

## Health Care System in the United States : Implications for Baccalaureate and Graduate Education

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### Abstract

Over the past 30 years, the health care system in the United States has grown to almost unmanageable proportions and complexity. A complicated mixture of social, technological and economic forces have led to the present crisis. While the need for health care reform is obvious, the shape of the reform is not yet clear. However, the movement from hospital-based and illness treatment care to community-based and health promotion care, is expected to continue into the next century.

As changes in health care delivery inform curricular decisions and challenge the historic emphasis on the acute care setting as the primary focus of clinical learning, faculty will need to reframe their thinking about themselves as nurse educators, about students, and about health care for communities of people. Nursing curricula must be geared toward the changing demographics of the population, new and expanded roles for nurses, and the escalating needs for an international/global focus to health care knowledge and innovations.

Health care in the United States (U.S.) is changing rapidly and will continue to change in the foreseeable future. Technological progress coupled with growth in scientific knowledge, have dramatically altered the way health care is delivered and practiced in the U.S. The free enterprise system of health care with its emphasis on competition and free-for-service payment, as well as the advances in medical science vastly affected the price paid for health care services. Since costs dictate access and quality, the issue most central to the nation's health is the effort to provide and finance adequate health care services equitably for all citizens. We will now look at the complex web of issues, policies, controversies, and problems that surround the U.S. health care system and its implications for nursing education.

### Technology

The proliferation of medical technology has been a major factor in rising health care costs. Technological advances encourage a greater reliance on expensive tertiary care to the detriment of prevention and primary care. Since providers are paid according to what

they do, it is in their economic best interest to do more. Thus in the traditional fee-for-service model, the more care that is provided, the higher the level of reimbursement.

### Demographics

Two major demographic changes in the composition of the U.S. population present challenges for health care providers well into the next century. First, Americans are living longer today than ever before in history. Improvements in living conditions and lifestyles, and advances in science, medical technology and pharmaceutical therapies have resulted in dramatic gains in life expectancy. Our population is aging and this demographic change has important implications for the nation's health, social and economic institutions.

Second, the racial/ethnic composition of the nation is undergoing a dramatic change. The state of California data serves as an early indicator of population shifts that are occurring across the country but at a slower pace. California accounted for 40% of the immigration for the entire nation in 1991. Projections for the years 2000 to 2050 indicate the U.S. population will be 48% white, 21% Hispanic, 16% African American, and 11% Asian (U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census, 1993).

### The Impact of an Aging Population on the Health Care System

Improvement in mortality rates has resulted in increased longevity. The distribution of the

population in the U.S. has shifted with considerable rapidity in both the number and the proportion of the population aged 65 and over. By the year 2030, it is likely that one out of five Americans will be 65 years or older; and the total number is projected to 64.3 million, more than doubling in the 50-year period, 1980-2030. Within the age 65 and over, the number and proportion of the very old have also increased rapidly. Those 85 years and over are projected to be the fastest growing segment of the population (Rice, 1990).

The incidence of chronic illness increases with age and becomes a major cause of disability requiring medical care. Table 1 and Table 2 presents the estimates that have been made of the impact of changes in the age structure of the population on health status,

Table 1 Health Status by Age

Measure	All Ages	17-44 Years	45-64 Years	65& Over
Feeling fair or poor	11.8%	8.3%	22.0%	30.1%
Limited in Activity	14.4%	8.4%	23.9%	45.7%
Needs help in one or more basic physical activities per 1,000 pop.	22.5	5.1	520.6	90.2

Table 2 Utilization Measures by Age

Physician visits per person	4.6	4.2	5.1	6.3
Average length of stay in shortstay hospitals	7.2	5.2	8.0	10.5
Needs help in one or more basic physical activities per 1,000 pop.	22.5	5.1	20.6	90.2

health services utilization to the year 2040. The total population is expected to increase 41%, while the group aged 65 and over will increase 160%. The total number of persons limited in activities of daily living is projected to more than triple. Presently, 30% of total health care expenditures are attributed to the 65 and over population, by 2040 almost half of the expenditures are expected to be made in behalf of the 65 and over population (Rice, 1990).

### **Racial / Cultural and Socioeconomic Factors in Health Care**

The concerns of health care providers is not simply the increasing number of ethnically /culturally diverse patients ; it is the challenge of providing appropriate and quality care to individuals representing an array of cultural values and economic dilemmas. In American society many health care inequalities exist along racial lines. Recent immigrants, members of ethnic minority groups, and the poor are adversely affected because they lack the income to purchase health services, the knowledge of which services to purchase, and the knowledge of how to use the services.

Achievement of a healthy population requires not only health care and preventive care, but also full employment, adequate family income, decent housing, good nutrition, improved opportunities for rest and recreation, and end of fear of violence and discrimination, among others. Studies have shown that there is a relationship between health status, income, and racial/ethnic group. In the United States, Hispanics and African Americans share high

rates of poverty. Prenatal care, obesity and diabetes are considered serious problems experienced by Hispanic women. The highest prevalence of diabetes among Hispanic females with low socioeconomic status may be related to the prevalence of obesity, which in turn is associated with poor diet and eating habits (Juarbe, 1995). African Americans are 1.3 times as likely to die of heart disease, 2 times as likely to die of a stroke, 2.2 times as likely to die of diabetes, 3.2 times as likely to die of kidney disease, and 6 times as likely to be murdered as their white counterparts (Funkerhouser, Moser, 1990).

### **Financing of Health Care**

History reveals some dominant values underpinning the U.S. political and economic system. From its inception, the United States has had a long history of individualism, emphasis on freedom to choose among alternative options, and an aversion as a nation to large-scale government intervention into the private realm. Social programs have been the exception rather than the rule and have arisen primarily during times of great need, such as in the 1930s (the Great Depression) and the 1960s (heightened concern for poor and elderly populations). As costs surged in the 1970s and 1980s, the balance of power in the health care field, changed from the private sector to the government and private insurance companies. By the 1990s the health care arena had undergone radical changes that ultimately revolutionized the financing and delivery of health care.

Prior to the 1960s, most medical costs were

covered by insurance that was provided as part of the benefits package paid by employers for their workers. This system worked effectively for those who were employed and provided reimbursement to physicians and hospitals in a satisfactory manner. Over the years, however, and aging population, increased numbers of people who are not part of the workforce, and increasing costs of insurance to employers have resulted in a situation open for government intervention. With the enactment of Medicare and Medical legislation in 1965, the federal government became the insurer for vulnerable groups—the elderly and the indigent who were not covered by employer-provided health care insurance and were unable to pay for their own health care. Medicare is a federal program for the aged and disabled, and Medical is a jointly funded program of both federal and state governments, with eligibility determined by income and resources (Pulcini, Davis, 1993). Soon after the enactment of these programs it was realized that health care expenditures were rising much faster than the economy, and initiatives were undertaken to address the issue. Over the past 30 years a variety of legislative approaches have been taken to try to control escalating costs. These approaches can be classified as either *competitive*, describing a condition in which forces of supply and demand determine the most efficient allocation of resources, or *regulatory*, which assumes that market forces function imperfectly and that government intervention is required to control costs (Garg, Pinsker, Grace, 1997).

### Regulatory Approaches

The reimbursement systems of Medicare, and Medical created intense inflationary pressure on health care costs. Substantial reimbursement was available for increasing hospital revenue for additional procedures requiring new staff and equipment. By creating a surplus of income over revenues, this money went back into further expansion of facilities and staff, ultimately resulting in increased cost. The increased cost, which was not retrievable from public sources, was then passed on to private patients and their insurers, creating inflationary pressures on the entire system. From 1971 to 1983 the major efforts to control costs were through regulatory efforts. None has appreciably slowed the growth in total health care costs.

Two examples of these regulatory approaches are the Professional Standards Review Organizations and the Prospective Payment Systems. With the establishment of Professional Standards Review Organizations, the quality, and cost of hospital care provided under Medicare was to be monitored primarily through mandatory establishment of utilization review committees in participating hospitals. Through review processes conducted under the supervision of physicians, their function was to control medical services such as admissions, diagnostic investigations, and therapeutic interventions provided by physicians to their hospitalized patients. A 1970 Senate Finance Committee Report judged the utilization reviews to be ineffective as an approach to control unnecessary use of institutional care and services.

In 1983, Congress established the Medicare Prospective Payment system (PPS), which replaced retrospective cost-based reimbursement for hospital care with the primary objective of controlling escalating hospital costs. Under PPS, inpatient hospital services for Medicare eligible patients, were bundled into 468 diagnostic-related groups (DRG), with a fixed reimbursement scheduled and adjustments for important factors such as case severity, rural/urban cost differentials, teaching costs, and disproportionate shares of uncompensated care. Despite these major regulatory programs, health care costs continued to escalate at a higher rate than the general economy.

