Nurses at the top table: the Munich Declaration and its sequalae

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The two of us originally had intended to write our own separate articles for this RCN Fellows' publication but, with shared interests in policy development, we decided to team up. We are both passionate about the need for nurses to be involved in – and sometimes to lead – policy formation, and we both have experience of being at 'the top table'. We vehemently believe in advocating for the contribution of nurses in envisioning, formulating, and implementing nursing, health, and social policy.

At the heart of this article is the question as to why nurses should be involved in policy formation. We believe nurses bring a unique perspective to healthcare policy development because of their education, professional values and ethics, advocacy skills, and experience (Benton et al 2017). Social justice is a core value, and nurses have an opportunity to serve as advocates for patients, families, communities, vulnerable populations, other nurses, and healthcare organisations.

Nurses know the specific needs of the communities they serve. They can protect quality of care and mitigate risk by ensuring a safe environment and access to required resources and opportunities. They are a crucial caregiver, spending more time with patients than most other professions. It is nearly impossible to imagine a care system without them. Nurses have always been at the forefront of change in healthcare and public health (Benton et al 2019). Nurses innovate. So, decision-makers need to hear from nurses.

Accordingly, we have chosen to focus principally on a significant regional declaration endorsed by the World Health Organization (WHO). The development of the Munich Declaration was driven by the first author (Ainna) and served as a touchpoint for assessing the profession's progress for the second author (David) when working for the International Council of Nurses.

The declaration made at the WHO European Ministerial Conference on Nursing and Midwifery in Munich (2000), spoke directly to the role and contribution of the profession. We look at what went well with its implementation as well as examining the barriers to progress. In many regards the content of the declaration was well ahead of its time and contained material that is fully aligned with several of the United Nations' General Assembly (2015) sustainable development goals (SDGs).

Munich declaration: nurses and midwives: a force for health

Abstract
At the WHO European Ministerial Conference on Nursing and Midwifery in Munich in 2000, ministers identified their policy objective – 'to tackle the public health challenges of our time' – and acknowledged nurses and midwives as best placed to deliver them. The 'Munich Declaration' called on relevant authorities in the WHO European Region to strengthen both 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 interests 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 roles of nurses and midwives in public health, health promotion and community development.

Citation

World Health Organization Regional Office for Europe (2000) Munich Declaration: Nurses and midwives: a Force for Health. World Health Organization Regional Office for Europe, Copenhagen

Link

www.euro.who.int/__data/assets/pdf_file/0007/53854/E93016.pdf

Introduction and background

The genesis of the 2000 Munich Declaration is important to understand. The first World Health Organization (WHO) nursing conference was held in Vienna, Austria, in June 1988. The Vienna Declaration on Nursing published by the World Health Organization Regional Office for Europe (1988) had three principal objectives that embraced the concept of health for all, set a range of targets and offered a way forward (Salvage and Heijnen 1997).

However, by 2000 Europe had changed. The region had expanded to 51 countries, which included the more disadvantaged countries of the Newly Independent States (NIS) and Central and Eastern Europe (CEE). The population was ageing. There was a vast increase in non-communicable diseases, including cancers, and several countries were grappling with the return of malaria and polio. Tuberculosis (TB) was also on the rise. HIV, AIDS and the increasing problem of antimicrobial resistance, were adding to the disease burden.

On a positive note, many countries were enjoying extended life expectancy, but there were inequalities in all, and these inequalities were increasing. If this was not enough, some countries faced internal conflict and war causing additional burdens for some parts of the region (WHO Regional Office for Europe 1999).

It was against this formidable public health agenda that the Munich Ministerial Conference, the follow-up from Vienna, was organised. Ainna, in her capacity as Regional Adviser Nursing and Midwifery at the World Health Organization Regional Office for Europe, arranged for ministers from across the region to join together with nurses, doctors, patient representatives, and non -governmental organisations (NGOs) to jointly consider the future direction for the professions. The aim of the three-day event was to identify the reasons for the limited success of the implementation of the Vienna Declaration, lessons learned, and set a new direction.

It was agreed that changes in education, legislation, and practice would be required to ensure that nurses and midwives could assist with the public health challenges. Nurse shortages and fewer entrants to the profession were issues. How should we prepare the professions so that they were capable of working in interprofessional and intersectoral ways? How far should educational programmes be health- rather than illness-focused, and what legislation and regulation were in place across the region? Furthermore, to what extent could nurses and midwives undertake research, measure patient outcomes, and convert the data into information that could influence health policy? All these questions shaped the narrative and search for a declarative statement on the way forward.

Ministers agreed to the Munich Declaration, which supported the right of nursing and midwifery to be involved in relevant decision making (WHO Regional Office for Europe2000). The appointment of a government chief nurse in every country of the region was vital if progress was to be made, particularly to address long-standing and challenging issues of achieving gender equality, raising the status of nurses and, at times, medical dominance of the profession.

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To this end, financial incentives and effective workforce strategies were needed and as a result, Moving on from Munich (WHO Regional Office for Europe 2001) provided a modus operandi to pursue the agenda.

