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FINANCING AND STRUCTURAL ARRANGEMENTS FOR THE FAMILY HEALTH NURSE

Report on a WHO Meeting

Barcelona, Spain
28–29 April 2000

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EUROPEAN HEALTH21 TARGET 18

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DEVELOPING HUMAN RESOURCES FOR HEALTH

By the year 2010, all Member States should have ensured that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote health

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

ABSTRACT

To take forward the concept of the family health nurse in primary health care, the meeting examined mechanisms of financing and implementing this concept in different health care systems. The aims were: to discuss how to introduce the concept of the family health nurse into different health care systems; to assess the implications of the concept; and to identify the structural and financing arrangements that would be required. The participants comprised a consumer representative, nurses, midwives, doctors and third-party payers.

The participants formed working groups to discuss various themes: integration, financing, and the range and coverage of nursing services in primary health care. Three models of health care systems were considered: the Beveridge model, the Bismarck model, and that of countries in the transition phase. Based on the discussions in the working groups, the participants made specific recommendations for the implementation the concept of the family health nurse in different health care systems.

Keywords

NURSING
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PRIMARY HEALTH CARE
ECONOMICS, NURSING
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Introduction

The health care reforms of the 1990s in Europe have had two common features: rising health care expenditure and decentralization of decision-making. Objectives such as prevention and pursuit of equity have not been high on the agenda. Consumers' rising expectations and unfulfilled health needs must be seen as challenging market gaps where nurses, among others, can provide real opportunities related to the health of all people.

In recent years it has become clear that significant contrasts in health inequities, unemployment, homelessness and poverty are not confined to the developing countries but also to many of the richer ones. The WHO Regional Office for Europe has, therefore, introduced HEALTH21, the health for all policy framework for the WHO European Region, as a comprehensive model to meet this new situation. By being more productive, having a longer working life and participating more actively in their communities, healthier people can contribute to society and become more effective citizens.

As defined in HEALTH21, the family health nurse model provides a comprehensive approach to nursing in primary health care (Annex 1). Together with eight Member States, WHO will select demonstration areas to test appropriate models of family and community-oriented nursing in different countries. Representatives of government, health insurance funds, nursing associations and consumers were invited to attend a meeting in Barcelona in April 2000 to discuss the implications of the family health nurse model, its infrastructure and financing requirements, and the pilot schemes.

Family health nurses act as front-line workers in listening to consumers and are a new resource for the public through empowering clients to take responsibility for and make informed choices regarding their health development. The target groups of the family health nurse will include a number of families and individuals living within a defined geographical area, covering all age groups as well as the community itself. The activities of the family health nurse include health promotion and disease prevention, curative care of illness, care in the final stages of life and rehabilitative care.

The literature suggests that excellent outcomes can be achieved in effectiveness, cost-containment and patient satisfaction by employing nurses and using their expertise in the community. The implementation of the family and community nursing services appears to be easier in countries where the national health care system ensures universal coverage and a comprehensive range of health services than where health care systems are predominantly based on health insurance. In countries with experience of public health nurses' services, all social groups accept them and about 95% of families use them. These positive results would suggest that the role of family health nursing is worth further exploration.

The meeting was held at the WHO European Centre for Integrated Health Care Services in Barcelona on 28 and 29 April 2000. It was attended by 20 representatives and observers of ministries of health, nursing education, nursing and midwifery associations, health insurance funds, consumers and the WHO Regional Office. The participants formed an expert group representing health care systems based on the Beveridge model, the Bismarck model and countries in the transition phase from central control. Ms Gillian Biscoe from Australia was invited to facilitate the meeting (list of participants in Annex 2). Ms Ragnheidur Haraldsdottir

chaired the meeting and Dr Mårten Kvist was nominated as rapporteur until the arrival of Dr Marjukka Vallimies-Patomäki, who thereafter continued as rapporteur.

Ms Anita Simoens-De Smet and Ms Ragnheidur Haraldsdottir were the chairpersons and Ms Madrean Schober and Dr Grazyna Wojcik the rapporteurs of the working groups.

Objectives and process of the meeting

Ms Gillian Biscoe described the purpose and the process of the meeting. The objectives of the meeting were:

- to discuss how to introduce the family health nurse concept into different health care systems
- to discuss the implications of this expanded model, and
- to identify the structural and financing arrangements that will be required.

The programme is in Annex 3. During the opening presentation Dr Mila Garcia-Barbero described the main roles of WHO and the main tasks of the WHO European Centre for Integrated Health Care Services in Barcelona.

During the first day the objectives of the meeting were dealt with in discussions and in a presentation given by Mr Harald Kesselheim in a plenary session. Discussions continued in parallel working groups on the following two themes, which were introduced through two presentations of ten minutes in each working group:

- How can family health nursing services be integrated into and financed as part of primary health care in different health care systems?
- How can the comprehensive range and the universal coverage of the family health nursing services and direct access to them be ensured in different health care systems?

During the second day the working groups reported their conclusions to a plenary session. After the feedback session the participants discussed the possible family health nurse models in different health care systems in groups of three or four people. The smaller groups again reported their final proposals to a plenary session.

Family and community-oriented nursing services in primary health care in different health care systems

Mr Kesselheim introduced the nursing perspectives in home care in Germany (Annex 4). Health policy in Germany has changed considerably during the last decade. The aim has been to promote the integration of medical care, nursing, rehabilitation, and preventive and social services and at the same time to prevent excessive use of the services. Since the long-term care insurance came into force in 1995, the amount of home care has increased by 75% and the number of institutional care providers has doubled. However, there are deficits in the structures and processes of the current nursing services which need to be addressed if the use of expensive institutional care is to be reduced, efficiency increased, and integrated care and evidence-based and quality-oriented nursing services developed.

According to Mr Kesselheim, health insurance funds in Germany support the use of nursing services in long-term care. He was of the view that the implementation of the family health nurse concept would contribute to the necessary changes in nursing in Germany.