### Competitive Approaches

As health care costs have continued to escalate in the past two decades, attempts to contain costs by restructuring the health care market to make cost-effective competition possible have supplemented the regulatory programs described above. The two most common competitive approaches are the use of managed care organizations (MCO). The main feature of managed care that distinguishes it from retrospective and fee-for-service payments is that payment under managed care is prospective and capitated (a fixed per person payment). Under such systems, the managed care entity bears the financial responsibility, as well as functioning as the patient care provider. This means that the organizational focus of care shifts from individual illness care to concern for the health of a defined population; namely the members of the health plan. Thus the in-

centives shift to a case management function in which primary care providers coordinate all care and limit access to costly specialization and hospitalization.

The actions of employers to pressure managed care organizations to constrain their premiums has, in turn, led MCOs, hospitals, and physicians to align themselves through various forms of affiliations into what have become known as integrated health systems (IHS). In general, IHS patients receive a full range of health care services from providers who are affiliated with the system, and there is a coordinated case management and information flow among the providers and health professionals. The services provided by IHSs may include well-ness programs, preventive care, ambulatory clinics, outpatient diagnostic, pharmaceutical, and laboratory services, emergency care, rehabilitation, long term care, psychiatric care, home health care, hospice care. Coordination is aimed at reducing duplication of tests and services and making sure that appropriate providers are used instead of more costly ones (for example, advanced practice nurses instead of physicians, and generalists instead of specialists).

There are limitations to the effectiveness of competitive approaches. It is not yet clear how much of the savings they achieve are due to higher levels of efficiency and how much is due to selection bias (enrolling healthier members). In addition, because the costs of health insurance have escalated, many businesses that once provided health insurance can no longer do so. An increasing percentage of the population has no health

insurance coverage. Of those earning less than \$10,000 per year, 32% are uninsured (Wicks, Curtis, Haugh, 1994).

Because our current health system is comprised of multiple insurers (insurance companies, and health care organizations), considerable administrative costs are incurred. Today 24% of health care dollars are spent on administrative costs.

Finally, one of the most commonly voiced concerns of the public is the lack of choice of plan or of provider. The rise of managed care systems, with restrictions on self-referral to specialists, negatively impacts the strong American value of individual choice.

### Changing Nursing Education

As massive changes are occurring in the health care delivery system, nursing education faces challenges in preparing practitioners for the future. Over the past 50 years, much of the emphasis in nursing education has been on preparing nurses to practice in hospital settings. The impact of economics, technological advances, shift of care from hospital to community, the emphasis on health promotion and disease prevention, an increasingly diverse population, and the importance of interdisciplinary collaboration are new challenges and unique opportunities for nursing education. Perhaps the biggest challenge is applying very comprehensive and creative problem solving to the process of reforming and adjusting nursing education to thrive in the face of the ambiguities of the 21<sup>st</sup> century. The unique opportunity for nursing education is to collaborate with practice settings, to *shape*

practice, not merely respond to changes in the practice environment.

The American Association of Colleges of Nursing (1999) identified five priorities for nursing education within the next decade: 1) the development of skills in critical thinking and clinical judgment should be the top curricular priority; 2) nurses should be prepared to practice across multiple settings; 3) nursing curricula should include content on primary health care, patient education, health promotion, rehabilitation, self-care, and alternative methods of healing; 4) programs should strive for diversity among students and faculty that more closely mirrors society; and, 5) all curricula should focus, at appropriate levels, on case management, health care policy and economics, research methods, quality indicators, outcome measures, financial management, patient advocacy, and management of data and technology.

### Development of Critical Thinking Skills

As the discipline of nursing continues to change, define its role in health care, and create nursing knowledge, there is an urgent need to accept critical thinking (CT) as an outcome of highest value for nursing education and practice. Defining CT has been problematic, some have defined it as a set of skills, while others describe it as a process, and others as a combination of skills and characteristics. Kurfiss (1988) views critical thinking as an investigative process that focuses on the goal of the investigation, in order to arrive at a hypothesis or conclusion that synthesizes all available information and

that can be justified.

Nurse educators and researchers have found little evidence to support the view that the nursing process is the most important approach to clinical reasoning, that care plans reflect that process, or that care plans reflect actual clinical performance (Diekelmann, 1988; Gould & Bevis, 1990; Tanner, 1993). In the future faculty must encourage students to participate in their learning process both individually and as a group. Coursework and strategies for teaching need to encourage students to think actively, explore situations and open their minds to new ideas and different perspectives. Students must learn to think conceptually and translate concepts into practical problem-solving. For example, several strategies for fostering CT are using case methods for presenting materials, role playing, group activities that encourage problem-solving, and using the debate forum for examining new ideas. Strategies for fostering independent thinking might include having students develop portfolios that incorporate their own goals and objectives for learning within each course and clinical setting, and developing their own topics for discussion that incorporate clinical problems from practice. Students come with a variety of experiences and knowledge and we need to build on these differences. By having the students take an active role in defining their own learning needs, the learning experience incorporates diversity of abilities and encourages the active sharing of knowledge. Faculty can then become facilitators of learning instead of "feeders".

### Focus on Community-Based Care

As community-based health care delivery becomes an increasingly prominent feature of the health care system, nursing education programs are being challenge to prepare students for a broader array of practice roles and responsibilities to meet the workforce demands of an ever-changing health care environment. As more health care-including high tech and invasive care-is delivered in community-based settings (e.g., schools, churches / temples, the workplace), nurse educators must ensure that students have a substantial portion, if not the majority, of their clinical learning experiences in such settings. A community-based nursing curriculum can provide the foundation for a thorough study of major family and community theories. This curriculum also provides opportunities for faculty and students to explore nursing interventions that consider the cultural, social, political, ethical, ecological, and economical factors affecting health in the U.S. and around the world. The development of nurses' community health knowledge must also include a global perspective, with an awareness of the health care needs, health care advances and trends in other nations.

Bellack (1998) described how community-based practice experiences offer a number of advantages that typically are not available in acute care settings. Specifically, community-based practice experiences provide students with:

- Greater autonomy and independence, thus fostering critical thinking, creative problem-solving, and professional role development.

- Greater opportunities for innovation and risk taking, less encumbered by the complexity and regulations of the hospital bureaucracy.
- Exposure to a wider array of nursing roles.
- More experience with primary care, with numerous opportunities to practice health promotion and illness prevention.
- Opportunities to "live" the cultural context of health and learn the realities of health care in the daily lives of people and communities.
- Experience with the ethical, economic, political, and social realities of health care, from which students may be insulated in acute care settings.
- Opportunities to develop broad competencies, such as effective communication skills, coordination and case management of care, interdisciplinary teamwork, patient advocacy, and a recognition of personal and institutional accountability for cost effectiveness and clinical outcomes of a defined population.
- Increased understanding and appreciation of the use of alternative methods of healing (e.g. herbal remedies, acupuncture).

Communities need ongoing, continuous, integrated health care. The advent of integrated delivery systems makes it more possible than ever to provide students with an integrated continuum of learning experiences with a given community or population. Nurse educators must rethink the usual ways of structuring learning activities, which often act as a barrier to effective partnership with communities. Faculty must let go of the

notion that every group of students must have the same prescribed experiences. For example, instead of requiring each group of students to conduct a comprehensive assessment of the same community or home health client, the learning experience could begin where the individual client or community is at that point in time and build on what has been assessed previously, updating and validating as needed. This would eliminate each group starting at the beginning, and consequently, no group getting much beyond the assessment phase in the space of an academic term. This standard of educational practice not only violates the best interests of the patient or community, it fails to provide students with opportunities to develop flexibility, adaptability, and teamwork that will be demanded of them in practice. The development of sustainable partnerships with communities offers ways to simultaneously meet the learning needs of students, the practice and research needs of faculty, and the health care needs of communities.

### The Challenge of Increasing Diversity in Nursing

Leininger (1991) relate that each cultural group makes decisions regarding their health or well being; decisions about which food to eat, how to handle aches and pains, whom to consult when one does not feel well. Such decisions are strongly influenced by cultural values, traditions, and social structure. Presently less than 10 percent of the over 2 million nurses in the U.S. come from ethnic minority backgrounds. As a health care dis-



cipline, it is critical that nursing recruit individuals into the profession who reflect the population that nurses serve. Efforts by practicing nurses and nurse educators to understand the question, "Who is our consumer?" will lead to changes in educational programs, research strategies, and clinical practices to respond to the shifts that are occurring in the nation's population.

Nursing education programs must strive for an ethnic and racial diversity among students and faculty that more closely mirrors society. This will require more aggressive recruitment and retention programs. Such activities include early academic outreach programs targeting junior and high school students; financial assistance; access to mentoring and role modeling programs; recruitment and support into graduate programs in nursing; and support for entry and progression into faculty roles. Other types of diversity also need attention; for example, the entry of men into nursing is gradually increasing and should continue to be encouraged. Schools must produce nurses capable of providing care that is of high-quality, cost-effective, accessible, individual as well as population based, culturally relevant, and focused on the whole person across the life span.

