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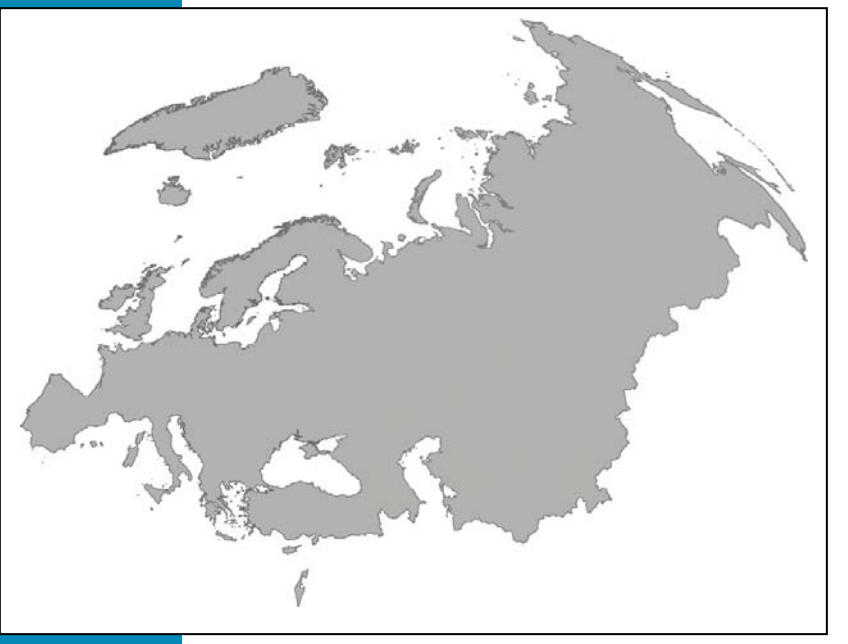

By: Andreas Büscher
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Nurses and Midwives: A force for health

Survey on the situation of nursing and midwifery in the Member States of the European Region of the World Health Organization

2009

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Foreword

Nurses and midwives make up the largest proportion of the health workforce, providing expert, skilled care to the population of Europe and as such, play a key role in the successful delivery of health services. As Europe heads into the second decade of the 21st century, it is timely to look at how nurses and midwives are developing their professional roles and determine what challenges affect their contribution to health service development and delivery.

Europe, like the rest of the world, is facing many challenges: inequality and social exclusion are still prevalent in society; climate change and urbanization affect living conditions; an ageing population means that more people live with chronic conditions and need long-term care, which has consequences on the workforce as the "Baby Boom" generation retire; and more recently, the implications of the global financial crisis and outbreak of H1N1 influenza. These factors all have health consequences for the population. Against this backdrop, it is well recognized that the WHO European Region is facing serious shortages of well-qualified nurses and midwives. This is part of an international health workforce crisis that is set to increase in severity in the coming decade.

The evidence from the review contained within this report points to the challenges for Member States in the coming years. There is a clear need to establish good health workforce planning processes; provide high-level initial preparation and ongoing staff development; robust yet permissive regulatory frameworks which ensure public protection, but allow role expansion; and appropriate recognition and reward. Steps must be taken to ensure nursing and midwifery is seen by individuals as an attractive career option, to safeguard the future workforce.

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Preface

This report sets out the findings from the third monitoring review of the situation of nursing and midwifery in Europe, undertaken in the World Health Organization (WHO) European Region during 2008/2009. Thirty-five countries, constituting two-thirds of the Member States, provided information.

The origin of this work is the WHO European Region Munich Declaration (2000), Nurses and Midwives: A force for health. (See pages 12-13 for the text of the Declaration.) The principles described within the Declaration are the basis of the Nursing and Midwifery programme of work, led by the WHO Regional Office for Europe. Regular progress reviews in respect of these principles have been undertaken in the 53 European Member States. Evidence from these reviews assists Member States in determining the actions they need to take to strengthen nursing and midwifery.

In recent years, attention to the important contribution nursing and midwifery makes to health has been a feature of global discussions. The 62nd World Health Assembly held in May, 2009, adopted a resolution committing Member States to the renewal of the principles of Primary Health Care (PHC), including strengthening health systems. The resolution makes specific reference to the nursing and midwifery workforce. The Assembly also received a report on the progress of the health related Millennium Development Goals (MDGs), noting poor progress in some areas such as maternal and child health. Nurses and midwives are well-recognized and essential to providing good health care. This view was reinforced in the International Conference on New Frontiers in Primary Health Care: Role of Nursing and Other Professions, which took place from 4 to 6 February, 2008, in Chiang Mai, Thailand. Representatives from the six WHO regions unanimously endorsed the Chiang Mai Declaration, which recognizes that:

> Nursing and midwifery is a vital component of the health workforce and are acknowledged professionals who contribute significantly to the achievements of PHC and the MDGs.

The information from the third monitoring review, contained within this report, is set out in 16 chapters, covering the methodology used for the survey and key aspects such as education, workforce planning, scope of professional practice and the evaluation of the impact of nursing and midwifery practice on the quality of patient care. The report also considers broader factors such as political will and commitment to strengthen nursing and midwifery, legislation and regulatory frameworks and the involvement of nurses and midwives in decision-making on health policy and service development. The report indicates the major public health challenges that need to be addressed across Europe, most significantly the increasing numbers of people living with chronic conditions and needing long-term care. A copy of the questionnaire used to gather the data can be found in the appendix.

Acknowledgements

The WHO Regional Office for Europe would like to thank the ministries of health, the national nursing and national midwifery associations and WHO collaborating centres for taking the time to contribute to this survey. Without their expert knowledge and willingness to share information about nursing and midwifery in Europe, this report would not have been possible.

WHO would also like to thank Ainna Fawcett-Henesy for initiating this process, enabling WHO and the European Member States to monitor the implementation of the Munich Declaration (2000) “Nurses and Midwives: A force for health”*;* Lis Wagner for leading the review in 2004; and Andreas Büscher, Bente Sivertsen and Jean White for their work in undertaking this survey.

Executive summary

In the year 2000, ministers of health in the European Region of the World Health Organization adopted the Munich Declaration: Nurses and Midwives: A force for health. The Declaration has become an important policy document and it serves as a baseline for the Nursing and Midwifery programme at the WHO Regional Office for Europe in Copenhagen. In the Declaration, ministers stressed key aspects by which nurses and midwives are a significant political and social force and resource for public health. Ministers of health, the WHO Regional Office for Europe and national nursing and national midwifery associations all expressed their commitment to strengthen nursing and midwifery by ensuring that the necessary legislative and regulatory frameworks are in place for developing comprehensive workforce planning strategies. The aim of these strategies is to enable nurses and midwives to work effectively, efficiently and to their full potential as independent and interdependent professionals.

The WHO Regional Office for Europe was requested to monitor and evaluate the implementation of the Declaration and to report regularly to the Regional Committee for Europe. This report presents the results of a survey among ministries of health and national nursing and national midwifery associations on the situation of nursing and midwifery in the European Region. It is the third survey undertaken by the WHO Regional Office for Europe to track the implementation of the principles of the Munich Declaration. Seventeen ministries of health/chief nursing officers and 36 national nursing or national midwifery associations, representing 35 of the Region's 53 countries, sent their questionnaires back between December 2008 and March 2009.

Compared with the results from the 2004 survey, considerable developments have taken place in nursing and midwifery in the WHO European Region. Political will and commitment of governments were reflected by a range of changes, including reforms in legislative frameworks that expanded the scope of practice and responsibility for nurses and midwives. In addition, further resolve was exemplified in moving initial nursing education to the higher education sector by establishing self-regulatory bodies for nursing and midwifery. Despite all these developments, the huge diversity between countries regarding nursing and midwifery in the European Region still remained the same as in previous years.

The increasing number of people with chronic conditions was identified as the main public health challenge in the countries of the Region. This main challenge was followed by: the means to ensure an adequate workforce of health professionals in the health system, an increasing need for long-term care, adequate funding for health care and the development of a sustainable health care system. Respondents see nurses and midwives as having an important role in tackling these challenges.

Progress towards ensuring adequate legislative and regulatory frameworks for nursing and midwifery has been achieved. In most countries of the Region, these frameworks are in place and have contributed to a sufficient, and sometimes high resolve of nurses and midwives to accept the responsibility of being adequate partners in health care delivery and health care decision-making.

Developments in initial nursing and midwifery education are evidenced by the fact that the level of initial professional education in more than half of the countries is that of a university degree. Supported by the Bologna Process in the European Region, this trend is ongoing and many countries recognize the need for university prepared nurses and midwives. Previously at 5% to 10%, the proportion of academically prepared nurses and midwives set to be achieved has increased to more than 20%, with many countries aiming much higher.

The growing recognition of the valuable contribution of nurses and midwives is also expressed by increases in their salaries in all but two countries. Nevertheless, in half of the countries, these salaries are below the national average. This is one of the reasons, besides limited career prospects, that make nurses consider leaving the profession in search of better career prospects in other professions.

The workforce in the responding countries amounts to 4.3 million nurses and 300 000 midwives. More than half of the countries reported that they do not have a particular workforce planning strategy implemented. Problems exist in terms of matching planning with actual health needs, lack of integration and coordination between sectors and responsibilities, as well as a general lack of data.

Despite all progress and achievements, obstacles still remain. Many respondents indicated that the main issues preventing them from working to their full potential include medically dominated health care systems, lack of financial resources, and, to a lesser degree, problems defining the professional roles of nurses and midwives.

Opportunities to improve the situation of nursing and midwifery also exist through increased participation in decision-making at all levels, as well as an increased involvement in public health and community development. Huge differences exist in the Region as some countries have several posts for nurses and/or midwives at politically relevant levels, whereas in other countries, the recognition and involvement of the profession is still the exception.

Compared to 2004, increasing importance has been placed on the practice of evaluating the quality of nursing and midwifery services. Measures for this evaluation, including standards for professional practice, as well as the definition of indicators for determining the quality of services, have been established in many countries.

Improvements have also been reported on the information that is available on nursing and midwifery. This information either stems from national registers or other official statistics on health care. Nursing and midwifery research exists in many countries, but only some have an explicit research strategy. Funding for nursing and midwifery research is available from different sources in almost two-thirds of the countries, but is not available at all in others.

Participants of the survey stressed the value and importance of international collaboration within Europe and beyond. WHO guidance and material have been used to a different extent throughout the European Region.

In summary, it can be stated that several improvements regarding the situation of nurses and midwives in the European Region have been achieved. Nevertheless, areas for further action can be identified:

- a broader implementation of workforce planning policies and strategies to make nursing and midwifery attractive career options for young people, and to retain those that are qualified;
- raising the level of initial professional education to the higher education sector, in those countries where this has not been done so far;
- introducing advanced practice roles for nurses and midwives;
- addressing the increased need of people suffering from chronic conditions;
- supporting leadership development of nurses and midwives, enabling them to contribute to decision-making at all levels of policy and service delivery;
- strengthening research capacity of nurses and midwives in terms of adequate qualification and sufficient funding opportunities; and
- strengthening approaches for conceptualizing, determining and measuring quality of nursing and midwifery services.

Results of a survey like this can provide ministries of health and national nursing and midwifery associations good examples of these challenges, which can be utilized in their efforts to sustain and improve the situation of nurses and midwives, and to provide better patient care.

1. Introduction

More than 20 years ago, in 1988, the first WHO conference on nursing and midwifery in Europe was held in Vienna, Austria. The Declaration of Vienna, which was adopted at that conference, stressed the importance of changes to enable nurses and midwives to contribute to the overall targets of WHO's Health for All strategy. At that time, the WHO European Region had 32 Member States. Since 1988, Europe has changed dramatically and so has the situation of nurses and midwives in the WHO European Region's now 53 Member States.

Political changes and significant health care reforms in the 1990s influenced the Second WHO Ministerial Conference on Nursing and Midwifery in Europe that was held in 2000 in Munich, Germany (WHO, 2001a). Debates from that conference were informed by a range of background documents that addressed important issues that remain concerns for nurses and midwives. These include:

- the nursing labour market in Europe
- accountability in nursing
- evidence-based practice and clinical effectiveness
- patient empowerment and health care reform
- assessment of family and community health needs
- research awareness in nursing and midwifery
- innovative practices in primary health care, nursing and midwifery.

At the conference, ministers of health and delegations from the European Member States adopted the Munich Declaration: Nurses and Midwives: A force for health (see box below). This Declaration is considered one of the most important European policy documents on nursing and midwifery. It forms the basis of the Nursing and Midwifery programme at the WHO Regional Office for Europe in Copenhagen.

Box 1: Munich Declaration: Nurses and Midwives: A force for health

Munich Declaration

Nurses and Midwives: A force for health

17 June 2000

The second WHO Ministerial Conference on Nursing and Midwifery in Europe addresses the unique roles and contributions of Europe's six million nurses and midwives in health development and health service delivery. Since the first WHO Ministerial Conference that took place in Vienna over ten years ago, some steps have been taken in Europe towards strengthening the status and making full use of the potential of nurses and midwives.

As Ministers of Health of Member States in the European Region of WHO, participating in the Munich Conference:

WE BELIEVE that nurses and midwives have **key and increasingly important roles** to play in society's efforts to tackle the public health challenges of our time, as well as in ensuring the

provision of high-quality, accessible, equitable, efficient and sensitive health services which ensure continuity of care and address people's rights and changing needs.

WE URGE all relevant authorities in WHO's European Region to step up their action **to strengthen nursing and midwifery,** by:

- ensuring a nursing and midwifery contribution to decision-making at all levels of **policy** development and implementation;
- addressing the **obstacles**, in particular recruitment policies, gender and status issues, and medical dominance;
- providing financial incentives and opportunities for **career advancement**;
- improving initial and continuing **education** and access to higher nursing and midwifery education;
- creating **opportunities for nurses, midwives and physicians to learn together** at undergraduate and postgraduate levels, to ensure more cooperative and interdisciplinary working in the interest of better patient care;
- supporting research and dissemination of information to develop the **knowledge and evidence base** for practice in nursing and midwifery;
- seeking opportunities to establish and support **family-focused community nursing and midwifery** programmes and services, including, where appropriate, the Family Health Nurse;
- enhancing the role of nurses and midwives in **public health, health promotion and community development.**

WE ACCEPT that commitment and serious efforts towards strengthening nursing and midwifery in our countries should be supported by:

- developing comprehensive **workforce planning strategies** to ensure adequate numbers of well educated nurses and midwives;
- ensuring that the **necessary legislative and regulatory frameworks** are in place at all levels of the health system;
- enabling nurses and midwives to work efficiently and effectively and to their full potential, both as **independent** and as **interdependent** professionals.

WE PLEDGE to work in partnership with all relevant ministries and bodies, statutory and non-governmental, nationally, subnationally and internationally to realize the aspirations of this Declaration.

WE LOOK TO the WHO Regional Office for Europe to provide strategic guidance and to help Member States develop coordination mechanisms for working in partnerships with national and international agencies to strengthen nursing and midwifery, and

WE REQUEST the Regional Director to make regular reports to the Regional Committee for Europe and to organize a first meeting to monitor and evaluate the implementation of the Declaration in 2002.

To support Member States in the implementation of the principles of the Declaration, the WHO Regional Office for Europe provided guidance in terms of the reference guide, Moving on from Munich, that aimed to:

- enable countries to carry out a review of their current position in nursing and midwifery, and help them to assess what kind of further progress is now possible;
- identify changes required in national legislation, education and training, strategies and employment policies;
- anticipate problems that might arise; and
- envisage the long-term outcome of the implementation process.

For particular principles of the Declaration, special programmes and initiatives were launched to foster the implementation process of these key aspects. To improve initial and continuing education, a WHO European Strategy for Nursing and Midwifery Education (WHO, 2000a) was developed. In addition, a WHO European Strategy for Continuing Education for Nurses and Midwives was published later on (WHO, 2003). Particular attention was also given to the principle of establishing and supporting family-focused community nursing and midwifery programmes and services. Core competencies and skills for practising in this way are part of the context, conceptual framework and curriculum for the Family Health Nurse (WHO, 2000c).

When implementing the educational strategy, progress was monitored using the Prospective Analysis Methodology (PAM) and published in regular reports, the last one in 2005 (Fleming & Holmes 2005). For the implementation of the Family Health Nurse, a multinational study was initiated from which regular reports were also published (WHO, 2006).

In order to track the general progress of implementation of the Munich Declaration, the WHO Regional Office for Europe conducted two surveys by sending out questionnaires to the ministries of health and national nursing and national midwifery associations. In March 2003, the first progress report was recounted at the meeting of the Region's government chief nurses in Madrid. Due to the rather disappointing results, the chief nurses endorsed a resolution: Re-emphasizing Munich: Nurses and Midwives: A force for health, that urged Member States:

- to strengthen and promote the participation of nurses and midwives in decision-making at all policy levels;
- to realize the potential of nurses and midwives in tackling the populations' health needs;
- to prepare a strategy for the evaluation of nursing and midwifery services; and
- to establish a system of information that allows for regular and updated reporting on nursing and midwifery issues.

The second survey was conducted in 2004 (Büscher & Wagner 2005), and although a direct impact from the Munich Declaration could not be identified, in most of the countries, the general results were more encouraging than those from the first survey. Progress was reported in legislative frameworks, participation in decision-making and contributions to public health

at the community level. In addition, progress concerning the improvement of initial and continuing education was reported. Nevertheless, medically dominated health care systems, lack of financial resources and difficulties defining the professional roles of nurses and midwives were obstacles that remained. Despite the progress in many areas, this diversity between countries remains a characteristic of the WHO European Region.

This report presents the results of the third survey on the situation of nursing and midwifery in the WHO European Region. Unlike its predecessors, the title is not explicitly related to the Munich Declaration. This change reflects that almost ten years after the adoption of the Munich Declaration, a direct impact may be hard to assess. The principles of the Declaration, however, are still relevant to nurses and midwives as they tackle these health care challenges now, and in the future.

2. Methodological approach

To conduct this survey, the questionnaire used for the 2004 survey on the implementation of the Munich Declaration: Nurses and Midwives: A force for health, was used and modified. The main modifications, which have been outlined in the introduction, concerned reference to the Munich Declaration. While it was very strong in the 2004 questionnaire, the one used in 2008 stressed the principles of the Declaration, without much reference to the Declaration itself.

Formerly separated chapters were integrated where appropriate. The section "Family-focused community programmes" was integrated into "Role in public health and community development". All chapters on educational issues (such as "Initial and continuing education" and "Joint learning opportunities") were synthesized and integrated. The educational section was expanded on aspects taken from the survey on the situation of initial nursing and midwifery education in the European Region (Fleming & Holmes 2005).

Instead of using open-ended questions exclusively, more quantitative questions were added to the 2008 questionnaire. Participants were mostly asked yes or no questions, but were also asked to specify their answers. In addition, some sections contained predefined options to answer, which added important aspects to questions and provided more detailed information. In 2004, two slightly different versions of the questionnaire were sent to ministries of health and to national nursing or national midwifery associations. However, this time only one questionnaire was used. (A copy of the questionnaire is available in Appendix 1.) Despite the questionnaire's modifications, most of the results are still comparable. For the most part, the structure and order of the questions were modified, but not the content itself. Not comparable are the results on public health priorities within countries, as this section was included in the 2008 survey for the first time.

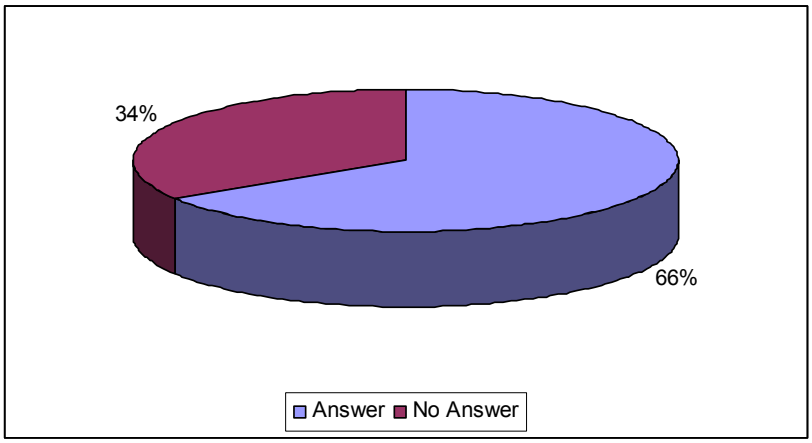
In November 2008, 144 questionnaires were sent out to 56 national nursing associations, 28 national midwifery associations and 60 chief nursing officers or other focal points for nursing and midwifery in the ministries of health in the 53 Member States of WHO's European Region. The number of questionnaires for each country may have differed. In some countries only one national association for nurses and midwives exists, while in others there are separate associations. In few countries the president of the national nursing association also serves as chief nursing officer or focal point for nursing and midwifery at the ministry of health.

A reminder to reply to the questionnaire was sent out via e-mail in January 2009. The last replies were received by the end of March 2009. In total, 53 responses to the questionnaire were received (see Table 1): 17 statements from ministries of health (response rate: 28%), 24 from national nursing associations (response rate: 42%) and 12 from national midwifery associations (response rate: 43%). The responses represented 35 countries (66% of all countries in the WHO European Region). In addition, the WHO collaborating centres for nurse education in Scotland and for nursing in primary health care in Slovenia contributed responses that were used in conjunction with answers from the the United Kingdom and Slovenia, but not counted as singular responses. The WHO collaborating centre for midwifery

and the Royal College of Midwives in the United Kingdom provided comments on the draft report.

Responses were received from the ministries of health of nine countries (The Czech Republic, Denmark, Finland, Greece, Ireland, Portugal, Serbia, Sweden and the United Kingdom). In addition, supplementary responses from professional associations were also received (Denmark, Midwifery) and a joint statement from the National Professional Association of Finland. The Slovenian Nurses and Midwives Association sent separate responses on nursing and on midwifery. Compared to 2004, the response rate improved in terms of total numbers (53 in 2008, compared to 47 in 2004) and in terms of countries (35 compared to 27) that participated in this survey. An overview is provided in the following graphs and table.