During the ensuing discussion, the participants paid attention to the definition of the family health nurse on the basis of the HEALTH21 policy, the expanded versus the traditional roles of nursing and the implications of the changed structure of primary health care. They emphasized the development of patient, family and community orientation in basic and continuing nursing education. However, there were some concerns about the possible paternalistic approach of family health nursing.

Working groups

Mr Kesselheim (Annex 4), Dr Marjukka Vallimies-Patomäki from Finland (Annex 5), Dr Grazyna Wojcik from Poland and Ms Elena Stempovscaia from the Republic of Moldova (Annex 6) introduced the first theme in the working groups. The second theme was introduced by Ms Anita Simoens-De Smet from Belgium (Annex 7), Ms Teresa Icart from Spain (Annex 8), Ms Ragnheidur Haralsdottir from Iceland and Ms Monika Klampfl from Austria (Annex 9).

The presentations and ensuing discussions resulted in the following conclusions.

Nursing services in primary health care in Finland, Iceland and Spain representing countries based on the Beveridge model

Finland and Iceland have primary health care systems going back about 30 years, while the current health care system in Spain was established in 1986 and the reform has not yet been completed in the entire country.

Financing:

- In Finland and Iceland nursing services are financed mainly through tax revenues via the state budget.
- In Spain financing is based on the participation of the communities in the general health care budget, but there is a general trend towards private insurance.

Legislation:

- In Finland and Iceland, legislation defines primary health care as a cornerstone of the health care system and the responsibility of the local authorities.
- In Spain, Catalonia, Andalusia, the Basque country and Valencia have their own public health services while the National Institute of Health is the largest public health service in communities which do not have autonomy in providing health services.

Coverage:

- Coverage is universal.

Service providers:

- In Finland and Iceland nursing services in primary health care are provided in municipal health centres across the country.
- In Spain the national network of public health care centres forms the basic level of health care.

Range of nursing services:

- Comprehensive.

Other aspects:

- In Finland and Iceland, legislation and education provide the necessary requirements for the expanded nursing role in primary health care.
- In Spain, the health care reform has improved the opportunities to provide preventive services for the public.

Nursing services in primary health care in Austria, Belgium and Germany, representing countries based on the Bismarck model

Financing:

- In Belgium and Germany, nursing services in primary health care are financed through statutory insurance. Money is allocated directly to the agencies against a bill.
- In Austria, nursing services are financed by the state, provinces and municipalities. Health insurance funds do not cover health promotion or illness prevention.

Coverage:

- Coverage is universal in Austria and Belgium.
- In Germany, the long-term care insurance covers 98.5% of the population.

Service providers:

- In Austria, welfare associations and the municipalities are the providers.
- In Belgium, general practitioners (GPs), centres for general medical care, the private sector, cities, the Roman Catholic church and associations related to patient groups all provide services; different health centres provide services for children, young people and industry.
- In Germany, GPs, groups of nurses, church, charity and welfare organizations and the community are the providers.

Range of nursing services:

- Nursing services in primary health care mainly comprise home nursing; preventive services are quite limited.
- The grade of the home nursing services is based on the professional assessment of the patient's needs. The number of the grades of the benefits varies in different countries.

- In Germany the modes of the benefits in home care consist of monetary benefits, professional care or a combination of both and institutional care.
- In Belgium an alternative pattern of care has been developed and resources have been allocated for home nursing services and short periods of institutional care.
- In Austria nursing services cover home nursing care, home help provided by auxiliary staff and meals on wheels. Only few health promotion and health education activities are provided in home nursing.

Other aspects:

- The purpose of the benefit system is to diminish the use of institutional care.
- The great diversity of health service providers may cause overlapping and the need to coordinate the services.
- Quality assurance is essential to gain financing for nursing services.
- Home nursing is provided by nurses with hospital-based education.

Nursing services in primary health care in Poland and the Republic of Moldova, representing countries in the transition phase

The health care reform in Poland starting in 1995 has focused on the development of primary health care and resulted in an increasing number of GPs, restructured hospitals network, communalization and privatization of the health care infrastructure and an increasing number and diversity of non-public service providers. In the Republic of Moldova the health care reform is also focusing mainly on primary health care.

Financing:

- In Poland nursing services except school nursing are financed through insurance funds.
- In the Republic of Moldova the financing of family nursing is based on the national budget. Health insurance is supposed to be implemented in the future.

Coverage:

- In Poland coverage is universal.

Service providers:

- In Poland nursing services are provided by public and non-public health care organizations, GPs, non-public nursing organizations and independent nursing practices.
- In the Republic of Moldova the family doctor and the family nurse systems have been introduced. Certain people in vulnerable groups are assisted by charity organizations and the church.

Range of nursing services:

- In Poland the reform has resulted in a diversity of the roles of the community and family nurses.

- In the Republic of Moldova the minimum benefit package guaranteed by the state covers emergency care, immunization and care of patients with cancer, tuberculosis and diabetes. Nursing services are based on the comprehensive development of family nursing.

Other aspects:

- In Poland nurses and midwives working in primary health care have gone through an intensive process of preparation, including family nurse and nursing director education.

Conclusions

The working groups drew the following conclusions on the basis of the presentations and discussions.

1. In countries based on the Beveridge model, nursing services in primary health care are available to everyone throughout their lifetime.
2. In countries based on the Bismarck model, nursing services in primary health care focus on insured people while the poorest part of the population may opt out.
3. Countries in the transition phase are reforming primary health care and developing family and community-oriented nursing services.
4. In the insurance-based systems, financing is also available for the family health nursing services but reallocation of the resources will be required.
5. The health insurance funds will finance nursing services based on the family health nurse concept if the quality of the services meets their requirements.
6. The implementation of the family health nurse concept will give rise to about 1.6% additional costs, mainly due to education.
7. The legal position of the nurses is an essential requirement for the implementation of the family health nurse concept.
8. In the insurance-based systems, there is overlapping in home nursing services while the supply of health promotion services is quite rare.
9. Nursing practice is not based on family and community-oriented education in many countries.