### **New Teaching Strategies and Technologies**

As nursing moves into the 21<sup>st</sup> century there are many instructional options potentially available for use in the classroom, in community settings (e.g., patients' homes), and in acute care centers. Effective use of tech-

nology places expectations on the teacher to serve as a facilitator or resource person. An understanding of the pedagogical advantages and disadvantages of the use of new technologies is imperative for the faculty to ensure that assignments are appropriate for meeting course objectives.

Computer conferencing has only recently gained momentum as universities increasingly seek efficient alternative ways to provide distance education to learners in rural areas. A question posed by the teacher is responded by all class members who will each have the opportunity to read their peers' answers. Dialogue across miles is thus facilitated as learners acknowledge and reply to one another's comments at times convenient to them.

Within an early decade of the 21<sup>st</sup> century it is realistic to expect that nursing education will incorporate virtual reality experiences into undergraduate and graduate curricula. Such opportunities will allow students to actually practice psychomotor nursing skills on a simulator using the exact motor movements they would in the clinical setting. These scenarios will provide learners with the stimulation of conversation with the patient in a replicated environment like that in which an actual clinical interaction would take place.

Many concerns have been generated by these nontraditional approaches to nursing education. When educational offerings are delivered off-campus, maintenance of program quality and integrity is always an issue. Another issue is the extent to which socialization toward role behaviors and values of the

profession can occur when students are not in residence and do not have regular, ongoing interactions with nursing faculty. It is clear that these issues will continue to challenge educational institutions and their faculty.

### Issues in Undergraduate Education

Preparation of nurses at the baccalaureate degree level is the minimum qualification to function in professional practice roles. Baccalaureate students should be skilled in delegation as well as in case management and system management, should be provided with learning and practice experiences in diverse settings, and should acquire skills in planning and integrating care for patients across health care settings.

Leadership and organizational skills must be presented in an experiential context both within the classroom and in the clinical setting. The development of skills such as delegation and supervision, must begin in the entry level courses and strengthened throughout the program. For example, students need to learn through the use of patient vignettes (case examples) that focus on patient problem identification and identification of nursing actions/tasks. Then they need to decide what type of nursing staff is required to provide nursing care. Students must then learn the responsibilities involved in delegation for ensuring quality of care within ethical and legal frameworks. A supervised clinical experience should accompany this learning so students have an opportunity to practice the skills of delegation and supervision prior to graduation.

The model of case management is excellent to teach students to assess and provide patient care across the continuum. For example, clinical sites need to be arranged to allow for multi-level learning experiences. This would enable the student to remain in one setting and build on their expertise from pre-admission through post-discharge (homecare /community interventions).

Nursing students need to develop an understanding of healthcare costs and fiscal management, politics /policy development and ethics. Classes need to provide opportunities for analyzing current nursing and healthcare issues and their implications for the future. A political awareness must be installed while they are students in order for them to become involved in the political and policy development process. Opportunities for professional nurses in all areas of the healthcare spectrum must be explored, such as the insurance industry, health maintenance organizations, professional organizations, such as political action committees and community groups.

### Issues in Master's Education

At the master's degree level, the issues closely reflect the rapid changes in the profession and in clinical practice. In addition, they reflect the social cultural, and technological transformations under way in society. The rapid changes in undergraduate nursing education as well as in advanced practice roles have resulted in many challenges to the content in master's degree programs. Given the agenda in the 1990s for reform in health care delivery, clinical practice in nursing has been

changing rapidly, especially for nurses in advanced practice roles. Increased opportunities for advanced practice have become available across the entire continuum of care. Nurse practitioners typically practiced in primary care settings but now are used in acute care settings. In response to increased opportunities, there have been dramatic increases in graduate enrollments for a variety of advanced practice roles. Yet consensus does not exist on the best approach for preparation of advanced practice nurses and the type of curricular content that is appropriate for specialization and practice.

The need for standardization in educational programs with a more uniform approach to preparation for advanced practice roles presents a major challenge to nursing education. The American Association of Colleges of Nursing, (1999) identified the chief priority for master's curricula to be the preparation of advanced practice nurses (APNs). However, schools should continue to offer specialization for students who choose to pursue indirect care roles—such as management, and informatics—to prepare leaders in systems of care.

As we rapidly move into a global community, program standardization becomes a challenge from another perspective. The need to consider standards beyond the United States must be dealt with as more international students seek education in American programs. Major variation exists in the health care and educational systems in the world community.

Another challenge relates to rapid scientific advances and technological changes and their

impact on both process and content in graduate education. For example, the breakthroughs in genetics for both diagnosis and treatment of a wide range of conditions present both challenges and opportunities for nursing education and practice. Certainly information technology continues to change the way we carry out our personal and professional responsibilities. One result, however, has been ongoing debate about how it should be incorporated into graduate learning experiences. The same challenges exist with all the enabling technologies that are available in the patient care environment. It presents major challenges in terms of curriculum content, faculty proficiency, and program resources.

### Issues in Doctoral Education

At the doctoral level, the issues reflect the evolving trends in society, the field as a whole, and specially the changes in the discipline and science of nursing. The broad goals of doctoral education are to prepare nurses who will expand the scientific knowledge base for the field through research and scholarly activities, and serve in leadership capacities in a variety of arenas within society and nursing. Historically, the majority of doctoral programs have focused on teaching “process” courses such as research methods, statistics, and theory development. More recently, a distinct move is evident toward focusing on substantive courses in the discipline of nursing. This movement has been motivated by the expansion of the research base of nursing and the number of nurses

engaged in knowledge generation. The consensus within the field at present is to endorse diversity of theoretical and research approaches, because it is deemed premature at this juncture to dictate a uniform approach. It is felt that such diversity makes for richness and enhances the discipline (Redman & Ketefian, 1997).

In view of the rapidly diversifying population in the U.S. and the globalization of many universities and industries, doctoral educators need to ask themselves what the impact of these societal changes are for what they teach. Ketefian and Redman (1995) contend that U.S.-developed nursing science does not possess global characteristics, and international nursing issues and global content do not feature significantly in doctoral curricula. Another area of concern in doctoral education, is that while we do a good job in socializing doctoral students for careers in research and scholarship, we do not pay sufficient attention to providing experiences that will prepare students for faculty positions. These issues need to be examined in order to generate recommendations for addressing them at the national and individual program levels.

### International Exchange Programs

International exchange is becoming a reality for many schools of nursing that would not have considered it as part of their scope 5 or 10 years ago. Rapid changes in our world are not only facilitating more international exchange but demanding it. Having fallen behind in meeting many basic needs of the population, we are increasingly forced to look

internationally for health care models. Nurses have a vital role to play in primary health care in both developing and developed countries. International exchange is a viable method of increasing our knowledge and ability to meet the needs of our population, and to educate nurses prepared to deal with nursing practice in the future.

International exchange activities may include faculty exchange or consultation, project and research collaboration on common problems, joint publications, sharing of ideas and resources, student exchanges and sharing of courses, materials, and resources from both institutions. Numerous models have been developed and implemented for international exchange in schools of nursing with various degrees of success. The most important concept is that the model be feasible, for no two institutions or schools will or should have identical programs.

In international faculty exchange programs between schools of nursing, knowledge acquisition and innovation in nursing education and practice approaches, occurs for both parties in the exchange experience. For example, the exposure to other countries' primary health care models and projects has influenced the development of both inner city and rural models in this country by U.S. nursing faculty and students, demonstrating the leadership of nursing in providing primary care. The testing of U.S. theories for relevance in other cultures and countries could also be a valuable step for developing more universal nursing theory related to health and responses to disease.

In 1994, 449, 749 foreign students were enrolled in U. S. universities, the largest foreign population of students in the world (Davis, 1994). Many of these students are supported by their government or home institutions in hopes that the education they gain will provide them with the professional, social, and personal skills required to play meaningful leadership roles in their societies. To ensure student retention and successful adaptation to the U.S. culture and educational system, educational exchanges must be planned carefully. The first step is to assess the needs of the international students, faculty, and school and to identify the necessary resources.

The effect of international exchange on schools of nursing in the United States is just beginning to be realized. International exchange programs have exposed students and faculty to other cultures' beliefs and health care models. They are having a major impact on developing a more culturally sensitive approach to health care around the world.

### Summary

The challenges ahead for the nursing profession are plentiful. While our course is far from clear, we have a wonderful diverse supply of courses of action to pursue in meeting our challenges, and these will be tested in decades ahead. Because nursing needs to be responsive to the health care arrangements that come about as a result of societal trends, we cannot know today what the final shape of our nursing practice and education will be. With this in mind, let us remain open to a diversity of ideas and strategies

to succeed in our quest for accessible, quality, cost effective health care for all.

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## Nursing Education in Korea

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### Abstract

One of the primary goals of nursing education is to provide an environment in which the student can develop cognitive, affective, and psychomotor skills to practice professional nursing independently and collaboratively. Before 1945, Korean nursing education was far from reaching this goal. Concepts from modern Western nursing were introduced after the Korean War (1953) from the United States.

