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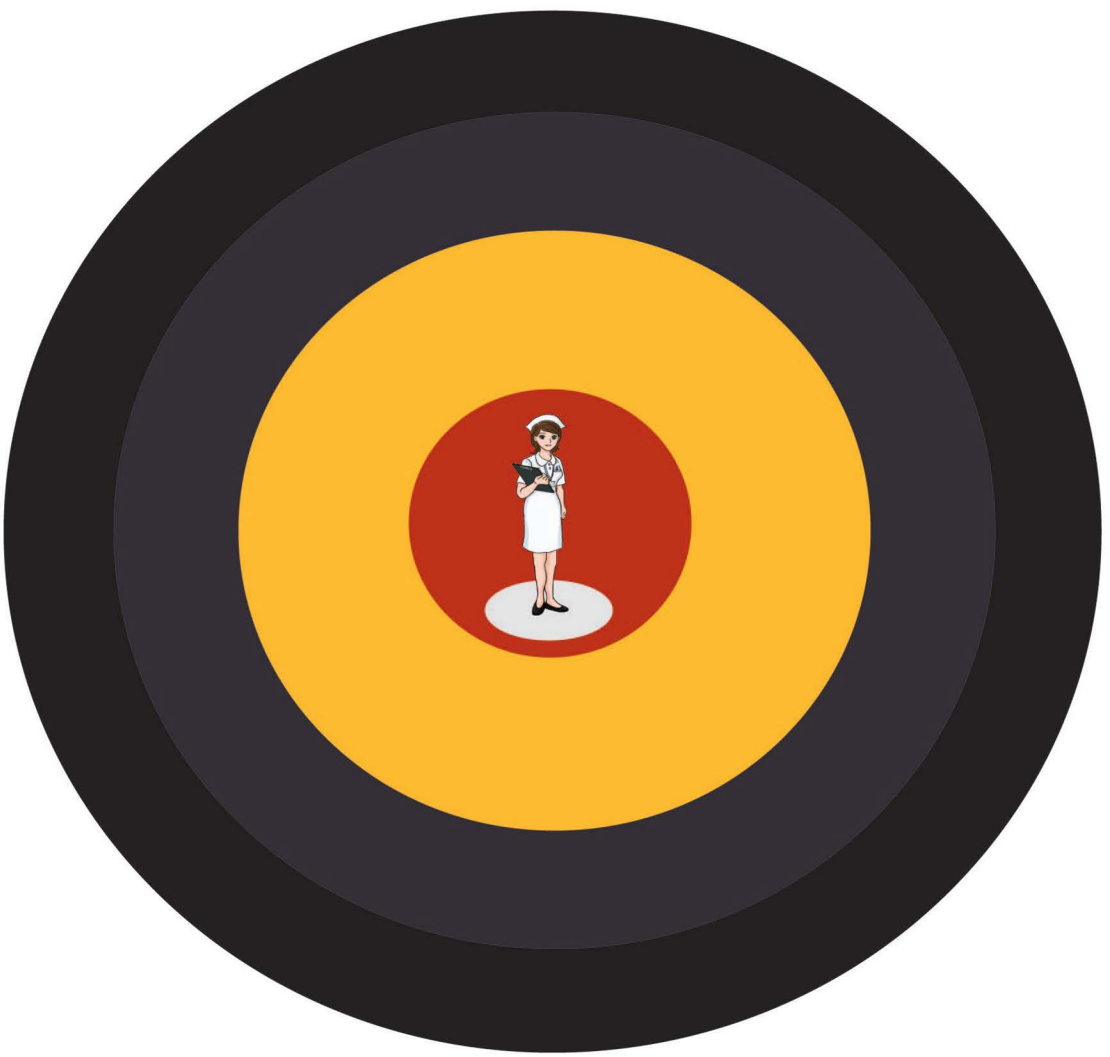
Third Edition

NURSING Administration



BT Basavanthappa

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2 Trends in Healthcare System

- RIGHTS TO HEALTH CARE
- NURSING IMPLICATIONS OF PATIENT'S RIGHTS
- CHANGES IN THE HEALTHCARE DELIVERY SYSTEM
- NURSING IMPLICATIONS FOR CHANGES IN HEALTHCARE DELIVERY SYSTEM

The very words *healthcare delivery system* speaks to the nature of change in how the health and illness needs of patients will be met in the 21st century. Most planners believe that one of the essential parts of an improved healthcare system will be an emphasis on prevention and the active participation of patients in their own health choices. While scientists will continue to search for and find cures for many illnesses, healthcare services will increasingly emphasize the importance of holism (treating the whole person, not just the diseased part). Another prediction is that healthcare professionals and governmental officials will work together to return the environment to a healthier balance, thus reducing pollution-related disease.

The delivery system of the future needs to be more efficient than the current one. Life-threatening illnesses and injuries will continue to be treated in centers where the technology and intensive care are available. People with non-critical injuries and illnesses will be cared for in homes or at work, in the schools and in community-based facilities such as neighborhood clinics. Healthcare workers will be educated to provide holistic, efficient, and cost-effective care.

A *healthcare system* is the totality of services offered by all health disciplines. Traditionally, the healthcare delivery system in India provides two general types of services: illness care services (restorative) and healthcare services (preventive). Illness care services help the ill or injured. Healthcare services promote better health and help prevent disease and accidents. Although most facilities within the system, for example, hospitals, clinics and physician's offices provide both types of services, illness care services predominate. However, now there has been increased awareness of the need to promote health and to prevent disease. Considerable emphasis has been placed on the role of the nurse in these areas.

Previously, healthcare facilities have been influenced largely by the needs of the people providing the service. For example, hospitals have developed in relation to medical and technologic advances and generally reflect the needs of physicians. Also, the public viewed healthcare facilities as sources of help primarily for the ill or injured. As a result, preventive healthcare facilities have been slower to develop. This delay can be attributed in great part to three factors:

1. Physicians are largely oriented to illness in their practice.
2. Consumers have been more aware of treatment of illness than of prevention and health promotion.
3. The nurse's role as the chief provider of preventive health care and health promotion has been slow to evolve and frequently the treatment of illness takes precedence over preventive healthcare activities.