Graph 1: Overview of responses



Graph 2: Overview of institutional responses

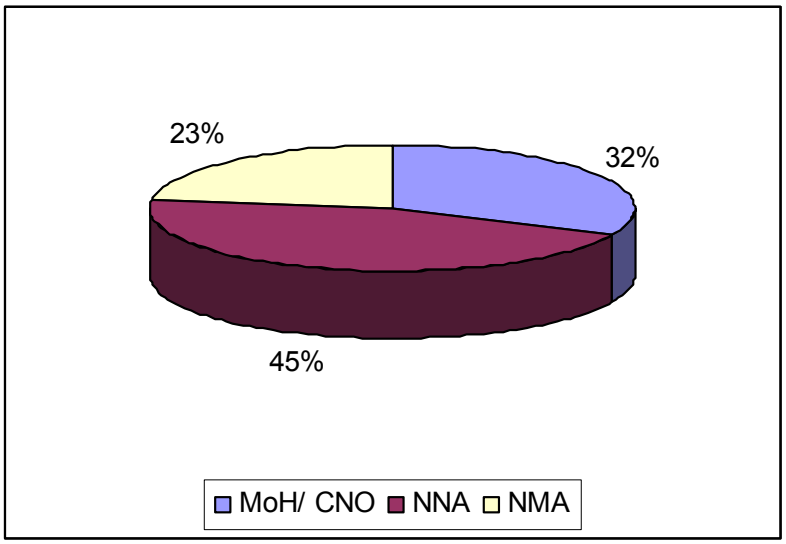


Table 1: Overview of responses

	Country responses[1]	MoH/CNO	NMA	NNA	No response
1	Armenia	X			Albania
2	Austria		X	X	Andorra
3	Belarus			X	Azerbaijan
4	Bosnia & Herzegovina	X			Belgium
5	Bulgaria			X	Hungary
6	Croatia			X	Israel
7	Cyprus	X			Kazakhstan
8	the Czech Republic	X	X	X	Kyrgyzstan
9	Denmark[2]	XX		X	Latvia
10	Estonia	X			Malta
11	Finland[3]	X		(X)	Monaco
12	France		X		Montenegro
13	Georgia			X	San Marino
14	Germany		X	X	Slovakia
15	Greece	X	X	X	Spain
16	Iceland		X	X	Turkey
17	Ireland	X		X	Turkmenistan
18	Italy			X	Uzbekistan
19	Lithuania		X		
20	Luxembourg		X	X	
21	the Netherlands		X		
22	Norway			X	
23	Poland			X	
24	Portugal	X	X		
25	Republic of Moldova			X	
26	Romania	X			
27	the Russian Federation			X	
28	Serbia	X		X	
29	Slovenia		X	X	
30	Sweden	X		X	
31	Switzerland		X	X	
32	Tajikistan			X	
33	the former Yugoslav Republic of Macedonia			X	
34	Ukraine	X			
35	the United Kingdom England Scotland Northern Ireland Wales	 X X X	X	X	
	Total	**17**	**12**	**24**	
36	CC PHC Slovenia			X	
37	CC Education Scotland			X	

The analysis of the questionnaires was conducted descriptively and by doing a content analysis of the open-ended questions. In instances where ministries of health and national

[1] MoH/CNO = Ministry of Health/Chief Nursing Officer; NMA = National Midwifery Association; NNA = National Nursing Association, CC = WHO collaborating centre

[2] The Danish Ministry of Health sent separate questionnaires for nurses and midwives. The response on midwifery was a joint response with the National Midwifery Association.

[3] The Finnish Ministry of Health and the Finnish Nurses' Association sent a joint response.

nursing or national midwifery associations answered differently on particular questions, this is indicated in the respective chapters.

Although the majority of responses dealt with nursing exclusively, the number of replies on midwifery increased compared to the previous survey in 2004. Therefore, a better insight into the situation of midwifery in the WHO European Region is provided. However, there are no separate chapters for nursing and midwifery in the results section. Differences between the situations of nursing and midwifery in countries are indicated.

In the results sections, the countries are mentioned with their particular answers. Where the indication of a country does not embrace all respondents from that particular country, additional information is provided in brackets. This is particularly true for the United Kingdom with its five different respondents and for questions where the answers were explicitly referring to nursing or midwifery issues.

Limitations of the survey

A survey like this has limitations. No responses were received from 18 countries (almost a third of the countries in the Region). The reasons behind the lack of responses could not be deduced. No particular patterns could be identified, as non-respondents were both European Union members and non European Union members, from Eastern and Western Europe and were from small countries and large countries. Limitations also existed in the information that was provided; the answers from the 35 countries were sometimes only on nursing or only on midwifery. In terms of the quality of the answers, the extent of in-depth description and explanation varied considerably between respondents. Some respondents ticked boxes exclusively, while others provided comprehensive information and additional Internet resources. In some instances, two respondents from the same country provided different answers, making it difficult to determine which one to rely upon. In these cases, either both statements have been indicated or, as far as numbers were concerned, different statements have been balanced.

A final limitation concerns the rigour and clarity of definitions. It cannot be assumed that respondents from all countries in the WHO European Region have the same understanding of the various topics addressed by this survey. This is particularly true for issues that are lacking an internationally consented definition. However, an international definition does not automatically lead to a joint understanding. For example, when an international defintion is translated from English into another language of the European Region, there is always the risk that different understandings will result.

Despite all these limitations, the results of this survey provide a rich impression and illustration of important areas of nursing and midwifery in the countries of the WHO European Region. Furthermore, they give food for thought about the role and contribution of nurses and midwives in health care delivery in individual countries, as well as internationally. By taking the results of this survey as such, readers have a chance to gain important insights and understand the invaluable work of nurses and midwives as they strive to provide the best possible delivery of services for health care users.

3. Political will and commitment

Questions regarding political will and commitment were intended to identify issues and threads of political debates and decisions regarding nursing and midwifery. They were also aimed at gaining insights into general political attitudes and ideas about the two professions, so as to trace differences in the political activities from the governmental level and from the professional associations' perspective. In 2004, there was a tendency for supportive action from the governmental or ministerial level. This tendency is confirmed by the responses from countries in this survey.

Twenty-five countries reported relevant governmental action and statements with regard to nursing and/or midwifery (Austria, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, Georgia, Germany, Greece, Iceland, Ireland [CNO], the Netherlands, Portugal, Romania, Serbia [NNA], Slovenia, Sweden, Switzerland, Tajikistan, the former Yugoslav Republic of Macedonia, Ukraine, the United Kingdom). Thirteen countries reported no statements (Armenia, Belarus, the Czech Republic [Midwifery], France, Greece [Midwifery], Italy, Lithuania, Luxembourg, Norway, Poland, Republic of Moldova, the Russian Federation, Serbia [MoH]).

Types of governmental activities included: new legislation, new national action plans or introduction of new strategies, statements, agreements and positions papers and convening events and regular meetings on subjects related to nursing and midwifery care. A more detailed description will be provided in the following paragraphs.

New legislation

Legislative processes have been reported as the most important form of governmental action from some countries. These processes ranged from passing new legislation to intensive drafting and consultation of new acts. Progress in the legislative and regulatory frameworks mainly focused on moving initial nursing and/or midwifery education into the higher education sector and was also related to the widening and expansion of the scope of nursing and midwifery practice. Changes in legislation on the scope of practice often implied an extended or advanced practice role that went along with the delegation of nursing and midwifery tasks given to health care assistants. Table 2 provides illustrative examples showing the breadth of legislative changes that have taken place in the WHO European Region.

Table 2: Illustrative examples of regulatory and legislative processes

Country	New legislation/draft legislation
Austria	Initial nursing education was moved to universities of applied sciences. Options for delegating nursing tasks to aides have been included. Reform of national long-term care cash–benefit system.
Croatia	Act on nursing regulates the contents and method of education, conditions of practice, responsibilities, quality control and professional supervision. New act on midwifery regulates the activities of midwives and the standard of their education.
the Czech Republic	New act on conditions for obtaining the qualification of non-medical

	professions and for performance of activities related to the provision of health care.
Denmark	Changes in nursing education – nursing is now part of the comprehensive legislation for all health professionals and is no longer regulated separately. Children's health visitors have taken over the physical examination at the start and end of elementary school.
Finland	Draft decree on primary health care defines the roles of public health nurses and midwives in examinations, counselling in maternity and child health clinics, school and student health care. Draft legislation on nurse prescribing. Draft act on health care defines roles of directors, including directors of nursing.
Germany	Reform Act on long-term care system.
Greece	New regulation on nursing including the implementation of a regulatory body, a definition of 'nurse', nursing rights and the scope of practice.
Iceland	New legislation on health care and health insurance that includes the responsibility of the insurances for health care administration and the negotiation of and the payment for health services. The legislation contains regulations on the primary responsibility of midwives in antenatal care in primary health care settings.
Ireland	The role of nurses and midwives has been expanded and includes the authority for ordering X-rays and prescribing medication.
Romania	A new legislation from October 2008 contains regulations on the practice of nurses, midwives and medical assistants and on the organization and functioning of the self-regulatory body.
Slovenia	New legislation offers nurses and midwives the opportunity for obtaining full university education.
Sweden	Existing legislation was adapted according to the requirements of the Bologna Process on Higher Education in Europe.
Switzerland	New legislation moved initial midwifery education to universities of applied sciences. Midwifery led 'birth houses' have been set up and are acknowledged as regular institutions of the Swiss health care system.
Ukraine	Different laws and decrees have become effective that have an impact on nursing and midwifery including regulation on primary health care, the development of family medicine, the improvement of education, patients' rights and health care for children.

National strategies and action plans

Several countries reported the implementation of national strategies or action plans on health care in general (e.g. Bulgaria, Estonia) or on nursing and/or midwifery in particular (e.g. Bosnia and Herzegovina, Finland, the former Yugoslav Republic of Macedonia, Ukraine and the United Kingdom).

The information received from countries varied considerably as can be seen from the following examples.

- A range of strategies and plans have been reported from Finland, including a national target and action plan ‘Health and well-being by evidence-based nursing’, a national action plan on ‘Effectiveness and attractiveness in nursing through leadership’, an interdisciplinary action programme on ‘Promotion of sexual and reproductive health’ and the development of advanced roles for nurses.
- In Bosnia and Herzegovina, priority areas have been defined.
- In the former Yugoslav Republic of Macedonia and the Ukraine, general nursing and midwifery strategies that are part of national programmes, have been implemented. These strategies comprise various measures, including legislation.
- In the United Kingdom, the ‘Modernising Nursing Careers’ and ‘Modernising Midwifery Careers’ initiatives were launched. ‘Modernising Nursing Careers’ is comprised of a series of interconnected actions, of which four priority areas have been identified. According to this initiative, the following actions will help make modern nursing careers better fit for purpose:
    - the development of a competent and flexible nursing workforce
    - updating career pathways and career choices
    - preparing nurses for leadership in a changed health care system
    - modernizing the image of nursing and nursing careers.

  The ‘Modernising Midwifery Career’ initiative (Midwifery 20:20) aims at maximizing the midwifery contribution to improving the maternity care experience of women. The initiative is actualized by five work streams, for which different countries in the United Kingdom take the lead:
    - maternity care pathways (including models of care, elements of skill mix, service delivery and social enterprise);
    - workforce and workload (including demographics, education commissioning, attrition and workforce planning);
    - education and career progression (including academic careers, mobility and flexibility, levels of practice, research, midwife managers and teachers);
    - measuring quality (metrics work, quality and outcome indicators); and
    - public health (including the public health role of the midwife taking account of inequalities, parenting education and multi-agency working).

Statements, agreements and position papers

Statements by ministries and governments have been issued on several occasions, with regards to various subjects. From Cyprus, a statement on the important contribution of nurses in the health care system was reported. In other countries, statements served as announcement of political determination and commitment. In Denmark, new recommendations for postgraduate nursing studies have been announced. A range of statements has been reported from the United Kingdom. Examples include: statements on health, work and well-being, violence against National Health Service (NHS) staff, family nurses in schools (Wales) and a review of nursing in the community in Scotland. Various governmental statements from

the United Kingdom also have been reported regarding the contribution of midwives in public health. These statements included recommendations for maternity services to engage proactively with women from vulnerable populations and highlighted inequalities in health outcomes between mothers and babies from different socioeconomic backgrounds. In addition, they described a programme for improving choice, access and continuity of care.

Moves by professional associations to ensure governmental and societal commitment
From the 31 out of 34 countries that replied to this question, various activities have been reported. On a general level, these activities were often in-line with governmental politics, but some countries addressed conflicting issues.

Many of the activities of the national nursing and national midwifery associations aimed to raise awareness on governmental and societal levels about the importance of the work of nurses and/or midwives. Activities to raise societal awareness included the launch of a website (Belarus), and publications and statements in the mass media (the Russian Federation); in Cyprus, the Munich Declaration was published in this way. In Switzerland, a campaign with support from Suzanne Gordon, the author of “From silence to voice – what nurses know and must communicate to the public”,(Buresh & Gordon 2003) took place. Campaigns to raise awareness on nursing and midwifery issues have also been reported from the United Kingdom.

On a political level, the professional associations have been very active in various lobbying activities including the establishment of regular contact/meetings with representatives from the ministries of health. In addition, the professional associations have been lobbying at the governmental level for better salaries, working conditions, initial and continuing education and staffing issues. Other important activities include active participation in health care reform, new legislation, decision-making at different levels and national health campaigns. (All these aspects will be covered in subsequent chapters in more detail.) Also, less consensual activities were described. Signatures have been collected and petitions have been submitted to parliaments. Professional associations also joined and initiated demonstrations and supported nurses on strike.

Finally, national nursing and national midwifery associations have published and disseminated position papers and statements on various topics related to professionalism (e.g. professional standards, quality indicators and clinical guidelines) as well as general health care issues (e.g. promotion of healthy lifestyles, preventing diseases, HIV/AIDS awareness, nutrition and normal birth).

From many countries, additional comments were related to future plans, including the need for amended legislation, the establishment of self-regulatory bodies or the improvement of education. Other respondents pointed to existing problems in the work of the national nursing and national midwifery associations, such as limited personnel and material resources or the excess number of nursing associations in some countries that prevent nurses from speaking with one voice.

Compared to the 2004 survey, a considerable improvement in the political will and commitment towards nursing and midwifery can be reported. Governments in the WHO European Region realized the potential of nurses and midwives for delivering high-quality and accessible health care services. The role of the national nursing and national midwifery associations in this development must not be underestimated. With often quite limited resources, the associations worked hard and continuously on improving the situation of nurses and midwives.

4. Public health challenges in the countries of the European Region of WHO

Policies on human resources for health depend to a large extent on both the public health challenges that actually exist in countries, as well as those that are perceived as important by the relevant actors within the health care system. Also, the anticipation of future challenges in health care systems is important. In the questionnaire, participants were asked to select the challenges relevant for their countries from a list of 15 challenges. Participants also had the option of adding other challenges that were not listed (which was an option that was used only by some respondents). In addition, participants were asked to rank the public health challenges according to priority in their country. This was done by 26 respondents, from 20 different countries. An overview of these rankings will also be provided in this chapter.

For 31 out of 35 countries of the WHO European Region, the main public health challenge is the increasing number of people with chronic conditions. Only Lithuania, Luxembourg (both nursing and midwifery associations) Romania and Serbia did not report this challenge. Ensuring an adequate health care workforce, increasing need for long-term care, adequate funding for health care and the development of a sustainable health care system were stated by 24 countries to be the second most important public health challenge. The following table presents the public health challenges according to the frequency of responses. (Please note that in order to save space in the following tables in this report, the abbreviation MKD will be used when referring to the former Yugoslav Republic of Macedonia. This is an abbreviation of the International Organization for Standardization (ISO), not WHO.)

Table 3: Public health challenges

No. of responses	Public health challenge	Countries
31	Increasing number of people with chronic conditions	Armenia, Austria, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Iceland [Nursing], Ireland, Italy, the Netherlands, Norway, Poland, Portugal, Republic of Moldova, the Russian Federation, Slovenia, Sweden, Switzerland, Tajikistan, MKD, Ukraine, the United Kingdom (England, Scotland, Wales, RCN)
24	Ensuring an adequate workforce of health professionals in the health system	Armenia, Austria, Belarus, Bulgaria, Cyprus, the Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland [Midwifery], Ireland, Italy, Lithuania, Luxembourg, Portugal, Republic of Moldova, Serbia, Sweden, Switzerland, MKD, Ukraine, the United Kingdom (Scotland, Wales, RCN, RCM)
24	Increasing need for long-term care	Austria, Belarus, Bulgaria, Croatia, Cyprus, the Czech Republic, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Norway, Poland, Portugal, Republic of Moldova, the Russian Federation, Serbia, Slovenia, Sweden, MKD, Uk-

		raine, the United Kingdom (England, Scotland, Wales, RCN)
24	Adequate funding for health care	Austria, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Denmark, Finland, France, Georgia, Germany, Greece, Iceland, Ireland, Italy, Lithuania, Portugal, Republic of Moldova, Romania, Serbia, Slovenia, Switzerland [Midwifery], MKD, the United Kingdom (Wales, RCN)
24	Development of a sustainable health care system	Austria, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Finland, France, Germany [Midwifery], Greece, Iceland, Ireland, Lithuania, Luxembourg, Norway, Portugal, Republic of Moldova, Romania, Serbia, Slovenia [Nursing], Switzerland [Midwifery], Tajikistan, MKD, the United Kingdom (RCN)
20	Increasing number of people with mental health problems	Austria, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Denmark, Finland, France, Germany [Midwifery], Greece [Midwifery], Iceland [Midwifery], Ireland, Luxembourg, the Netherlands, Republic of Moldova, the Russian Federation, Serbia, Sweden, MKD, the United Kingdom (Scotland, Wales, RCM)
18	Increasing health inequalities	Armenia, Austria, Bulgaria, Croatia, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Poland, Portugal, Republic of Moldova, the Russian Federation, Serbia, MKD, the United Kingdom (England, Scotland, Wales, RCM)
18	Maternal and child health risks	Armenia, Austria, Bosnia and Herzegovina, Bulgaria, Finland, France, Germany [Midwifery], Greece [Midwifery], Iceland [Midwifery], Lithuania, Portugal, Republic of Moldova, the Russian Federation, Serbia, Slovenia, MKD, Ukraine, the United Kingdom (Scotland, Wales, RCM)
17	Environmental health risks	Armenia, Austria, Bulgaria, France, Greece, Lithuania, Luxembourg, the Netherlands, Poland, Portugal, Republic of Moldova, the Russian Federation, Serbia, Slovenia, Sweden, MKD Ukraine
14	Access to primary health care	Belarus, Bulgaria, Finland, France, Greece, Iceland [Midwifery], Ireland, Norway, Republic of Moldova, Romania, Serbia, Sweden, Ukraine, the United Kingdom (Wales, RCN)
14	Noncommunicable conditions	Armenia, Austria, Bosnia and Herzegovina, Bulgaria, Denmark [Nursing], Finland, Germany, Luxembourg, Republic of Moldova, Serbia, Switzerland, MKD, Ukraine, the United Kingdom (Wales)
14	Injuries	Austria, Bulgaria, Cyprus, Estonia, Finland, Greece, the Netherlands, Republic of Moldova, the Russian Federation, Serbia, Slovenia, Sweden, Ukraine, the United Kingdom (Wales)

9	Communicable diseases	Austria, Bulgaria, Finland, Georgia, Ireland, Portugal, Republic of Moldova, Serbia, Sweden, Ukraine, the United Kingdom (Wales)
9	Migration of health care professionals to other countries	Bulgaria, Georgia, Lithuania, Poland, Republic of Moldova, Romania, Serbia, Tajikistan, Ukraine
8	Other: Increasing drug abuse Prevention and health promotion Ageing population; shortages of physicians and dentists in primary health care Immigration Increasing number of caesarean sections Increasing problems with fair distribution of financial resources Child obesity Migrant population and attendant pregnancy related or social conditions	 Cyprus Denmark [Nursing] Finland Greece Switzerland [Midwifery] Switzerland the United Kingdom (Wales) the United Kingdom (RCM)

This table highlights the prevalence of chronic conditions in today's health care systems that are increasingly more the centre of nursing, and sometimes even, midwifery practice. The increasing need for long-term care is highlighted as well. In fact, the importance of addressing chronic conditions has been known for many years, and numerous initiatives and programmes have been set up to cope with this challenge. Nevertheless, health care systems quite often still focus too strongly on acute health care needs, and spend only limited resources on the long-term care requirements and costs that go along with chronic conditions such as diabetes, arthritis, coronary heart disease and others. For nurses, midwives and health care users this implies that a strong focus is required on chronic care management.

After the statements on the public health challenges, participants were asked whether nurses and midwives have a particular role in tackling these challenges (see Graph 3 and Table 4). The responses indicate that nurses and midwives are playing an important role in tackling almost all of the public health challenges that have been identified in the WHO European Region.