Developments in nursing service and education are complementary. One accomplishment of nursing education during the 40 years since 1953 is its independence from the medical faculty. The educational contribution to the clinical development of nursing is within the context of human resource development and the search for new knowledge and innovation in nursing.

The expansion of education set the pace for the growth of nursing and called for an increasing number of skilled practitioners. In qualitative terms, education in nursing improves nurse's innovations toward quality care.

But quality of education has not shown a

commensurate improvement. Quality of education depends on the conditions for education, which include educational content, teaching methods, and quality of the faculty, facilities, financing, evaluation methods, and research. Schools are evaluated in terms of how they balance these resources. Educational development of baccalaureate and graduate programs is contributing to the public image of nursing. The public is becoming aware of nursing as a profession as well as a science.

Studies of nursing education in Korea may be of great significance to highlight current problems in public health and the availability of personnel in the health sector in Korea. People increasingly value their quality of life. The scope of patients in the nursing field is broadening from maternal to terminally ill patients, from patients with preventive to rehabilitative needs, from adaptive to maladaptive patients in a stimuli environment. Nursing education creates not only the methodology of the patient's care, but also public awareness of the significance of health promotion and quality of life.

In relation to the nursing patient's needs for a healthy life, Korean nursing education

should provide contents based on the country's culture. Presently, the Korean curriculum contains characteristics closely related to the American's nursing curricula.

The rapid economic development, changes in people's health needs, an increasing number of elderly people, and rapid developments in technology and international relations have changed the concept of nursing education and nursing service in Korea. As we move closer to the 21st century, we are faced with not only changes in the quality of care and contents in nursing, but with a structural change as well. The new values we encounter epitomize the information society. We must prepare ourselves for the challenges of this new era.

The present system of clinical nursing and nursing education in Korea is not only unable to produce excellent manpower for the future, but is incapable of providing any solutions to the problems besetting the Korean nursing sector of today. There is an urgent need for restructuring the present clinical nursing system as well as redirecting the nursing education contents in a more productive direction.

I think the Korean experience with nursing education may be potentially valuable in appraising nursing of both developing and developed countries.

## Introduction

I think nursing education in Korea is one of

the most conflicting science fields, influenced both by oriental and occidental ideas and values.

Modern nursing education in Korea has developed for over one century. Nursing science has been a special academic field, with education taking place both at school and training at practical settings.

In Korea most of the students in nursing schools are women. This is one unique characteristic of Korean nursing education. In the beginning of nursing education in Korea, women's social role was extremely limited. Women's activities were limited to household chores; any social "career" was prohibited. Women's education was facing great difficulties. In addition to this, nursing education had other problems: nursing science is based on the occidental culture, the ideology of freedom, and its basic contents are to provide humanistic care to everybody, not only one's own family but also others, men and women alike.

Influenced by Confucianism, having social occupations was prohibited for women. At that time, Korean society was based on a hierarchy of gender. This hierarchy of gender has greatly influenced the medical and nursing field. Now it is considered normal that women are taking up nursing care, whereas men will predominantly chose medical practice.

Considering people's health and quality of



life, education of health care professionals and their practical roles and capabilities should follow integrated guidelines with balanced progress.

Korean nursing education has been influenced both by the European and American systems. There have been great troubles in establishing a characteristic Korean education system for nursing.

Presently, we have 3 and 4-year (B.S.N) nursing colleges, which provide identical licenses for registered nurses. Therefore, integration of those two educational systems is one of our main goals. To do so, we have to assess the strong and weak aspects of both systems, have to evaluate graduated nurses, and also have to define their role function systematically. In order to achieve this goal, it is essential to grasp the needs and viewpoints of our people and professional health caregiver's opinions about the Korean nursing educational system. Nursing education should develop towards both academic accomplishment and practical experience in nursing.

## 1. General Background of Korea

Koreans have been a very homogenous people since ancient time, with no cultural or traditional deviations. Korea has a 5,000-year history as an independent nation, and has built her own tradition of society and culture. Confucianism became the guiding ideology of during the Yi Dynasty (1392-1910). This great code of human relationship and social structure set behavioral and traditional patterns which still greatly influence the

present day life in Korea.

## Population Trends and Economic Overview

Korea's annual population growth rate in 1960 was around 3%. Since that time, the rate has been decreasing steadily due to economic development and a successful family planning program, which was started in the early 1960s. As a result, the annual growth rate has remained below 1% since 1985. Based on a 1994 census, Korea's growth rate is expected to decline further, reaching zero growth around the year 2020 with a total population of 50.58 million. The projected total in 2020 for both South and North Korea is 88 million (Table 1).

The mortality rate has been decreasing from 12.1 per 1,000 in 1960 to 6.7 and 5.8 per 1,000 in 1980 and 1990, respectively. Infant mortality has also been decreasing rapidly. There were 62.3 deaths per 1,000 newborns between 1955 and 1960, but this rate improved to 17.3 and 12.0 deaths per 1,000 in 1980 and 1990, respectively. The maternal mortality rate decreased from 8.8 per 10,000 in the 1960s, to 4.2 and 3.0 per 10,000 in 1980 and 1990, respectively. Following a decreasing birth rate since the 1960s, ratio of Korea's population under 15 years of age has decreased continuously from 42.3% in 1960 to 22% in 1998. 71.1% of the population is between 15 and 64 years old, and 25.3% is under 15 years old in 1995. The ratio of people over 65 increased from 2.9% in 1960 to 6.8% in the year 2000 (Table 1).

A graph depicting age distribution in the past, especially in 1960, was pyramid-shaped, a typical structure for less developed countries. However, the pattern has become bell-shaped as a result of low birth rates and low mortality rates. In the near future, this will change to a post-shape, like in advanced countries, which have a relatively low birth rate (Fig. 1). Reasons are developments in health and medical science, living standards, improvement in nutrition and an upgraded quality of health and medical care, resulting in a longer life expectancy.

With the declining death rate as a result of improved sanitary standards, advanced medical technologies, and economic growth, the average life expectancy of Korean has been increasing, reaching 68.8 years of age for male and 76.1 for Korean female in 1996 (Table 2).

As of 1997, the population in Korea was 46 million, with nearly one-fourth (10.47 million) of the people living in Seoul. As a result of higher life expectancy and sustained implementation of birth control, annual population growth has declined to 0.98 percent. Population density is one of the highest in the world, with 455 people per 1 km<sup>2</sup>.

In 1995, out of 34,210,000 people aged 15 or older, 30.2% were single, 61.2% married, 7.5% widowed and 1.1% divorced (Fig. 2).

Korea has achieved remarkable economic and social progress through a series of five-year economic development plans launched

from 1962. The success of this approach is clearly shown by the fact that from 1962 to 1990, Korea's gross national product grew, in real terms, by an average of 8.5 percent p.a., and reached \$2.3 billion at the start of the first five-year development plan. During the same period, per capita GNP increased from \$87 to \$5,883 and an estimated \$10,000 for 1996 (Table 3).

#### Health Status, Health Care System and Health Manpower

The rapid economic development of Korea has brought about dramatic improvement in the health status of Koreans.

The leading causes of death in Korea were infectious disease such as tuberculosis, pneumonia, bronchitis, and gastroenteritis. The tuberculosis death rate, which was high in the past, has been dramatically reduced to 19.2 deaths per 100,000 persons for 1983. The current tuberculosis death rate is still high compared with developed countries and stands at 10.4 deaths for 1992 (Table 5). Current major causes of death are chronic diseases of the circulatory system and malignant neoplasm (Table 6).

In Korea, the mortality rate for coronary heart disease (CHD) is only 12.5 per 100,000 people in 1992. Korea has an unusually high mortality rate from liver and stomach cancer. For 1992, those rates stood at 30.6 deaths per 100,000 people for stomach cancer, and 23.7 deaths for liver cancer.

Due to industrialization, urbanization and aging of the population in the past years, the demands both in quantity and quality, for health and medical and nursing care services have increased. Health and medical care in Korea is unevenly distributed, depending on medical care resources. Mandatory health insurance for the whole nation increased demands for health care and revealed that more health manpower and facilities are needed. The crucial issue of the health care system in Korea is the improvement of accessibility, equality and availability of health care at lower costs for a majority of people.

At the end of 1996, there were 271 general hospitals, 516 hospitals, 30,175 clinics, 14 dental hospitals, 8,761 dental clinics, 81 oriental medical hospitals, 6,172 oriental clinics and 161 midwifery facilities in Korea (Fig. 4). There are classifications of medical qualification according to size and services (Table 7).

In 1998, there were 41 medical schools, 11 oriental medical schools, 11 dental schools, 113 nursing schools, and 20 pharmaceutical schools. There were 3,300 medical students, 760 dental students, 750 oriental medical students, 11,125 nursing students and 1,301 pharmaceutical students in 1998 (Table 8).