Now many people have become more conscious of their health and comprehensive health care, including health promotion and disease prevention services are receiving increased attention. In the future, increased efforts by nurses, all health professionals and governments can be instrumental in helping people gain a greater awareness of health as a way of life. Greater emphasis must be given to the ill effects of smoking, excessive consumption of alcohol, taking illicit drugs, and overuse of prescribed and over the counter medications rather than treatment of the consequences of these activities. Measures to prevent disease or reduce risks must also be emphasized. Examples are immunizing children; reducing the incidence of road accidents, particularly among adolescents; and preventing accidents in the home, especially among children and older people.

RIGHTS TO HEALTH CARE

The movement for clients' rights in health care aroused in the community. The broad goals of the movement were to improve the quality of health care and to make the health care system more responsive to clients' needs. Today clients are also seeking more self-determination and control over their own bodies when they are ill.

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Informed consent, confidentiality and the right of the client to refuse treatment are all aspects of this self-determination. The need for client's rights is largely the result of two circumstances—the vulnerability of the client because of illness and the complexity of the relationships in the healthcare setting. When people are ill, they are frequently unable to assert their rights as they would, if they were healthy. Asserting rights requires energy and an underlying awareness of one's rights in the situation.

The complexity and variety of healthcare relationships also increase the need for client's rights. In this day of specialization, a client is often helped by a variety of health professionals. The client becomes one person among many health professionals. Thus, the client's needs or priorities, for example, can become lost in the communications among health professionals. A new pattern of healthcare relationships is emerging as a result of several forces in society, including a more knowledgeable consumer and recognition of the role of lifestyle in disease. Today, the goals of health include the return of autonomy and independence to the client and the acceptance of good health as a responsibility of the care provider, the client and society. These goals cannot be met unless clients accept active responsibility for their health and health care and unless clients and care providers have mutual respect.

Four rights that are assertable in a healthcare facility:

1. The right to the whole truth.
2. The right to privacy and personal dignity.
3. The right to retain self-determination by participating in decisions regarding one's health.
4. The right of complete access to medical records, both during and after the hospital stay.

A Patient's Bill of Rights

A patient's Bill of Rights is an effort to promote the rights of hospitalized clients. Frequently, clients do not know their rights, although, many hospitals today give clients upon admission a statement of their rights, while in hospital:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his/her behalf. He/She has the right to know by name the physician responsible for coordinating his/her care.
3. The patient has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.
4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.
5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly involved in this care must have the permission of the patient to be present.
6. The patient has the right to expect that all communications and records pertaining to his/her care should be treated as confidential.
7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is transferred must first have accepted the patient for transfer.
8. The patient has the right to obtain information as to any relationship of his/her hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals by name, who is treating him/her.
9. The patient has the right to be advised, if the hospital proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.

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10. The patient has the right to expect reasonable continuity of care. Patient has the right to know in advance about the appointment timings and physicians availability. The patient has the right to expect that the hospital will provide a mechanism whereby he/she is informed by his/her physician or a delegate of the physician of the patient's continuing health.
11. The patient has the right to examine and receive an explanation of his/her bill regardless of source of payment.
12. The patient has the right to know what hospital rules and regulations apply to his/her conduct as a patient.
13. The patient has the right of access to medical records.

To sum up patient's bill of rights (Fig. 2.1).

NURSING IMPLICATIONS OF THE PATIENT'S RIGHTS

Brief descriptions of the nursing implications of the patient's rights are given below:

1. *The patient has a right to considerate and respectful care.* The client has a right to an explanation about what will happen, why and when. Clients also have the right to participate in planning their care. Considerate and respectful care also includes respect for the dignity of each person. Nurses can convey respect by listening carefully to clients and their support persons and reporting their concerns to the appropriate people.
2. *The patient has the right to obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis, in terms the patient can be reasonably expected to understand.* The responsibility for divulging this information belongs to the physician. If a client asks a nurse for this information, the nurse should relay the questions to the physician and document the client's questions and the nurse's actions on the client's record. Many people believe that even when ill, clients still have a right to the whole truth, i.e. complete information about their health care. Nurses should explain independent nursing actions truthfully and completely. Because these activities are solely in the nurse's domain, the nurse has sole responsibility for explaining them. However, dependent nursing functions, i.e. those nursing activities ordered by the physician, should be explained only after the nurse completely understands physician's and client's positions. Nurses should know information about independent and dependent nursing actions. Usually, a physician has no objection to a client understanding the ordered treatments; however, occasionally a physician does not wish a client to be fully informed, e.g. about a medication for a malignancy before the client has been informed of the diagnosis. Although, the client has a right to be fully informed, not all jurisdictions accept the patient's bill of rights as law. Therefore, nurses should inform the physician about the client's questions, discuss the matter thoroughly and document the client's questions.
3. *The patient has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedures and/or treatment.* The client has the right to give or withhold informed consent. Obtaining informed consent is primarily the physician's responsibility. The nurse's role in obtaining