Graph 3: Public health challenges and the important role for nurses and midwives

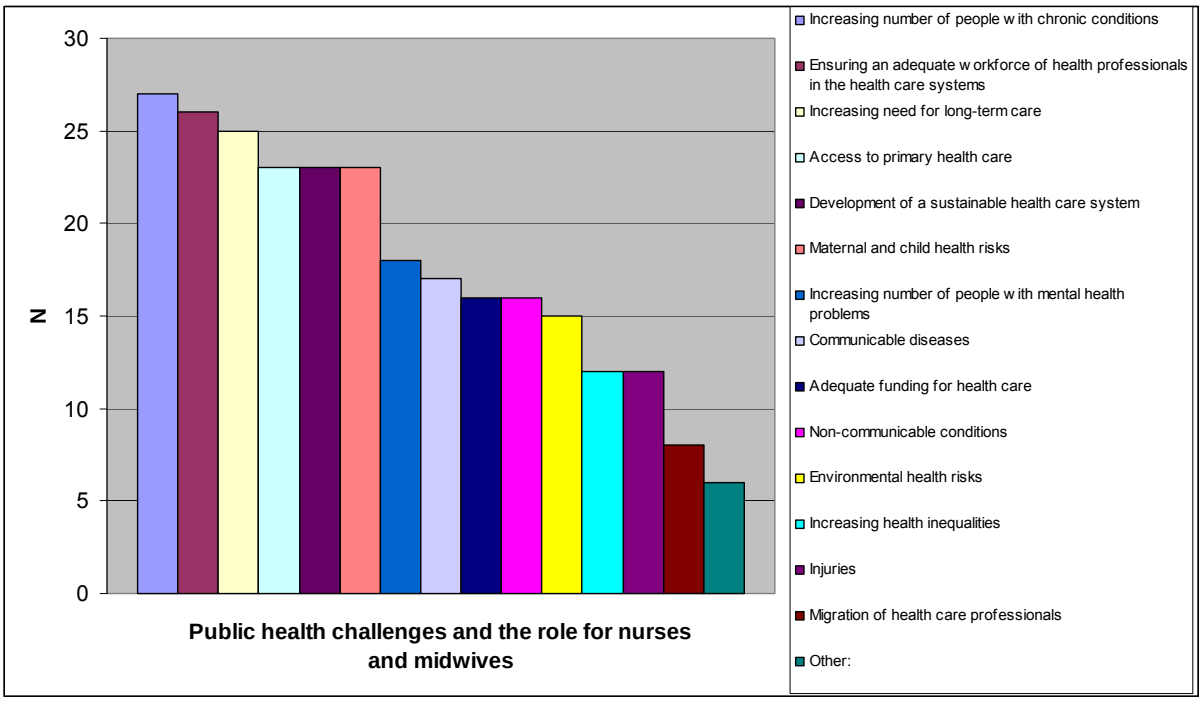


Table 4: Public health challenges and the important role of nurses and midwives

No. of responses	Role of nurses/midwives in tackling public health challenge
27	Increasing number of people with chronic conditions
26	Ensuring an adequate workforce of health professionals in the health care systems
25	Increasing need for long-term care
23	Access to primary health care
23	Development of a sustainable health care system
23	Maternal and child health risks
18	Increasing number of people with mental health problems
17	Communicable diseases
16	Adequate funding for health care
16	Noncommunicable conditions
15	Environmental health risks
12	Increasing health inequalities
12	Injuries
8	Migration of health care professionals
6	Other: Prevention and health promotion (Denmark) Ageing population (Finland) Child abuse (Ireland) Increasing number of Caesarean sections (Switzerland) Access to acute care (the United Kingdom: England) Child obesity (the United Kingdom: Wales)

While both tables present aggregated results of all replies, the public health priorities may be considerably different in individual countries. However, the analysis of the country-specific rankings provided a similar picture. The following list illustrates the public health challenges and in brackets the frequency with which they have been among the top three challenges in individual countries.

- Increasing number of people with chronic conditions (15)
- Increasing need for long-term care (9)
- Ensuring an adequate workforce of health professionals in the health care system (9)
- Adequate funding for health care (8)
- Access to primary health care (4)
- Increasing health inequalities (3)
- Migration of health care professionals to other countries (3)
- Development of a sustainable health care system (2)
- Environmental health risks (1)
- Injuries (1)
- Maternal and child health risks (1)
- Noncommunicable conditions (1)

This list confirms that chronic conditions, the need for long-term care, the ensurance of an adequate workforce and adequate funding for health care all pose the biggest challenges for countries in the Region. There was a broad consensus (see Table 4) that nurses and midwives have an important role to play in tackling these challenges.

National midwifery associations ranked maternal and child health risks as a bigger overall challenge than the national nursing associations did. Interestingly, the responses from national midwifery associations also emphasized increasing health inequalities as more important public health challenges than national nursing associations and ministries of health indicated. This may suggest that midwives encounter and have to address health inequalities more often or more directly than nurses in their daily practice, as they provide their services.

5. Legislation and professional regulation

The role of nurses and midwives and the contribution they make to health care systems as they tackle public health challenges, depends to a large extent on the legislative frameworks that govern professional practice and determine who will enter the professions. WHO regional offices and professional organizations such as the International Council of Nurses (ICN) and the International Confederation of Midwives (ICM) have provided guidance and produced helpful documents for reviewing existing legislative frameworks. These actions have helped lay a foundation that ensures legislative frameworks are in place that enable nurses and midwives to work to their full potential.

The 2004 survey revealed several reforms of existing legislation. These reforms were mainly due to new European Union Member States adapting national legislation to meet European Union standards. The survey focused on issues covered by national legislation and areas of political agreement or disagreement. The first question in the survey was related to the definition of nurses and midwives, and asked whether the role of nurses and/or midwives was defined by legislation, custom or practice in the country. Once a nurse/midwife is defined, the scope of practice can be determined and a general societal understanding can be gained regarding the role of nurses and/or midwives. The definition can also serve as a reference point that professionals can use when arguing their professional status and discussing their contribution to existing public health challenges.

When a nurse or midwife is defined in legislation, the definition is stated in an act on nursing/midwifery and the definition can only be altered in legislation by the relevant authorities. A definition by custom is a definition that professionals, health care service users and society have widely accepted, but is not available in an official written form. A definition by practice is when there is only a very broad definition in a written act or law, however, the actual definition takes place or is negotiated at the practice level, and according to the activities performed by nurses and midwives. A definition by legislation is the recommended type of definition as it provides transparency and little room for misunderstanding.

In most countries the definition of nurses/midwives is controlled by legislation. However, in some countries they are still defined by customs and practice. Furthermore, some of the answers from the survey indicate that nurses and midwives in some countries are defined by practice as well as by customs and legislation (Greece [NNA], Lithuania, Serbia and the former Yugoslav Republic of Macedonia). No definition by legislation was reported from Bosnia and Herzegovina, Georgia and Norway. Bosnia and Herzegovina do not have a definition of a nurse/midwife. Norway reports a definition of nursing (by custom), according to which a nurse is a person who has a special function to promote health and help people that have, or may be exposed to illness and disease, attending to their fundamental needs.

Graph 4: How is the role of a nurse or a midwife defined?

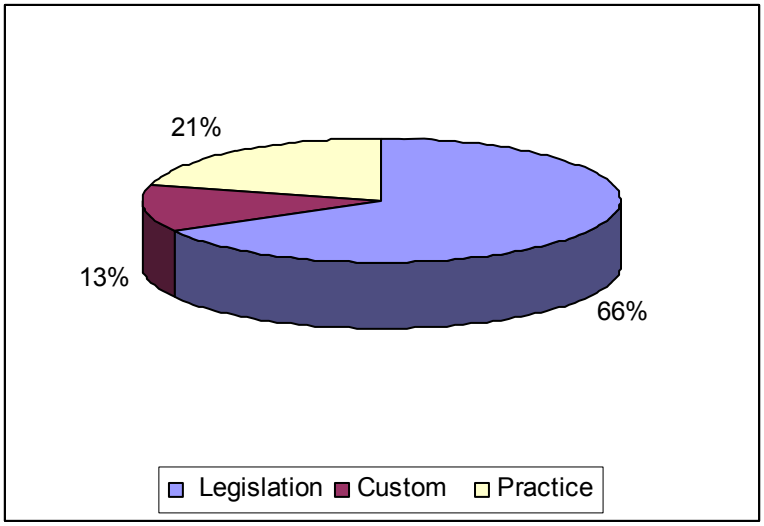


Table 5: How is the role of a nurse or a midwife defined?

How is the role of a nurse or a midwife defined?	
By legislation: 32	Armenia, Austria, Belarus, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Lithuania, Luxembourg, the Netherlands, Poland, Portugal, Republic of Moldova, Romania, the Russian Federation, Serbia (NNA), Slovenia, Sweden, Switzerland, Tajikistan, MKD (partly), Ukraine, the United Kingdom (England, Scotland, Wales, RCM)
By custom: 6	Georgia, Greece (Nursing), Lithuania, Norway, Serbia (CNO) MKD,
By practice: 10	Bosnia and Herzegovina, Croatia, Georgia, Greece (Nursing), Lithuania, Norway, Serbia (NNA), Switzerland, MKD, the United Kingdom (England, RCN)

The definition of nurses and midwives was expressed in relatively formal terms and requirements such as:

- acceptance into an educational programme
- successful completion of all requirements necessary for obtaining a degree from a formal educational programme
- receiving a license or being registered after the successful completion of the programme.

These formal requirements do not provide information on the scope of practice and the activities and responsibilities of nurses and midwives. A more detailed overview regarding the scope of professional practice can be obtained from the following graph.

Graph 5: Scope of professional practice

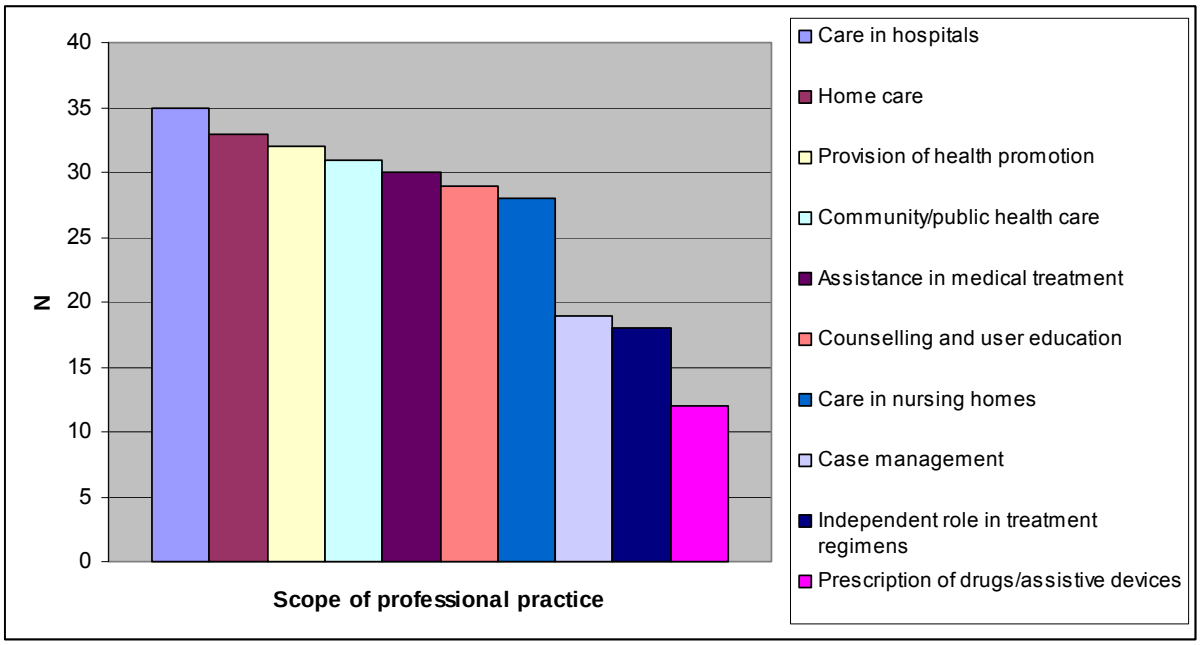


Table 6: Scope of professional practice

No. of responses	Scope of practice	Countries
35	Care in hospitals	All countries that responded
33	Home care	All countries except Georgia and Tajikistan
32	Provision of health promotion	All countries except Bosnia and Herzegovina, Georgia and Luxembourg (NMA)
31	Community/public health care	All countries except Belarus, Georgia, Luxembourg (NMA), the Netherlands (NMA)
30	Assistance in medical treatment	All countries except France (NMA), Georgia, Iceland, Poland, Romania
29	Counselling and user education	All countries except Bosnia and Herzegovina, Georgia, Poland, Tajikistan, MKD, Ukraine
28	Care in nursing homes	All countries except Bosnia and Herzegovina, Croatia, Estonia, France (NMA), Lithuania (NMA), Luxembourg (NMA)
19	Case management	Austria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Iceland, Ireland, Italy, the Netherlands, Portugal, the Russian Federation, Sweden, Switzerland, the United Kingdom
18	Independent role in treatment regimens	Austria, the Czech Republic, Denmark (Midwives), Finland, Germany, Greece (Midwives), Iceland, Ireland, Lithuania, the Netherlands, Norway, Portugal (only in emergency situations), the Russian Federation, Sweden, Switzerland (Midwives), MKD, Ukraine, the United Kingdom (England, Wales, RCN, RCM)
12	Prescription of drugs/assistive de-	Austria, Denmark (limited rights to prescribe drugs for midwives), Netherlands, Finland, France, Georgia,

	vices	Germany (Midwives), Greece (Midwives), Ireland, the Netherlands, Portugal (only in emergency situations), Sweden, the United Kingdom (England, Scotland, Wales, RCN)
6	Other	Finland: draft legislation on nurse prescribing under preparation the Russian Federation: school health, disease prevention Sweden: difficult role concerning care in society Switzerland: work and performance of midwives in birth houses and independent practices the United Kingdom (Scotland): regulatory framework rather facilitative than restrictive; allows nurses and midwives professional judgement and expansion of duties (such as taking a lead role in treatment regimens) under the expectation that the interests of patients/users/clients are put above all other interests the United Kingdom (Wales): health policy development

The hospital sector is still the most prominent setting for nurses and midwives and it is part of the professional scope of practice in all countries. The following aspects such as home care, health promotion, community/public health care and the role in patient and user education indicate that in many countries the public health role of nurses and midwives is increasingly recognized and forms a part of the everyday practice.

A small number of countries included nursing homes in the scope of practice for nurses only, since this setting is usually not part of midwifery practice. In more than half of the responding countries, advanced roles such as case management functions are part of the professional role.

Compared to nurses, midwives seem to be in a more independent role regarding treatment regimens and the entitlement of prescribing drugs and/or devices, In order to be able to provide adequate services to mothers, babies and families, midwives need to have a legislative framework that allows for independent decision-making. It also has to be recognized that the right to prescribe drugs may be related to the educational level of nurses and midwives, only granted after particular courses of continuing education, or not given to all nurses and/or midwives.

The replies from the United Kingdom reveal an interesting approach to the scope of practice. Professional competence is acknowledged by a regulatory framework that allows for an expanded professional practice that follows thorough and professional consideration and decision-making. This regulatory framework relies on the high competence of nurses and midwives and on their commitment to make decisions in the best interest of the recipient of their services.

The debate on the advanced and expanded roles of nurses and midwives seems to be gaining importance. For some countries, as the example from the United Kingdom indicates,

these debates have lead to regulatory frameworks that allow for independent professional decision-making that relies on professional competence. Discussions on this aspect in other countries often are focused on particular tasks (such as prescribing) and do not rely on professional judgement and competence to the full extent.

Responsibility for legislation and regulation

In most of the countries, ministries of health are responsible for professional regulation. Sometimes it is not the national ministry of health alone that is in charge of professional regulation, but an additional professional self-regulatory body or a subnational authority. A self-regulatory professional body plays an important role in half of the countries, federal or regional authorities in eight countries.

Graph 6: Responsibility for professional regulation

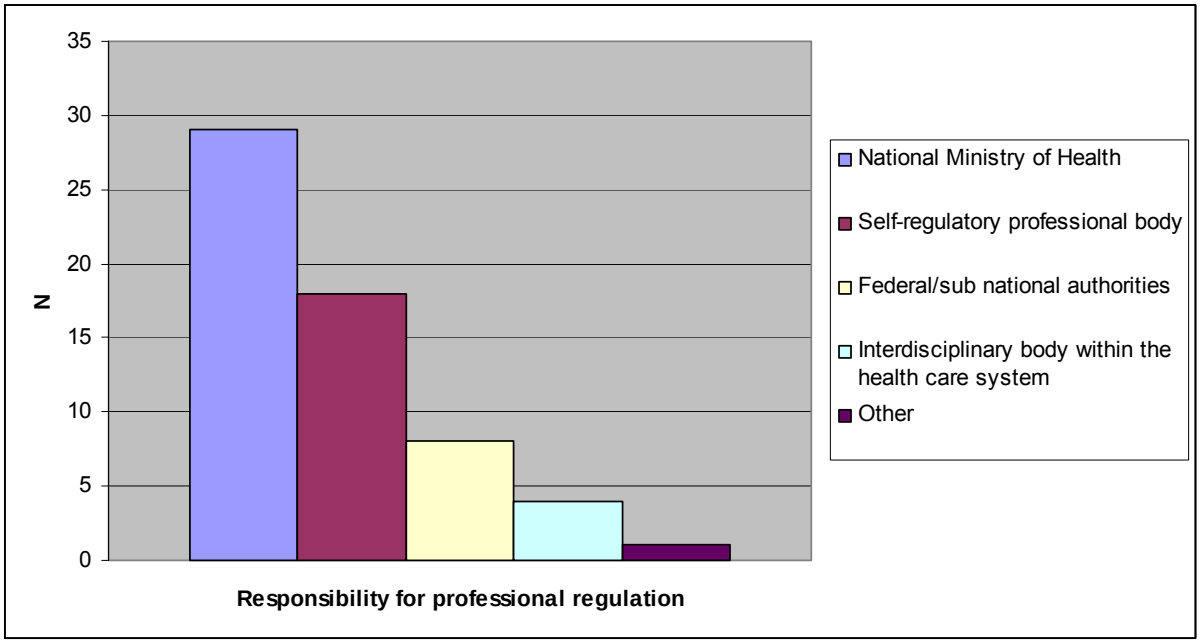


Table 7: Responsibility for professional regulation

No. of replies	Responsibility for regulation	Countries
29	National Ministry of Health	Armenia, Austria, Belarus, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Iceland, Italy, Lithuania, Luxembourg, Norway, Poland, Republic of Moldova, Romania, the Russian Federation, Serbia, Slovenia, Sweden, Tajikistan, MKD, Ukraine
18	Self-regulatory professional body	Austria, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Finland, France, Georgia, Greece, Ireland, Italy, Lithuania, the Netherlands, Poland, Portugal, Romania, Slovenia, the United Kingdom
8	Federal/subnational authorities	Austria, Bosnia and Herzegovina, Finland,

		Germany, Greece, Poland, the Russian Federation, Ukraine
4	Interdisciplinary body within the health care system	Republic of Moldova, Tajikistan, MKD, Ukraine
1	Other	Switzerland: until 2012 it is the Red Cross; during the transition phase many open questions remain

Contents of the legislative framework

In the European Region a range of legislative changes has occurred in past years. A closer look at the contents of the legislative framework will provide a more detailed overview of core aspects of legislation on nursing and midwifery. The following table summarizes the results.

Graph 7: Aspects covered by legislative framework

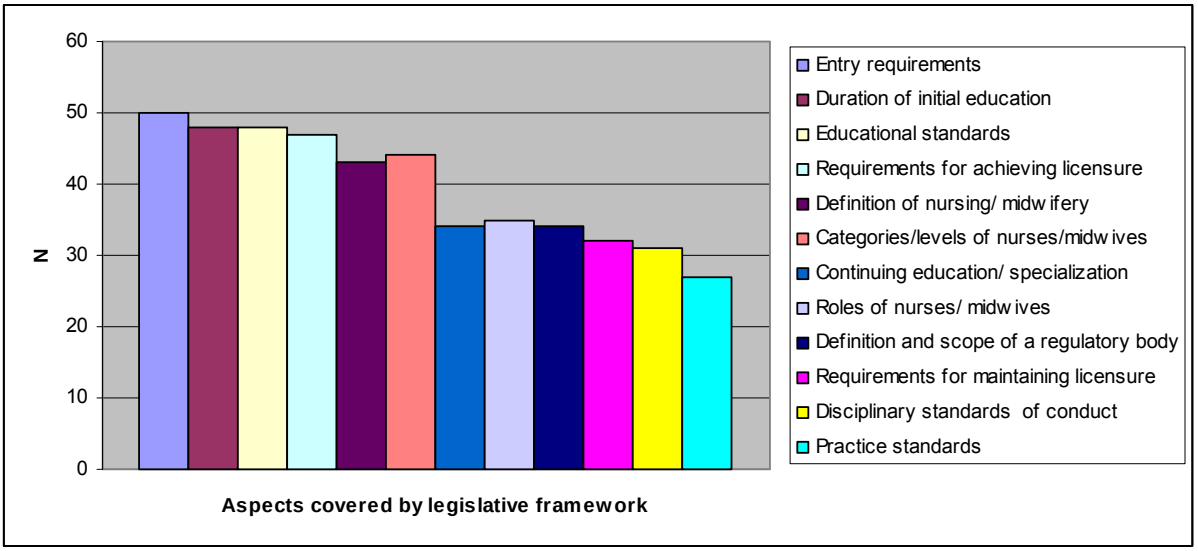


Table 8: Aspects covered by legislative framework

Respondent	Entry requirements	Duration of initial education	Educational standards	Requirements for achieving licensure	Definition of nursing/ midwifery	Categories/levels of nurses/midwives	Continuing education/ specialization	Roles of nurses/ mid-wives	Definition and scope of a regulatory body	Requirements for maintaining licensure	Disciplinary standards Standards of conduct	Practice standards
Armenia	X	X	X	X	X		X	X	X	X	X	X
Austria NNA	X	X	X	X	X	X	X					X
Austria NMA	X	X	X	X	X	X	X					X
Belarus	X	X	X			X	X				X	
Bosnia and Herzegovina						X	X	X				
Bulgaria	X	X	X	X	X		X	X	X	X	X	
Croatia	X	X	X	X	X	X	X	X	X	X		
Cyprus	X	X	X	X	X	X	X	X	X	X	X	X
the Czech Republic MoH/CNO	X	X	X	X	X	X	X	X	X	X	X	X
the Czech Republic NNA	X	X	X	X	X	X	X	X	X	X	X	X
the Czech Republic NMA	X	X	X	X	X	X	X	X	X	X	X	X
Denmark MoH/NMA	X	X	X	X	X		X	X				X

Denmark NNA	X	X	X	X	X		X	X	X			
Estonia	X	X	X	X	X			X		X		
Finland	X	X		X		X	X				X	
France	X	X	X		X	X		X	X			
Georgia	X	X	X									
Germany NNA	X	X	X	X	X	X	X					
Germany NMA	X	X	X	X	X	X			X	X		
Greece MoH/CNO	X	X	X	X	X	X	X	X	X	X	X	
Greece NNA	X	X	X	X	X	X	X	X	X	X	X	
Greece NMA	X	X	X	X	X	X	X	X	X	X	X	X
Iceland NNA	X	X	X	X	X	X	X		X			
Iceland NMA	X	X	X	X	X			X	X			X
Ireland MoH/CNO	X	X	X	X	X	X			X	X	X	X
Ireland NNA	X	X	X	X	X	X			X	X	X	X
Italy	X	X	X	X	X	X	X	X		X	X	X
Lithuania	X	X	X	X	X	X	X	X		X	X	X
Luxembourg		X		X	X	X						
the Netherlands	X	X	X	X	X		X	X	X	X		X
Norway			X	X								
Poland	X	X	X	X	X	X	X	X	X	X		
Portugal (Ordem dos Enfermeiros)	X	X	X	X	X	X	X	X	X	X	X	X
Portugal NNA	X	X	X	X	X	X	X	X	X	X	X	X
Republic of Moldova	X				X	X	X	X	X		X	X
Romania	X	X	X	X	X	X	X	X	X	X	X	X
the Russian Federation	X					X	X	X			X	
Serbia MoH/CNO	X	X	X	X	X	X		X		X		
Serbia NNA	X	X	X	X	X	X		X		X		
Slovenia NNA	X	X	X	X	X	X		X	X	X	X	
Slovenia NMA	X	X	X	X	X	X		X	X	X	X	
Sweden MoH/CNO	X	X	X	X	X	X	X	X	X		X	X
Sweden NNA	X	X	X	X	X	X	X	X	X		X	X
Switzerland NNA	X	X	X	X	X	X						
Switzerland NMA	X	X	X	X	X	X			X	X		
Tajikistan	X	X	X	X		X	X					X
MKD	X	X	X	X		X					X	
Ukraine	X	X	X	X	X	X	X	X	X	X	X	X
the United Kingdom (England MoH/CNO)	X	X	X	X		X			X	X	X	X
the United Kingdom (Scotland MoH/CNO)	X		X	X	X	X		X	X	X	X	X
the United Kingdom (Wales MoH/CNO)	X	X	X	X	X	X	X	X	X	X	X	X
the United Kingdom RCN	X	X	X	X		X			X	X	X	
the United Kingdom RCM	X	X	X	X	X	X	X	X	X	X	X	X

The overview agrees with what has been stated about the definition of nurses and midwives. Clearly, the easiest aspect of the legislative framework is the determination of entry requirements and the duration of the educational programmes. Twenty-eight countries reported that changes of the legislative framework are to be expected. Besides the wide-ranging reasons why legislation must be adapted to actual and changing health care needs, many of the intended reforms are focused on professional roles (i.e. the expansion of the professional scope of practice). Such a step requires a clarification in the legislative framework and usually goes along with options for high-level education.