At the end of 1997, there were 507,315 licensed medical personnel. Of them, 59,399 were physicians, 9,299 oriental medical doctors, 14,371 dentists, 127,145 nurses, 197,788 nurse's aids, 8,447 midwives, 85,517 medical technicians and 5,349 medical record officers

(Table 9). At the end of 1997 one physician served 736 patients, one nurse served 372 patients, one oriental medical doctor served 4,999 patients, a dentist served 2,992 patients and a pharmacist served 1,004 clients.

Figure 5 shows the number of health related personnel per 100,000 people. The number of health related personnel has increased in the last decade, but is still lower than in developed countries.

The prevention of chronic diseases in adults is most important, because most chronic diseases exhibit no symptoms and are not detected until the terminal stage. Currently, the mortality rate from chronic diseases (or "non-infectious" diseases) show a rapidly increasing trend because of the aging of the population, change in dietary habits, an increase in the smoking population, and a decrease in physical activities. The crude mortality rate (per 100,000 population) for major chronic diseases in adults in 1996 were malignant neoplasm 111.9, cerebra-vascular 74.7, hypertensive diseases 13.8, chronic liver disease 27.3 and diabetes mellitus 17.4 (Table 10).

Therefore, our focus is on preventive treatment, public information campaigns, and the 13 chronic disease screening centers of the Korea Health Control Association (KHCA), where screening at low cost is offered, utilizing mobile screening teams.

## 2. General Education and Nursing Education

Since the Education Law was promulgated in 1949, a ladder-type school system has been in use (the current school system is 6 years of elementary school, 3 years of middle school, 3 years of high schools and 4 years of university or college). (Figure 6).

Even in the midst of the tragic Korean War, education continued incessantly in makeshift barracks and outdoor classrooms. While going through these dark days, education became inclined toward a functional orientation, emphasizing its role in the revival of Korean education to fulfil the missions of overcoming the national crisis and leading to reconstruction. The "Wartime Emergency Education Act." promulgated in 1951, showed Korea's strong will in continuing educating their children even in the confusion of war.

The 1970s are characterized as the "decade of fundamental reform" in education. In the educational sector, reforms were directed toward the major goal of producing self-directed and future-oriented Koreans.

The rapid process of economic and social change gave birth to new concepts such as lifelong education and adult education. The opening of the "Korea Air and Correspondence College" in 1972 was recognized and described as a delayed means of releasing a bottleneck on the way to tertiary education.

The bachelor's degree examination program for the self-educated, recognized as a college education equivalent, was formally launched in 1990. After a four-year study, in order to normalize high school education and extend university autonomy, a new system for college admission tests was announced in April 1991, and implemented in 1994. Riding on the ongoing wave of reforms and in response to aspirations of the people, the Commission on Educational Reform worked on the creation of the "New Korea".

In terms of the historical overview of Korean nursing education, I will present briefly here.

### Historical Overview

Korea first became interested in Western medicine in the early 1900s. Medical care in Korea was available only to the wealthy and royalty and was administered in their homes by traditional medical practitioners. The vast rural population and ordinary people received care only from their families or traditional healers. The first modern Western hospital in Seoul, established in 1899 by the government of Korea, has developed mainly in urban areas. Health care for rural areas continued to be underdeveloped until the Ministry of Health and Social Affairs proclaimed the Mother and Child Health Law in 1973.

Between the early 1900s and the late 1940s, there were no major changes in the development of nursing education and practice. From the beginning of nursing education in Korea,

nurses and midwives were trained by Western missionary nurses at Christian hospitals or by hospital schools operated by the government. Nursing education development owed its impetus to efforts of two distinct groups: the government and Christian missionaries. In 1913 regulations concerning the education of nurses and midwives were proposed, and became law in October 1914. Qualification tests for nurses have been in place since 1914, testing both theoretical and practical knowledge (Table 12-1). Testing was done on a provincial level until 1962. In 1962, the law was revised to require licensing which could be obtained by passing a national examination after graduating from a nursing school in either a 4 or 3-year program.

After Korea's liberation in 1945, the Nursing Bureau at the Ministry of Health and Welfare was set up to work toward the standardization of nursing education. However, until 1973, there was neither any standardization for entrance requirements, or for any course length for nursing education institutions. Until 1973, there had been two different educational systems for nursing: secondary school education and higher education. The former system was a high school nursing level (6-3-3), the latter system was divided into two levels: one a junior college level (6-3-3-3) and the other a university level (6-3-3-4). The nursing curriculum in high school and junior college was the same length and content, differing only in entrance requirements.

The first students in a bachelor's degree program in 1955 admitted at Ewha University in Korean graduate program in nursing started at the master's level at Ewha University in 1960 and at the doctoral level at Yonsei University in 1978. The first nursing educator completed a doctoral degree in nursing at Yonsei University in Korea in August 1982.

Concepts of modern nursing were introduced after the Korean War (1953), mainly from the United States. Nursing education based on modern concepts has stimulated the development of new nursing knowledge and clinical research. Since 1967, the Ministry of Health and Social Affairs initiated a preparatory program for nurse's aids.

#### **Four-year Baccalaureate Programs in University**

Higher education aims at conveying knowledge of fundamental academic theories and their various applications, as needed for the progress of society and the global community, thus fostering personalities capable of leadership. The period of study in a nursing college is four years.

As of Jan. 1999, there are 48 Bachelor's Programs (8 national and 40 private schools) in Korea (Table 13).

#### **Three-year Diploma Program at Junior Nursing Colleges**

High school graduates and those with an equivalent academic background may apply for junior vocational college. Admission to

junior nursing college is determined on basis of school achievements, scholastic achievement test scores, interviews and aptitude tests.

Although junior nursing colleges put emphasis on practical education aimed at producing mid-level technicians, this is not necessarily an end to schooling. It keeps doors open for students to continue education at universities: R.N., B.S.N. courses, the Korean Air and Correspondence University, and self-study as an alternative to a Bachelor's degree. At present, there are 65 Junior Nursing Colleges (4 national and 61 private schools) in Korea (Table 14-1 14-2).

#### Graduate School

There are 36 general graduate schools attached to general universities for a master degree in nursing and 15 schools have doctoral programs in nursing (Table 15). The goal of graduate schools is to pursue university education more deeply and to enhance the creativity and leadership of academic research.

With increasing demand for high-level manpower, the government has embarked on ambitious programs to advance graduate education by means of reforming curricula, teaching and evaluation, raising academic standards of dissertations, reinforcing the number of teaching staff, and recruiting qualified professors. Other measures include an emphasis on basic sciences and an increased number of scholarships in areas of strategic importance. At present, there are

about 340 nurses with a doctoral degree and about 3,000 nurses with a master degree.

### 3. Current Status of Nursing Education

#### General Characteristics of Nursing students

All applicants to a nursing university, college or junior college must be graduates from high school, have passed the qualifying examination for high school graduation, or be graduated of schools recognized by the Ministry of Education as being equivalent to high schools. All applicants must take the college entrance examination prescribed by the government after they have selected a college and submitted relevant application forms. Universities or colleges select their first-year students on basis of the composite score of the scholastic achievement examination for college entrance, high school grades, and an essay test conducted by each university or college.

Most students first apply for a 4-year college or university and then, if they fail, may decide to take the junior college entrance examinations. The junior college entrance examination is held after 4-year college entrance examinations are finished. Some students will wait to take university entrance examinations again the following year.

#### Nursing Faculty in Korea

Doctoral programs in nursing started to provide a qualified nursing faculty. According to 1987 Ministry of Education data, professors of nursing with doctoral degrees

account for 10 percent of the total faculty. However, there has been an increasing number of professors with doctoral degrees since 1990. As of 1998, almost 90% of professors in 4 year nursing schools are doctors.

There are almost 800 educators (included part-time instructors) in 4 year program schools, and about 1,300 educators in 3 year programs in nursing schools in Korea (Table 6).

### The Learning Environment for Nursing Education

The Ministry of Education has evaluated nursing schools only for academic affairs, such as the number and qualifications of students and the faculty and for facilities for teaching nursing. However, the Ministry of Health has focused on licensing of registered nurses (RNs) and legislation of RN activities. All 4-year baccalaureate programs in universities use university hospitals for clinical practice in the medical-surgical sector, maternal childcare, and psychiatric care. Community health nursing practice takes place in public health centers operated by the government. There are many problems related to clinical experience for students of 3-year junior colleges. Many junior colleges were established without connection to a practice hospital. With the exception of several schools with good clinical experience, most of the 3-year program schools have major weaknesses in the provision of practical education. The faculty is continuously looking for government or private hospitals to provide

clinical experience. If the college can not find appropriate hospitals for practice, the students may not have the minimum experience necessary. Even if most clinical experience for physiological care can be found, psychiatric care experience is more difficult to obtain. Students use summer or winter vacations for 1 or 2 months of experience in psychiatric care at public or private psychiatric hospitals.

The 4-year bachelor program colleges, except the six colleges of nursing, are under control of the Dean of the College of Medicine, and thus do not have control over a budget for operating academic affairs. Requests for teaching equipment for the nursing arts laboratory and classrooms are handled by the university.

