of *ad hoc* technical subgroups for study of the many specialized problems which emerge during the planning.

While the first phase of CHP (stages 1 and 2, leading up to broad programming) would mainly be the responsibility of the planning group, detailed programming could in many instances best be done by more specialized groups for different planning areas. In many cases this programming should preferably be carried out at peripheral level, depending on the planning system of the country.

In this structure it is imperative to ensure representation of nursing in the CHP planning group, as well as in several of the specialized groups for different planning areas. How this should be achieved depends on the administrative structure, as many countries do not have high level representation of nursing in the national health administration. My view, however, is that it would be difficult to develop a sound nursing programme when the necessary backing of the national health administration is not ensured through a competent nursing authority within the ministry of health or similar body. However, such problems may be partly overcome when national health councils are formed, have appropriate nursing representation and exercise decision-making power.

[a] WHO recently developed a draft guideline for programme evaluation which is to be tested in different health programmes in the European Region.

Clearly, for nurses to have strong input in the formulation of a health plan in a CHP exercise, they need basic training in the analytical methodology of the programming. WHO has developed standard guidelines for the organization of workshops to teach CHP to health personnel and health administrators. The Regional Office has assisted in holding such workshops and more are foreseen in 1979. Important in this respect is the fact that CHP is not an exercise applicable only at the national level. As stressed by a recent working group on education of managers in health services (Düsseldorf, 1977), planning is a management function and must therefore also relate to patient care in a clinical setting (*8*). This means that groups of health personnel, including nurses, require intensive training in planning and management principles if they are to have a full understanding of their role in the general health system and to orient their activities, and those of their subordinates, in line with the objectives set for the health services as a whole.

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Annex III

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