Final proposals

Participants gained a better understanding of the financing of family and community-oriented nursing services, how they are integrated into primary health care and their range in different health care systems. However, the objectives related to the provision of the models of financing family health nursing services, particularly in countries based on the Bismarck model, were not entirely achieved.

The following proposals were made on the basis of the discussions.

1. Implications of the family health nurse concept from the perspective of people's needs:
 - primary health care should be strengthened as a base line of the health care system;

- the focus should be on the entire population and different target groups in a certain area;
 - access to nursing services in primary health care based on the needs of individuals and families should be improved;
 - clients' involvement should be strengthened;
 - a complementary option should be provided for clients;
 - quality, continuity and the range of the nursing services should be improved as compared with existing services;
 - there should be greater understanding of people's needs and the effects of lifestyles;
 - there should be greater awareness of the need for information and social support;
 - comprehensive working patterns and a holistic approach in nursing practice should be strengthened;
 - integration of the health and social services as well as between health services at the different levels should be improved;
 - networks should be promoted with other sectors and consumers' organizations;
 - the division of work between health care professionals should be developed.
2. The changed health care structure should result in the development of:
- regulatory and financial arrangements to ensure equal access to family health nursing services;
 - primary health care services according to the needs of the population and local circumstances;
 - a comprehensive range of family health nursing services as an integral part of the multidisciplinary approach in primary health care;
 - mixed payment systems to promote health policy priorities and the same value to be attached to nurses as to other health care professionals.
3. The implementation of family health nursing services in countries based on the Beveridge model should:
- be in accordance with the legislation regulating primary health care;
 - be based on the current primary health care service and financing system;
 - develop nursing education and working patterns in primary health care on the basis of the family health nurse concept and within the primary health care definition adopted at the Alma-Ata Conference in 1978 and re-affirmed twenty years later in Almaty, Kazakhstan.
4. Implementation of family health nurse services in countries based on the Bismarck model should:
- increase an understanding of the family health nurse concept and its impact on health;
 - allocate the existing resources and funds to family health nursing services;

- yield evidence related to the quality and effectiveness of the family health nursing services for the insurance funds;
- assess the cost-effectiveness of the family health nursing services at the national and European level;
- ensure that clients may choose between different options and have equal access to nursing services;
- coordinate the different health care service providers in primary health care;
- expand the range of nursing services covered by the insurance funds from home nursing to health promotion and preventive services;
- reorientate the working patterns in primary health care on the basis of the family health nurse concept;
- develop both basic and continuing education on the basis of the family health nurse concept.

Closure of the meeting

Ms Ainna Fawcett-Henesy expressed her warmest thanks to the participants. She said that the Regional Office will continue collaborating with the pilot countries over the preparatory work related to the provision of the appropriate financing and structural models for the implementation of the family health nurse concept in different health care systems.

Ms Ragnheidur Haraldsdottir also expressed her gratitude to the participants for their contribution during the meeting and emphasized the remarkable efforts and achievements by Ms Ainna Fawcett-Henesy in developing and strengthening nursing in Europe.

Annex 1

SCOPE AND PURPOSE

The family health nurse is a relatively new concept promoted by WHO in *HEALTH21: an introduction to the health for all policy framework for the WHO European Region*.¹ The concept was developed out of a belief that the family was the most important unit in society and could benefit from having direct access to the services of a nurse competent to work along the health illness continuum. Additionally, there was an increasing body of evidence which suggested that nurses who worked in this way could reduce the burden of disease, provide valuable support to families (especially those in need), and be cost- and clinically effective as well as being well accepted by the public.

While there is evidence that nurses working in community settings can be found in most of the 51 European Member States, there are huge variations in how that role is carried out. The proposed new model offers a comprehensive approach to the modern family along the whole health-illness continuum, paying special attention to the empowerment of individuals, families and communities. The role is envisaged to take account of the critical periods along the life course as well as meeting the special needs of marginalized and vulnerable groups.

The aim of the meeting in Barcelona is to discuss how best to introduce this expanded model of nursing in the countries of Europe and the implications of this model, and to identify the structural and financing arrangements that will be required to realize this objective. The outcome of the meeting will be used to develop guidance as well as a methodology to test the family health nurse concept in some selected Member States. Representatives of government, health insurance funds, nursing associations and consumers are invited to participate in the meeting

¹ Copenhagen, WHO Regional Office for Europe, 1998 (European Health for All Series, No. 5).

Annex 2

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Annex 3

PROGRAMME

Friday, 28 April 2000

- 09:30 – 10:00 *Registration*
- 10.00 – 10.10 Opening and nomination of chairman and rapporteur, *Mila Garcia Barbero*
- 10.10 – 10.20 Introduction of the scope and purpose of the meeting, *Ainna Fawcett-Henesy*
- 10.20 – 10.40 Family health nurse – a new opportunity to provide comprehensive nursing services for the public, *Ainna Fawcett-Henesy*
- 10.40 – 10.50 What is the added value of family and community-oriented nursing? Research results and country evidence, *Marjukka Vallimies-Patomäki*
- 10.50 – 11.00 Discussion period
- 11.00 – 11.30 *Coffee break*
- 11.30 – 12.00 Perspectives of nursing in home care, *Harald Kesselheim*
- 12.00 – 12.20 Introduction to the working groups, *Gillian Biscoe, Facilitator*
- 12.20 – 13.00 *Working groups*: How can family health nursing services be integrated into and financed as a part of the PHC system in different health care systems? (Brief introductions to the theme)
- 13.00 – 14.00 *Lunch*
- 14.00 – 15.00 Working groups (continued)
- 15.00 – 17.00 *Working groups*: How can the comprehensive range and the universal coverage of the family health nursing services and direct access to them be ensured in different health care systems? (Brief introductions to the theme)
- 17.00 – 17.15 *Brief reports from working groups*: Work in progress
- 17:15 *Closing – first day*