### Continuing Education System for Bachelor's Degree in Nursing

#### 1) Korea Air and Correspondence University (B.S.N. Program after R.N.)

In order to give opportunity for higher education based on the ideals of lifelong education; to expand social education for the promotion of the intellectual level of the nation and to offer chances for development, Korea Air and Correspondence University was established. The genesis of this university was a junior college established in 1972, which offered two-year post high school courses. By 1982, Korea Air and Correspondence University developed into a sprawling institute offering one junior college course and 8 bachelor's degree courses. The number of

admitted students in nursing program is 2,500 students p.a.

No examination is needed to gain admission. Entrants are selected through documentary screening and the period of study for graduation ranges from four to ten years.

For the convenience of provincial students, lecture applications can be made at 29 city and provincial education centers.

Since the beginning of the nursing program at the Korea Air & Correspondence University, 5,481 students graduated with a B.S.N. degree (Fig. 7).

## 2) Self-study as an Alternative to a Bachelor's Degree (after R.N.)

Through a standard examination conducted by the government, self-study has been recognized as a new way to a bachelor's degree for those young people and adults, who have a high school diploma but have missed the opportunity for higher education because of financial difficulties or lack of time.

The self-study system as an alternative to a bachelor's degree has been implemented since 1990 on the basis of the "Self-study as an Alternative to a Bachelor's Degree Law."

The nursing fields were set up by the implementation of the self-study system as an alternative to a bachelor's degree. The process of obtaining a bachelor's degree through self-study requires passing a four-stage examination. There are 120 nurses who earned a

B.S.N. degree from the examination since 1995 (Table 17).

## 3) B.S.N. Courses for R.N. at Universities

17 Universities have provided a different Bachelor's degree program in nursing for registered nurses that graduated from a 3-year program school from 1995 (Table 18). This program is one of the lifelong educational system for nurses who want to earn a Bachelor's degree. Since the establishment of Chodang University B.S.N. program for R.N. at the University in 1995, 17 Universities with an annual enrollment of 1100 students have been established. The students should take almost 70 credits for the degree. The number of nurses to earn the B.S.N. degree since 1995 is about 550.

## Health Care Application and the Role of Nursing Personnel

There are two health care application systems in Korea. One is offered by the private sector, the other one is conducted by the public sector. The private health care system is mainly a hospital-based medical care service. The public sector provides community health services at health centers as well as medical care services at hospitals.

According to statistics of the Ministry of Health and Social Affairs from 1997, private clinics and hospitals account for more than 95 percent of all medical facilities, employ 72 percent of physicians, and hold 72 percent of total hospital beds. However, most private sectors are concentrated in urban areas. In



Korea, although only about 68 percent of the population live in urban areas, 92 percent of physicians and 86 percent of hospital beds are located in the cities. Thus access to medical care for the rural population is scarce. Moreover health care problems faced by the rural population are complicated by geographical and socioeconomic conditions. Significant health problems in rural areas are inadequate maternal and child care, low immunization levels, unsanitary living conditions, inadequate acute disease care, and inadequate care for the elderly.

Responding to these shortcomings, the government established a special law for rural health care in 1981. This legislation included support for the training and development of professional nurses as Community Health Practitioners (CHP) to deliver public health services in remote rural communities. According to this special law, the CHP was specified as a registered nurse with 6-months additional training as a community health practitioner. A total of 2000 CHPs has been recruited countrywide through local governments.

#### 4. The Future of Nursing Education in Korea

More and more demands will be continuously placed on baccalaureate nursing programs to provide opportunities for diploma-prepared nurses to earn the baccalaureate degree. Demands could be met by chance, when many universities open nursing courses for registered nurses.

An increasing number of doctoral-degree courses will become available. University administrators and the public will understand nursing as a science and profession, but the clinical practice component may not be well understood unless nursing demonstrates quality care. Nursing education will develop as a community-oriented preparation, based on primary health care concepts as well as hospital practice. The nursing curriculum will focus on preparing professional nurses, who are concerned with the health of the individual, families and the community.

To provide adequate clinical education for nursing students, strong affiliations between academic institutions and practical settings must be developed. The faculty should maintain clinical expertise and come to some agreement on a common knowledge base for the development of nursing education, practice, and research. Private and public funds supporting nursing research should be expanded. The Korean Nursing Association (KNA) should seek to resolve the most pressing issues related to nursing education by obtaining a consensus among the public, those in national socioeconomic policy development, and relevant medical laws to support KNA's plan for the integration of the two levels of nursing education programs.

The new era of globalization holds several implications for the future direction of our nursing education. First, to meet the challenges posed by globalization, the quality of

our education should be raised to meet world standards. Second, in order for us to develop nursing science and to live in cooperation with other disciplines in the era of globalization, special emphasis must be placed on strengthening and deepening our understanding of our cultural heritage and newly acquired knowledge. Third, to become truly globalized citizens, we should not only keep our minds open and foster a multi-cultural perspective, but also develop cross-cultural communication skills. Fourth, the principle of autonomy and decentralization should also be observed in education.

For the quality of Korean education to reach international standards, it is essential that it break with the present emphasis on rote memorization of fragmentary information and shift toward fostering creativity. In this context, the institutions of higher learning should revitalize their role, not as a mere transmitter of knowledge, but as the cradle of new theories and inventions.

## Conclusion

Korean nursing education is strongly influenced by educational models from the United States, and in the enthusiasm for developing nursing education, we would be unwise to adopt uncritically the system of another country. We must be selective to develop nursing education based on our country's culture, system of general education, economic and social development, system of medical and health service, and the needs of our communities. Moreover, the effectiveness

of the implementation of nursing education goals depends on the development of nursing as an independent discipline and on taking the initiative to solve health problems in a variety of practical settings. Professional and academic autonomy is essential to develop nursing education within the mainstream of higher education.

A new direction in Korean nursing should be oriented towards nursing as an attractive and necessary discipline to the public, second, nursing should be changing towards an autonomous, excellent, communicative service through information technology.

The principles for the establishment of the new nursing system are:

- Students are to choose nursing with commitment to their career rather than degree.
- Educators, as the agent for nursing reforms, participates in innovative undertakings at the grassroots level. They also serve to anticipate and open the way to the future for the next generation.
- The government evaluates nursing educational institutions, and provides necessary support for them, based on the evaluation results.

Hospitals and Health Institutions are strongly encouraged to treat nurses according to educational attainment; they are also to put more emphasis on their ability. The press, mass media, educators' organizations, social groups and nurse's associations need to

take the initiative in changing the values of people and actively participate in the improvement of nursing conditions.

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「看護教育の改革—自国の特色を生かした教育課程の構築と国際交流」

改革とは、何か別のものにするのではなく、目指すものに近づくこと

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“看護は社会のヘルス・ニーズに応える”という図式からすれば、その“社会のニーズ”が明らかに変わりつつあるいま、看護する者を育てる看護教育がそれに対応して変化するのは当然であろう。対応して変化を起こさねばならないというべきかもしれない。しかし、それは看護教育についてのみならず、医学教育をはじめ各種のヘルスケア・ワーカーズの教育についてもいえることである。変わりつつある社会のヘルス・ニーズに応えるために、“看護教育の改革”だけを取り上げて論じるのは必ずしも効果的ではないように思う。

とはいえ、現にヘルスケアの場にはさまざまな問題状況が噴出している。“問題状況”と乱暴に一語を使うが、市場原理がはたらき、テクノロジーが人間的なタッチを追いやり、人口は高齢化した、そういう状況である。ここにおいて、状況改善のためにどこからか、何らかの行動を起こさねばならないこと、自明ではないか。いざ、看護はどうするか、看護教育はどうか。

私の発言の要旨は次のようである。①看護はそもそも、今日の問題状況のかなりの部分に対応する力、あるいは今日の問題状況のかなりの部分を予防する力をもっている。②そうした力の知識基盤を相当に築き上げてきており、教育においてはそれを学生に伝えている。③しかし、その知識基盤を踏まえた、本来の力を発揮する看護の実践は十分なされていないのではないか。④知ってはいるけれども十分に行なってはいない看

護、つまり“目指すもの”に、行なうことをもって近づく、そのスピードを今こそアップしたい。看護教育の改革は、まずはその路線に乗せたい。

思うに、確かに看護は社会のニーズに応えるのであるが、看護がもっぱら時代に応じる、言い換えれば、社会のニーズの変化に対応していつも看護のほうが変わる、と私達看護職者は実のところ考えていないのではないか。時を超え国を超えて変わらない看護、という感触を私達は伝統的にもっているのではないか。

あのフロレンス・ナイチンゲールはこう言った。「看護婦に決して欠けてはならないこと、それは自分の根の底に、困難に出会っても決してくじけることのない原理をもつこと、つまり、私達看護婦の、よって立つ土台をもつこと、そして、むやみに枝を広げることよりも根を深く張らせることに打ちこむことである。」(“そして”までは『看護婦と見習生への書簡』4<1875>、後半は同6<1878>。“そして”でつないだ根拠は小玉香津子他、現代看護につながるF. ナイチンゲールについての総合的研究、その4『看護婦と見習生への書簡』について、総合看護 Vol. 26, No. 2を参照されたい。)

