

Nurses: A Force for Change

Care Effective, Cost Effective



INTERNATIONAL NURSES DAY 2015

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May 2015

Dear Colleagues,

The cost of healthcare is rising worldwide, placing a heavy financial burden on health systems and populations globally. Nurses, as the single largest profession in the health workforce, are well positioned to drive efficiency and effectiveness improvements while providing quality care and attaining optimal patient and population outcomes.

Nurses are concerned and understand the landscape of healthcare delivery including financing, cost effectiveness and resource management, cost of healthcare and access to care. The decisions that every nurse makes multiple times a day in everyday practice can make a vital difference in the efficiency and effectiveness of the entire system. Nurses are at the core of attaining the best quality/access/cost balance. It is therefore essential that nurses and policy makers focus on the nursing role in care effective and cost effective healthcare systems as a key priority and determinant for achieving equity, delivering universal health coverage and ultimately improving health outcomes globally.

The theme for IND 2015, *Nurses: A Force for Change: Care, Effective, Cost Effective* reflects ICN's commitment for action to strengthen and improve health systems around the world. It leverages the contribution that nurses can make and acknowledges that as a profession we reach people that other practitioners never see both in urban and in rural and remote communities. In short, global health cannot be achieved without nurses and without our proactive contributions and participation at all levels of the healthcare system.

Our IND kit is intended to provide tools and information to assist and encourage nurses and national nurses associations to become engaged in and knowledgeable about health system financing as an important means to achieving quality of care and patient safety in a cost effective way. The kit provides an overview of health financing, including efficient use of resources, and looks at efficient service delivery, effective management, effective health workforce and the value of nursing. The examples we feature represent a small sample of what is possible when nurses bring their creativity and professional perspective to the transformation agenda. As always we include some resources that you can display prominently and use widely. We complete the kit with action-ideas for nurses and national nursing associations that will support you in driving home this critical initiative.

We are certain that your association will have examples of your own and other resources that you have developed - we ask that you share them with us so we can share them with others. Nurses, as those health care professionals closest to people in all settings of society, can have an enormous impact in reducing health costs and increasing quality of care.

Sincerely,

Judith Shamian
President

David C. Benton
Chief Executive Officer

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Do not follow where the path may lead, go instead where there is no path and leave a trail – Ralph Waldo Emerson.

In its *Vision for the Future of Nursing*, the International Council of Nurses (ICN) affirmed that “*United within the ICN, the nurses of all nations speak with one voice. We speak as advocates for all those we serve, and for all the unserved, insisting that social justice, prevention, care and cure be the right of every human being. We are in the vanguard of health care progress, shaping health policy around the world through our expertise, the strength of our numbers, our strategic and economic contributions, the alignment of our efforts, and our collaboration with the public, health professionals, other partners, and individuals, families, communities for whom we provide care*” (ICN 1999).

It is within this noble ICN vision that this year’s International Nurses Day (IND) theme of *Nurses: A Force for Change: Care Effective, Cost Effective* resonates with commitment for action to change health systems around the world to achieve better health outcomes for all. In order to do this, nurses need an understanding of the landscape of healthcare delivery including financing, cost effectiveness and resource management, cost of healthcare and access to care.

Because of the sheer numbers of nurses and their multiple roles in varied settings, the decisions that every nurse makes multiple times a day in everyday practice can make a vital difference in the efficiency and effectiveness of the healthcare system. It is essential that nurses and policy makers focus on the nursing role in care effective and cost effective healthcare systems as a key priority for achieving better health for all.

Rising cost of healthcare

The cost of healthcare is rising worldwide largely driven by the heavy and growing burden of noncommunicable diseases (NCDs) including mental health disorders, ageing societies, innovations of expensive treatments and techniques, and increasing demands of clients (Organisation for Economic Cooperation and Development OECD 2013). The rising cost of healthcare is placing a heavy financial burden on health systems and populations globally. Costing information is important for the planning and decision-making process on how to do better within the constraints of financial, human and other resources.

It is prudent to make best use of available resources. Nurses, as the single largest component of the health workforce, are well positioned to do more with less while providing quality care and optimal patient outcomes. It is imperative that nurses develop a proper understanding of health care financing, budgeting, resource allocation and strategic planning. Such competencies will facilitate nurses’ participation in policy making and resource allocations in order to lead from the frontline as the force for change and as cost effective and care effective professionals.