Another change in existing legislative frameworks is the introduction of requirements for maintaining the professional licensure to practise. This includes measures by which nurses and midwives are to demonstrate their fitness to practise. Countries that expect a change in the legislative framework are: Armenia, Austria, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark [Midwifery], Finland, Georgia, Germany [Midwifery], Greece [Midwifery], Iceland, Ireland, Lithuania, Luxembourg, Poland, Portugal, Republic of Moldova, the Russian Federation, Serbia, Slovenia, Switzerland [Nursing], Tajikistan, the former Yugoslav Republic of Macedonia, Ukraine, the United Kingdom (England, Scotland).

Professional self-perception

From all but six countries (Austria [Nurses], Belarus, Bosnia and Herzegovina, Georgia, Greece [Nurses], Serbia) a high or sufficient professional self-perception was reported. Clear indicators for a high professional self-perception are the development of independent roles in health care and the recognition that nurses/midwives are partners in multidisciplinary contexts of the health care system. Both of these aspects go along with each other – the development and official recognition of the independent roles of nurses and midwives often is a prerequisite for being accepted as equal partners in health care delivery and in decisions on health care policy.

Compared to the 2004 survey, professional self-perception has improved. Many countries reported a continuously improving self-perception of nurses and midwives. This increased awareness of professional potential leads to stronger claims in terms of roles and rewards, but it is also actualized by a stronger commitment to accept an expanded role in health care and the responsibilities that are attached to it. On the other hand, many nurses see their professional commitment undermined by political decisions and have the impression of low societal recognition (e.g. Croatia). Some nurses see the future of their profession at stake, as young people don't seem motivated to choose a future career in nursing (e.g. the Czech Republic).

Despite the high professional self-perception of nurses and midwives, some respondents addressed problems. One problem concerned the increasing separation of different kinds of nursing staff – highly and better qualified nurses on the one hand and others who face serious de-professionalization in terms of staffing levels, poor skill-mix and low and inappropriate salaries. This statement was related to different levels of nursing personnel in terms of years of professional education, but also to nurses working on sectors with high numbers of workers without any professional education. Another concern was that nurses still often play a subordinate role compared to physicians and other health professionals. The national midwifery associations reported a strong and high self-perception and commitment of midwives.

The countries (above) that reported low self-perception of nurses and/or midwives, attributed the situation to a lack of adequate regulations and low-levels of education within the profession. It was also recognized that nurses have traditionally held subordinate positions within health care teams. Raising the status of nurses to increase their levels of responsibility, their roles in clinical decision-making and their sphere of influence is likely to take time. This professional status change will have an impact on relationships between nurses and their health

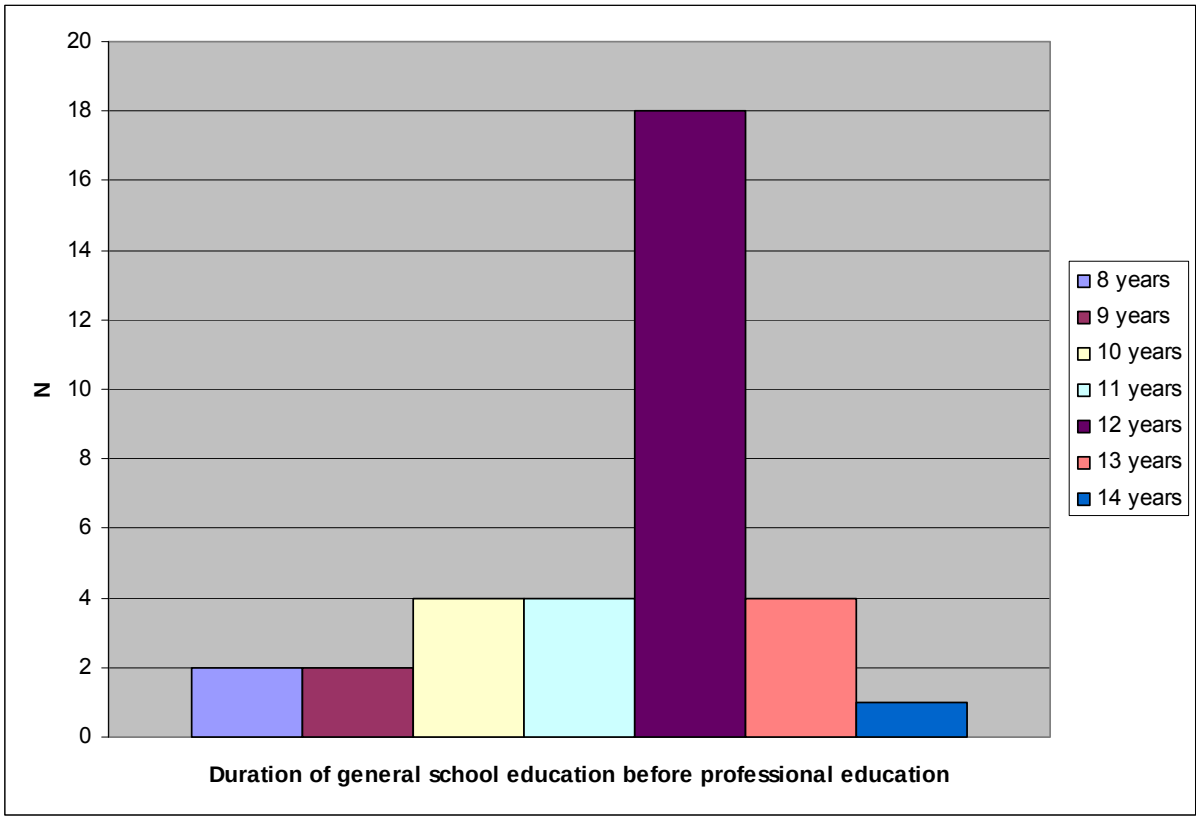
professional colleagues, and is likely to be seen as threatening to some nurses who are content with the current situation.

6. Initial and continuing education and higher education

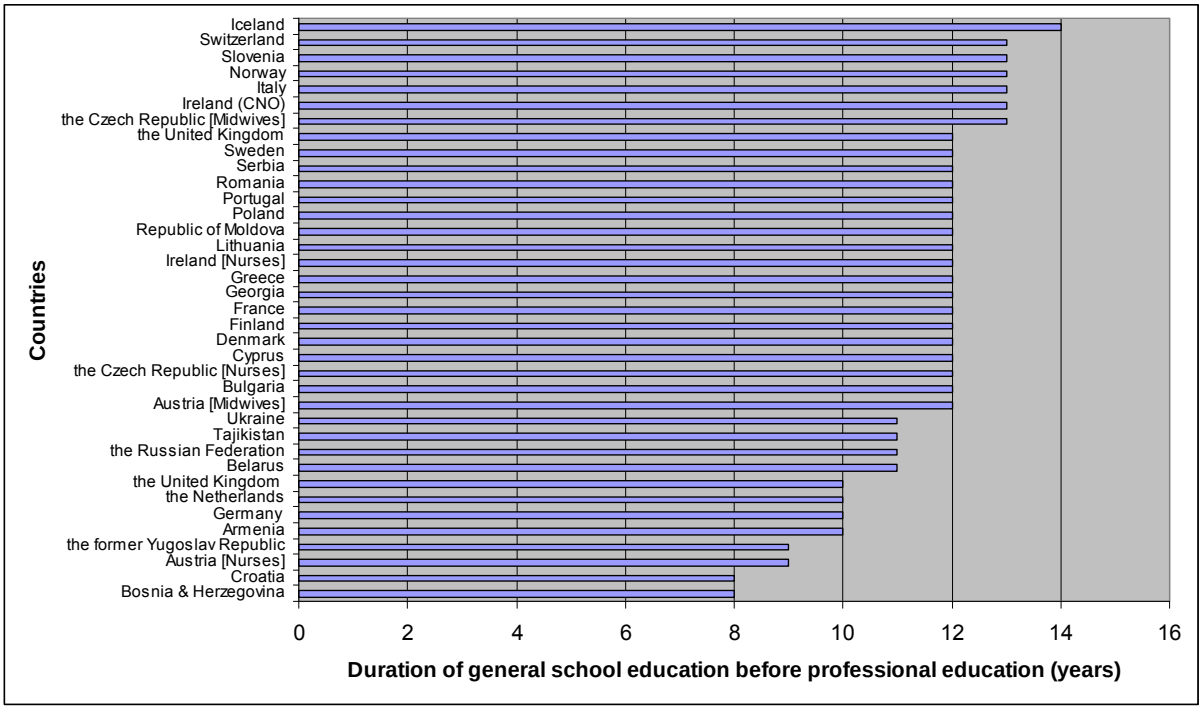
This chapter provides a closer look at the initial and continuing education of nurses and midwives. Professional education is a key aspect of professionalization. It determines, to a large extent, the roles and functions that nurses and midwives can perform in today's health care systems. Most of the aspects covered in this chapter have been investigated separately by the WHO Regional Office for Europe in previous years. Regular monitoring of important educational aspects has been initiated with the implementation of the WHO Educational Strategy for Initial Nursing and Midwifery Education (WHO, 2000a). By using the Prospective Analysis Methodology (PAM), the key principles of this strategy have been monitored. The last progress report on initial and continuing nursing education was published in 2005 (Fleming & Holmes 2005). This report concluded that nursing and midwifery education in Europe has responded to the changes in health care, but the necessary level of basic education still has not been achieved throughout the Region. The report stressed the key recommendation, which is to establish university education level programmes as entry to nursing and midwifery.

The main principles from the WHO Educational Strategy for Initial Nursing and Midwifery have been included in this survey and are presented in this chapter. The first question regarded the duration of general school education required prior to acceptance into an initial nursing or midwifery educational programme. It should be noted that countries within the European Union must comply with the European Union Directives, which stipulate a minimum of 10 years general education.

Graph 8: Duration of general school education before professional education



Graph 9: Duration of general school education before professional education, listed by country



In most countries, 12 years of general school education is required before admittance into an educational programme in nursing and midwifery. In some of these countries, this requirement is the same as in other professions. This indicates that progress towards the goal of moving initial nursing and midwifery education to a higher level has been achieved since 2004. Further evidence of this progress can be found in the following table. In 22 countries, nursing and midwifery education is university based, whereas in 15 countries it is based on vocational qualifications. A similar trend was identified in the last report on the implementation of the WHO Educational Strategy for Nurses and Midwives (Fleming & Holmes 2005). Two-thirds of the responding countries indicated that initial nursing and midwifery education had been advanced to the university level. While these data reveal considerable progress, they also show that the ultimate objective of moving initial education for all nurses and midwives to a higher education level has not yet been achieved. This progress may serve as a good example for national nursing and national midwifery associations or other actors who work on raising the educational level of nurses and midwives in their countries. It also creates a strong argument for convincing decision-makers to raise the educational level of nurses and midwives and for initiating the steps necessary for this development.

Graph 10: Level of professional qualification after initial education

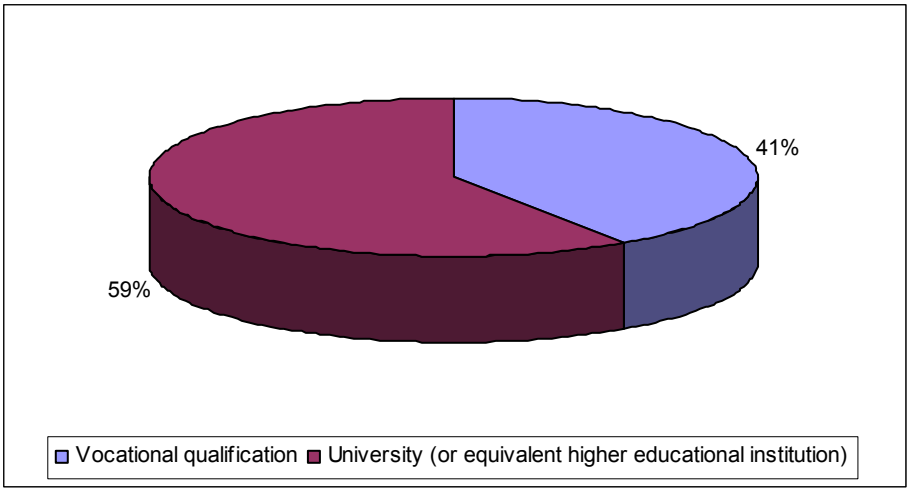


Table 9: Level of professional qualification after initial education

No. of responses	Level of professional education	Countries
16	Vocational qualification	Armenia, Austria, Belarus, Bosnia and Herzegovina, Croatia, Georgia, Germany, Greece, Luxembourg, Poland, Republic of Moldova, Romania, the Russian Federation, Serbia, Tajikistan, MKD,
23	University (or equivalent higher educational institution)	Belarus, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Greece, Iceland, Ireland, Italy, Lithuania, Norway, Poland, Portugal, Romania, Slovenia, Sweden, Switzerland, Ukraine, the United Kingdom

In some countries, both levels of professional education exist. For example, in Belarus the majority of nurses are still educated in vocational programmes, however, one medical university for nurses with higher education exists. A similar situation was reported from Croatia. In Switzerland regulations vary by canton; the French speaking part of the country has a higher percentage of university-educated professionals compared to the German and Italian speaking part.

In the majority of responding countries, students have “student status” during their education. Only five countries reported that students have the status of employees of a health care facility, usually a hospital: Austria [Nurses], Bosnia and Herzegovina, Germany, Lithuania and Portugal (for nurses studying for specialization).

As you can see in the graph below, the educational curricula has prepared most nurses and midwives to practise in hospitals and similar numbers have been reported for competencies to practise in community or institutional long-term care settings. A competency-based curriculum was implemented in almost all countries and a research-/evidence-based curriculum is used by slightly fewer countries.

Graph 11: Characteristics of educational curricula

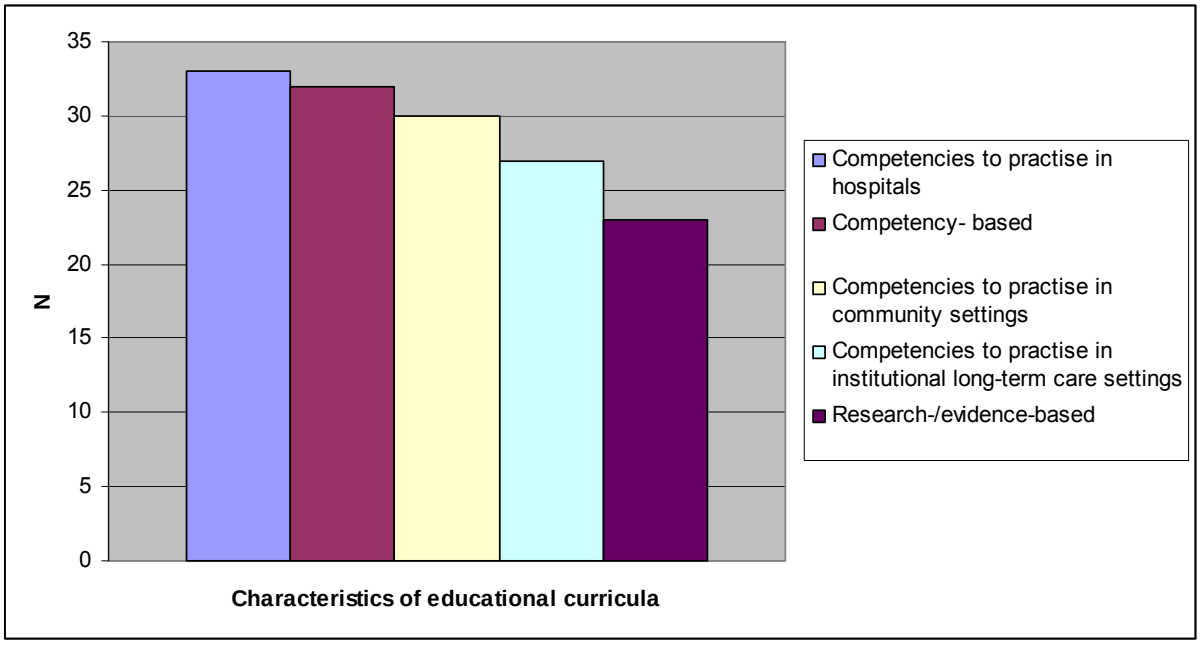


Table 10: Characteristics of educational curricula

No. of responses	Characteristics of curriculua	Countries
33	Competencies to practise in hospitals	All countries except Georgia (no answer to this question) and Estonia
32	Competency-based	All countries except Croatia, Georgia (no answer to this question), MKD
30	Competencies to practise in community settings	All countries except Croatia, Estonia, Georgia (no answer to this question), Italy and Tajikistan
27	Competencies to practise in institutional long-term care settings	All countries but Austria, Belarus, Georgia (no answer to this question), Iceland, Italy, Lithuania, Luxembourg, the Russian Federation
23	Research-/evidence-based	Armenia, Austria [Midwifery], Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Lithuania, the Netherlands, Norway, Portugal, Slovenia, Sweden, Switzerland, Ukraine, the United Kingdom

Other characteristics that were mentioned include: competencies to practise in-home care, primary health care, family planning, management, research and competencies for independent entrepreneurship. Educational institutions are formally accredited in most of the countries. Only in six countries this is not the case (Denmark, Finland, Germany [Midwives], Iceland [Nurses], Portugal and the United Kingdom [RCM – note that the MoH/CNO responses from the United Kingdom state that there is accreditation]).

Participants were asked whether the teaching during the initial education is done by nurses and midwives themselves, or by other professions. Respondents from 24 countries stated that nurses and midwives are also teachers of nursing and midwifery. In 12 countries other

professions are involved in teaching as well. Some respondents explicitly indicated that nurses and midwives do not do all of the teaching, as the curricula contain components of other disciplines. In addition, a distinction has been made in some countries between practical/clinical education (that usually is done by nurses and midwives) and theoretical education (that is done by nurses and midwives, but also by other professions, often physicians). Twenty-three countries report that the requirements to teach in a nursing and midwifery programme are equivalent to those in other professions (i.e. teachers are required to have an academic degree).

In most of the countries' university departments, faculties or schools have been established that provide different types of nursing and midwifery education. The number of educational institutions that offer the full range of professional education is rather limited. This is because initial educational programmes are not yet part of academic education (e.g. Germany) or not all universities offer master's degree or Ph.D. programmes for nurses and midwives (e.g. Denmark).

Almost all countries reported that the university nursing and midwifery departments are part of the regular educational system and operate under the requirements of the educational sector. University programmes for nurses and midwives are often offered at medical universities, medical faculties or medical schools. There are also independent nursing/midwifery faculties or departments and nursing and midwifery departments that belong to the faculties of health sciences, schools of public health or faculties of social sciences.