“よって立つ土台”とは、まわりがどうあろうともゆるがない土台、であろう。“枝よりも根を張る”は、目立たない土台をよりしっかりさせることこそ看護本来のありかたであり、かつ看

改革とは、何か別のものにすることではなく、目指すものに近づくこと

護のパワーの在りどころである、という含みであろう。

また、ヴァージニア・ヘンダーソンがしばしば引用する彼女の師アニー・グッドリッチは、看護は世界的社会活動の1つであるとし、それは社会における創造的にして建設的な力であると言った。“創造的にして建設的な力”が指しているのは、看護のもつ、社会を新しく創っていく能動性であろう。

これらが意味するのは、看護は社会の変化にいかに対応すべきか、したがって看護教育をいかに改革すべきか、と問う私達には、もっと根を深く張り、本来もっている看護の力で、今日の問題状況の緩和された新しい社会を創っていく、そういう道を進む可能性があるということである。「改革とは、何か別のものにすることではなく、目指すものに近づくこと」という私の表題は、その道を指している。

今日の問題状況の中の私達に、この“目指すもの”が何であるかを改めて納得させてくれるのが、国際看護婦協会の“看護婦の規律”の一節である。ICNはそこに、「看護には、人の生命と尊厳と権利の尊重が固有の特性として備わっている」とうたう。

その人の生命と尊厳と権利、この三つともを、どのような時にも尊重するという他に類をみない特性、これはナイチンゲールの言うゆるがなない土台、グッドリッチを引いてヘンダーソンの言う究極的には社会をつくり変えていく本来の看護の力、の核心であろう。「看護は人の生命と尊厳と権利を尊重する」、これこそ、私達の目指すものの、今日の問題状況を意識しての雄弁にして端的な表現ではないか。私は、私達は、看護という職業は、これに照らして問うべきである。その人の生命と尊厳と権利の尊重を、三つともを尊重を、どのような時にも徹底して行なっているだろうか、教育

の内容と方法においてもそれを徹底させているだろうか、と。

徹底して行なっている、あるいは徹底して行なうことに努めてやまない、と答えることができるのであれば、看護という職業は、そして看護教育は、目の前のヘルスケア・ニーズの変化に対応して新たに、いわば戦略的な改革をこそ起こす時を迎えているのである。しかし、徹底してその人の生命と尊厳と権利を尊重しているとは言えない、と私達の声小さくなるのであれば、徹底してそれを行なう方向に踏み出して、ほかに類をみない特性をもつ看護の力によって、すなわちその力を強化するような看護教育を行うことによって、今日の問題状況を改善に導く道を選ぶのが順序というものではないだろうか。

その人の生命と尊厳と権利を三つともにどのような時にも尊重する看護～それは、その人の病気や障害に目を奪われることなく、病気や障害を体験しているその人から目をそらさない看護である。その人がいかに病むかを、私達がその人をいかに看護するかの中に包み込み、その人の重荷をときに半分背負い、必要とあればその人を代弁する看護である。

それはまた、『ライフサポート』のスザンヌ・ゴードンによれば、看護婦の行為としては、世話をし、交わり、学ぶのを助ける、これらをとことん行うことである。世話をする～これは身体的ならびに心理社会的な人間の生活行動への援助であり、その人の生理的・心理的平衡を保ち基本的欲求を満たすように、その人の自由と自立を大切に、して過不足ないように、なされる働きかけである。交わる～その人の身になり、その人のその時々表現を感じとり、解釈判断し、一方私達看護婦も自らを表現して、その感じとりや解釈判断の誤りを正すとともにその人のさらなる表現を促す。ここでは active listening や presence などの看護行為が不可欠となる。学ぶのを助ける～その人がセ

セルフケアすることを動機づけられ、自分の健康についての情報を手に入れ、セルフケアするための技術を身につけて、要は自分の健康にとって好ましい生き方を自分のものとするのを助けることである。

言うまでもなく私達は、その人の生命と尊厳と権利を尊重するこのような看護をいまではよく知っている。その理論的根拠、すなわち看護学の知識が今世紀の半ば以来、主にアメリカにおいて開発されてきたこともよく知っている。その開発は一つには、生理学や心理学や社会学などの他の専門から最初は借りて使っていた知識を看護学の中に取り込み、位置づけるというルートでなされた。生理学的平衡、ストレス、欲求と行動の関係、対人関係、適応などが、そのようにして看護が自分のものにした知識の例である。

またその開発は二つには、ストレートに看護学の知識を生み出すための研究をすることによってなされてきた。三つには、看護の歴史は古いのだからと、今世紀初頭まで遡って看護の知識を探ることによってなされた。

そのようにして看護が看護特有のものとし、以来看護特有のものとして育てている知識基盤は大きく分けて二種類である。一つは、看護が関心を寄せる患者の体験、たとえば疼痛体験、疾病受容などを説明する知識である。この種の知識を手にする以前の看護婦は、患者の体験をではなく、患者の病気を説明する医学の知識を使っていたのだ。もう一つは、それら患者の体験をケアしたりコントロールしたりするための根拠を示す知識である。セルフケア、援助的關係、コーピングなどの知識がそれであり、この種の知識を手にする以前の看護婦は、ケアしたりコントロールしたりするための根拠をではなく、診断したり治療したりするための根拠を示す医学の知識をもっぱら使っていたのだ。

かくして私達は、いまでは目指す看護をよく知っている。この知識は世界的にほぼ平されている。私達の多くはこの知識をもはやあたりまえのことと思ひ、看護教育の場にはそれが飛び交っている。もっともここ20年ほどは、看護の知識の中でも、看護そっくり全体を説明する知識、つまり看護という分野の概念枠組なるものが優勢で、そうした看護学の知識基盤は意識されにくかったようではあるが、実際には着実に増えつつ確かなものになってきた。日本の看護はこの知識を、生み出すよりははるかに多く“輸入”したと思われるが、知識の検証には大いに貢献してきていること、学会活動の足跡に明らかである。地球上どこにおいても“人間性は変わらない、習慣が変わるだけ”であれば、看護学“先進国”からの知識の輸入にも、この知識が世界的に平されていることにも、異和感はない。

以上のしだいのもと、さて、“よく知っている、あとは実行あるのみ”というモードで私達は今日まで、どのくらいの年月やってきただろうか。気がつけば目の前に問題状況が迫り、実は私達はあわてている。いえ、あわてなければならないのである。

データは省くが、今日の主要な健康問題は、心臓病、脳卒中、癌、心因性の疾患、事故など、一人ひとりの不健康なライフスタイルや生活習慣に由来するもの、あるいは環境公害に由来するものである。加えて、高齢を生きる、障害をもって生きる、といった健康問題も目立つ。これらに対処するには、長い間行なわれてきたような、病氣中心の、つまり医師中心の、したがって病氣中心のセルフケアは適当ではなく、有効でもない。そのようなセルフケアはライフスタイル、生活習慣、環境公害、高齢などには対応しにくいのである。ということは、病氣中心ではなく人間中心の、つまり医師中心ではなく看護をはじめいろいろなヘルスケア・ワーカーズ協力の、そして病院中心で

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はなくいうところの地域社会中心のヘルスケアが必要なのである。そこでは診断・治療よりも、その人が自分の健康について学ぶのを助ける、その人の日々の生活行動を助ける、したがってその人と十分に交わる看護が、いろいろな専門が機能する中でもとくに有効であろう。私達はこれを徹底して行なわねばならない。

一方、そのようなヘルスケアのもとでは、病院等の施設には、非常に重症な方、学ぶのを助けるような働きかけがあまり有効ではない高齢の方や障害をもつ方が集まるであろう。現に集まっている。そこには、世話をする・交わるを中心とした、生命と尊厳と権利の三つともを常に尊重する看護が、これまで以上に不可欠である。全面的援助を含めて、私達は徹底して行なわねばならない。

また、ヘルスケア・コストアップという背景が、入院期間の短縮のような、その人に無理な自立を強いる様相を見せているが、これは、その人の重荷をときに半分背負い、必要とあれば積極的にその人を代弁する看護の“出番”が増えていることを意味する。私達はどしどし出で行かねばならない。

知識は現実より先を行くものであるとはいえ、“これが看護である”から“その看護をする”への移行は十分になされていないのである。ヘンダーソンも四半世紀前に著わした『看護論』に追いつきをして(1991年)、彼女が述べるような看護をアメリカ中の人々が享受しているわけではなく、むしろほんの一部の場所でしかそれは行なわれていない、と無念をもらす。同じく1991年にアメリカ看護婦協会が、20年前に作成した“看護実践の基準”を“臨床看護実践の基準”と改め、それまでの役割拡大的な看護の行く手を臨床にしばり、なおかつ「実践基準の多くは時を超えて不変である」と声明したことも、“これが看護である”が“その看護をする”になりきっていない実態