Saturday, 29 April 2000

- 09.00 – 10.00 *Working groups*: Final conclusions and development of plenary presentations
- 10.00 – 11.00 *Feedback from working groups*: How to employ family health nurses, ensure direct access to clients and finance family health nursing services in different health care systems, *Gillian Biscoe, Facilitator*
- 11.00 – 12.30 *Discussion*: Implications and strategies how to implement the family health nursing services in different health care systems on the basis of the working groups, *Gillian Biscoe, Facilitator*
- 12.30 – 12.50 Conclusions and final strategy, *Ainna Fawcett-Henesy*
- 12.50 – 13.00 *Closing*, *Mila Garcia Barbero*
- 13.00 – 14.00 *Lunch*

Annex 4

PERSPECTIVES OF NURSING IN THE GERMAN HOME CARE SYSTEM

Harald Kesselheim
Head
Long Term Care Department
AOK-Bundesverband
[Federal Union]

Ladies and Gentlemen,

The German health-care policy has changed considerably in the last decade. Demographic changes and the knowledge that the approximately 280 billion DM available in the health-care system from health insurance and long-term care insurance together - that's more than 15% of the salaries - have to suffice, has led to a series of reforms.

For German politicians at least, new terminology has played its part in these reforms, i.e. managed care and disease management.

The aims of this discussion are not new for nurse practitioners: for a long time it has been their aim to administer the complex situation of those requiring care. It must incorporate the correct amount of medical care, nursing, rehabilitation, preventative and social nursing and services in each individual case and at the same time forego superfluous and questionable methods of treatment and aids.

The scope of action of nursing is characterized by structural defects. In particular, there are intricate supplies and financing structures as well as a surplus in services offered, which determine the demand.

In the period between the start of the new long-term care insurance in 1995 and today, the total amount of home care services has increased by 75% to around 12 000.

In the same period, the amount of providers of institutional care has about doubled. Altogether, there are also around 12 000 institutions. The waiting lists we had in former days are now history!

In comparison to 1995, there were only around 200 000 more beneficiaries in 1999.

During 1999, health insurance and long-term care insurance paid out more than 30 billion DM to the service providers. If you include payments made by individuals and welfare institutions, altogether around 50 billion DM is made available annually for the nursing of those requiring it.

The care for those requiring it is characterized by:

- the overvaluing of nursing on the part of the medical profession, which always takes second place to rehabilitation – especially of old people;
- the hospitalization and giving of medication for, amongst others, chronic illnesses; and
- the lacking interconnection and the considerable deficit in quality assurance.

This situation requires the control of the existing nursing care structures, nursing care procedures and scope of nursing care. The following expectations by those requiring care are the focus of this process:

- promotion of the network;
- involvement in the expansion of an efficiency-increasing incentive system;
- elaboration of guidelines for the determination of health-care standards;
- the application of nursing care based on evidence.

And a quality-oriented supply of services which bring the people out of short-term care and the institutional long-term care. We know: especially the elder people want to stay or to go back to their beloved home very soon!

Ladies and Gentlemen,

Whoever is chronically ill, must often learn in difficult processes, to live with his illness and to know how to adequately deal with complications and deteriorations of the situation. Nursing practitioners can help to maintain a bit of autonomy.

Home care is therefore more than just medically orientated care in the doctor's shadow. It must be in the position to offer integrated help in managing everyday life and holistic nursing concepts. It must serve the purpose of maintaining or regaining as much independence as possible despite the need for care and/or a chronic illness.

Home care is unthinkable without the family network and care by the layman. Around 70% of the beneficiaries of home care in Germany are nursed exclusively by relatives, friends and neighbours. This clearly shows that this network is an imperative link in the nursing chain.

However, the families need professional help in the form of advice, instructions, support and also relief for the running of the nursing procedure. This requires an increased turn towards procedural-orientated and situation-related treatment concepts in home care. These concepts must be characterized by respect for the individual and the ability to make autonomous decisions of the individual requiring care.

The important function carried out by the layman, therefore, is not realisable without the support of nurse practitioners. It is however necessary to dislodge nurse practitioners from their traditional duties. The German health insurers want - also by financial incentives - to encourage the use of nurse practitioners for planning the nursing processes and to promote the ability of those requiring care and their relations to look after themselves.

This change in structure is a lengthy, difficult process. The carers' associations predominantly pursue the goal of maintaining the current structure. Even initiatives to quality-assured work and to market transparency have hardly been welcomed with open arms.

Models and work organizations for the fields of outpatient and inpatient treatment are being developed with the accompanying help of the science of nursing – and with a look at our European neighbours. The basis for these models are nursing assessment procedures, on which the case history can build on, referring in fact to the individual's requirements.

In this context, we are concerned with RAI for example, with managed care and with the procedure P.L.A.I.S.I.R. in institutional care. Maybe situation-related nursing standards can be developed from this in the long term, nationally as well as institution-related.

A further keyword is "integrated home care", which however requires a new appreciation of the role of professional nursing. We are holding the specialist discussion of how high-quality nursing can be achieved for all those who require it. It must be made clear in the future which nursing activities can be delegated, and which ones should be left to the professionals.

Through the inclusion of semi-skilled staff, professional nursing obtains a new value as long as the professional staff are capable of making decisions about specific participation and the inclusion of other people into professional nursing and if the professional carers are given the necessary time, training and control.

This does not limit professional competence, but rather strengthens it. The decision of which team member takes over the professionally correct nursing is fundamental. This decision must be reserved for the responsible professional on the grounds of his/her knowledge of the specific situation. It is necessary to have a reasoning that is also comprehensible for the colleagues.

In perspective, this means that comprehensible and controllable indicators for various nursing situations within the nursing institution should be drawn up, with which the method and scope of professional and other services should be determined.

Of course, these indicators should be supplemented by evaluation instruments which make result-orientated care measurable. Planned and evaluated nursing procedures ensure the comprehension and quality-orientation for those requiring care, care institutions and service providers. With this, nursing could provide a comprehensive contribution to the whole quality of care, including preventative and rehabilitation aspects.