The last five to ten years have been very important in terms of changes in initial nursing and midwifery education. Apart from the countries in which initial education was moved to the university level more than ten years ago (such as Finland, Greece, Iceland, Portugal, Sweden or the United Kingdom), significant changes have taken place over the last five years in other countries. One of these changes was the introduction of university-based educational programmes for all levels of professional qualification. An overview of the changes in professional education over the last five years is provided below:

Graph 12: Changes in nursing and midwifery education

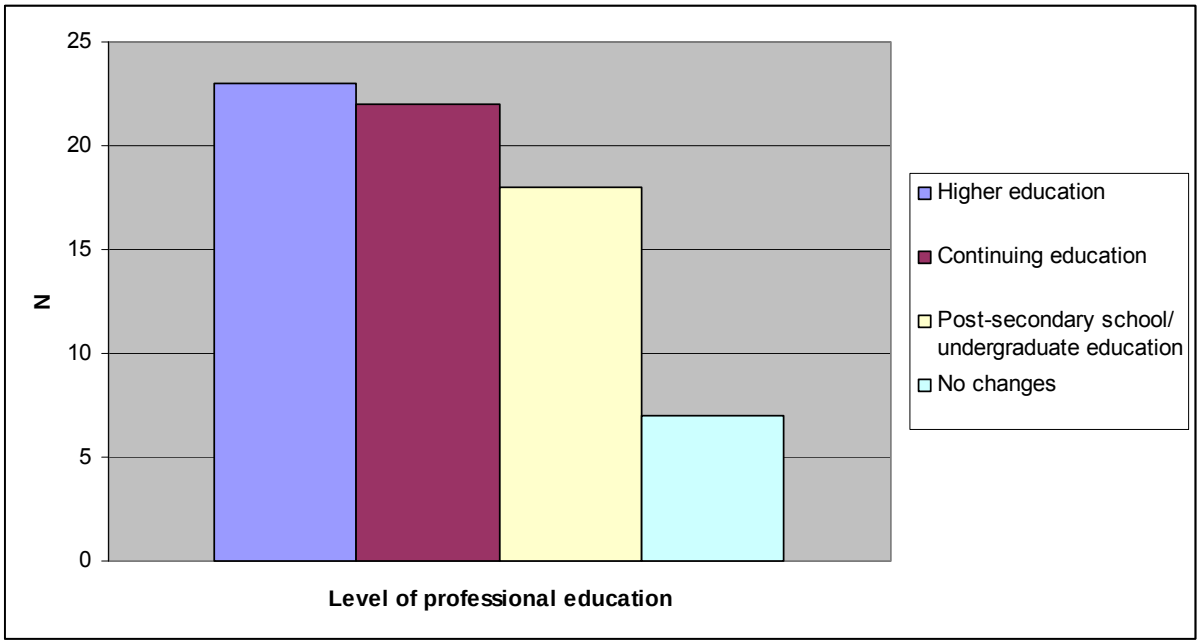


Table 11: Changes in nursing and midwifery education

No. of responses	Level of professional education	Countries
23	Higher education	Austria, Belarus, Bosnia and Herzegovina, Croatia, Cyprus, the Czech Republic, Estonia, Finland, France, Georgia, Germany [Nursing], Iceland, Ireland, Lithuania, Poland, Portugal, Romania, the Russian Federation, Serbia, Slovenia [Nursing], Switzerland, Ukraine, the United Kingdom (RCN)
22	Continuing education	Armenia, Austria [Midwifery], Belarus, Croatia, Cyprus, the Czech Republic, Estonia, Finland, Germany, Greece [Midwifery], Iceland [Midwifery], Ireland, Lithuania, the Netherlands, Poland, Romania, the Russian Federation, Serbia, Switzerland [Nursing], MKD, Ukraine, the United Kingdom (RCN)
18	Post-secondary school/ undergraduate education	Armenia, Austria [Nursing], Belarus, Cyprus, Denmark, France, Georgia, Germany [Nursing], Ireland, Italy, Poland, Romania, the Russian Federation, Slovenia [Nursing], Switzerland [Nursing], MKD, Ukraine, the United Kingdom (England, RCN)
7	No changes	Germany [Midwifery], Greece, Norway, Portugal, Slovenia [Midwifery], Sweden, the United Kingdom (RCM)

The increase of university-based educational programmes for nurses and midwives raises questions concerning the skill-mix of the nursing and midwifery profession, but also concerning the numbers of nurses and midwives qualified on different educational levels. The following table provides an overview of targeted numbers of academically prepared nurses and midwives in the left column and the actual figures in the right column.

Table 12: Desirable and actual percentage of academically prepared nurses and midwives

Country	Proportion to be achieved		Actual proportion	
	Nurses	Midwives	Nurses	Midwives
Armenia	50%	50%	1:99%	
Austria		80%		Rather low[4]
Belarus	No actual objectives		<1%	
Bulgaria	All		Rather low[5]	
Croatia	20%[6]			
Cyprus	All		20%	
the Czech Republic	40-50%		30% (Bachelor)	
Denmark		15%	2,7%	5-8%
Estonia	20 new students per year		24 Master of Science (MSc) 64 Bachelor (BSc) 159 Diploma graduates	
France		All		low[7]
Georgia	70%			
Germany	15%		Approx. 1%	<5%
Greece	100%		10%	100%
Iceland	100%		100%	
Ireland	100%		100%	
Italy	100%		70%	
Lithuania		50%		20%
the Netherlands		30-50%		2%
Poland	2:1			
Portugal	100%		majority	
Serbia	20%		4-9%[8]	
Slovenia	All		70%	
Switzerland	10-20%	Approx. 33%	Approx. 1%	4 individual midwives
MKD	60%		10%	
the United Kingdom	All		66-100%[9]	

Compared to the survey in 2004, the recognition of academic qualification and the need for highly educated nurses and midwives has increased. The intended numbers of academically prepared nurses ranged in 2004 from 5% to 30% with most of the countries aiming at a proportion between 5% and 10%. The figures in Table 12 reveal a quite different picture as the numbers to be achieved range from 20% to 100%. To understand these figures, it is important to note that the definition of academically prepared nurses and midwives varied between some countries. Those that indicated a 100% rate of academic preparation were referring to

[4] Because academic education did not start before 2005
[5] University education obligatory since 2007, previously qualified nurses are allowed to practice
[6] After the next 20 years, the following nursing workforce would be desirable: 60% general nurses qualified on the bachelor level, 20% with a specialization, 10% with a master's degree and 5% with a PhD.
[7] Only some educational programmes at university level
[8] Different numbers from MoH and NNA
[9] Different figures from CNOs and RCN

nurses and midwives qualified for initial entry into their professions by university degrees. On the other hand, countries that reported numbers in the 10–30% range were referring to nurses qualified by a master's or doctoral degree (such as Denmark, Germany, Switzerland). Nevertheless, the numbers of academically prepared nurses and midwives to be achieved have increased considerably.

Participants stated various prerequisites that need to be fulfilled before the desired numbers of academically prepared nurses and midwives will be achieved. For example, they mentioned the need for a close collaboration between the health and the educational sector in the rapid development of new educational programmes designed to meet actual needs of the health care system. Only in this way, can it can be guaranteed that young people will make the right choices for their professional careers and will stay in the professions. Other aspects included the need for the appropriate legislative framework and a sufficient number of educational facilities for nursing and midwifery programmes.

The final aspects of this chapter concern options for interdisciplinary learning for nurses and midwives with physicians, but also with other health care professionals. The WHO Framework for Action on Interprofessional Education and Collaborative Practice states that "…interprofessional education occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes". It also states that collaborative practice "… in health care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings." (WHO Framework for Action on Interprofessional Education and Collaborative Practice, WHO 2010, p. *13*)

The ideas and understanding behind the answers on interdisciplinary learning do not necessarily reflect the definitions stated above, but give an overview of existing options and approaches. In the majority of countries such opportunities exist (26 versus 9 countries), however, interdisciplinary learning is rarely a regular part of initial nursing and midwifery education. Rather it is an option for continuing or postgraduate education, where joint programmes and seminars are offered. In programmes of specialization (such as family-oriented care, management, public health and palliative care) other joint learning opportunities exist. Despite the existence of these opportunities, many respondents have the impression that they are not very widespread and regularly used.

Joint learning at the undergraduate level seems to be an exception. Sweden reported that medical and nursing students attend the same seminars and work on particular wards dedicated to educating for future professional roles. Joint learning opportunities with other professions also exist mainly on the level of continuing or postgraduate education.

7. Fair rewards, recognition and opportunities for career advancement

In order to make a significant contribution towards tackling the public health challenges of our time, nurses and midwives need to have fair rewards, recognition and opportunities for career advancement. In 2004, a very heterogeneous picture with regards to these issues was painted as in some countries the principles of the Munich Declaration had been almost fully achieved, while in others nurses and midwives were not even able to live off of their salaries.

In this survey, responses were positive with regards to the salary level of nurses and midwives, but still in many countries this level is lower than the national average.

Graph 13: Salary level compared to national average

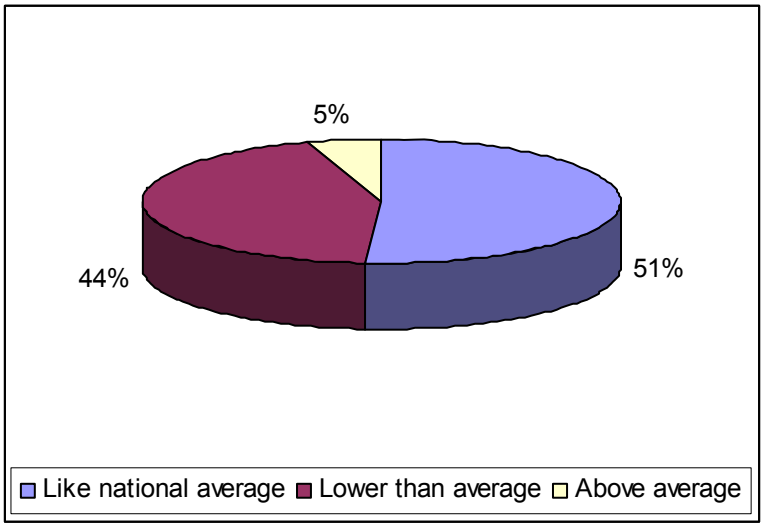


Table 13: Salary level compared to national average

No. of responses	Salary level	Countries
21	Like national average	Armenia, Austria (differences in federal states), Bosnia and Herzegovina, Croatia, Cyprus, the Czech Republic, Denmark (Midwifery), Estonia, Germany (Midwifery), Greece, Iceland (Midwifery), Ireland, Lithuania, Luxembourg, Portugal, Romania, the Russian Republic, Serbia, Slovenia, Ukraine, the United Kingdom (England, Scotland, Wales, RCM)
18	Lower than average	Belarus, Bulgaria, Denmark (Nursing), Finland, France, Georgia, Germany (Nursing), Iceland (Nursing), Ireland, Italy, the Netherlands, Norway, Poland, Republic of Moldova, Switzerland, Tajikistan, MKD (for nurses/midwives with vocational qualification), the United Kingdom (RCN)
2	Above average	Sweden, MKD (nurses with university education)

Only a few countries provided actual figures of monthly or annual salaries. In general it must be assumed that the real figures do not significantly contribute, as the salary amount has to

be evaluated according to national standards and options. One respondent indicated that the salary level alone does not allow a full picture of reward and recognition. For that purpose, the total reward package (including social security benefits, vacation and options for continuing education and personal development) would need to be taken into account.

With the exception of two countries (Germany [Nurses] and Portugal) all countries reported that salaries have been stable or have increased. Eastern European countries in particular reported significant salary increases.

The career prospects for nurses and midwives are driven by position availability. The survey responses reveal a rather heterogeneous picture of such career prospects. While in most countries various clinical career prospects are available including specialization and taking on leading positions, some countries have additional career opportunities in teaching, management and research. Very detailed career prospects were reported from the United Kingdom and Finland, and also from the Ukraine, where due to recent changes, new career prospects are open to nurses. In the United Kingdom a detailed NHS career framework is in place that outlines the options and requirements for nurses and midwives on various career paths. Finland reported existing career pathways in clinical practice, management, research, education and governance.

Twenty-two countries reported the existence of formal pay and career structures. Fourteen respondents indicated that such structures do not exist. In general, pay structures have been the result of negotiations and collective agreements between representatives from unions, providers and others. Where formal pay and career structures do exist, they are governed by several principles. The principles that are applied quite often include the level of education, years of working experience and actual position (e.g. head nurse). Some countries reported that specialization in clinical areas, management positions and the size of institutions are additional criteria.

Different pay schemes may be in place because of different agreements in public and private health care facilities and the decentralized structures that exist within different regions. Some countries reported freelance professional structures for midwives, and a pay scale related to case-loads. This reveals the increasing variety of employment options available for nurses and midwives, which on the individual level may contribute to better career options, but also makes it more difficult to compare and evaluate these various opportunities.

A formal pay and career structure combined with a job evaluation system is in place in the the United Kingdom, where a nine-level career structure for all health workers exists and a top and upper range for each of these bands has been defined. Where a post is to be situated is determined by job evaluations.

Most respondents stated no gender issues related to pay and career structure within the nursing profession. However, general differences between the salaries of men and women throughout the societies of 10 countries (from across Europe, within and outside the European Union) were reported. Although this desparity does not affect career prospects and payment within nursing, it does impact the overall compensation of nursing as a whole. Since it is mainly a female-dominated profession, nurses (regardless of gender) generally receive

lower payments than employees in comparable public services that are more male dominated.

Problems in existing pay and career structures were also revealed by the 27 countries that reported a trend in nurses and midwives seeking better career prospects outside their profession. In particular, those qualified for higher education professions seem to carefully consider their options in nursing and midwifery. The trend to seek options outside the profession was reported to be stronger when the general economy was robust and the unemployment rates were low. People know that nursing and midwifery is a solid option for hard times, but it is not necessarily a preference when other options are available.

8. Workforce planning strategies

The availability of a sufficient workforce of health care professionals, particularly nurses and midwives, is a growing concern in almost all countries in the WHO European Region. This focus is also reflected in the meetings, conferences and publications of other international organizations, such as the European Union and the Organisation for Economic Co-operation and Development. A key factor for setting up sufficient workforce planning strategies is the availability of a solid database. Some of the data that are needed is summarized in this chapter.

Table 14 provides an overview of the numbers of nurses and midwives educated and practising in the WHO European Region. The table shows that more than 4.3 million nurses and almost 300 000 midwives are practising in the countries that responded to this survey.

Table 14: Overview of total and current number of nurses/midwives

Country	No. of nurses	No. of nurses in current workforce	No. of midwives	No. of midwives in current workforce
Armenia	25 000	18 574	10 000	
Austria			1 750	= no. of midwives
Belarus	74 468	= no. of nurses	4 777	= no. of midwives
Bosnia and Herzegovina	8 100	= no. of nurses	805	= no. of midwives
Bulgaria	34 043	31 599	4 382	3 429
Croatia	30 000	29 583	3 000	
Cyprus	3 611	= no. of nurses	171	= no. of midwives
the Czech Republic	77 360		3 901	
Denmark	75 279	59 845	2 400	1 600
Estonia	10 766	8 359	582	444
Finland[10]		64 880		3 410
France				20 000
Germany		Approx. 1.1 million		
Georgia	10 000		5 000	
Greece	35 000	35 000	6 000	5 000
Iceland	3 000	2 788	300	220
Ireland[11]	Approx. 40 000		2 600	
Italy	420 000	= no. of nurses	16 000	= no. of midwives
Lithuania				1 500
Luxembourg				170
the Netherlands			3 300	2 200
Norway	96 000	85 800	2 951	2 631
Poland	270 583	178 291	32 795	20 746
Portugal[12]	Approx. 51 000	= no. of nurses	Approx. 2 000	= no. of midwives
Republic of Moldova	2 000	= no. of nurses	1 500	= no. of midwives
Romania	80 000	= no. of nurses	6 000	= no. of midwives

[10] 52 540 nurses + 12 340 public health nurses
[11] Different figures from NNA (44 755) and CNO (37 825)
[12] Different figures from NNA (48 000 nurses/1 900 midwives) and self-regulatory body (54 827 nurses/2 032 mw)

the Russian Federation	922 403		66 205	
Serbia[13]	Approx. 38 000		2 500	
Slovenia	4 781	3 825 (80%)	600	540 (90%)
Sweden	135 064	94 890	8 066	6 189
Switzerland	75 000		3 500	2 033
Tajikistan	20 449		3 828	
the former Yugoslav Republic of Macedonia	8 000	5 000	2 000	1 300
Ukraine	299 786		22 945	
the United Kingdom	651 709	England: 376 504 Scotland: 40 685[14] Wales: 33 523 N. Ireland: 16 209	35 177	England: 25 093 Scotland: 3 148 Wales: 1 977
Total		**4 321 244**		**298 527**

Calculating the total number of nurses and midwives was challenging because some countries reported the same number for both the number of nurses/midwives column and the number of nurses/midwives in the current workforce column. Other countries referred either to the total number of nurses/midwives or the number in the current workforce. These statements reveal the general lack of data on workforce issues in many countries and point to an important aspect for action in the future. In Table 14, the totals were calculated from the 'current workforce' column. Where information was lacking regarding a country's current workforce, the total number of nurses/midwives of that country was chosen instead.

Countries reported a significant need for nurses and midwives in the future. For purposes of comparison, the total/current number of nurses/midwives is presented again in the following graph and table.

Table 15: Current numbers and estimated need for nurses and midwives

Country	**Total/current no. of nurses**	**Desired total no. of nurses**	**Estimated need for nurses**	**Total/current no. of midwives**	**Desired total no. of midwives**	**Estimated need for midwives**
Austria				1 750	3 500	1 750
Belarus	74 468	90 166	15 698			
Bulgaria	31 599	58 000	26 400	3 429	5 800	2 370
Croatia	29 583	35 500	6 000			
Cyprus	3 611	3 841	230	171	186	15
the Czech Republic	77 360	79 360	2 000	3 901	4 001	100
Denmark	59 845	61 345	1 500 now 5 000 by 2020	1 600	2 000	400
Estonia[15]	8 359	12 000	3 640	444	772	328

[13] Different figures from NNA (37 870) and CNO (38 952)
[14] Headcount quoted. Nurses 35 018 Whole Time Equivalent (WTE), midwives 2 532 WTE
[15] Estonian Ministry of Health estimates 0.5 midwives and 8 nurses per 1 000 inhabitants as appropriate

Finland	64 880		53 600 – 88 000 health & social care workers by 2020	3 410		
France				20 000	35 000	15 000
Greece	35 000	120 000	85 000			
Iceland	2 788	3 399	611			
Italy	420 000	519 000	99 000	16 000	17 500	1 500
the Netherlands						3 000
Norway	85 800		9 200 by 2025			
Portugal[16]	51 000	83 000	32 000			
Republic of Moldova	22 000	28 600	6 600	1 500	1 650	150
Romania	80 000	100 000	20 000	6 000	10 000	4 000
Switzerland				2 033	2 600	567
the former Yugoslav Republic of Macedonia	5 000	10 000	5 000	1 300	3 000	1 700
the United Kingdom England Scotland RCN (UK) RCM (UK)	 35 018 WTE	 37 598 (in 2012)	 2 580 by 2012 40 000 by 2012	 25 093 2 532 WTE	 2 617 (in 2012)	 4 000 by 2012 85 by 2012 5 000

Countries reported increases and decreases in the total number of nurses and midwives. From countries that reported an increase (Austria [Midwives], Bosnia and Herzegovina, Cyprus, Estonia, Finland, France, Georgia[17], Ireland, Italy, the Netherlands, Poland, Portugal, Slovenia, Sweden, the United Kingdom [Nursing]) the following reasons were indicated:

- an increase in the number and quality/level of training and educational capacities
- expansion of existing services and establishment of new roles for nurses
- investments in nursing/midwifery in terms of raising attractiveness and increasing training capacity.

At the same time, respondents mentioned financial constraints as an issue driving decreases in posts for nurses and midwives. In addition, the increased number of educated nurses and midwives still does not seem to be sufficient for future needs. Serious shortages are expected.

The countries that reported a decrease in the current number of nurses and midwives (Armenia, Bulgaria, Croatia, Georgia, Greece [Nursing], Iceland [Midwives], Lithuania, Republic

[16] No real figures available – estimation on the basis of OECD information on nurses per population ratio

[17] Georgia indicated an increase as well as a decrease in the total number of nurses and midwives – compared to the data from the 2004 survey, there was a decrease in nurses and no information on midwives was provided in 2004.

of Moldova, the Russian Federation, Serbia, Switzerland [Nurses], Tajikistan, the former Yugoslav Republic of Macedonia, Ukraine, the United Kingdom [Midwives]) explained that this decrease was mainly due to:

- migration (mainly from Eastern to Western European countries)
- moves to other professions that seem to offer better career prospects
- the retirement of a significant amount of staff.

Other reasons included the uncertainty of professional status due to expected changes, and high entry requirements for initial education, which prevented young people from choosing a nursing career. These findings indicate an even greater need for workforce policies than what was outlined above. They also stress the need to focus more strongly on how migration processes influence workforce issues. These processes have not been stated as influential in the previous survey, but obviously have a profound influence in many countries now.

Workforce policy

Eighteen countries reported that there is a workforce policy in place (Belarus, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany [Midwifery], Ireland, the Netherlands, Norway, Republic of Moldova, Sweden, Switzerland [Midwifery], Tajikistan, Ukraine, the United Kingdom [England, Scotland, Wales]). This is only about 50% of all countries that replied. Compared to the survey in 2004, this represents a slight increase.

Countries that have an explicit workforce policy reported several approaches: on the basic level, ongoing studies about the future are supposed to inform workforce policy development. On the next level authorities or boards have been established that monitor staffing levels and educational capacity and recommend or initiate measures according to their findings. In some countries these boards and authorities operate on national level only, whereas in others regional or country-based boards are responsible for workforce planning. The most detailed workforce policies are based on explicit strategic documents or directions, in which the principles of forecasting labour demand and supply are outlined. These are used by several sectors/ministries/authorities.

The strategies reported ranged from the improvement of working conditions through the increase of salaries, to the development of detailed health workforce planning models and software on national and institutional levels. Another approach is based on actual performance (e.g. one country reported that the number of deliveries a year determines the number of students admitted into midwifery educational programmes). The problem with such an approach is that it is not actually workforce planning, but retrospective adjustment.

When it comes to detailed workforce planning strategies, the number of countries without such strategies is larger than those that actually have a workforce policy. There are 23 countries without workforce planning strategies (Armenia, Austria, Bosnia and Herzegovina, Bulgaria, the Czech Republic, Denmark, Georgia, Germany [Nursing], Greece, Iceland, Ireland, Italy, Lithuania, Luxembourg, Norway, Poland, Portugal, Romania, the Russian Federation, Serbia, Slovenia, Switzerland [Nursing], the United Kingdom [RCM – note some MoH/CNO responses differ]).

The statements received regarding problems with workforce strategies reveal a clearer picture about the current situation. Problems have been reported from 19 countries (Austria, Bosnia and Herzegovina, Croatia, Cyprus, the Czech Republic, Denmark, Finland, France, Germany [Midwifery], Ireland, Poland, Portugal, Republic of Moldova, Romania, the Russian Federation, Serbia, Slovenia, Ukraine, the United Kingdom [England, RCN, RCM]). The main problems with workforce strategies are listed below:

- no relation between workforce planning and actual health needs
- no coordination or insufficient coordination between sectors
- measures only have long-term consequences, some of which can hardly be estimated
- political neglect of the need for workforce planning strategies
- insufficient training capacity
- increasing participation of private providers that do not necessarily contribute to national strategies, but focus more on economic needs
- imbalances between the number of different professions
- lack of data
- too short-termed planning activities
- lack of integration between national and regional levels
- supply-driven and neglecting careful analysis of demands
- lack of collaboration between professional organizations and political decision-makers.

This list not only provides information about existing problems in workforce planning, but may also serve as a checklist for action in countries and on the level of international organizations in terms of providing guidance on these aspects. Also, other problems from countries that do have a workforce planning strategy need to be mentioned here. These problems include:

- regional differences of needs such as the difficulty to ensure that there are enough nurses and midwives in rural areas; and
- the high living costs in metropolitan areas that may prevent nurses and midwives with an average income to live and work there.