をほのめかしているように思われる。残念ながら私達も身近かにその実態を見ているのではないだろうか。今日の問題状況のもとではその“する”の足らなさは一段と目立つのではないだろうか。

私達は目指すものについてはよく知っており、しばしば口にし、書きもし、教えるもする。それを、今日の問題状況におおわれたヘルスケアのあらゆる場で、知っているのと同じほどに、言っているのと同じほどに、あたりまえに行なわれるようにする、そのようにしていくスピードを一気にアップする～私はそれをするのが現在おそらくは世界的にかなり共通で、急がれている看護教育の改革ではないかと思うのである。法律の山やマネジド・ケアを相手に、看護教育を戦略的に改革しようと奮闘することを決して否定はしないが、その人の生命と尊厳と権利を尊重する看護を徹底させることに看護教育がエネルギーを集中するのも看護教育の改革であり、今日の問題状況を改善するために私達が最初に取り道ではないかと思われてならない。

たとえば、これが看護である、とイメージを教えるのではなく、世話をし、交わり、学ぶのを助ける看護は現場で日々創り出されるものであることを教えるために、実習に重きを置く；

実習の場では、看護婦はあくまでもその人(患者)の延長線上にいる者であるという役割概念を学生に体得させる。医師の延長線上にいる者であるというような意識が学生の頭をかすめもしないうちに；

assertivenessの訓練を意図し、目指すものの実現のためには強引にさえる必要のあることを教員が身をもって教える；

その人の生命と尊厳と権利を尊重することに焦点をあてたケース・カンファレンスを行う；

そして忘れてはならないのは、生命と尊厳と権利を尊重する看護の知識基盤の発達上の要となった書物や研究文献を、できるだけ数多く、ていね

改革とは、何か別のものにすることではなく、目指すものに近づくこと

いに読ませる授業をすることである。知識は口移しを重ねるうちにやせ細ることを銘記して、ペーパー、オーランド、リディア・ホール、外口玉子などを読ませる；

などなどにより、この改革は静かに進めること

ができるであろう。

言うまでもなく、看護教育を大学で行なえばこの改革路線が確実になるわけではない。しかし、大学における看護教育が率先してこれを進めずして何が大学か、と私は思う。



「看護教育の改革—自国の特色を生かした教育課程の構築と国際交流」

特 別 発 言

千葉大学名誉教授 吉 武 香代子

看護教育の改革についてのシンポジウムに、すでに看護教育の第一線を離れている私が発言致します mismatch を、まずお許し頂きたいと思いません。従って、教育課程の構築などについての発言は遠慮させていただきます。

シンポジストのご発言から、私たちはアメリカではすでに大学教育が確立されており、韓国では現在、看護学士号を与えるさまざまな方法が考慮されて居ることを知りました。

日本の看護教育は、現在驚くべきスピードで専門学校教育から大学教育への移行を進めています。看護大学は看護の指導者の養成を目標に掲げるべきであると、看護大学の認可に当たって監督官庁が強く主張していたことを思いますと、この10年間の看護教育を取りまく環境の激変に驚かされます。

この激変の中で、看護大学の卒業生が同年度の看護教育施設の新卒の1%にも満たなかった時代とは明らかに異なる環境が、教育施設側にも、卒業生の受入れ施設側にも生まれています。はっきりいえば、看護大学の卒業生に希少価値が付いて回り、時に実力以上に評価されていた時代は終わったのです。

折からの日本における経済不況とも相乗して、看護職の需給関係は微妙に変化しています。大学卒であるが故に何か許されたり免除されたりすることを期待する時代はとうに終わり、大学を卒業したのだから普通の看護婦にはならないなどと

いってれば、卒業生がどこからも歓迎されないという時代にやがて突入すると私は考えています。看護大学は14校、21校、30校、40校と、まるで階段を駆け上がるような勢いで増加し、本日の学会長のお話によれば本年は72校に達したとのことです。本年3月には平成7年度入学生、すなわち大学数が40校に達し、2630人余りが入学した平成7年4月入学の学生が卒業しました。入学者数と卒業者数とはイコールではないとしても、卒業生数はもはや希少価値を期待する数ではないことがよく分かります。

私は以前から世界に冠たる高学歴国日本において、大学卒看護婦だけが希少価値を云々されることはおかしいとやってきましたが、ようやく大学卒看護婦も普通の看護婦として扱われる正常な環境が整ったと理解しています。この環境の変化、求められている卒業生像の変化を、看護大学の志願者もその両親も、看護大学の設置者も看護教員も、また保健医療施設の指導者・管理者も冷静に受け止め、現実を直視する必要があると考えています。

最近の日本の社会一般では、学歴不問などの考え方が台頭しています。現在の日本の看護の世界は、異常なまでに学歴を重視する世界であるように私には思われます。私は看護婦と准看護婦については、教育内容の明らかなレベル差から全く別の職種との考えを持っていますが、大学卒看護婦と専門学校卒の看護婦はともに看護職におけるファー

ストレベルの新人、昨日のご講演の英語によればエントリーレベルの新人であり、同一のスタートラインに立っての自由競争であるべきとの見解を持っています。自由競争という表現は争うという意味ではなく、大学卒であることによって何かが無効されたり、優遇されたりするべきではなく、地位も待遇も、同一のスタートラインに立っての公正な実力の評価によって獲得すべきものであるという意味です。

大学と専門学校の教育内容・教育水準に差があることは当然であり、差がないとすれば著しく不自然であると私は考えています。最近まで大学教育を行ってきたものとして、このことは自信を持って明言したいと思います。それでもなお、卒業生は大学卒という事実を評価されるのではなく、専門学校では学び得ないものを大学において学んだ結果として、大学卒に相応しいレベルの看護を行う能力を身につけ、現に行っていることを周囲に示すことによって、はじめて正当な評価を得るものと考えています。

もし大学卒看護婦に大学卒にふさわしいレベルの看護を行う能力が伴わず、それにふさわしい働きをしていないものが居るとすれば、昨日のご講演にありました経済効果、コスト効果の点からも、大学卒看護婦は歓迎されない存在になりかねないと思われれます。

看護婦になりたいという思いには、大学入学者も看護専門学校入学者も変わりはないと私は信じます。人間を愛し、看護を愛する志願者が、自ら求めて看護大学に入学し、看護婦以外の地位を得るためのステップとしてではなく、看護を愛するがゆえに自らの選択によって看護実践の場で働き、やがて周囲からその実力が評価されて自然に指導者となり、教育者となっていくこと、そのためにさらに学びたいと願うようになることが、大学卒看護婦の望ましい成長であると考えています。

看護大学の急速な増加と平行して、看護学修士

課程も急増の傾向にあります。少し遅れて、博士課程も増加しています。私はこれを望ましい傾向と受け止めながらも、看護教員のエネルギーの多くが一握りの修士課程・博士課程の学生のために費やされ、大多数を占める学部学生、すなわち大切な看護学基礎教育を受けている学生への教育が手薄になるかもしれないことに少々の危惧を抱くものですが、ここではこの話題は避けます。

私は修士課程への進学を、学部卒からのストレートである必要はなく、むしろストレートでないことの方を強く望むものです。看護実践の場での第一段階の看護実践の経験を経た後に、よりよい看護を求めての進学が増加することを強く願うものです。そのためにも、修士課程に専門看護婦育成の課程が増加することを願うとともに、このような課程で実践を通じてより深く看護を理解し、より高度の看護を実践できる能力を身に付けた修了者の多くが、それぞれの領域の看護のスペシャリストとして第一線で活躍することを願っています。同時に現在の日本の看護界においては、このような課程で本当にいい指導ができる教育者こそが最も不足しているのではないかと感じることもあります。

修士課程を経て博士課程に進む研究志向の進学者についても、看護研究の最終目的は研究を通してのよりよい看護による患者、あるいはもっとひろい意味での看護の対象である人々の幸せであってほしいと願っています。そのためにも、職業人としてのスタートの初期には、看護を実践する場で働く何年かの経験を持つことが、生涯にわたる看護学研究の原点として不可欠であると考えています。

このような研究者こそが、臨牀的に価値あるテーマによる研究を行うことができ、またその結果が看護実践者に素直に受け入れられてかنگの工場に繋がっていくものと考えています。

41年前、アメリカ留学中に聞いた言葉で今にい

## 特 別 発 言

たるまで忘れられない言葉があります。看護婦の教育の高さと、看護婦と患者の間の距離とは比例するという言葉です。当時、アメリカで増加しつつあった大学卒看護婦への痛烈な皮肉と思われま  
す。40年の間に看護の対象は大きく変わり、今や対象は決して入院中の患者に限定されるものでは

ありませんが、看護教育のレベルアップが決して看護婦と患者の距離を遠くするのではなく、病に苦しむ患者の幸せにつながり、日本国民全体の健康増進につながり、やがて世界の人類の健康増進につながる方向に発展することを願っています。