Ladies and Gentlemen,

This description of the environment of nursing activities shows that the discussion about the family health nurse has important pace-making functions for the necessary changes in the nursing profession. This approach is best suited to bringing out more intensely the advisory and coordination duties of the nurse practitioners and to secure them firmly in the public's consciousness.

Nursing must succeed in determining its place within the framework of an integrated care concept. At the same time, nursing will need to distinguish itself from other job outlines.

This German impression of nursing in the German home care system doesn't move as unisex t-shirt either in my mother country nor in this other country. Cooperation, in particular with nutritionists, social workers and social education workers seems to me to be imperative. These occupations cannot be replaced by nurse practitioners.

In this way lost attraction of nursing will come back.

Thank you for your attention.

Annex 5

INTEGRATION AND FINANCING NURSING SERVICES IN PRIMARY HEALTH CARE IN FINLAND

WHO meeting in Barcelona, 28–29 April 2000
Dr Marjukka Vallimies-Patomäki

Three features can be identified in health care in Finland:

1. Health services are mainly financed through tax revenues.
2. Everyone in Finland has the right to health care regardless of one's economical or social status or place of residence.
3. Municipalities are obliged to arrange health services.

The Finnish health care system is mainly financed through national and local taxation. On the whole, the share of public funding has decreased while households pay a larger proportion of health care costs.

Under the Primary Health Care Act (1972) the functions of the health centre are to provide:

- health promotion and health education including family planning advice
- diagnostic procedures and treatment for diseases, rehabilitation and screenings for local people as well as emergency services
- maternity and child health services
- school, student and occupational health care services
- dental services
- home nursing services
- non-specialist medical care in health centre wards
- those mental health services which can be provided at the level of primary health care
- local ambulance services.

The Finnish health care system is very decentralized, because a considerable part of the responsibilities and decision-making power has been delegated to the local level. Legislation does not regulate in details the range and method of providing the health care services. Therefore municipalities can organize health services according to the needs of the local population and local circumstances.

Nurses, public health nurses and midwives work in all health services in primary health care and they are employed by municipalities or federations of them. In most health centres physicians and nurses form teams which are responsible for geographically defined areas covering from 1500 to 5000 persons. This system is called a small area population responsibility.

There has been a great emphasis on the development of nursing services already for decades in Finland. The Primary Health Care Act (1972) supported the development of nursing workforce and services in primary health care. Nurses, public health nurses and midwives are in a position to come into contact with the entire population. Their work covers health promotion and illness prevention but also care of the ill patients. The acceptance of for example maternal and child health services by the families is very high.

Annex 6

INTEGRATION AND FINANCING OF FAMILY HEALTH
NURSING SERVICES IN PRIMARY HEALTH CARE IN MOLDOVA

The reforms taking place within the health sector are mostly focused on primary care. For the time being Moldova has assumed family doctoring and family nursing. The activity of a family nurse (or community nurse) is based on the following four principles:

- I. Elaboration of a new model for family nursing:
 - regulation of functional responsibilities of family nurse;
 - staff training;
 - specialization and skills improvement of nurses in accordance with the new demands and programmes;
 - practical implementation of community nursing;
 - elaboration of standards for primary care quality improvement;
 - development of legislative documents;
 - collaboration with mass media in order to make public the new roles of a family nurse, such as coordinator, consultant, lawyer, tutor, etc.;
 - popularization of services provided by family nurses;
 - multidisciplinary teamwork;
 - research work;
 - tutorship.

- II. Health education
 - healthy lifestyle promotion;
 - creation of health schools in medical centres;
 - family education to maintain health;
 - promotion of national programme on cancer, tuberculosis, sexually transmitted diseases, alcoholism, drug abuse, diabetes care, etc.;
 - promotion of HEALTH21 targets;
 - special disease prevention through vaccination, prophylaxis of certain diseases.

- III. Secondary prevention
 - curative intervention for disease treatment and prevention of aggravation and complications;
 - early evidence of problems through home visits and regular community work;
 - regular control with prophylaxis aim (micro radiography, etc.);
 - creation on services – home care inpatient department, hospice.

- IV. Tertiary care
 - health rehabilitation services:
 - i. massage;
 - ii. physiotherapy;
 - iii. cenotherapy;
 - iv. ergo therapy.

Financing of family nurses is made from the national budget. The salaries are 20% higher than those of usual nurses. In general, primary care is funded by 35% of the total sum allocated for the Ministry of Health of Moldova.

All the services to the population should be paid for. Children, invalids, retired people have a discount of 50%.

The minimum guaranteed by the state is for emergencies as well as for the patients with cancer, tuberculosis, and diabetes and for immunization.

Until now health insurance has not been introduced in Moldova. However it is supposed to be implemented in the future.

Certain part of vulnerable patients is assisted by different charity organizations like Caritas Moldova, Emanuel Medical Centre, Humanitas Association and churches.