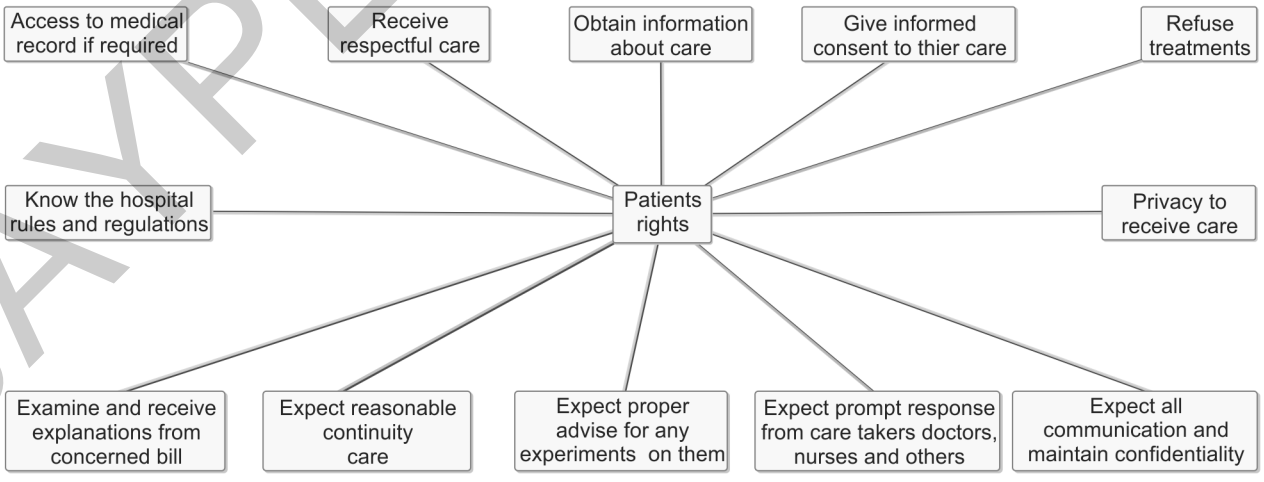

Figure 2.1: Rights of patients

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informed consent is essential. An important nursing strategy is to "coordinate the medical, technical and nursing activities on behalf of the patient's well-being into a meaningful process that the patient and family can utilize in the shared decision process."

It has been found that in many instances treatments are refused because of conflicting information. Therefore, when nurses and other health professionals collaborate and encourage the client's participation, the client feels more secure and more comfortable about making decisions regarding care.

4. *The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.* Clients have the right to self-determination. Just as they have the right to informed consent, they also have the right to refuse a treatment. An adult client who is conscious and medically competent has the right to refuse any medical or surgical procedure. When the client refuses treatment, no person has the right to impose the treatment. The clients still have the right to the best possible care within the limitations they impose. In regard to a parent's refusal to allow treatment of a child, it is only in extreme cases involving the potential of death or permanent disability to the child that courts are likely to over-rule a parent's refusal of treatment for a child.
5. *The patient has the right to every consideration of his/her privacy concerning his/her own medical care program.* People vary in what they consider an invasion of privacy and a threat to dignity. Therefore, only the client can decide whether to permit any invasion of privacy. Although, a client who signs a consent form for an examination or treatment may be giving up certain aspects of privacy in the course of the examination or treatment, the invasion of the client's privacy must be kept to the minimum. For example, a client who consents to a physical examination is expected to disrobe; however, the nurse can provide some degree of privacy by supplying an appropriate gown, drapes, and a room or enclosed area. Also, by consenting to the examination, the client does not agree to the presence of people other than those directly involved in the examination.

   The right to privacy is closely linked to the individual's personal dignity. Individuals 'on exhibit' can feel demeaned and embarrassed. The experience of being viewed by a group of health professionals, e.g. nursing students can live in a person's memory for many years as a distasteful incident. Nurses must ensure that the client fully understands and consents to the presence of health personnel not directly involved in treatment.

   Clients have a right to privacy even after death. Privacy also means not intruding into the client's private life and disclosing confidential information. Nurses can be held legally liable for taking any action without consent that would offend a reasonable person's sensibilities. Ways of intruding into a client's private life include eavesdropping on a conversation, searching a client's clothes or handbag, taking photographs of an unconscious client or asking questions that have no relation to the client's health.
6. *The patient has the right to expect that all communications and records pertaining to his/her care should be treated as confidential.* Privacy is closely related to confidentiality. Only clients have the power to let people not directly involved in their care view their medical records. Only the client has the right to provide information to support persons or others. Another aspect of confidentiality is related to computers. Although, computers have facilitated health care in a number of ways, any person who knows an access code can view confidential client information. Therefore, nurses and all health professionals must guard the confidentiality of client records and not give computer codes to unauthorized people.
7. *The patient has the right to expect that within its capacity a hospital must make a reasonable response to the request of a patient for services.*
8. *The patient has a right to obtain information as to any relationship of his/her hospital to other health care and educational institutions insofar as his/her care is concerned.* Rights 8 and 9 are largely related to hospital administration. However, nurses are becoming increasingly involved in such matters as budget as it relates to client care. Clients who believe their care is inadequate should communicate this fact to the appropriate person in the hospital. Every health agency should have a procedure for handling client grievances. One trend in health care is client advocacy, a function assumed by nurses in some settings.
9. *The patient has the right to be advised, if the hospital proposes to engage in or perform human experimentation affecting his/her care or treatment.* Clients also have a right to consent or refuse to participate in any research or experimentation.
10. *The patient has the right to expect reasonable continuity of care.* Clients have a right to know what health care they will need after they are discharged from a hospital. It is often the nurse's responsibility to teach follow-up care and to make appropriate referrals to other health agencies.

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11. *The patient has the right to examine and receive an explanation of his/her bill regardless of the source of payment.* Nurses often record billable items such as dressings, medications and the like. In some settings, it may be the nurse's responsibility to explain a bill to a client, although, this task is often carried out by someone in the hospital's business office.
12. *The patient has the right to know what hospital rules and regulations apply to his/her conduct as a patient.* Some agencies provide pamphlets that list rules, such as those governing visiting hours and explain services, such as cafeteria and telephone service. Often nurses clarify information and answer a client's questions about hospital rules. Nurses also explain rules associated with special procedures, such as those that apply when oxygen is in use or when a client has an infection.
13. *The patient has the right of access to medical records.* Although, in some jurisdictions, clients have the right of access to their health records, agency practices vary widely in this regard. Some hospitals, e.g. military hospitals, permit clients to keep records at the bedside. At the other extreme, some agencies release records to clients only if they have a subpoena. A number of state legislatures have passed laws requiring health agencies to establish reasonable policies by which clients are permitted access to their records. Laws about access to records have changed in recent years and it is generally recognized that only, clients can grant others access to their records or permit the release or transfer of their records.