Healthy and safe working environments

An important issue of working life is the availability of healthy and safe work environments. This aspect was addressed by the last question in this section concerning the availability of healthy workplaces and quality of work. Twenty-two countries reported that such programmes and policies have been established (Armenia, Austria [Nursing], Belarus, Bulgaria, Denmark, Estonia, Finland, Germany [Nursing], Greece, Iceland, Ireland, the Netherlands, Norway, Portugal, Romania, the Russian Federation, Slovenia, Sweden, Switzerland [Nursing], the former Yugoslav Republic of Macedonia, Ukraine, the United Kingdom). From the other countries such programmes and policies were not reported.

Programmes and policies for healthy workplaces and quality of work are usually part of the wider occupational health or occupational safety regulations in countries. Some are in line with European Union regulation on quality of workplaces. Other countries reported the occupational regulation is a result of negotiations between the ministry of health and employees' representatives or unions. A problem that exists in some countries (Bulgaria, Denmark (effects of staff shortages on stress and burn out), Greece and Portugal) regards the limited implementation of existing occupational health and safety regulation.

In addition to the national level, other regulations or recommendations exist on the regional or institutional level. Unfortunately, only few respondents have gone into more detail about what it contains. The most detailed description was provided by the United Kingdom where several reports have been published with the last one (*Improving health and work: changing lives*) now being implemented. It announces a review of the health and well-being of the current workforce that will be conducted jointly by employers and staff, to identify and recommend action for local implementation. In addition, in several parts of the United Kingdom, standards on health and safety topics have been jointly set. These standards include topics such as violence and harassment as well as needle-stick injuries and falls.

9. Obstacles for nurses and midwives to work to their full potential

Besides insufficient legislative and regulatory frameworks, there may be other obstacles that prevent nurses and midwives from working to their full potential. In the 2001 and 2004 surveys, medically dominated health care systems and a lack of financial resources were identified as major obstacles. Societal aspects were also identified, such as the role of women in society and the availability of young people who may enter the nursing and midwifery profession. The following table illustrates the ranking of existing obstacles from this survey.

Graph 14: Obstacles for nurses and midwives to work to their full potential

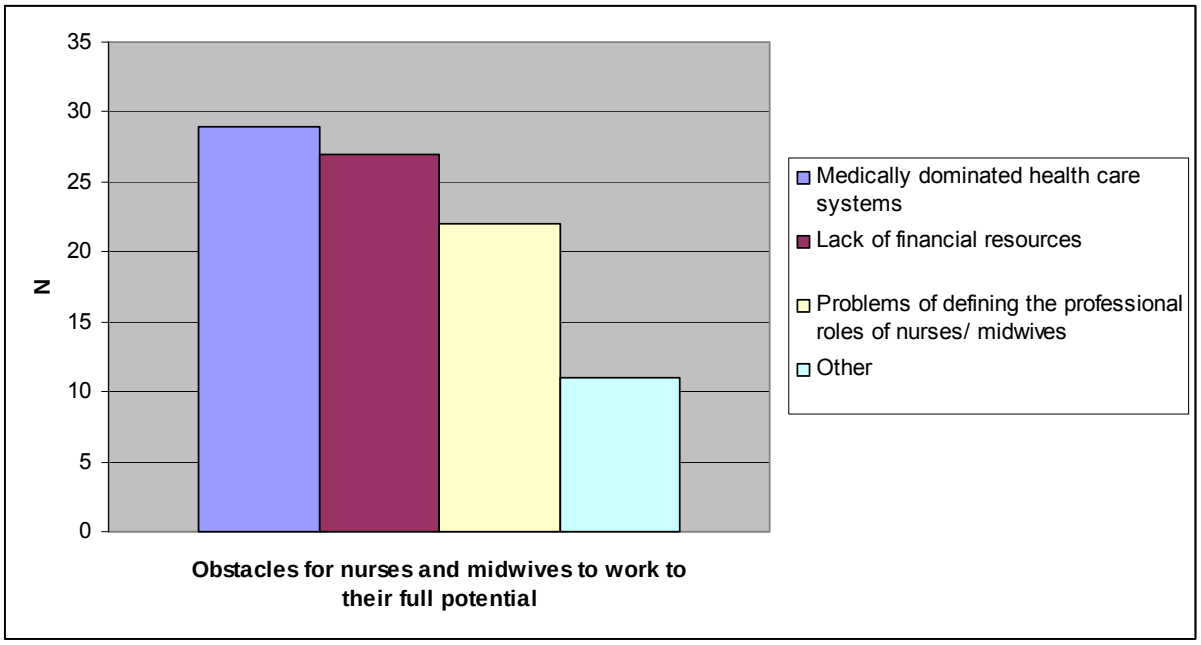


Table 16: Obstacles for nurses and midwives to work to their full potential

No. of replies	Obstacles	Countries
29	Medically dominated health care systems	Austria, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Finland, France, Georgia, Germany, Greece, Iceland, Ireland, Italy, Lithuania, Luxembourg, Poland, Portugal, Republic of Moldova, Romania, the Russian Federation, Slovenia, Sweden, Switzerland, MKD, Ukraine, the United Kingdom (Wales, RCN)
27	Lack of financial resources	Armenia, Austria [Midwifery], Bulgaria, Croatia, the Czech Republic, Denmark, Finland, France, Georgia, Germany, Greece, Iceland, Ireland, Italy, Lithuania, Norway, Poland, Portugal, Republic of Moldova, Romania, the Russian Federation, Slovenia [Midwifery], Switzerland, Tajikistan, MKD, Ukraine, the United Kingdom (Wales, RCN, RCM)
22	Problems of defining the professional roles of nurses/ midwives	Armenia, Austria [Nursing], Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic [Midwifery], Denmark [Nursing], France, Germany [Nursing], Greece [Nursing], Lithuania, Luxembourg, Portugal, Republic of Moldova, Romania, the Russian Federation,

		Serbia, Slovenia, MKD, the United Kingdom (RCN)
11	Other, including: no adequate legislation, problems with state registration, lack of permission to practise independently, shortages of nurses, interdisciplinary competition, lack of experience in leadership and lack of opportunities to learn how to become leaders, no adequate reimbursement system for nursing care services	Armenia, Denmark [Nursing], Estonia, Finland, Germany [Nursing], Greece, Iceland, Romania, Serbia, Sweden, Switzerland, the United Kingdom (England, RCN)

The overview shows that the obstacles preventing nurses and midwives to work to their full potential are still the same. Considering the responses on other questions that point out developments for expanded nursing practice, changes may be expected. Whether these changes are due to a shortage of physicians that calls for urgent action and increased reliance on nurses, or whether there is broader understanding and recognition of the actual potential of nurses and midwives is not always easy to determine, but it will be interesting to observe these developments.

Only five countries (Denmark, Finland, Germany, Poland and Switzerland) reported obstacles related to gender. These included the general problems of women in society such as low pay or violence that also are applicable to nursing and midwifery. The same is true for societal attributions to the role of women (particularly in rural areas) that do not envision the need for university-educated individuals in these female professions. Gender issues were also mentioned in terms of the difficulties to attract men to the profession and an increasing awareness of men's health issues.

Most of the countries reported that more than 90% of nurses are female. Only Bosnia and Herzegovina and Cyprus reported that the percentage of women is said to be lower than 80%. In midwifery, as was to be expected, men hardly appear at all. The ratio within health care systems as a whole also reveals that women are predominantly working in health care.

Stronger obstacles for nurses and midwives exist in regards to professional status. Despite the progress reported in the chapter on legislation, professional status still seems to be rather low in 17 countries (Armenia, Austria [Nursing], Bosnia and Herzegovina, the Czech Republic, Denmark [Nursing], Germany, Greece, Iceland [Midwives], Luxembourg, Poland, Romania, the Russian Federation, Serbia, Slovenia, Switzerland, Ukraine, the United Kingdom [RCN]). Obstacles in regard to professional status can be classified into those of societal perception, equal participation in health care and insufficient regulation of the scope of practice and role of the profession (see Section 5 on professional self-perception, p. 33).

Some countries reported that higher education opportunities for nurses does not automatically lead to higher status and better recognition. The public image of nurses is not necessar-

ily related to a profession with a university degree. The same is true for the health care system. The higher the proportion of academically prepared nurses, the more likely it is that nurses are involved in decision-making, however, it takes some time and it requires a lot of effort and endurance by the nurses themselves.

One statement asked for a more differentiated perspective (i.e. that closer consideration would reveal differences in the various areas of nursing practice). The way forward should include a stronger focus on user orientation and quality development as opposed to professional and provider-driven concerns. Providing high-quality care and serving health care users in the best possible way, was recommended as a more appropriate approach, because it allows for evaluating each profession's contribution to patient care.

Recruitment and retention problems were the last issue addressed in this chapter. Actual recruitment and retention policies were only reported from 10 countries (Austria [Nursing], Belarus, Cyprus, Georgia, Iceland [Midwifery], Ireland, Poland, Republic of Moldova, Ukraine, the United Kingdom [England, Wales, Scotland, RCN]). The most detailed approach to recruitment and retention was reported from parts of the United Kingdom, where regular workforce monitoring takes place and serious investments to enhance student recruitment, selection and retention were mentioned.

WHO has addressed the issue of brain-drain and migration of health workers for some years. While it was not covered by the 2004 survey and also not reported by countries, the issue was raised within this survey. Seventeen countries stated that the recruitment policies of other countries have an impact on the nursing and midwifery workforce (Armenia, Austria [Nursing], Bulgaria, the Czech Republic, Denmark [Nursing], Finland, Georgia, Germany [Nursing], Lithuania, Poland, Republic of Moldova, Romania, the Russian Federation, Serbia, Switzerland [Midwifery], Ukraine, the United Kingdom [RCN]).

In addition to obstacles, resources were also reported. There is an obvious positive public perception of nurses and in many countries this is reflected by nursing and midwifery being an issue in the media. As some of the national nursing and national midwifery associations stated, they use the media to influence policy and to get their messages to a wider audience. This may be an area for further action in terms of improving media representation and acquiring skills for working with the media. For example, The Royal College of Nursing (Wales) has a regular slot in the most widely read regional newspaper, where it raises and discusses nursing issues.

10. Decision-making at all levels

Strengthening the role and contribution of nursing and midwifery in national health care systems requires the participation of these professions in decision-making at all levels of policy development and implementation. The responses on the role of nurses and midwives in political decision-making were very heterogeneous. A range of countries reported only limited participation in and contribution to decision-making, while others boasted regular participation and the establishment of positions for nurses and midwives in politically relevant places.

The degree of participation in decision-making varies considerably. A hierarchy of the degree of involvement includes five levels:

1. no participation at all
2. receiving information and being occasionally part of working groups without having a vote
3. regular consultation, which involves ongoing participation in working groups and regular invitations to submit comments on political ideas, plans and proposals
4. regular membership and participation in advisory boards
5. post of chief nursing officer and/or nursing/midwifery division in ministry of health.

While the 2004 survey heralded the position of a chief nursing officer or a government chief nurse in the ministry of health as the most influential roles for participation in decision-making, this survey reveals that many countries actually moved beyond that and established departments or divisions in ministries of health that are responsible for nursing care. Nurses as members of parliament were also reported.

Political participation does not only take place at the national level. Regional and local participation of nurses and midwives has been reported, too. In addition, some countries stated important managerial roles in health care facilities that nurses and midwives often have. Depending on a country's health care system, these institutional roles can have a strong influence on health care policy.

Unlike others, the decision-making section seems to present a different situation for nurses and midwives, as the hierarchy of involvement that was described above was reported more from a nursing perspective. Most of the national midwifery associations reported even lower participation in decision-making. The reasons for this are unclear, as there are no obvious barriers to prevent the midwives' involvement.

Only limited information was provided on the type of decisions in which nurses and midwives are involved. While in many countries the influence of the medical profession in all aspects of health care is taken for granted, the participation of nurses and midwives was often said to be related to their 'area of responsibility' which was not further defined. Although it was reported in some countries, participation in general health care issues by nurses and midwives can be assumed to still be the exception in the European Region. In line with the statements on participation in decision-making were the responses on the current input of nurses and midwives on political processes. Clearly nursing and midwifery representatives are actively

engaged in continuing discussions and meetings on health care. They contribute to ongoing debates and policies. Contributions often are made in terms of statements or position papers to influence political processes. Nevertheless, many of the respondents considered the current input to be rather limited, but increasing compared to previous years.

In general, nurses and midwives adopted two strategies to contribute to decision-making. One strategy is related to various lobbying activities and the other is best addressed by 'going public'. The first approach implies many of the steps (i.e. participation in meetings, setting up discussions, writing statements and position papers) that have been described above. Additional activities include campaigning on particular subjects (either alone or with other professions) and the identification of key people that might be supportive for nursing and midwifery issues. This includes regular 'parliamentary activities' such as parliamentary questions or petitions. The 'going public' approach addresses the general public. It was not as frequently reported as the lobbying approach, yet some countries did indicate that the media was used to deliver important messages. These messages were not necessarily related to purely professional issues, but also to general health information that nurses provide to the public. 'Going public' also included positive messages about nursing and midwifery that were intended to change the public image of nurses and midwives. One of these messages was that nurses and midwives are not a problem or cost-contributing factor, but a solution for today's health care challenges.

Most countries report that the contributions of nurses and midwives are considered in policy formulation. As with the other aspects mentioned above, there is also a difference here between countries, but the general tendency was positive. The participatory principles that were applied by governments positively impacted the participation and perception of nurses and midwives. On the other hand, the increasing number of nurses and midwives with academic degrees was reported to contribute significantly to the appreciation of relevant authorities.

Finally, the involvement of nurses and midwives compares to that of other stakeholders and professions in the health care system. Respondents reported that physicians still seem to have the leading role in health care, but nurses often are in a better position than other health care professionals. One respondent indicated an increasing influence of economists in health care decision-making and stated that participation in decision-making is not only related to health care professionals, but also involves other actors such as lawyers and economists.

11. Role in public health and community development

During recent years, considerable achievements have been reported towards increasing the important role nurses and midwives play in public health and community development. However, their contribution has been limited by a lack of financial resources and reimbursement policies for health care services. A strong role for public health, nursing and midwifery lies in family-focused programmes and services that acknowledge the invaluable role that families play in establishing health behaviours and when taking care of sick family members.

Twenty-six countries reported that nurses and midwives actually contribute to debates on public health priorities at the governmental level (Austria, Bulgaria, Croatia, Cyprus, the Czech Republic [only to a limited extent], Denmark, Estonia, Finland, France, Germany, Iceland, Ireland, the Netherlands, Norway, Poland, Portugal, Romania, Serbia, Slovenia, Sweden, Switzerland, Republic of Moldova, Tajikistan, the former Yugoslav Republic of Macedonia, Ukraine, the United Kingdom). The means by which nurses and midwives contribute differ considerably. They range from information gathering, public discussions, the use of media, development of statements and position papers to active and regular participation in committees and working groups. Influence on public health debates is not limited to the national level, but also includes activities on the local level.

In many countries, nurses and midwives receive special training or education in public health and public health policy. In some countries, basic knowledge of public health is part of the curricula for the initial education of nurses and midwives. It should be noted that the European Union Directives for nursing stipulates that initial training should include ‘home nursing’. Compliance with the Directive usually involves teaching aspects of community and public health nursing. However, in most countries public health is more an issue of postgraduate qualification and specialization.

For the establishment and consolidation of the role of nurses and midwives in public health, several needs and approaches have been mentioned including: a clear definition of competencies, a stronger focus on primary and community health care, clear regulation and legislation, better professional education (via university-based education) and better data and information.

Family-focused and community-based programmes are an important part of public health. Twenty-five countries reported the existence of such programmes (Armenia, Austria, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Poland, Portugal, Romania, the Russian Federation, Serbia, Slovenia, Switzerland, the former Yugoslav Republic of Macedonia, Ukraine and the United Kingdom). Examples for such programmes include:

- user-based approaches in which families are offered a cross-disciplinary range of services
- health visiting services for children and families
- community health centres
- family doctor offices.

WHO launched the Family Health Nurse several years ago as a strategy to strengthen the role of nurses and midwives in the provision of family-oriented and community-based care. Only a limited number of countries made efforts to implement the Family Health Nurse when it was launched in 2000. During the 2004 survey, the state of implementation was not addressed due to the ongoing WHO multinational study on the implementation of the Family Health Nurse. Meanwhile, the number of countries that have implemented the Family Health Nurse amounts to 19 (Armenia, Austria, Belarus, Cyprus, Estonia, Finland, Georgia, Germany, Greece, the former Yugoslav Republic of Macedonia, Poland, Portugal, Republic of Moldova, the Russian Federation, Serbia, Slovenia, Tajikistan, Ukraine, the United Kingdom [Scotland]). The full curriculum has not always been used, only parts of it. Some countries are still in the phase of demonstration or model projects, while others can build upon several years of experience.

Results from the implementation of the Family Health Nurse were reported to be positive in terms of the services provided by family health nurses. The programme has influenced other areas of nursing education and nursing role development, particularly in terms of how the Family Health Nurse complements activities in countries that have a tradition of family medicine.

Not as successful were experiences in some other countries where the family-focused or public health roles of nurses and midwives already existed before the implementation of the Family Health Nurse. Concerns from other health care professionals about their own roles and how the Family Health Nurse would impact those roles were mentioned. In addition, it was indicated that the success of the programme also depends on the regions in which the Family Health Nurse is implemented. Clearly it is more difficult in urban areas, where a range of other services besides this new role are available for nurses and midwives, than it is in rural areas, where access to services is an ongoing matter of concern.

12. Evaluation and quality of nursing and midwifery services

In 2004, only a few countries reported that measures were in place for the evaluation of nursing and midwifery services. The 2008 survey reveals a different picture: 22 countries stated that such measures have now been established (Armenia, Austria, Belarus, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Iceland, the Netherlands, Poland, Portugal [Nursing], Republic of Moldova, Slovenia, Sweden, Switzerland, Ukraine, the United Kingdom).

Responsibility for the evaluation of nursing and midwifery services has been given to different people and institutions. Some countries reported self-regulative measures by which nurses and midwives themselves are responsible for the evaluation of the quality of services, in others, head nurses or provider organizations have formal responsibility for the evaluation.

In some countries, official bodies such as professional chambers, national boards or other independent bodies have been assigned the task of evaluating the quality of nursing and midwifery services. Obviously the formal responsibility for ensuring the quality of services has been and remains an important issue in many countries.

Formal legislation or regulation on the quality of nursing and midwifery services exists in half of the countries (18 compared to 16 where such legislation does not exist). It was noted that nursing and/or midwifery is not necessarily regulated separately, but as part of the general health care regulation that applies to all health care professionals. Alternatively, it can be part of the reimbursement policies for services that are also applicable to all professions and providers.

One of the approaches to high-quality care is the establishment of professional standards. The existence of such standards has been reported from 25 countries (Armenia, Austria [Nursing], Belarus, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark [Midwifery], Estonia, Finland, France, Germany, Greece [Nursing], Iceland [Midwifery], Ireland, Lithuania, the Netherlands, Norway, Poland, Portugal, Slovenia [Nursing], Sweden, Switzerland, Ukraine, the United Kingdom). Professional organizations or bodies often have developed these standards before they were given official status. In addition to general standards that are applied on a national or regional basis, health care facilities or providers themselves may be active in developing and establishing guidelines and protocols for ensuring quality of service delivery.

Standards have been developed for work in particular settings or for particular activities. In addition, standards with an interdisciplinary approach have been mentioned that address the care of particular populations, such as the elderly. Setting specific standards included: intensive care, operating theatre (Cyprus), community midwifery (the Czech Republic), a quality management handbook for delivery homes (Germany), choice of birth place, home care, postpartum and home birth (Iceland).

Among the standards related to activities were: anaemia, breech position, hygiene, insufficient dilatation (the Netherlands), data collection for extramural maternal care (Germany), and nurse prescribing (Ireland).

Examples for interdisciplinary and/or population-specific standards included: infection control (Cyprus), supporting women in labour (the Netherlands), further education for health care staff, safe pharmacotherapy, services for elderly people, child health clinics in support of families with children, school health care (all from Finland), palliative care and neonatology (Switzerland).

An approach based on general principles for pursuing excellence in nursing care was reported from Portugal. These principles are: client satisfaction, health promotion, prevention of complications, well-being and self-care, functional re-adaptation and nursing care organization.

Another approach to ensuring quality in the provision of nursing and midwifery services is the definition of indicators for monitoring processes and outcomes. Examples of indicators included:

- patient satisfaction
- disease control
- hospital-acquired infection
- quality assessment of interventions in relation to established standards
- absence of complications
- absence of patients' complaints
- number of registered nurses
- patient falls
- incidence of pressure ulcers
- pressure ulcer prevention
- nutrition
- pain
- staffing levels
- frequency of interventions
- educational level of clients
- perinatal and maternal mortality and morbidity indicators
- waiting lists
- monitoring and observation.

The final question on the evaluation and quality of nursing and midwifery services was related to public reports on these services. Such reports do exist in 13 countries (Armenia,

Austria, Bulgaria, Finland, France, Germany, Greece, Luxembourg, the Netherlands, Slovenia, Switzerland, Ukraine, the United Kingdom [England, Scotland, RCM]). The main concerns of nursing and midwifery services highlighted in these reports are listed below:

- Bulgaria: lack of proper legislation, lack of understanding from physicians and lack of financial resources;
- the Czech Republic: paradigm shift in health care in terms of stronger involvement from patient/user perspective, there were indicators of problems with communication between health care professionals and patients, respecting patients' privacy and ethical issues;
- Finland: sufficiency of the nursing workforce, patient safety, effective distribution of advanced roles of nurses, allocation of counselling services to families with special needs, attractiveness of the nursing profession, competencies for changing working life, development of benchmarking in nursing and electronic patient record;
- Germany: lack of autonomy and recognition, inappropriate payment schemes, lack of financial resources;
- Greece: understaffing and shortage of nurses;
- the Netherlands: high perinatal mortality and high referral rates;
- Norway: clinical outcomes such as falls, pressure ulcer, nutrition and pain;
- Switzerland: pressure ulcer and falls;
- Ukraine: number of nurses with educations that are not up-to-date; and
- RCM: postnatal environments that lack staff and cleanliness.

The findings in this section indicate the increasing importance of evaluation and quality of services. The examples of standards and indicators illustrate the issues being currently discussed. It can be expected that the importance of evaluation will increase even more. This is a challenge for nurses and midwives because it implies the application of solid approaches for collecting data and determining the processes and outcomes that are sensitive to nursing and midwifery interventions. The definition of standards and indicators from a nursing and midwifery perspective is highly recommended. Otherwise evaluation criteria may be defined for economic or other reasons.