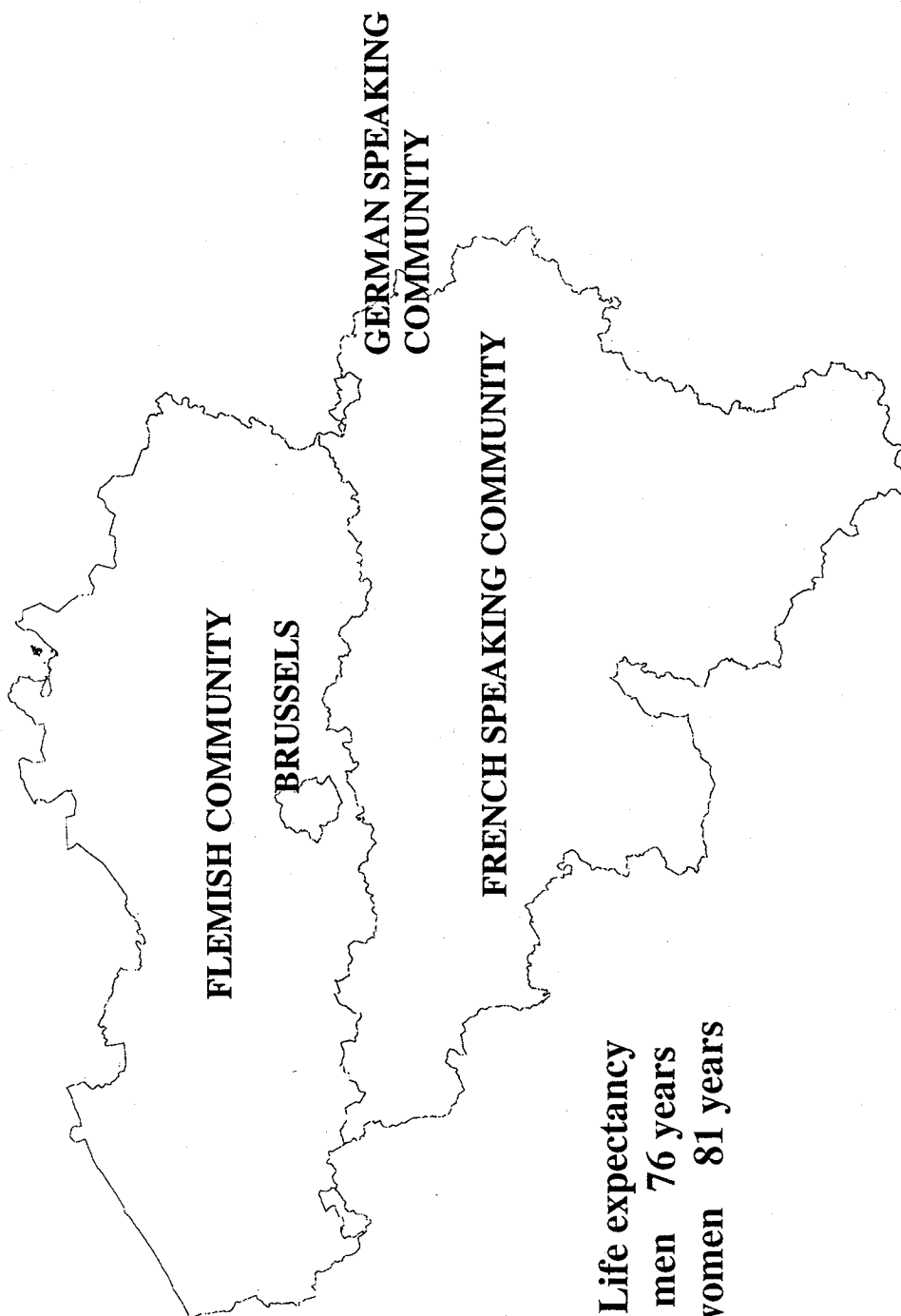
Annex 7

NURSING SERVICES IN PRIMARY HEALTH CARE IN BELGIUM

BELGIUM

10 million inhabitants

4 local communities



FLEMISH COMMUNITY

BRUSSELS

**GERMAN SPEAKING
COMMUNITY**

FRENCH SPEAKING COMMUNITY

Life expectancy
men 76 years
women 81 years

Bismarck Model (applied according to Beveridge model principles) :

- Social Security Coverage = +/- 100%

sickness insurance

disability insurance

- Prevention : all responsibilities on the Community level
- Curative Care : responsibility on the federal level (national government) + initiatives by cities, private organizations...

PREVENTION :

- Health Centers : childhood, schools, industry...
- Associations against cancer, TBC ...
- General Practitioners
- Family Nurses
- Centers for general medical care (GP)

Prevention

Main Services of Nurses in PHC :

- **health check ups :**
 - **mother and child**
 - **pupils and students**
 - **workforce**
- **Health Screenings :** - **target groups**
- **individual and group counseling**
(**health promotion included**)
- **home visits**
- **case-management**