CHANGES IN THE HEALTHCARE DELIVERY SYSTEM

Changes in the healthcare delivery system have had a dramatic impact on the practice of nursing. In the early part of 20th century, nurses made home visits and focused on personal care of sick individuals. As hospitals became the workplace where physicians provided medical and surgical care, nurses were employed to provide nursing care and nursing followed common organizational patterns by establishing specialty areas of practice, such as psychiatric, pediatric, obstetrical, medical and surgical nursing. As nursing education evolved and nurses began to understand more about what constituted the practice of nursing, the boundaries expanded. During the later part of 20th century, nurses began to seek more autonomy in the practice of nursing, particularly with regard to physicians and hospital administration. Simultaneously, healthcare costs were rising at an alarming rate, so there was a congressional demand for cost containment related to the government funded Medicare program. This began with a demand for prospective payment through diagnosis related groups. Private insurance companies followed suit and hospital administrators were forced to cut costs to survive. Care became focused on costs and profits with less concern about quality. Healthcare providers were then forced to do more with fewer resources, resulting in stress, burnout and nurses leaving the profession. New models of care delivery emerged in response. This resulted in major changes in the patterns of health care as shown in Table 2.1.

A commitment to high-quality care challenges nurses as never before to find ways of providing such care with fewer resources from the administrative levels of the healthcare organization.

Factors Influencing Change in the Healthcare Delivery System

Demographic Factors

One of the most significant influences affecting healthcare delivery is the increasing population of elderly. As a result of improvements in life expectancy at birth, the age 65 or over population is expected to grow rapidly. Because elderly persons often have chronic conditions that require treatment and care, the increasing numbers of elderly will exert a continuing upward pressure on healthcare costs. Skilled nursing care for the critically ill and the handicapped, and disabled will be in high demand, but demand for general duty nursing in hospitals is predicted to be low. These anticipated shifts in the locations for care offer both significant opportunities and possible threats for nursing.

Other demographic influences include changes in geographic distribution and composition of the population. Today, some areas losing population, but urban midsized cities are experiencing rapid growth in the need for healthcare delivery services for the very young as well as for the elderly. As a result of the increased pregnancy rate in teenagers with poor health habits, the continuing needs of low-birth-weight infants have assumed major importance.

Epidemiologic Factors

The increasing numbers of elderly persons will fuel need for "acute care hospitalization for diseases of the heart, malignant neoplasms and chronic incurable diseases with multisystem failures and functional decline." Chronic disorders, such as diabetes and osteoarthritis, cognitive impairment and the increased fragility of advancing age

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TABLE 2.1: Patterns of old health care with new health care

Old Health Care	New Health Care
Hospital-based acute care	Short-term hospital: Same-day surgery, 23-hour stays prehospital testing and precertification; telehealth/telemedicine; home health; mobile vans; school and mall clinics
Specialty units	Cross-training (multiskilled workers): Operating room (OR)/postanesthesia care unit (PACU), critical care unit (CCU)/telemetry
Hierarchical management	Decentralization (unit budget, scheduling, variance); shared governance; strategic plan
Physician 'captain of ship'; others are followers	Inter/multidisciplinary team, collaboration; case management (registered nurse/ broker)
Nurse as employee: Job focused, 'refrigerator nurse'	Nurse as professional: Career focused; clinical ladder; continuing credentials; tuition reimbursement, paid certification examination
Medical condition, focus on segment	Holistic person in family/community; pastoral care, parish nurse
'Sick care', focus on cure	Health care, health promotion, prevention programs; care and continuity of care; complementary health alternatives
Cost containment, focus on billing	Focus on patient and accountability of caregivers/agency; electronic patient record, continuous quality improvement, care maps
Written medical record	Integrated electronic records: Smart card, bedside computers
Fee for service	Managed competition
Physician as employer	Physician as employee; capitation system
One insurance plan	Variety of insurance options ('covered lives'): Basic plan plus dental, eye, long-term care, cancer, disability
80%–100% insurance	Greater deductible, lower percentage coverage or copayment

are of major concern. Mental health and dental needs will also increase. Nursing home and home health programs are an especially high priority. Health promotion, illness prevention and rehabilitative services are needed to enhance the quality of life for the elderly. The increasing need for coordination and continuity of care provides an opportunity for managed care by professional nurses.

Infant mortality continues to be of major concern, but there is evidence that primary care directed at high-risk mothers can be effective. Good prenatal care can prevent prematurity and low-birth-weight infants. Health promotion efforts aimed at impacting high-risk behaviors among adolescents are especially needed.

Acquired immunodeficiency syndrome (AIDS) is now a world pandemic. The number continues to increase. A number of therapies have been developed, but no cure is known. There will be an increasing need for acute and community care, education and counseling. Nurses are the largest group of health professionals caring for human immunodeficiency virus (HIV) infected people.

Abuse of alcohol and other drugs is a causative factor in a variety of severe health and social problems, including:

1. Traffic accidents.
2. Transmission of HIV through contaminated needles.
3. Lowest wages and productivity.
4. Increased pregnancy and infant mortality among teenagers.
5. Increased 'crack' and 'ice' babies.
6. Increased homelessness, disability, poverty and crime.

The poor people are at particularly high risk. Community health nurses in particular provide essential services for prevention, detection, referral for treatment and education.

Our industrial age is associated with numerous environmental problems that have an impact on health, including:

- Air pollution
- 'Greenhouse effect'
- Acid rain
- Deforestation
- Increased ultraviolet radiation (holes in ozone layer)
- Toxic and nuclear wastes
- Lead-based paints and asbestos
- Radon gas.