The key message of the IND toolkit is that nurses are part of the solution to achieve better health for all in a cost effective and care effective way.

The determinants of the rising cost of healthcare

In all countries, healthcare demand and long-term care are driving up the cost of healthcare. The drivers of healthcare expenditure are demographic and non-demographic. Demographic factors include population growth and population ageing. Older populations demand and consume more healthcare because of the increased prevalence of chronic and non-communicable diseases that require prolonged inpatient care (Palangkaraya & Yong 2009).

Ageing is also associated with an increasing frequency of multi-morbidity. For instance, in the industrialised world, as many as 25 percent of 65–69 year olds, and 50 percent of 80–84 year olds, are living with two or more chronic health problems (WHO 2008a), which requires more community and specialist health services and more long-term care of patients.

Non-demographic cost drivers include wage inflation, technology and cost of drugs. Technology in healthcare, such as new and expensive drugs and equipment for diagnosis and treatment, has led to great improvements in health services and the health status of populations, but it is also a major driver of health expenditure (OECD 2013; Costa-Font et al. 2009). The rising healthcare cost is also related to poor health literacy. People with low health literacy tend to be hospitalised more often and for longer periods of time, have poorer health outcomes, and thus higher health care costs (Baker et al. 2002; Berkman et al. 2004).

The global annual expenditure on health is about US\$ 5.3 trillion (WHO 2010a). With the burden of communicable diseases continuing to be high in some parts of the world, and the prevalence of noncommunicable diseases – heart disease, cancer, diabetes and chronic respiratory disease – increasing everywhere, healthcare cost will continue to rise. This trend will be exacerbated by use of more sophisticated medicines and procedures that are being developed (WHO 2010b). The reality is new medicines and diagnostic and curative technologies are introduced into the health system faster than availability of new financial resources, thus inflating the cost of healthcare and driving a need to be more cost effective.

Cost of healthcare is also impacted by commitments of a growing number of countries to achieve universal health coverage (UHC) of populations with essential healthcare.

Universal health coverage

Underpinned by equity in health, universal health coverage (UHC) has become the internationally agreed objective of health and development policy. UHC aims to ensure that all people can use the promotive, preventive, curative, rehabilitative and palliative health services that are of sufficient quality, while at the same time ensuring that the use of these services does not cause financial hardship to the consumers (WHO 2013a).

However, UHC is not a “one size fits all” and coverage for all people does not mean coverage of everything. For example, Thailand offers disease prevention, health promotion, prescription medicines, ambulatory care and hospitalisation free of charge to patients, as well as more expensive medical services such as radiotherapy and chemotherapy for cancer treatment, surgical operations and critical care for accidents and emergencies. But Thailand does not cover, for example, renal replacement therapy for end-stage renal disease. Other countries provide different services based on their policies and resources (WHO 2010b).

UHC represents three related objectives (Carrin et al. 2005):

- equity in access to health services - those who need the services should get them, not only those who can pay for them;
- the quality of health services is good enough to improve the health of those receiving services; and
- financial risk protection, ensuring that the cost of using care does not put people at risk of financial hardship.

This means, governments must generate resources for UHC, distribute the resources equitably, and use them efficiently to meet healthcare needs, ensuring quality of care, and protecting users from financial hardship due to out-of-pocket expenses (Özaltın & Cashin 2014).

ICN believes that people have a right to equitable health services and that these services should be patient- and family-centred, evidence-based (ICN 2012a). As ICN affirmed in its position statement, *“equity and access to primary health care services, particularly nursing services, are key to improving the health and wellbeing of all people”* (ICN 2007). Universal health coverage is a means to achieving better health outcomes for all people.

Health and development

Health is central to development; it is a precondition for, as well as an indicator and an outcome of sustainable development. That is because it makes an important contribution to economic development, as healthy populations live longer and are more productive. In contrast, unhealthy populations can erode economic gains in a country. For example, the health gains and increase in life expectancy in Africa were reversed by the HIV/AIDS epidemic with a devastating economic effect (Bloom et al. 2004).

Despite the contribution of health to development, the international community and particularly low-income countries, have given little attention to investments in health services in general and to health workforce issues in particular. The health workforce seems to be considered as a drain on the budget rather than an investment for economic development and poverty reduction. Some countries even put a brake on recruitment of health professionals and, thus, unemployment of health professionals occurred while needs for health services were high (WHO & World Bank 2002).