Three years later, Büscher and Wagner (2004) provided an analysis of progress. However, two decades on, success has been limited.

Influence and impact

Although not every country had a government chief nurse, the group that met in Madrid in 2003 endorsed the Munich Declaration. Still, in 2004, it was considered that while innovative thinking had been encouraged, there was little evidence of any impact on the quality of nursing and midwifery practice or services (Büscher and Wagner 2004). Additionally, a survey in 2009 showed patchy progress (Büscher et al 2009). Positive developments in education were found but there was limited, if any, interprofessional learning. Role expansion was increasing, yet little support and funding were available for research. Gender issues persisted. Even by 2009, not all governments had appointed a chief nurse, with the knock-on effect of an absence of nurse input in policy arenas.

So why, 20 years on, do many of the messages need to be repeated? While many broad-brush statements of what we want, such as those featured in the SDGs, support our case, what can they themselves achieve? Certainly, the second author, (Benton and Ferguson 2016, Benton and Shaffer 2016), has repeatedly highlighted the possibilities. But we must go further. In short, we must ask what action is needed? On reflection, the 2000 Munich Declaration was ahead of its time in identifying an agenda for action since it targeted, what would become, six of SDGs (SDG 3, 4, 5, 8, 10 and 17 – health, education, gender equality, decent work, reduced inequalities, partnership).

Oliver et al (2014) and Shariff (2014), identified in their studies on participation in policy development, that facilitators and barriers exist. The former included: being involved in health policy development, having knowledge and skills, enhancing the image of nursing, and enabling structures and processes. The latter included lack of involvement, a negative image of nursing, and structures and processes which exclude them.

A significant issue in Europe is the diversity of traditions, for health systems carry with them the cultural features of the societies in which they have developed (Gobi 2014). This has been apparent in the problems of harmonising nurse education, which underpins the freedom of movement European citizens have come to expect.

Few members of our profession would regard our current modest influence on policy as satisfactory. The coronavirus pandemic has thrown much into focus. Policies have sprouted up rapidly, but often at national and international levels, where patient representatives and nurses have been conspicuous by their absence. This, despite repeated verbal platitudes from government that the contribution of nurses to patient care has been fully recognised. Why? There are reasons intrinsic to the profession, and external to the environment in which we operate. However, evidence from other disciplines, such as the medical profession, can provide insights into how we might be more effective (Benton et al 2020a). Namely, the need to focus on real world policy problems that help politicians address the concerns of the day rather than focus on issues exclusively of interest to the nursing profession. This may result in many more requests for input to policy formation, not simply its enactment.

Current and future relevance

In our profession, as throughout politics, administration and business run on the concept of 'value-added'. People are esteemed in policymaking, not for the symbolic utility of their professional group, but for what they bring to the table (Benton et al 2020b). If we wish to develop a vaccine, we do not employ a social scientist.

Anyone who has worked his or her way up an organisation will know that worth must be proven. As it is said, we should judge on performance and not on promise. Florence Nightingale earned her position of leadership by hard work, endurance, speaking out, and statistics. She proved her value. Not every one of us is a Florence Nightingale, but we are not short of quantity and quality of candidates. The number of nurses, for example, who have become successful chief executives of health and social care organisations demonstrates this, sad though their loss has been to nursing. It is the responsibility of every senior nurse to mentor, encourage, and develop those around them. We need politically astute nursing leaders able to influence public policy and operate strategically. We must avoid an interned nursing silo and aim for partnership working

with doctors, economists, politicians, and the media. We must learn to make our case succinctly and effectively (Benton et al 2020c).

Externally, however, we do need help. It has long been the case that while many doctors – more in some countries than others – will treat nurses as subordinates, there are others who will become helpful allies. In government, things can be grim. It has been said that a week is a long time in politics. If the three critical functions of government are defence, the preservation of the currency, and the maintenance of public order, health itself is not at the top of the list (Encyclopaedia Britannica 2020).

The nurturing of an individual professional group is even lower down. Changing parties bring new priorities. Even with a new government, there is a limit on the number of changes they can achieve before the spectre of re-election looms. A new chief executive is often equally selective. There is little point in the profession arguing against this. We must work with it, turning each crisis to our advantage and maintaining pressure on our professional organisations and governments to keep their word.

The new WHO Director General, Dr Tedros Adhanom Ghebreyesus, the driver behind WHO's decision to mark 2020 – the bicentennial anniversary of Florence Nightingale's birth – as the International Year of the Nurse and the Midwife, called on all governments to recognise the crucial role of these professions in contributing to the achievement of the SDGs. To date, there is little to convince us that the response of governments to this WHO calling will be more than transitory. Long-term success will largely be dependent on the action of our profession itself.

So, whether you are at the start of your career or have been in the profession for some time, there are multiple opportunities to bring the nursing voice to the many policy tables that exist at local, organisational, regional, national and international levels. Build alliances, open doors, and make your voice heard. The SDGs provide opportunities, not just in the health space, but across many other policy domains. We are the largest health profession in the world. We can – if we are smart, connected, and focused – be the most influential.

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