Economic Factors

Healthcare costs have constituted an increasing percentage of the gross national product. Inflation in healthcare costs has also been increasing at a rate higher than that of general inflation. A number of factors have influenced healthcare costs. The growth in spending for physician services outpaced growth in total health spending. High physician fees have been encouraged by lack of competitive pressures and by insurance reimbursement practices that allowed physicians to determine both fees and the

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level of insurer reimbursement. However, the physician surplus, along with prospective payment and caps on Medicare reimbursement for physicians, are expected to moderate future increases in physician's fees.

Hospital costs have been a major component of rising healthcare costs. Several factors have influenced hospital costs. The development and intense use of advanced technology has been encouraged both by federal monies for medical research and by almost automatic insurance reimbursement. Because insurers unquestioningly paid costs and consumers have had limited out-of-pocket costs for health care, no group has perceived responsibility for rising costs. Specialization of knowledge has promoted growth of medical specialties supported by a complex network of non-physician healthcare workers. In the past, physicians and third-party reimbursers have urged consumers to expect extensive use of hospital resources for diagnosis is as well as treatment. Many hospitalizations have been unnecessary; costs also have been increased by multiple unnecessary laboratory tests, by procedures to avoid the threat of lawsuit and by excessive lengths of stay. Although, these practices have been changing, the costs of hospital care have continued to increase.

New technologies, such as magnetic resonance imaging, genetic engineering, the artificial heart, monoclonal antibodies for the treatment of cancer and liver, heart, and other organ transplants, are creating much pressures on healthcare costs, just as hip replacement, chronic dialysis, coronary bypass grafts and computed tomography (CT) scans did in recent years.

Despite efforts to limit increases for prospective payment rates for hospital inpatient services, there are still few economic incentives to encourage physicians and patients to choose less expensive alternatives to hospital care. Efforts to contain increases in healthcare costs will need to influence changes in every aspect of the healthcare delivery system, including the psychology of the consumer.

Changing Attitudes of People

Over the last 2 decades, the public has become increasingly aware of and interested in promoting health. People are more aware of the relationship between lifestyle and incidence of stress-related diseases, chemical and drug dependencies and predisposition to other diseases. To prevent illness and promote health, many have focused attention on moderating stressful aspects of their lifestyles; developing habits of good nutrition and adequate exercise, rest and relaxation; and controlling the use of abusive substances, such as tobacco, alcohol and other drugs.

People are seeking increased responsibility for personal health and self-care, requiring increased health education. As consumers have requested and received information, they have begun to question the adage that 'the doctor (or nurse) knows best'. There is evidence of a shift in attitudes toward personal involvement in choices affecting health status. As informed consumers become more involved in health-related decision-making, they may increase the emphasis on expressive values, research on non-invasive (and cost-effective) preventive and therapeutic interventions and the demand for mutuality rather than paternalism by healthcare professionals. This movement has created a real opportunity for nursing to:

1. Disseminate information and promote an educated public.
2. Strengthen the professions influence on health promotion.
3. Foster alliances with consumers and collaborative relationships with physicians.
4. Become accepted as a primary care provider for long-term care.

Changes in Manpower

Now there is 'shortages' of nurses. The most recent shortage was due to increased demand for registered nurses (RNs) by hospitals. In the early, nurses salaries were very reasonable compared with less versatile providers. As demand and the subsequent perception of 'shortage' grew, hospitals finally responded with substantial increases in RN salaries. As a result, nurses became more expensive compared with unregistered nurses and aides. A short-term salary increase has a limited effect on supply and no impact on demand. Hospitals have already begun to reduce salary increases and are not addressing significant working environment issues. Thus, it is highly likely that supply will decrease in response to a number of factors, including:

1. A decrease in the age 18–24 population.
2. A shift in interest from a career in nursing compounded by the number of career choices for women.
3. Compression of salary and promotion increases throughout a nursing career.
4. Image problems, including an emphasis on hard technical work, low entry salaries and limited career financial potential, limited return for increased education, an 'employee image,' and low status.
5. Increased labor intensity of acute illness, coupled with attention given to understaffing.
6. Widespread fear of contracting AIDS.

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Turnover is also an issue, as nurses express dissatisfaction with basic working conditions, such as schedules and adequate numbers. The correct proportion of nursing and support personnel and with professional issues including control over nursing practice, adequate autonomy for client care, respect from others (especially physicians and administrators) and opportunities for growth and promotion.

The surplus available physicians will have a significant impact on nursing practice as well as on other aspects of the healthcare delivery system. As competent among physicians increases, the organized medical community has begun to increase its opposition to expanded role functions by nurses. Physicians have become more active in prevention, elderly ambulatory care and community settings that previously were less appealing, thereby threatening non-hospital jobs and the status of many nurses. Physicians already are showing increased interest in health promotion activities and in relocation to rural and underserved areas that previously have been served by nurse practitioners. Although, structural changes already underway in the system will reduce the influence of physicians in the hospital industry, physicians will have financial incentives to exert professional power to limit the growth of third-party reimbursement competition by nurses.

Changes in the Healthcare Environment

There are several changes in the healthcare environment, which are outlined in the accompanying list given below:

1. The elderly will be the fastest growing segment of the population because the baby boomers are entering middle age; therefore, the number who are young and who provide services to this group will be relatively small.
2. Hospitals will restructure their organizations and redirect their goals toward a health maintenance versus illness-based culture.
3. Health promotion services, child rearing services, and weight reduction programs will increasingly be provided by the same organizations that offer long-term care and physical rehabilitation.
4. The organizational design of the healthcare service will be decentralized and information based rather than centralized and bureaucratic.
5. The service focus will become consumer focused and information based rather than treatment focused and highly technologic.

Aydelotte (1987) predicts healthcare system divided to four branches:

1. Health promotion, health education, self-help and health evaluation.
2. Chronic disease management.
3. Trauma and severe illnesses.
4. Care of the frail elderly, the physically limited elderly, and the dying.