The deterioration of health services and the provision of nursing human resources is a consequence of a health reform process implemented through structural adjustment programmes (SAP) of the World Bank and the International Monetary Fund (IMF). These reforms were aimed at cost-containment through better management of public wages, reduction of public expenditures, privatisation of public enterprises, elimination of subsidies, liberalisation of the economy, and devaluation of the national currency (Liese & Dussault 2004).

Health in the post-2015 development agenda

The Millennium Development Goals (MDGs) with the end-point of 2015 have been a powerful force in maintaining political support for health development because of the clarity of the objectives and measurable targets. The debate about how the next generation of post-2015 development goals will be framed is nearing completion. The discussions highlight the need for post-2015 health priorities to address the neglected elements of the MDGs such as the social determinants of health, including girls' education, health equity and gender equality, human rights and human dignity (WHO 2012a). Further, there is a call for several new priorities that need to be addressed: ageing and noncommunicable diseases (NCDs), the health impact of climate change, and human mobility and refugees. There is also a call for clarity of the links between health and sustainable development. There is consensus that health must have a place in the post-2015 development goals; however it is not clear how these health goals and targets will be framed (WHO 2012a).

The post-2015 development agenda is driven by the United Nations (UN), which convened a High-level Panel of Eminent Persons comprised of leaders from government, civil society and the private sector, which delivered its report in June 2013. The High-level Panel received a report from a United Nations System Task Team, which set out a broad framework for post- 2015, with four pillars: inclusive economic development; environmental sustainability; inclusive social development - including health; and peace and security, underpinned by human rights, equality and sustainability (WHO 2013b).

It is anticipated that the consultative processes will result in new goals and targets addressing the post-2015 development agenda and health will constitute a key element. That agenda is expected to address the “unfinished business” of the MDGs as well as take the new health landscape into account. While keeping the health MDG targets, the growing challenge of NCDs and their risk factors is also expected to be included, with clear indicators (WHO 2012b).

The impact of the global nursing workforce shortage

Impact of economic downturn on nursing workforce and access to care

The global economic crisis which started in 2008 had a devastating impact on the nursing workforce and access to care, acting as a brake on recruitment and staffing levels, at a time when the global shortage of nurses faces a growing demand for health care. In many countries around the world, governments have cut back on expenditure on healthcare and, in particular, on nursing. In many developing countries, progress towards universal health coverage is hindered by the shortage of health workforce in the right numbers, right location, and with the proper skills to deliver quality services to the entire population (WHO 2006). Developed countries are also not immune from a severe shortage of health workers because of budget cuts due to the global economic downturn (Sousa et al. 2013). Some of Europe’s poorest nations, such as Romania, slashed their health budgets by 25 percent (International Medical Travel Journal 2011).

In addition, the crisis has resulted in many nurses being forced to seek work elsewhere, whether outside their home country or outside the profession. For example in November 2013, the Irish Nurses and Midwives Organisation (INMO) said “the Nursing and Midwifery Board of Ireland revealed that 1,231 registered nurses sought certificates to work abroad in the first ten months of this year [...] on top of the estimated 5,000 nurses who left Ireland between 2009 and 2012. The INMO described the figures as extremely worrying and warned the ‘brain drain’ would intensify as 1,500 new graduates searched for work. INMO general secretary, Liam Doran, [...] added that the figures indicated that 50 new graduates a week sought papers to work abroad and that each nurse and midwife leaving cost between € 75,000 and 80,000 to train over their four-year degree” (INMO 2013/2014).

Nurses are the largest group of health professionals and account for a large proportion of total healthcare cost. As a result, at times of economic austerity nurses are often the first to be reduced which is detrimental to patient safety and quality of care. To illustrate, the economic downturn had a negative impact on nurses in Iceland where there have been mergers of health care facilities to decrease cost, terminations or cutbacks, and reductions in overtime and shift allowances resulting in high dissatisfaction levels (ICN 2010). Similarly, a study of nurses in 12 European countries showed a high percentage were dissatisfied and expressed their intention to leave their jobs. Nurse dissatisfaction was related to wages, educational opportunities and lack of professional advancement (Aiken et al. 2013).

The global nursing shortage

The country examples below depict a grim picture of the dire nursing shortages.