13. Information on nursing and midwifery

Data and information on nursing and midwifery are needed for several regional, national and international purposes. This section investigates the kinds of data the information on nursing and midwifery in Member States is based on, and who is collecting, analysing and presenting the data.

The existence of a national nursing register was reported in 24 countries (Austria [Midwifery], Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Greece, Iceland, Ireland, Italy, Norway, Poland, Portugal, Romania, Serbia, Slovenia, Sweden, Switzerland, Tajikistan, Ukraine, the United Kingdom). Administrative responsibilities of the register, including ensuring accuracy of the collected data, are either given to general health care authorities (such as national boards of health, health directorates, etc.) or are maintained by professional self-regulation performed by professional chambers, self-regulatory bodies or the national professional associations.

Where there is no such register, other means are in place to provide data on the situation of nursing and midwifery. Some countries report general statistics on health care to be available (such as national health information centres, national statistics by ministries of health or official statistical offices). In most of the countries, updating of the existing databases occurs on a regular and ongoing basis. In others, the update is done once a year. Only rarely is it performed on a less frequent basis.

The poorest information base exists in countries that neither have a national register nor national health databases with data on nursing and midwifery. In some instances, national nursing or midwifery associations that work on collecting and compiling relevant data have been reported to often operate on scarce resources. Information stored in registers such as these reveal the contribution that the professions make to health care systems. Thus, these data are invaluable resources for any planning purposes with regards to nursing and midwifery, and it is vital that the quality and quantity of the data be maintained with the utmost care.

Examples of information that are covered by registers and national statistics on health care include:

- number of nurses and midwives and other professionals (number of professionals educated, number in current workforce, number of full-time equivalents, number per population);
- number of employers of nurses and midwives (public and private);
- number of health care facilities such as hospitals, nursing homes, home care agencies/services;
- number of educational facilities for nurses and midwives, number of actual students, number of educational capacity in terms of places for students; and
- number of patients and users served in different settings.

14. Knowledge and evidence base for nursing and midwifery

The 2004 survey revealed that nurses and midwives in many countries initiated their own research or participated in interdisciplinary health care research. However, regular funding for nursing and midwifery research was only available in some countries and coherent research strategies were the exception. Also, opportunities for nurses and midwives to pursue careers in nursing/midwifery research were not available throughout the region. The replies to this survey reveal some improvements.

A national nursing or midwifery research strategy was reported from 10 countries (Armenia, Austria, the Czech Republic, Denmark, Ireland, Norway, Portugal, Slovenia, Switzerland, the United Kingdom [Wales, Scotland, RCM]). Topics included in these strategies were:

- quality of nursing care
- multicultural nursing
- organization of community nursing
- structure and organization of nursing
- integration of research and practice
- education for nursing research
- national and international collaboration
- health education for capacity building
- innovative strategies in management/leadership
- appropriateness of nursing care
- impact of nursing interventions
- adaptation of services to changing health care systems
- identification of relevant nursing phenomena
- impact of working environment on nursing care quality
- functioning of family systems and social networks
- integration of variety in individual life circumstances
- implementation of ethical principles.

The United Kingdom reported that strategies are focused on research for patient benefits and using an interdisciplinary approach. This reflects a more tailored user orientation of health related research and moves beyond the professional perspective only. Institutions that support nursing and midwifery research are basically universities, university departments, colleges, universities of applied sciences, research societies and research institutes.

More than half of responding countries (Austria [Midwifery], Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, Germany [Nursing], Greece, Iceland, Ireland, Italy, Lux-

embourg, the Netherlands, Norway, Poland, Portugal, the Russian Federation, Sweden, Switzerland, the United Kingdom [England, Wales, Scotland, RCN, RCM]) offer opportunities for nurses and midwives to study for research-based degrees. In 18 countries nurses and midwives would need to choose other disciplines to obtain those degrees and in 15 countries they would be required to get such degrees abroad.

Some of the countries that do not offer the full range of educational options for nurses and midwives have established strong links with partner countries that provide such opportunities. Additionally, links to medical organizations or public health institutions are established for the purpose of developing research capacity.

In order to disseminate research results, conferences and seminars take place in many countries. Still the most common means of distribution is publication in nursing and/or midwifery journals. Only six countries lack such journals (Bosnia and Herzegovina, France, Lithuania, Luxembourg, Romania and Tajikistan). The following graphs and tables illustrate the number of professional and scientific journals available in the other countries.

Graph 15: Number of professional and scientific journals

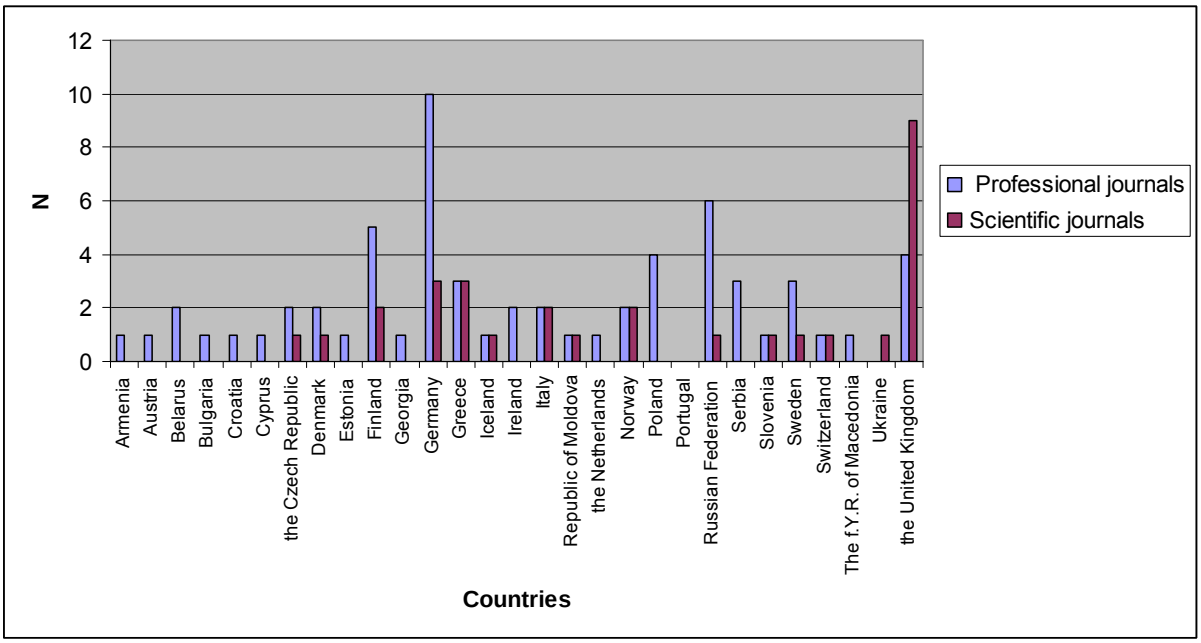


Table 17: Number of professional and scientific journals

No. of professional journals	Countries	No. of scientific journals	Countries
1	Armenia, Austria, Bulgaria, Croatia, Cyprus, Estonia, Georgia, Iceland, the Netherlands, Republic of Moldova, Slovenia, Switzerland, MKD	1	the Czech Republic, Denmark, Iceland, Republic of Moldova, the Russian Federation, Slovenia, Sweden, Switzerland, Ukraine
2	Belarus, the Czech Repub-	2	Finland, Italy, Norway

	lic, Denmark, Ireland, Italy, Norway		
3 or more	Finland, Germany, Greece, Poland, Portugal, the Russian Federation, Serbia, Sweden, the United Kingdom	3 or more	Germany, Greece, Portugal, the United Kingdom

Table 17 shows that despite the strong pressure in the academic world to publish in English peer-reviewed journals, a number of professional scientific journals in other languages influence the professional debates in nursing and midwifery. However, in a globalized world it must be considered that while scientific journals in English are a valuable source of information, a range of scientific journals from South America, that are in Portuguese or Spanish and accessible to nurses, are therefore important sources as well. Indeed, for a large number of nurses and midwives, information in their native language is vital for the improvement of their professional practice.

Another important aspect in establishing a professional knowledge base is the availability of funding for nursing and midwifery research. The availability of funding was reported from: Armenia, Austria, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, Germany, Greece, Iceland, Ireland, the Netherlands, Norway, Poland, Portugal, Serbia, Slovenia, Sweden, Switzerland and the United Kingdom. No funding options were reported from: Belarus, Bosnia and Herzegovina, France, Georgia, Greece, Italy, Lithuania, Luxembourg, Republic of Moldova, Romania, the Russian Federation, Serbia, Tajikistan and Ukraine. Disagreements exist in Greece where the professional associations report no funding and the Ministry of Health indicates that funding is available. The following graph and table provides an overview of different funding sources for research.

Graph 16: Sources for funding nursing research

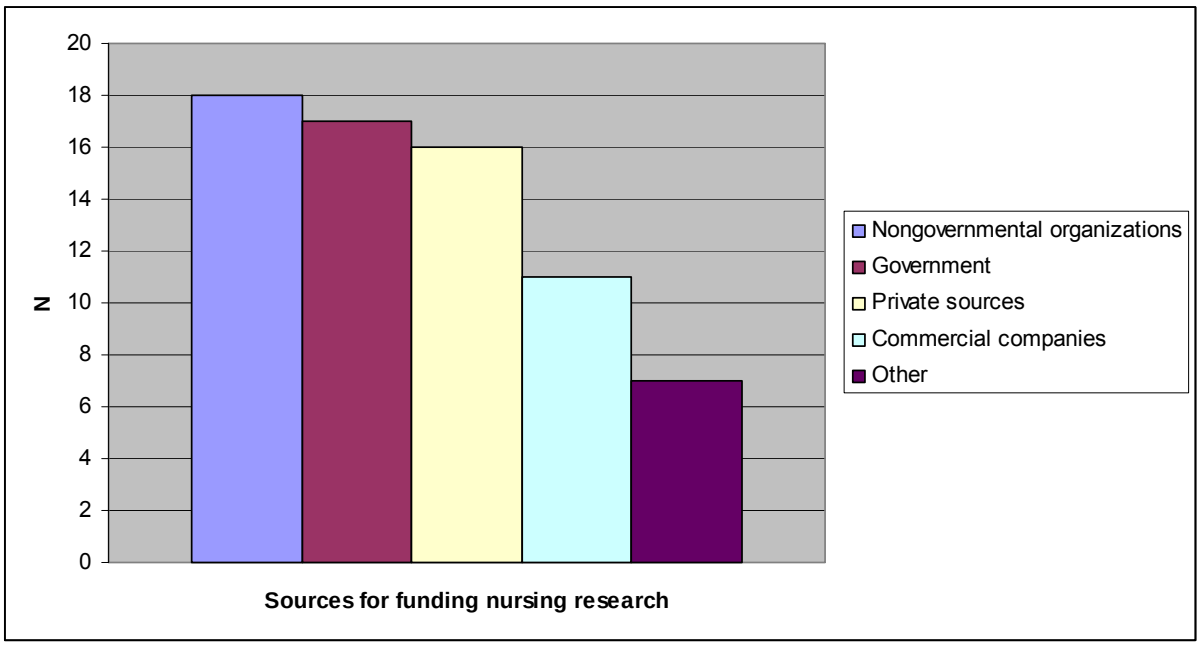


Table 18: Sources for funding nursing research

No. of countries	Funding source	Countries
19	Nongovernmental organizations	Armenia, Austria, Bulgaria, the Czech Republic, Denmark, Estonia, Finland, Greece, Germany [Midwifery], Iceland, the Netherlands, Norway, Poland, Portugal, Serbia, Slovenia, Sweden, Switzerland, the United Kingdom (Wales, Scotland, RCN, RCM)
17	Government	Austria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, Germany [Nursing], Iceland, Ireland, the Netherlands, Norway, Poland, Portugal, Slovenia, Sweden, Switzerland, the United Kingdom (Wales, Scotland, RCN, RCM)
16	Private sources	Armenia, Austria, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, Germany, Iceland, the Netherlands, Portugal, Sweden, Switzerland, the United Kingdom (Scotland, RCN, RCM)
11	Commercial companies	Austria [Nursing], Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Germany [Nursing], the Netherlands, Portugal, Switzerland, the United Kingdom (Wales, Scotland, RCN)
3	Other	Germany: different foundations Switzerland: foundations, universities (of applied sciences) England: funding of particular nursing research centres

15. International collaboration and guidance from WHO

In recent years several documents on nursing and midwifery have been produced and disseminated by the Nursing and Midwifery programme at WHO Europe. In order that helpful and useable materials might be developed for nursing and midwifery policies in Member States, it is important to know how these materials have been used in the past and what future needs exist for support and guidance. In addition to the direct support provided by the WHO Regional Office for Europe, collaboration between countries and different organizations within countries has been reported to be very helpful. Examples of such collaborations were twinning projects and direct partnership agreements between organizations and/or countries. This last section of the survey addresses international collaboration and the usefulness of WHO guidance documents.

Most of the countries reported utilizing guidance materials from the WHO Regional Office for Europe. The following respondents reported that WHO material has not been used in recent years: Denmark (Ministry of Health), France, Greece, Lithuania, Luxembourg, Serbia (Ministry of Health) and from England and the Royal College of Midwives. The documents that have been referred to by other countries include:

- The Munich Declaration: Nurses and Midwives: A force for health
- The Family Health Nurse: context, conceptual framework and curriculum
- The WHO educational strategy for nursing and midwifery education
- Resolutions of the World Health Assembly on nursing and midwifery
- Health for All Strategy
- Statements from the Annual Meetings of the European Forum of National Nursing and National Midwifery Associations and WHO
- The Health 21 Framework
- LEMON (Learning materials on nursing)
- Others: Strategic Directions for Nursing and Midwifery 2002-2008, material on breastfeeding, complications in pregnancy or childbirth, documents on human resources for health, the preparation of National Action Plans, professional standards, the Ljubljana Charter, guidance for chief nursing officers, and the Alma-Ata Declaration.

Wishes and requests for support in the future include:

- continuing provision of consultation, guidelines and information
- support for the development of primary health care
- implementation of legislative standards, the Family Health Nurse and the educational strategy for initial nursing and midwifery education
- guidance in strategic planning and policy development
- establishment of research networks

- support in the permanent recognition of midwifery as a distinct and independent profession
- collaboration and guidance on health promotion, quality of services and patient safety
- stronger involvement of nursing and midwifery experts in WHO programmes
- closer networking and exchange among nurses working in ministries of health
- European benchmarking
- putting more pressure on governments to implement nursing and midwifery policies
- funds to review, implement and adapt European standards of care
- international collaborative research on nursing economics, cost efficiency and health economy from a nursing and midwifery perspective
- providing a library with academic literature for nurses and midwives
- guidelines for workforce planning
- more material on nursing policy (staffing issues, influencing policy and decision-making processes)
- support in the development of international collaboration
- prioritizing in terms of spending resources on helping developing countries and those needing particular assistance in professional development.

Representatives from countries reported a range of activities on how they strengthened international collaboration. Among those activities were regular participation in international meetings and conferences, membership in international networks and organizations (including regionalized or language-based international collaborations such as those among the Nordic or German speaking countries). Such international collaboration has been useful in several respects: it strengthened the knowledge base on various issues related to nursing and midwifery; it initiated international student exchange programmes; it supported education and research; and it was helpful in strengthening leadership skills.

The organizations that have been particularly helpful besides WHO in international collaboration included first and foremost the International Council of Nurses (ICN) and the International Confederation of Midwives (ICM). Of similar importance were the European Federation of Nurses (EFN) and the European Midwifery Association (EMA). The European Forum of National Nursing and Midwifery Associations (EFNNMA) have also been mentioned quite often. The impact of bilateral international collaboration and twinning projects was obvious in statements in which the importance of the Danish Nursing Organization and the Royal College of Nursing was stressed along with the WHO collaborating centres. Other organizations mentioned included: Sigma Theta Tau International, Workgroup of European Nurse Researchers (WENR), International Federation of Gynecology and Obstetrics (FIGO), United Nations Children's Fund (UNICEF), European Association of Institutions in Higher Education (EURASHE), European Observatory on Health Systems and Policies, International Labour Organization (ILO), World Alliance for Patient Safety and the European Commission Technical Assistance Information Exchange Unit (TAIEX).

16. Conclusions

The results of this survey provide insight into the multitude of developments that have taken place in nursing and midwifery in the WHO European Region over the past five years. They reveal that real progress has been achieved in implementing the principles of the Munich Declaration, but they also point to areas where further action and commitment is needed to ensure that nurses and midwives can contribute to their full potential in tackling the public health challenges in WHO's Member States.

These findings indicate the relation that exists between the different principles of the Munich Declaration. Establishing the right legislative frameworks to support better health system conditions and implementing a system for advancing initial nursing and midwifery education to higher educational levels are prerequisites to allow nurses and midwives to equally and effectively participate in decision-making, to play a role in public health and community development, and to contribute to knowledge generation and the expansion of the evidence base for professional practice[18].

The following paragraphs will address some of the issues that arise from this survey that will need further attention in the future.

Workforce issues

It is widely recognized throughout the WHO European Region that there are serious problems ensuring a sufficient number of well-qualified nurses and midwives, as well as other healthcare professionals. This international workforce crisis is reflected by an increasing amount of publications from international organizations such as OECD (2008) and the European Commission (2008), but also in the nursing literature (Buchan & Aiken 2008).

Workforce planning is affected by several developments. More and more countries face the establishment of market principles in health care that go along with increased privatization of health care service delivery. Whether these developments produce desirable or undesirable results in terms of outcomes for the populations served, they increase complexity for policy makers in workforce planning. When doing workforce planning, approaches that take into account the numbers of persons in need of health care, actual figures of professionals, actual training capacities and patterns of service delivery only work to a limited extent on a market-based health care system, where increased competition between providers is a primary driving force.

The issues addressed in the literature embrace workforce planning issues, migration of health care workers, shortages of health care professionals, working conditions and workforce planning strategies. A common conclusion in these papers is a call for co-ordinated and urgent action from policy makers. The results from this survey reveal that the current state of

[18] It is recognized that some of the Member States, who are members of the European Union, are required to comply with the European Union Directives on the initial preparation of nurses and midwives. Responses from these countries have not been separated out in this analysis. These Directives indicate the number of hours, length of training, balance of theory and practice hours, and specific components to be delivered on the programmes. (For further information on the EU Directives see European Commission 2009a; 2009b.)

progress in workforce policies with regard to nursing and midwifery can not be considered desirable or appropriate.

In reality, the situation is actually worse because even when workforce policies are in place, there is no guarantee they will lead to a sufficient number of nurses and midwives. Demographic change in most of the countries of the WHO European Region not only implies an increasing number of elderly people with often long-term care needs, but also a decreased number of young people that may choose careers in nursing and/or midwifery. This underlines the need for increased attention to this issue because the supply side of nursing and midwifery, in the educational area, is in strong competition with other disciplines that often offer better career prospects.

Expansion of professional practice

It has been shown that the expansion of the scope of professional practice of nurses and midwives is a matter of debate in several countries. (It is actually more related to nurses and less to midwives.) This expansion of practice is either focused on the right and responsibility to perform particular activities, such as the prescription of drugs and/or assistive devices, or it is associated with a general expanded role that is, due to its role models, often referred to as advanced nursing practice.

In a paper summarizing the international development of advanced nursing practice, Sheer and Wong (2008) state that the introduction of advanced nursing practice emerged because of the need to contain costs, improve access to care, reduce waiting time, serve the underprivileged and maintain health among specific groups. Bryant-Lukosius et al. (2004) discuss six influencing issues on advanced nursing practice, among those the emphasis on a physician-replacing role that is also addressed as the 'delegated medical function' by Browne and Tarlier (2008). However, nurses should not be seen as 'mini doctors', but rather as health professionals with an expanded scope of practice. Results from this survey also indicate that physician shortages, problems with access to care and increasing health inequalities were driving factors for the establishment of new and advanced roles for nurses. These roles often started with the delegation of particular tasks from physicians to nurses. Clearly, serious problems in health care delivery are a trigger for the introduction of expanded practice[19]. The impact of the European Working Time Directive has to be taken into account.

This problem-driven expansion of roles and responsibilities for nurses implies several risks. The recommended entry level for advanced nursing practice is usually a master's degree (Sheer & Wong 2008). It has been shown that in many countries of the European WHO region, the prerequisite of a critical mass of adequately prepared nurses to take over advanced practice roles is not yet available and probably will not be available in the next decade. A second problem that may arise concerns the assumption that nurses in general will be more willing and ready to practise in remote areas and to serve underprivileged populations than physicians. It can be assumed that besides the recognition of an advanced practice role with

[19] Also, other influencing factors have been reported such as the European Working Time Directive which is a matter of concern in the United Kingdom. It reduces the number of hours junior doctors are able to work and therefore nurses have been up-skilled in recent years in order to take on the roles previously performed by junior doctors in order to fill the deficit.

increased responsibility, other incentives will be necessary to attract highly qualified nurses to less attractive places of work. In general it can be stated that nurses as a 'just in case' option may be somehow attractive to policy makers, but definitely are not a sufficient basis for a sustainable health care system.

Meanwhile, there are examples available that illustrate what roles nurses and midwives can take over and how they can practise independently (Joel, 2009). It is now up to decision-makers and educationalists to use these as models of good practice and to introduce programmes for advanced nursing practice in their countries. With the Family Health Nurse, the WHO Regional Office for Europe has created a role for nurses and midwives that goes beyond the actual roles nurses and midwives have in many countries (WHO Europe, 2006) and that is in line with primary health care and community-based health care policy.

Initial nursing and midwifery education

It has been shown that many countries raised the level of initial nursing and midwifery education to a higher education level. Nevertheless, in a significant number of countries no such developments have taken place. Initial nursing and midwifery education has been addressed from several perspectives internationally, particularly in the last decade. The WHO Regional Office for Europe has launched its educational strategy for initial nursing and midwifery education (WHO Europe, 2000a) and stated fundamental principles of initial educational programmes. In its Strategic Directions 2002-2008, WHO identified education of health personnel for nursing and midwifery services as one out of five key result areas (WHO, 2002) as they stated the objective: "to strengthen the core skills of nursing and midwifery practitioners in order to meet changing population and practice needs". Recently a WHO task force has published 'Global standards for the initial education of professional nurses and midwives' (WHO, 2009) that again puts emphasis, despite all differences in countries, on the need to move initial education to a higher educational level.