Within each of these branches at least four classes of nursing roles are needed:

1. Provider of direct services.
2. Researcher and developer, who will develop new knowledge, educational programs, technology, media, *telematics* (new information technologies) and the like.
3. Case manager in the health promotion and maintenance branch, who will emphasize prevention rather than remedy.
4. Executives to administer groups of nurses in the units, who will secure resources; allocate resources; develop policy; and distribute, evaluate and revise services.

Nurses will provide these services through four different arrangements:

1. Professional corporations headed by nurses, which will contract with specific groups or other organizations to provide nursing services, such as school nursing, home health care or intensive care.
2. Nurse specialty practice groups, which will provide special services, such as counseling, health maintenance and certain technological services on a contractual basis with individuals or groups.
3. Practice on an individual basis, which will provide highly specialized nursing service on a one-to-one basis or consultation with other healthcare professionals (this service will also be arranged by contracts).
4. Employment in profit and non-profit healthcare systems primarily oriented toward acute care.

The changes and future trends in the healthcare system have many implications for nursing practice. Aydelotte describes the following strategies:

1. The nature of the profession needs to be clarified and understood. The knowledge of nursing should be exclusive and the education of nurses should be on a professional level. The title 'nurse' should be more highly restricted to only one class, i.e. the *professional* and not include support personnel.
2. Individuals entering nursing must meet high standards of intelligence and motivation, especially motivation to public service. The nursing profession must be concerned with building a nucleus of true professionals.
3. The nursing education system needs to be remodeled, so that it will be much more extensive and sound. Such a remodeling should include

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more depth in the sciences, an understanding of economics, emphasis on legal and ethical issues, an introduction to management and business, an increased understanding of information technology and greater clinical application.

4. Preparation in self-governance and self-management is needed for the professional of the future. Ways to develop clinical nursing judgment need to be explored and made available to students.
5. Nursing's relationship with the public and the power elite must change. Political action should extend beyond the legislative arena into every aspect of community affairs. Nursing leaders need to make a concerted effort to become college and university Presidents and Vice Presidents, leaders in business and community affairs, heads of corporations and chairpersons of boards. Increased leadership skills for functioning in corporate structures will be needed.
6. The costs of nursing services will need to be established. Currently, nursing costs are often disguised as hospital room costs or payments to non-nurse supervisors. Thus, a system of reimbursement that pays directly to nursing services obtained by contracts needs to be developed. To develop such a system, nurses will need to learn the management of contracts and business, attach a value to services and at the same time, ensure the maintenance or quality of care provided.
7. Nursing strategies need to be designed to meet the health promotion and health maintenance needs of people, especially the elderly, low-income persons, rural residents, the chronically ill, the unemployed, pregnant women, working women, children and adolescents. The nurse's role in primary care needs to be expanded in hospitals, homes and industry and the public and government need to be convinced that such services would coordinate care, decrease fragmentation and be cost-efficient. Nurses will need to develop the following:
   a. Improved assessment and evaluation skills.
   b. Increased skills in communication, e.g. a second language or computer skills.
   c. Increased knowledge and acceptance of cultural diversity.
   d. Increased acceptance of change.
   e. Increased use of technology in teaching clients.
8. Nurses need to understand and appreciate their own worth and actively participate in meeting the challenges of providing quality health care for all. Nurses must educate the public about nursing's unique capabilities in meeting healthcare needs. Nursing care can be an alternative as well as an adjunct to medical care.

NURSING IMPLICATIONS FOR CHANGES IN THE HEALTHCARE DELIVERY SYSTEM

Structure and Organization

The healthcare delivery system provides *primary* care for health promotion and prevention of illness, *secondary* care for treatment toward the cure of illness and *tertiary* care for technologically complex diagnostic, treatment and rehabilitative services. Hospitals have been the dominant provider of care; but recently, various alternative structures have been developed.

Alternative Delivery Systems

Alternative delivery systems, particularly for ambulatory secondary care, have developed over the past few years, primarily to provide care at a lower cost than is possible through hospitalization. Some examples of alternative ambulatory care systems include diagnostic, minor emergency and surgery centers; birthing centers; substance abuse facilities; and rehabilitation sites. Additionally, home health agencies and hospices provide continuity of nursing care to the home setting. And hospitals are increasing outpatient services in an effort to balance the loss of inpatient revenue.

Group Practice by Physicians

Further, alternative delivery systems are being supplemented by a dramatic movement toward group practice by physicians. The greatest growth in physician group practice is expected to be in either preferred provider organizations (PPOs) or health maintenance organizations (HMOs). A PPO enables a group of providers to negotiate fee schedules with hospitals and third-party reimbursers to reduce out of pocket expenses and to receive rapid payment for claims. The advantage to the system is the incentive toward decreasing the use of resources and thereby decreasing costs. The HMO, a different mechanism involves a group of providers who contract with consumers for a prepaid schedule of services. The HMO was designed to emphasize preventive care and consumer education to reduce the cost of treatment (including hospitalization) for illness. A new kind of health plan, known as a social/health maintenance organization, "combines Medicare HMO coverage of hospital and physician services with chronic care benefits

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(e.g. nursing home, personal care, homemaker services) and other expanded benefits (e.g. prescription drugs, eyeglasses and dental care)."

Hospital Occupancy

Hospital occupancy is expected to continue to decline and capacity will contract as a result of closings and permanent destaffing of floors and wings of hospitals. But although, occupancy rate has been decreasing, the severity of illness of clients who are hospitalized has been increasing. Another change in the hospital industry involves the movement toward large corporations. Multiunit organizations "set out to provide what they sell in an efficient and effective manner" by providing economies of scale, no unnecessary duplication, channeling of referrals and organizational stability. The linking of similar kinds of services or institutions located in different geographic areas is called 'horizontal integration'. In contrast, 'vertical integration' involves relationships between and control of an array of different services, e.g. hospitals, nursing homes and ambulatory care services, drug and equipment suppliers, insurance services and healthcare providers such as physicians and nurses. The centralization of control in large corporations, both horizontally and vertically integrated, is promoted as economical. However, the emphasis on the bottom line of cost efficiency is associated with risks of reduced access and decreased influence of nurses on a quality environment for care.