Belgium

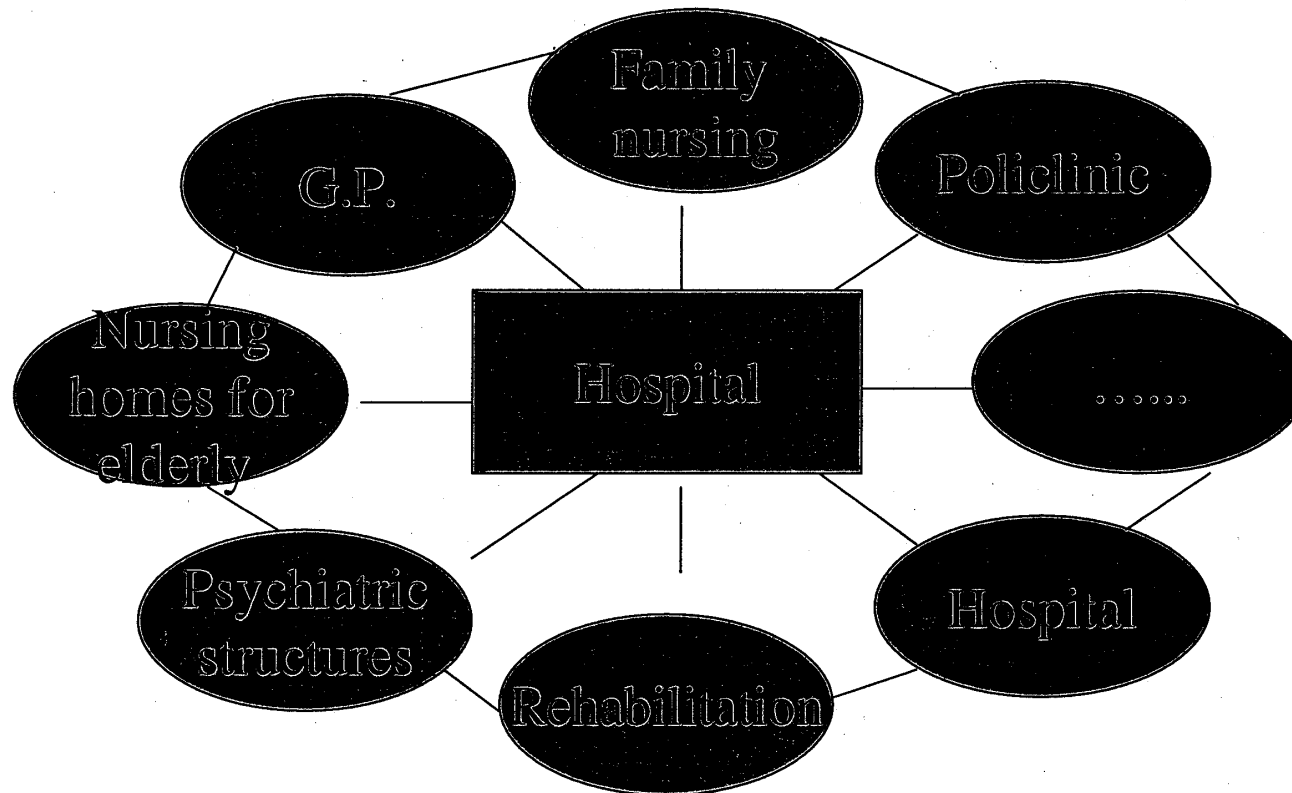
% of patients for each cat. →	% patients	% patients self-initiative	% transfered by GP	% transfered by specialist
GP	75%	99%	-	1%
Specialists	52%	70%	30%	-
Physiotherapist	10%	-	60%	40%
Family nurse	9%	40%	40%	20%
Dentists	31%	85%	10%	5%
Biologists	41%	-	65%	35%
Special technics	38%	5%	30%	65%
Radiology	36%	-	45%	53%
Hospitalization	14%	15%	30%	55%

Political priorities :

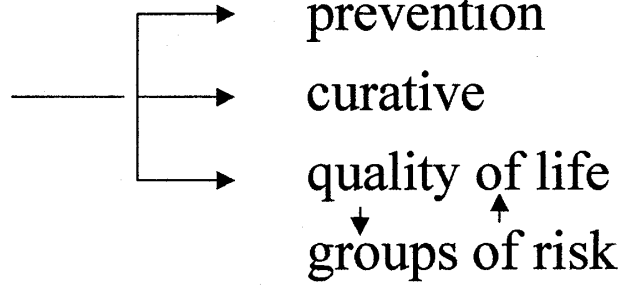
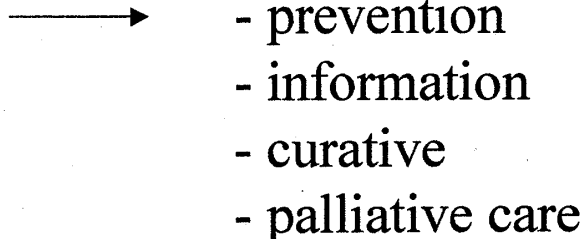
- Rationalization
- Cooperation between hospitals
- Cooperation between different levels of care

- IMPORTANT ARE :
 - communication
 - documentation
 - information flow

A integrated horizontal approach



Main Themes for the future :

- Patient centered policy
- Global disease management 
 - prevention
 - curative
 - quality of life
 - groups of risk
- Continuity of care - networks 
 - prevention
 - information
 - curative
 - palliative care
- Cooperation between :
 - GP and specialist
 - family nurse and hospital nurse
 - case-management

Cooperation Characteristics :

- Complementarity
- Subsidiarity

Annex 8

**FINANCING AND STRUCTURAL ARRANGEMENT FOR THE
FAMILY HEALTH NURSE. WHO.**

Ms Teresa Icart Isern. BCN: 28–29 April 2000

In this presentation two topics will consider:

- the Spanish Health Care System, and
- the current position of the nurse in the Spanish PHC

I. The current Spanish Health Care System was established in 1986 when the General Health Law passed Parliament.

The most important aspects of this law were (Table 1):

Table 1. Main characteristics of the Spanish Health Care System

The Spanish Health Care System	
•	Creation of the National Health System
•	Decentralization of the organization
•	Universal insurance
•	Changed financing
•	National network of PHC centres

- **Creation of the National Health System.** This system is made up of all health services of central government and the autonomous communities
- **Decentralization of the organization** of health care. The National Institute of Health (INSALUD) is the largest public health service in the communities without autonomy in health care delivery. The rest of the communities have competencies in public health, social services, education; this is the case for Catalonia, Andalusia, the Basque country and Valencia, where the health competencies have been transferred. So these regions have their own public health services that organize the health care.
- **Universal insurance** of medical costs for all. We have moved from insurance system to national health system. The government provides direct health services through health centres, general hospitals, surgical units, maternity centres, children's hospitals and psychiatric units.
- **Changed financing.** The present system of financing is based on the participation of all Spanish communities in the general health care budget which is built up through taxes. Thus when people use health care services, they do not pay directly; so except in case of medication and some other services, like psychotherapy, dental care, etc, they pay a percentage. Briefly our health system relies on general taxation, but there is a general trend to pay for a private insurance to ensure our future.
- The General Law set a **national network of PHC centres**. In Spain PHC is the basic level of medical attention, the one closest to the population and thus the most extensively used.

So, the reform of PHC began in 1986, and since then a lot of changes took place. This reform has not yet been completed in all Spain; causes are mainly lack of resources and sometimes lack of willingness to change. Table 2 summarizes some of these changes, some of them are related with nursing.