- In Malawi, there is a critical shortage of nurses and the country has only 25% of the required numbers. In 2010 Malawi had a nurse/population ratio of 1.7:10,000 and the ratio is said to have improved to 3.4 nurses per 10,000 population; but this ratio is still low compared with the WHO recommended 50 nurses per 10,000 population (Mphande 2014).

The situation is similar in other Southern African countries (Nullis 2007).

- South Africa has 39.3 nurses per 10,000 population, but a high percentage of these work in the private sector and shortages are especially acute in rural areas. This shortage is one of the challenges for expanding AIDS care and treatment services in the country.

- In Lesotho, which is also ravaged by AIDS, there are just 6.3 nurses per 10,000 population and more than half the nursing jobs were vacant leading to poor access to health services.
- In Mozambique, there are 2 nurses per 10,000 population, and as a result in one district many patients died during a two-month wait to start antiretroviral treatment.

The nurse shortage in five Caribbean Community (CARICOM) countries, namely Guyana, Jamaica, St. Lucia, St. Vincent and the Grenadines and Trinidad and Tobago, is critical. It is estimated that there are about 7,800 nurses (in 2007) in the region. This translates into a ratio of 12.5 nurses per 10,000 population, which compares unfavourably to those in OECD countries where ratios tended to be 10 times higher (World Bank 2009). In the CARICOM countries less than 10 percent of nurses are providing primary care; a level which is likely to be insufficient to effectively respond to the health challenges associated with the demographic and epidemiological transitions. The vacancy rate stands at 30 percent. While the nursing shortage has many reasons, annual attrition rate of 8 percent due to migration adds to the loss. It is estimated that the number of English-speaking CARICOM¹-trained nurses working abroad was roughly three times the number working in the English-speaking CARICOM (World Bank 2009).

In the Americas, the number of nurses per 10,000 population ranges from countries at the lowest end, such as Chile which has a ratio of 1.4 nurse per 10,000 population; to those with highest ratios such as Canada with 92.9 nurses per 10,000 population (WHO 2014).

With relatively high HIV/AIDS and growing prevalence of NCDs, the overall low proportion of nurses providing primary care has important implications for the CARICOM's ability to prevent and control these conditions through effective interventions (UNAIDS 2007; Hennis & Fraser 2004). Indeed, previous studies in the CARICOM indicated that the primary care services well managed by nurses, for example, glycaemic control in diabetic patients, need to be strengthened and scaled-up, but the nursing shortage limits access to these services (Hennis & Fraser 2004).

Similarly, OECD countries have expressed concern about the shortage of nurses and its impact on access, safety and quality of health services. The majority of OECD countries report nurse shortages: Australia predicts a shortfall of 109 thousand nurses by 2025 (Health Workforce Australia 2012). In a recent UK survey (NHS Employers 2014, p.14), 83 percent of surveyed organisations reported experiencing shortages of qualified nursing workforce supply.

Negative effects of nursing shortage on patients

Nurses are a vital force for providing quality care in difficult times by helping the system to be more cost effective and care effective. The nurse staffing level and working environment have direct implications for patient care.

According to a report by the Joint Commission on Accreditation of Healthcare Organizations, inadequate nurse staffing in the USA has been a factor in 24 percent of the cases involving patient death, injury or permanent loss of function. The report also says 90 percent of long-term care facilities face inadequate nurse-staffing to provide even the most basic care, and by 2020, there will be even fewer nurses. However, the "Magnet hospitals" in the USA recognised for quality patient care, nursing excellence and innovations in professional nursing practice, have successfully avoided or overcome shortages because of positive working conditions and increased funding (Joint Commission 2005).

Research evidence shows that hospitals with a higher ratio of nurses to patients have lower mortality rates (Aiken et al. 2014). Similarly, lower nurse staffing, increased workload, and unstable nursing unit environments were linked to negative patient outcomes including falls and medication errors (Duffield et al. 2011).

¹ NOTE: The English-speaking CARICOM includes the following countries: Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Montserrat, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago.

Improved work environments and reduced ratios of patients to nurses were associated with increased care quality and patient satisfaction (Aiken et al. 2012). The study also found that deficits in hospital care quality were common and concluded that improvement of hospital work environments might be a relatively low cost strategy to improve safety and quality in hospital care and to increase patient satisfaction.

While the global nursing shortage is hurting healthcare systems and patients, it also has negative impacts on nurses.