Pleuralistic Choices

The changes occurring in the structure and organization of the healthcare delivery system are associated with increased competition among providers, which gives the consumer pleuralistic choices for health care. The philosophy of a competitive marketplace is firmly entrenched in the system and competition is expected to lead to the higher quality of service at lower cost. But it also leads to confusion among consumers, increased potential for fragmentation and lack of clear access to care.

Nurses can help to bridge the gap between consumers and the delivery system, promoting both continuity of care and education to foster appropriate use of services. A major way to reduce healthcare costs is to limit the needs and desires for medical care. "Reducing desire for services requires changing people's views of the value of different types of medical care, making them more aware of the real costs of service in relation to the benefits received and legitimizing alternatives for dealing with many problems that physicians increasingly deal with as the boundaries of medical care expand." In addition, nursing has a major role in helping consumers to fulfill their personal responsibility for health promotion to reduce the need for treatment of illness.

Costs of Health Care

In the past, criticism of the cost of health care to the individual and the resulting low level of access to care stimulated:

1. The rapid growth of employer-provided and privately purchased health insurance.
2. The initiation of federal government Medicare insurance for the elderly and disabled.
3. State Government Medicaid Insurance for the poor. However, the current insurance system, developed largely as a passive risk-sharing system, has contributed to overwhelming inflationary pressure on the costs of health care. The normal concern about access to care has contributed to major proposals for national health insurance.

The following proposals was supported and lobbied for by most nursing organizations, emphasizes:

1. A core of essential services available to everyone, financed by integration of public and private funding.
2. A shift from a predominant emphasis on illness toward wellness and care.
3. Direct access to "a full range of qualified providers."
4. Provisions for long term care and vulnerable populations (including pregnant women and children).
5. Managed care, case management and incentives for cost-efficiencies.
6. A restructured system that enhances consumer access and fosters consumer responsibility.

There is growing consensus on the need to deal with the uninsured problem and a basic gap filling strategy. However, the cost-containment environment, the lack of political commitment to health reform and the public disagreement on the best design of any national plan indicate that passage of comprehensive reform is unlikely. More likely are incremental changes within the framework of the existing pluralistic system.

The medical model of episodic care for acute illness has dominated insurance reimbursement philosophy. The system has allowed free choice of provider (physician and hospital) regardless of cost, reimbursement based on cost-plus charges, fee-for-services and subsidies favoring inpatient hospital care. Individual physician judgment has determined treatment, with automatic reimbursement and limited out-of-pocket costs to the client. This approach has favored use of elaborate technologies even

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in questionable cases, extensive use of laboratory testing and excessive hospitalization. Consumers have developed unrealistic expectations of the system and have not been restrained from using services excessively.

Corporations are the largest purchasers of private health insurance, covering million workers and their dependents. In an effort to contain costs, companies are beginning to:

1. Limit consumer choice of providers through HMOs or PPOs.
2. Increase cost-sharing by shifting more cost to the consumer through.
3. Larger premiums, deductibles and out-of-pocket charges.
4. Require authorization for hospitalization and second opinions for medical treatments.
5. Substitute ambulatory and homecare reimbursement for hospitalization.
6. Encourage reduced use of services.

Pressures for change in insurance policies have potential opportunities for nursing. Nurses are a competitive alternative choice as both gatekeepers and care providers, decreasing costs and improving quality of care. Nurses also are appropriate providers to educate consumers in reducing unnecessary use of services and practice healthful living to improve the quality of life and prevent illness. It is hoped that nurses, as responsible client advocates, will actively participate in the process of creating change in the delivery system.

Competition

Increased competition as a cost-containment mechanism provides an opportunity for nurse practitioners to expand primary and secondary healthcare services with direct reimbursement from the client and from third-party insurers. For effective competition, consumers must be actively involved in choosing alternatives and qualified providers must have free entry into the system. "Not only are (nurses') direct costs lower than those of physician providers but also the cost of ancillary services is greatly reduced when nurses are the primary careers." Clearly, expanding the scope of services reimbursed for or substituting nurses for other providers leads to head on competition with physicians. It is thus understandable that expanding competition by nurses has been strenuously resisted by organized medicine. Although, substituting nursing care for physician care reduces costs, there is concern that providing third-party reimbursement to nurses will ultimately increase system costs, as additional healthcare providers, such as pharmacists and social workers also seeks direct reimbursement.

Quality of Care

Cost-effectiveness provides a source of potential power when viewed in relation to the impact of nursing care on the quality of care provided to the consumer. "The quality of medical care services provided by nurse practitioners is at least comparable to the quality of services provided by physicians. Furthermore, in some cases, nurse practitioners following protocols have shown performance superior to physicians in symptom relief, diagnostic accuracy and patient satisfaction." From 70% to 90% of primary care services could safely be delegated to nurses by physicians. Nurses contribute to reduced morbidity, reduced mortality and improved quality of life. Nurse practitioners do a better job than physicians in areas, such as continuity of care and emphasis on prevention, amount of advice offered and amount of time spent listening to clients and communication skills and support. Holistic and individualized nursing care can provide a highly desirable alternative to medicine's 'intrusive, disease oriented model'. But although it is very difficult to quantify quality of care, it is critical that nursing make increased efforts to document effectiveness by determining what nursing activities and interventions produce beneficial outcomes under which conditions. As efforts to contain costs increase, quality of care and other ethical issues become increasingly urgent. Nurses must be able both to communicate their unique contributions to quality health care and to exert moral leadership as advocates for access and consumer choice in the system.

Ethical Considerations

Nursing "helps to serve society's interests in the area of health." Therefore, it is imperative that nurses take art active leadership role in discussing and resolving a number of philosophical issues and ethical concerns that affect the delivery of health care.