Table 2. Features of Spanish Health Care System, before and after reform

Features	Before reform	After reform
Major focus	Hospital and treatments and curative interventions	Primary health care and prevention of diseases and health promotion
Teamwork	No. Isolation. Doctors work isolated with a nurse assisting them	Yes. Multidisciplinary teams
NG responsibilities	A lot in hospitals. Few in PHC centres	More independent
NG recognition	More in hospitals	More in PHC centres
NG salaries	Higher in hospitals	Have raised in PHC
NG education: pre-graduate postgraduate	0% practice in PHC No courses in PHC	50% practice in PHC Diplomas (1 year) and Masters in Public Health Nursing (2 years)
Consultation rooms	Doctor and nurse together	Each one have its own room
Clinical records (HCAP)	No use of HCAP	Use of multidisciplinary HCAP
Basis for work	No protocols, no programmes	Protocols and programs. Clinical guidelines
Nurse/Physician	ATS (assistant in health/general practitioner)	Nurse/family doctor

The nursing community saw this reform as a major opportunity to offer the public, continuous and substantial preventive care. Nurses made it clear in every conference and meeting that they intended to use the new structure to force physicians to work with them as a team.

II. Current position of the nurse in PHC

Within its own consultation, the nurse perform the following activities:

1. Follow up of chronic patients (diabetes, obesity and hypertension)

Nurses are involved in:

- the detection and control of diabetes mellitus and the complications derived from it;
- detection and prevention of modifiable risk factors which predispose to worsen chronic obstructive pulmonary disease;
- nurses formulate recommendations on the management of patients with chronic cardiovascular diseases.

Nurses carry out:

2. Preventive activities such as:

- vaccinations;
- screening (measuring blood pressure and blood glucose levels);
- nurses are trained for the early detection of cognitive and behavioural disorders, like dementia;
- they give health education related to smoking, nutrition, physical exercises, hygiene habits;
- use of medicines. Nurses are involved in the administration of drugs so they develop health education activities and they train patients and their relatives in the use of medicines;
- nurses are encouraged to give educative counselling and to promote the social support system and self help groups, because family, peer groups, and self help groups as the informal and community resources play an important role in the promotion of healthy habits and lifestyles.

Particularly, nurses are involved in giving:

- information and health education to prevent and detect excessive consumption of alcohol, tobacco, high fats food;
- counsel for the general population especially vulnerable groups, in order to prevent HIV infection and AIDS. They insist on the need of avoiding the practices entailing a risk of HIV infection, like the consumption of intravenous drugs and unprotected sexual relationships.

3. Care of children. Nurses carry out

- the immunization of the infant population in accordance with Regional health authorities and they follow children development;
- the few nurses that work at schools take care of the program for mouth-washing with fluoride solutions and give advice to prevent accidents that involve children.

But community nurses move from PHC centres to patients' homes and they provide:

4. Home nursing care. In this sense we can divide our patients or clients in two groups:

- those who need acute care at home, because they have left hospital after surgery, and
- those who have a chronic disease which interferes to go by themselves to the PHC centre. Almost all of these patients are elderly, have cancer or are terminally ill.

So our community Nurses at PHC level, take care for critically ill chronic patients and terminally ill, but in some cases those patients can benefit more from the palliative care.

- It is admitted that health professionals, nurses and physicians, who work in the palliative care teams show more skills to reduce pain and the risk of complications and have more knowledge concerning the procedures and the palliative treatment of the terminally ill.

I think nurses are essential in giving psychological support for patients and their families. Sometimes nurses facilitate the contacts with mutual self-help groups and social support resources like social and family workers.

Now let's see what **aspects are not covered** by nurses at PHC level and, from my point of view, should be.

- Nurses should evaluate the quality and efficiency of the services and process they used.
- They should do more to improve communication between different services and levels (hospital and PHC) to ensure a more broad based continuity in the nursing care process.
- They should adopt criteria based on scientific evidence, for improving the quality of the health care process and reduce the variability in the nursing management of very common problems like sore pressures.
- They should analyse their activities in terms of health quality, the satisfaction of the citizens and the impact on the health system.
- They should improve the channels of communication with citizens and self-help groups and voluntary organization. They must inform the population about what they do.

Annex 9

PHC-NURSING IN AUSTRIA

Country	Source of funds	Benefit package	Population coverage	Nursing services in PHC	Employer of nurses in PHC	Fees for customers	Reform trends in nursing
Austria	<p>The funding of the PHC nursing takes different forms in the various provinces.</p> <p>Largely the powers granted for nursing services in PHC are divided among the federation, the provinces and the municipalities. Health insurance funds pay for medical nursing care only.</p>	<p>The most important services are:</p> <ul style="list-style-type: none"> • Home nursing care (nursing service) • Home help carried out by auxiliary nursing staff (help in the household, simple nursing services) • Meals on wheels <p>Very little health promotion and health education activities are done in home nursing.</p>	<p>Universal.</p> <p>Whether the provided home nursing activities are according to health care need is questionable.</p> <p>The number of home nurses vary between the provinces and is calculated on a ratio base.</p> <p>In total, about 310,000 (4%) Austrians were receiving nursing benefits* at the end of 1997. Nearly half of them were receiving stage two nursing benefits. Nursing benefits of stage seven were received by about one percent.</p>	<p>Home nursing only.</p> <p>The use of home nursing services in private household is to allow physically and mentally handicapped people to maintain their situation in life.</p> <p>Home nursing is provided by nurses with a hospital based three years full-time education.</p> <p>A specialization in any of the PHC nursing fields is <i>not</i> required by the nursing law, which was passed in 1997.</p>	<p>Home nursing activities across the country are provided by welfare associations and municipalities.</p>	<p>The clients pay a fee which is calculated on the basis of gross income and their nursing benefit.</p> <p>*Nursing Benefit: The nursing benefits are provided so as to enable the affected people to obtain the required care and help to carry on a life based on their personal requirements. The amount of the nursing benefits is based on the required nursing needs. The assessment of nursing needs is made by doctors.</p> <p>The nursing benefits are graded into seven stages.</p>	<p>Reducing the duration of hospital stays and moving into PHC.</p> <p>Community Chief Nurse</p> <p>Training for nurses and reforms in financing are needed!</p>