In addition to these important policy documents from WHO, initial nursing and midwifery education in the European WHO Region is also strongly influenced by the Bologna Process that aims to create convergence in higher education across the European Union (Davies, 2008). It is expected that this process will provide an impetus to raise the level of initial nursing and midwifery education to the graduate level (Davies, 2009) and by doing so, urging those European Union countries in which nursing and midwifery is still taught at a vocational level to initiate the changes required. This is necessary to achieve the objectives in the basic action lines of the Bologna Process, i.e. the adoption of easily readable and comparable degrees; a system of two-cycle of degrees (undergraduate and graduate); a system of transferable credits; the promotion of mobility; the promotion of quality assurance; and the promotion of the European Dimensions of Higher Education. There is still some way to go before these objectives will be met; for example, in 2009, nurses in Italy were required to study for three years to attain a bachelor's degree, while nurses in Germany needed six years to attain the same degree (three years of vocational training followed by three years of study). This is a situation that is not characterized by easily readable and comparable degrees and is in need of improvement.

Within the Bologna Process, the Tuning Project (Tuning Educational Structures in Europe) was initiated. The Tuning project focused on educational structures and content of studies

(González & Wagenaar 2003) and addressed the responsibility of higher education institutions in Europe. Nursing was the first health care regulated group and practical discipline to be included in the Tuning Project (González & Wagenaar 2005). Taking into account all these developments from the global and European levels along with a range of examples from Member States, it is clear that a lot has been achieved. Countries that have not been part of these developments now have the chance to search for examples of good practice and have role models. Given all these developments, it will be increasingly difficult to maintain a situation in which progress in initial nursing and midwifery education is rejected.

Nursing and midwifery research

Despite the considerable progress in the area of initial education, progress in the area of nursing and midwifery research has not been achieved to the same extent. There is a need for further improvement in several respects. The first concerns the need for improving a research capacity among nurses and midwives. So far, a strong research capacity is only available in countries that have a long tradition of research-focused programmes at masters and doctoral levels. This capacity is needed to set up regional and national nursing and midwifery research strategies. Although there is growing recognition of the need to involve nurses and midwives in interdisciplinary research approaches, particular nursing and midwifery research strategies are needed in order to address important questions in nursing and midwifery care. This is particularly true because of the public health challenges stressed in this survey by respondents. The increase of chronic conditions and the need for long-term care as well as increasing health inequalities calls for a broader approach that goes beyond the biomedical and cure-oriented model that is still prevalent in many health care systems. On the other hand, there is a richness and diversity of nursing research globally (Polit & Beck 2009; Mendoza-Parra et al. 2009; Adejumo & Lekalakala-Mokgele 2009) that should be acknowledged, maintained and expanded.

Besides issues of qualification and the direction of nursing and midwifery research, one of the basic requirements is the availability of research funding. The results of this survey show that various funding sources for nursing and midwifery research do exist, but no sources are available in more than half of the countries. It can be assumed that the more frequently experienced nursing and midwifery researchers contribute to knowledge and evidence generation nationally and internationally, the more recognition they receive in terms of public interest and research funding. As long as no nursing and midwifery researchers are involved in defining national research priorities, it will remain unlikely that more funding for nursing and midwifery research will become available.

Evaluation and quality of services

Related to the areas of knowledge generation and research are the improvement and expansion of methods for the quality development and monitoring, as well as the evaluation, of nursing and midwifery services. The increased attention to the quality of services was clearly indicated by answers to this survey, and there are activities across the WHO European Region focused on developing appropriate quality-control measures. It is to be expected that further increases in cost containment policies and cost pressures will provoke a more thorough investigation into the quality of services and will play a more important role in distributing scarce resources. Nurses and midwives should be aware of these developments and be prepared by developing their own quality development and assurance systems. Also, health

care decision-makers should be aware of the quality of nursing and midwifery services, as it will highlight the important contributions nurses and midwives make in patient care.

Data on nursing and midwifery

Another aspect that is also closely related to the generation of a knowledge- and evidence-base is the general availability of data on nursing and midwifery. Situations within the Member States of the European Region are rather diverse, and while solid and longitudinal information is available in some countries, others lack even the most general figures.

This also impacts any attempts to make international comparisons. While it is a huge achievement that international data on nursing and midwifery is available via WHO, OECD or the European Union, all databases include warnings about the quality of the data and the difficulty of comparability between indicators and countries. A lot of work lies ahead in terms of creating comparable indicators and monitoring systems with regard to nursing and midwifery.

The role of the national nursing and national midwifery associations

The national nursing and national midwifery associations have launched various activities to improve the status of the professions and by doing so to improve and sustain patient care. These efforts had different starting points and not all associations could contribute as much as they would have liked to. The huge diversity of nursing and midwifery in the WHO European Region is reflected by the differences between associations. While some have a long standing history and the membership of the majority of nurses and midwives in their country, others suffer from few resources and few members. A situation like this limits the options of professional associations and often progress depends on the commitment of individual nurses and/or midwives that take on the challenge of moving their professions forward.

Recommendations

The following aspects are recommended as areas for further action:

- countries should work on a broader implementation of workforce planning policies and strategies to make nursing and midwifery attractive career options for young people and to retain those that are qualified;
- raise the level of initial professional education to the higher education sector in those countries where this has not been done so far;
- introduce advanced practice roles for nurses and midwives;
- address the increased needs of people suffering from chronic conditions;
- support leadership development of nurses and midwives, enabling them to contribute to decision-making at all levels of policy and service delivery;
- strengthen approaches for conceptualizing, determining and measuring the quality of nursing and midwifery services; and
- strengthen research capacity of nurses and midwives in terms of adequate qualification and sufficient funding opportunities.

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Appendix 1:

Questionnaire on the situation of nursing and midwifery in the European Region of WHO

1. Political will and commitment This general question is intended to identify political debates from a governmental as well as from the professional associations' point of view.	
Question	**Answer**
Have there been any relevant governmental statements with regard to nursing and/or midwifery?	□ Yes □ No
If so, what kind and on what subjects?	
Have the national nursing and/or national midwifery associations made any moves to ensure and/or initiate governmental and/or societal commitment?	□ Yes □ No
If so, how has this been done?	
If not, are there any plans to do so and what are the obstacles for not doing it?	
Additional comments and remarks:	

2. Public Health Challenges in the countries of the WHO European Region Policies on human resources for health depend to a large extent on the public health challenges that actually exist in countries and those that are anticipated to become challenges in the future. This question is intended to learn about the public health challenges of individual countries and whether they influence policies on nursing and midwifery.	
Question	**Answer**
What would you consider the biggest Public Health Challenges in your country? (Please tick the appropriate boxes and, if feasible, rank them with numbers according to their priority in your country)	□ Increasing number of people with chronic conditions □ Access to primary health care □ ensuring an adequate workforce of health professionals in the health care systems □ Increasing health inequalities □ Increasing need for long-term care □ Communicable diseases □ Migration of health care professionals to other countries □ Adequate funding for health care □ Development of a sustainable health care system □ Increasing number of people with mental health problems □ Environmental health risks □ Maternal and child health risks □ Noncommunicable conditions □ Injuries □ Other (please specify):_____

Do you see a particular role for nurses and midwives in tackling these challenges? If so, in what areas? (Please tick all the appropriate boxes):	□ Increasing number of people with chronic conditions □ Access to primary health care □ Ensuring an adequate workforce of health professionals in the health care systems □ Increasing health inequalities □ Increasing need for long-term care □ Communicable diseases □ Migration of health care professionals to other countries □ Adequate funding for health care □ development of a sustainable health care system □ Increasing number of people with mental health problems □ Environmental health risks □ Maternal and child health risks □ Noncommunicable conditions □ Injuries □ Other (please specify):_____

3. Legislation and professional regulation of nursing and/or midwifery

How nurses and midwives can contribute to the health systems requirements within a country depends to a large extent on the legislation and professional regulation by which professional practice is governed and organized. Legislation and regulation are the means by which it is determined who will enter the nursing and midwifery profession and what scope of practice characterizes the professional performance.

In the previous surveys on the situation of nursing and midwifery in the European Region of WHO, a lack of financial resources for nursing and midwifery as well as difficulties in defining the roles of nurses and midwives have been identified as weaknesses that prevent nurses and midwives from working to their full potential.

But also very positive developments have been reported by many countries in terms of moving from a definition by custom to a definition by legislation. In this survey the focus should be on how the role of nurses and/or midwives is defined. In addition it would be desirable to have a more detailed overview of existing definitions and the scope of practice in the different countries. Therefore we ask explicitly to include or attach the definition and legislation on nursing and midwifery in your country, if it is available in the English, French, German or Russian language.

Question	**Answer**
How is the role of a nurse and/or midwife defined?	o By legislation o By custom o By practice
What is the definition of a nurse/midwife in your country? (You may also attach a file or URL to answer this.)	

What is the scope of practice of nursing and midwifery in your country? (Please tick all appropriate boxes)	o Provision of health promotion o Care in hospitals o Care in nursing homes o Home care o Community/public health care o Assistance in medical treatment o Independent role in treatment regimens o Prescription of drugs/ assistive devices or else o Case management o Counselling and user education Other (Please specify): _____
Who is responsible for the regulation of nursing and midwifery? (Please tick all appropriate boxes.)	o Self-regulatory professional body o National Ministry of Health o Subnational/federal/regional authorities o Interdisciplinary body within health care system Other (please specify) _____
What aspects are covered by the legislative framework of nursing and midwifery in your country? (Please tick all appropriate boxes.)	o Definition and scope of a regulatory body o Definition of nursing/midwifery o Role of nurses/midwives o Categories/levels of nurses/midwives o Entry requirements for programmes of initial professional education in nursing and midwifery (such as age and years of school education) o Duration of initial education o Requirements for achieving licensure/ registration to practice as nurse/midwife o Requirements for maintaining licensure/ registration to practice as nurse/midwife o Educational standards o Practice standards o Continuing education/ specialization o Discipline/conduct standards o Other (please specify):_____
Are there any plans to change the existing legislative framework? If so, for which reasons?	□ Yes □ No
Are nurses and midwives themselves aware of their potential? How do you perceive the professional self-perception?	

4. Initial and continuing education and higher education	
One, if not the key aspect for nurses and midwives to contribute their full potential to health care systems is their initial and continuing education. The WHO Regional Office for Europe has launched a strategy for initial nursing and midwifery education and for their continuing education as well. In previous years the implementation of the strategy for initial education was evaluated using the Prospective Analysis Methodology (PAM). This year the evaluation will be included in this survey.	
Question	**Answer**
How many years of school education are required to enter programmes for initial nursing and/or midwifery education?	

What is the level of professional qualification after successful completion of the initial education?	o Vocational qualification: o University (or equivalent higher education institution)
What is the status of students during their initial education?	o Employees of a healthcare facility o Student status o Other (please specify):_____
Characteristics of the curriculum for initial nursing/midwifery education (Please tick all appropriate boxes)	o Research-/evidence-based o Competency based o Competencies to practice in hospitals o Competencies to practice in community settings o Competencies to practice in institutional long-term settings Other (please specify): _____
Are the settings for theoretical and practical initial education formally accredited?	□ Yes □ No
Is the teaching in both theory and practice done by nurses/midwives? If so, do these nurses and midwives hold a degree equivalent to the requirements for teachers in other professions? If not, who is teaching nurses and midwives in the theory and practice of nursing and/or midwifery?	□ Yes □ No □ Yes □ No
Have university departments/faculties/ schools been established to provide the full range of professional education for nurses and midwives (pre-registration, post basic, continuing education, master and PhD level)?	□ Yes □ No
How do such departments fit in within the national educational and health care system?	
When have these programmes been established?	
Have there been important changes in nursing and midwifery education during the last five years? (Please tick all the appropriate boxes):	□ Post secondary school/undergraduate (initial) education □ Higher education □ Continuing education □ No changes
In your judgment (and on what grounds) will the health sector's needs for university-educated nurses and midwives be met? What proportion of nurses and midwives should be educated to this level? What are the current proportions?	□ Yes □ No
Are there any existing opportunities for nurses, midwives and physicians to learn together in your country? If so, at what educational level and with what scope or focus?	□ Yes □ No

Are there opportunities for interdisciplinary learning with other professions (such as social workers, physiotherapists etc.)?	□ Yes □ No

5. Fair rewards, recognition and opportunities for career advancement In order to make a significant contribution to tackling the public health challenges of our time, nurses and midwives need to have fair rewards, recognition and opportunities for career advancement. In 2004 a very heterogeneous picture was found on these issues. While in some countries this principle has almost been fully achieved, in others nurses and midwives were not able to make a living on the salaries they got. As nursing and midwifery are strongly gendered professions an important question is, whether and if so in what way that influences rewards, recognition and career prospects.	
Question	**Answer**
What is the salary of nurses and/or midwives? In relation to other professions how high is the national average wage (where known)?	□ Like average □ Higher than average □ Lower than average
What has been the trend over the past five years?	
What career prospects are available within nursing and/or midwifery?	
Is there a formal pay and career structure? If so, what are the guiding principles?	□ Yes □ No
Are there gender issues related to the pay and career structure?	□ Yes □ No
Is there any trend for nurses and midwives to seek better career prospects outside their professions?	□ Yes □ No

6. Workforce planning strategies In the 2004 evaluation on nursing and midwifery 2.9 million nurses and midwives constituted the actual workforce in the participating countries (30 out of 50). But only in few countries a targeted workforce strategy had been implemented. In this survey it is of particular interest whether the stated reasons for not having a workforce strategy (lack of data, lack of funding, and lack of assessment of future needs) have changed or do still exist.	
Question	**Answer**
How many trained nurses and midwives are in the country?	Ranges: □ < 250 □ 251–1 000 □ 1 001–10 000 □ 10 001–50 000 □ 50 001–100 000 □ 100 001–200 000 □ 200 001–500 000 □ >500 000 Nurses:_____ Midwives_____
How many nurses and midwives constitute the current workforce?	Nurses:_____ Midwives:_____
According to estimates, how many nurses and midwives are needed currently and in the future in the health care system?	Nurses:_____ Midwives:_____

Has there been a significant increase or decrease of trained nurses and midwives over the past years? If so, for what reasons (retirement, migration, move from/to other professions etc.)	□ Yes □ No □ Increase □ Decrease
Is there a workforce policy based on explicit assumptions about future needs? If so, please specify:	□ Yes □ No
Is there a workforce planning strategy in the country? If so, please specify:	□ Yes □ No
Are there any problems with workforce planning strategies? If so, please specify:	□ Yes □ No
Are policies and programmes established which ensure healthy workplaces and quality of the work environment for nurses and midwives? If so, please specify:	□ Yes □ No

7. Obstacles for nurses and midwives to work to their full potential Beside the legislative and regulatory framework there may be other obstacles that either support or prevent nurses and midwives from working to their full potential. In previous surveys medically dominated health care systems and a lack of financial resources have been identified to be major obstacles. But also societal aspects such as the role of women in society or the availability of young people who may enter the nursing and midwifery profession may be influential.	
Question	**Answer**
What obstacles exist that prevent nurses and midwives to work to their full potential? (Please tick all appropriate boxes)	□ Medically dominated health care systems □ Lack of financial resources □ Problems of defining their professional roles □ Other (please specify):
Are there obstacles for nurses and midwives related to gender? If yes, please comment.	□ Yes □ No
Are there obstacles for nurses and midwives related to professional status? If yes, please comment.	□ Yes □ No
Is there a national recruitment and retention policy in place? If so, is it gender-sensitive?	□ Yes □ No
Do recruitment policies of other countries (such as countries from Western Europe attracting nurses from Eastern Europe) have an impact on the nursing and/or midwifery workforce in your country?	□ Yes □ No
What is the approximate ratio between women and men:	o within the nursing profession: o within the health care system as a whole
How is the public perception of nurses and midwives? Is nursing and midwifery an issue in the media?	□ Yes □ No

8. Decision-making at all levels Strengthening the role and contribution of nursing and midwifery in national health care systems includes the participation of the professions in decision-making at all levels of policy development and implementation. A chief nursing officer in ministries of health has been reported to be the most powerful way of ensuring the participation of nurses and midwives in decision-making. Regular participation and membership in executive and advisory boards also enables nurses and midwives to contribute to decision-making. Of particular interest in this section is on what kind of decisions nurses and midwives are participating, those related to nursing and midwifery issues or also those on general health care affairs.	
Question	**Answer**
How are nurses and midwives acknowledged to be relevant stakeholders at the different levels by government and how are they involved in decision-making processes by national and subnational health administrations?	
What is the current nursing and midwifery input into the policy-making decision process on health related issues?	
What strategies do nurses and midwives themselves adopt to contribute to decision-making at all levels?	
How are the contributions of nurses and midwives received by the relevant authorities? Are they taken into account in policy formulation?	
How does the involvement of nurses and midwives in decision-making compare with the involvement of other interests in the health sector?	
To what extent nurses and midwives were involved in decision-making on health related issues in your country? (Percentage of number of decisions)	o National level:_____ o First subnational level (Regions, Federal States, Districts etc.):_____ o Community level: _____

9. Role in public health and community development During the last years considerable achievements have been reported in terms of nurses and midwives playing an increasingly important role in public health and community development. However, there have been aspects that limit the contribution of nurses and midwives to public health and community development such as lack of financial resources and reimbursement policies for health care services. An important part of public health nursing and midwifery are family-focused programmes and services that acknowledge the invaluable role that families play in establishing health behaviours and taking care for sick family members. Such programmes and services could be provided, for example, by the Family Health Nurse.	
Question	**Answer**
Do nurses and midwives contribute to debates on public health priorities at governmental level? If so, in what way? If not, what are the reasons?	□ Yes □ No

Do nurses and midwives receive any special training in public health and public health policy? If so, in what way? If not, do plans exist to include public health and public health policy into the educational curricula?	□ Yes	□ No
What measures are required to establish/consolidate a public health and community-oriented role for nurses and midwives?		
Are there any family-focused community programmes or services established? If so, where are they based? And how are they structured? If none, what are the reasons that no such programmes and services have been established?	□ Yes	□ No
Has your country implemented the WHO concept of the Family Health Nurse or parts of it? If so, to what extent and what are the experiences? If not, do plans exist to do so in the near future and is there a need for particular support?	□ Yes	□ No

10. Evaluation and quality of nursing and midwifery services

Only very few countries in 2004 reported measures for the evaluation of nursing and midwifery services. Where measures were in place the evaluation usually is done according to predefined indicators.

Question	**Answer**	
Are there measures established for the evaluation of nursing and midwifery services? If so, Who is responsible for the evaluation?	□ Yes	□ No
Is there a legislation or regulation on the quality of nursing and midwifery services?	□ Yes	□ No
Are there professional standards of practice available? If so, could you give examples?	□ Yes	□ No
What indicators are used to determine the quality of nursing and midwifery services? If there are no measures in place, do plans exist to introduce such measures?	□ Yes	□ No
Are there reports on the quality of nursing and midwifery that are publicly available? If so, what have been the main concerns, problems and achievements on the quality of nursing and midwifery services?	□ Yes	□ No

11. Database on Nursing and Midwifery Data and information on nursing and midwifery are needed for several regional, national and international purposes. In this section it is asked on what database the information on nursing and midwifery in Member States is based and who is collecting, analysing and presenting the data.	
Question	**Answer**
Is there a national nursing register?	□ Yes □ No
If yes, who is responsible for the administration and accuracy of the register:	
If no, are there other means of monitoring the actual number of nurses/midwives in your country?	-
Are facts related to nursing and midwifery included in national statistics? If yes, what kind of data is included and what are the current figures:	□ Yes □ No Numbers of nurses:_____ Numbers of midwives: _____ Employers of nurses and midwives: _____ Number of hospitals:_____ Number of nursing homes:_____ Number of home care services/agencies:_____ Number of educational institutions for nurses and midwives: _____ Other (please specify):
How often are the existing databases on nursing and midwifery updated?	□ continuously □ every year □ every second year □ every three years □ every 4 years □ every 5 years

12. Knowledge and evidence base for nursing and midwifery The 2004 survey revealed that nurses and midwives in many countries initiated their own research or participated in interdisciplinary health care research. However, funding for nursing and midwifery research on a regular basis is only available in some countries as is the opportunity for nurses and midwives to pursue a career in nursing/midwifery research.	
Question	**Answer**
Is there a national nursing and midwifery research strategy? If so, what topics does it include? What institutions exist to support nursing and midwifery research?	□ Yes □ No
Do nurses and midwives have the opportunity to study for research-based degrees in their field of practice? or are such options only available in other disciplines? or do they have to go abroad in order to pursue research training and careers?	□ Yes □ No □ Yes □ No □ Yes □ No

What research questions are students interested in?	
If nursing/midwifery research facilities do **not** yet exist: Are there any links with other countries that do provide research training? If so, please specify. Are there other professional groups within the country for the purpose of developing research capacity? If so, please specify.	□ Yes □ No □ Yes □ No
How are research results disseminated in the country? Are there journals for the dissemination of research results? If there are journals, do you know how many:	□ Yes □ No 1. Professional Nursing/Midwifery Journals:_____ 2. Academic/scientific Nursing/Midwifery Journals: _____
Is funding available for nursing/midwifery research? If so, where does the funding come from (Please tick all appropriate boxes)	□ Yes □ No □ government, □ private sources, □ nongovernmental organizations, □ commercial companies? □ Other, please specify:

13. International Collaboration and Guidance from WHO

Over the last years several documents on nursing and midwifery have been produced and disseminated by the Nursing and Midwifery Programme at WHO Europe. To develop materials that will be used and are helpful for nursing and midwifery policies in Member States it is important to know how these materials have been used and what future needs on support and guidance exist.

Beside direct support from the WHO Regional Office for Europe collaboration between countries and different organizations within countries have been reported to be very helpful. An example for such collaboration were twinning projects and direct partnership agreements between organizations and/or countries.

Question	**Answer**
Has any of the guidance from WHO Europe on nursing and midwifery been used in shaping the nursing and midwifery policy in your country? If so, which one and for what purpose?	□ Yes □ No
What support would be helpful in the future?	
What mechanisms have been set up that have been helpful in strengthening international collaboration and ties with counterparts in other countries?	
In what areas has international collaboration been particularly useful?	

What organizations have been most helpful?	

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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