Ethical Concerns

Ethical concerns have been raised by an increasing lifespan, the development of healthcare technology and the increasing cost of delivering care. Because it is not possible to meet all possible goals of accessibility, equity and quality given available resources, difficult choices must be made among competing values and multiple desirable alternatives. One basic issue is the relative valuing of predictability and containment of the costs of health care versus the access to health care for all persons:

- How willing are some to assume the costs to make the system affordable, acceptable and available to all?
- How much health is a basic right?

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- If there are limits on access to health care, who should have priority?
- What is an acceptable level of health care?
- Should technology be available to all regardless of cost or should it be rationed?
- What should be the criteria for rationing?
- Who should determine the criteria?
- How much choice should be determined by ability to pay?
- What (and when) is death?
- How much is the prolongation of life worth?
- Does reducing costs reduce the quality of care?
- What rights do clients have?
- Is cure of all disease possible?
- Is it desirable at any cost?

"Increasingly, the important decisions concerning the size, shape and direction of the healthcare system (as a whole) are being made by those paying the bills and those making the regulations that determine how those bills will be paid." It is critical that the voice of the nursing profession be added to that of the public in discussions of the philosophical considerations and values that will shape the decisions.

Philosophical Issues

Until now, philosophical considerations of the role of the healthcare delivery system have been affected by the domination of the medical model of curing disease. In addition, "lack of money, lack of detailed experience in multiple disease prevention, lack of adequate means of measuring results, and lack of psychological and professional rewards to individual practitioners have all combined to give prevention a relatively low priority for the public, for health professionals and for health-care system." "Medical care requires a better balance between prevention and treatment, promotion of function and cure, and educational as compared to technical approaches to care. Most of the great advances in health status arise from basic improvements in economic status, education, nutrition, lifestyles and the environment."

Nursing, with its 'dominant paradigm of caring' can advocate for increased emphasis on:

- Promotion of health and prevention of illness
- Maintenance of function in the elderly and chronically ill
- Reduction of stress
- Attention to quality of education, nutrition and other aspects of the environment.

In the past, physicians have assumed a paternalistic attitude toward healthcare decision-making by consumers: the doctor knows best. With cost pressures, government has become intimately involved in almost every aspect of planning and provision of services. However, nurses can help consumers to understand that more services does not necessarily mean better health or better care. Nurses can advocate for more egalitarian relationships between providers and clients and an increased role of the consumer in:

1. Setting the values of the system.
2. Having an enlarged knowledge base to increase self-reliance, self-determination and autonomy in healthcare choices.
3. Assuming increased personal responsibility for health promotion through risk reduction in life-style.

The role of the provider is to provide sensitive, competent care reflecting respect for each client's autonomy. Nursing's potential contribution has been limited by:

1. Lack of an adequate educational base of the majority of its practitioners.
2. Inability of nursing leadership to mobilize collective professional action.
3. Historical lack of involvement and influence in political decision-making.

However, the changes that have occurred in the system provide an ideal opportunity for nursing to secure influence and power for the profession, thereby assuming a major role in shaping the future direction of healthcare delivery. As a result of significant demographic, economic, attitudinal and available manpower forces, the healthcare delivery system is in the process of structural change and reorganization, raising multiple ethical considerations. The nursing profession has the opportunity to influence the direction of change to assure the improvement of health and health care.

Humanizing Health Care

The goal of any healthcare delivery system is intrinsically human, the system is perceived as increasingly dehumanizing. Dehumanization is associated with vulnerability, powerlessness and loss of identity in large, faceless institutions. The blame usually falls on society in general, technologic change, the rat race, or bureaucratic red tape.

Howard and Strauss (1975) discuss four ways nurses and other healthcare professionals can humanize care:

1. Value the concept of inherent worth, which reflects notions of equality among people. Health systems now recognize the inherent worth of persons by trying to prolong life, reduce pain and restore social functioning. Clients themselves emphasize that they should be treated with dignity and respect,

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even if discriminated against in the larger society. The concept of inherent worth needs to apply to all professional/client interactions and must be reflected in institutional policy.

2. Recognize that each person is a unique individual, even though all humans have some commonalities, and avoid stereotyping or treating clients in a routine, uniform way. Remember that at any given moment, the sum of a person's past and present experience influences the person's feelings, attitudes and actions.
3. Recognize that although humans do not have infinite freedom of action, most people have considerable control and choice over their destinies and need to be given the freedom to consider all options available to them. Clients are restricted by such factors as illness, ignorance and financial constraints. Practitioners are restricted by institutional commitments, colleague pressures, scarce resources for therapy and cost considerations. Sharing decision-making and responsibility:
   a. Reflects the ideology that all clients, regardless of education, have a right to participate as much as possible in decisions about their care.
   b. Makes the client and provider partners and therefore, in a way, equals. To share in decision-making, the client must be informed about prognoses, alternative therapies and the rationales behind them.

   The client's level of education will influence the client's desire and capacity to accept shared responsibility for care. In addition, some clients may be too sick, anxious or irrational to analyze facts and to make appropriate decisions.
4. Convey empathy and positive affect: *Empathy* is the ability to identify and sympathize with others. Clients expect healthcare professionals to show sympathy and concern. Otherwise, clients feel depersonalized and dehumanized. For example, in the words of one client, "He should know how much my leg hurts and what it means to me." The dilemma of the practitioner is that too much empathy can be emotionally draining. In some instances, it may also be impossible to put oneself in the client's shoes. For example, an able-bodied nurse who cares for paraplegics knows that these clients are well-aware the nurse has two legs and cannot possibly identify with them as well as another paraplegic. Thus, a balance between too little and too much empathy is necessary. The means of achieving this balance needs research.

Positive affect is the conveying of genuine feelings of warmth to the client. Positive feelings appear to be necessary for continued human-to-human contact.

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