Effect of nursing shortage on nurses

Communities demand excellence of nurses in patient care. In turn, nurses deserve that their working conditions and pay be commensurate with the quality of their care. In much of the world, however, the socio-economic welfare of nurses is poor or inadequate. Some nurses work in very difficult conditions. In both developed and developing nations, nurses are stressed and overburdened by increased workloads.

The nursing shortage has meant that nurses often work long hours under stressful conditions, which can result in fatigue, injury and job dissatisfaction. Nurses in countries with shortages carry heavy workloads and are exhausted, as other nursing staff has left for better-paid jobs in the private sector or for opportunities abroad. Job dissatisfaction is on the rise due to increased workloads, longer hours and not having the resources to provide quality care (Aiken et al. 2013).

For these reasons, and more, ICN is committed to improving the workplace safety for nurses globally through its projects, including the Leadership for Negotiation programme and the Positive Practice Environments (PPE) campaign. Launched in 2010, the PPE campaign aimed to improve the quality of health services by raising awareness, identifying good practice and developing tools for managers and health professionals, and implementing national and local projects to improve practice environments. The campaign promoted safe, cost effective and healthy workplaces, thus ultimately strengthening health systems and improving patient safety (ICN 2013a).

The paradox of unemployed nurses

Despite the global shortage of nurses, nurse graduates in some countries are unable to find employment. For example, in 2006, WHO reported that nurses in Grenada, Uganda and Zambia were faced with unemployment as their health systems could not afford to pay their salaries (WHO 2006). Even in industrialised countries, such as Australia, there were nurses who are without employment. The Australian Nursing and Midwifery Federation (ANMF) reports that more than 3,000 highly-educated Australian nursing and midwifery graduates are unable to find permanent jobs, and that this remains one of the profession's biggest workforce issues (ANMF 2014).

This means within a context of shortage there is the paradox of nurse unemployment. For example, in 2005, Volqvartz found that although half of all nursing positions in Kenya were unfilled, a third of all Kenyan nurses were unemployed (Volqvartz 2005). Similarly many nurses in Tanzania, the Philippines, and parts of Eastern Europe were obliged to work for free in order to maintain their competencies, with the hope that the system would employ them when a budgeted position became available (Kingma 2008). While these data are not current there is no evidence to suggest that the situation has improved.

As noted above, unemployment of health professionals occurred as the health workforce seemed to be considered as a drain on the budget and some countries even put a brake on recruitment of health professionals while needs for health services were high (WHO & World Bank 2002). Healthcare reform driven by cost containment measures such as reduction of public expenditure and wages, privatisation of public services, devaluation of currencies and elimination of subsidies has resulted in deterioration of services and erosion of the health workforce (Liese & Dussault 2004).

Evidence supports increased nurse staffing for better patient outcomes. An appropriate workforce planning according to the population needs would help improve the health of the population.

Why nurses should engage in healthcare financing and policy

The ICN Code of Ethics for Nurses (ICN 2012b) underpins the nurses' professional responsibility to provide a continuum of care and also the wider advocacy role of nurses for equity and social justice. The roles of nurses in addressing the social determinants of health and in reducing violence against women and children are some examples of additional nursing contributions to society. Engagement of nurses in development of sound health policy dialogue is key to realising the nursing potential.

Drawing on their professional legacy as patient advocates, patient care expertise, and a focus on community, nurses are ideally positioned to make major contribution to shaping health policy that is underpinned by equity and cost-effectiveness (Lathrop 2013). Their close interaction with healthcare consumers in a variety of settings gives nurses a good understanding of health needs; how factors in the environment impact the health of clients and their families; and how people respond to different services and interventions. Yet, nurses often lack support from policy makers or funds to introduce innovations in care. For example, nurse executives see evidence-based practice (EBP) as a driver of quality care, patient safety and improved patient outcomes. However, they lack funding and only a small percentage of the budget is allocated to EBP (Elsevier Clinical Solutions 2014).

Nurses have an important contribution to make in health services planning and decision-making, and in development of appropriate and effective health policy. They can and should contribute to public policy related to preparation of health workers, care delivery systems, health care financing, ethics in health care and determinants of health.

ICN (2008a)

Nurses are a pivotal part of the healthcare team. They understand the interaction of patients and their families with the range of other providers involved in their care. Nurses work within the context of cost-quality constraints of health service delivery and they are in an a position to advise on the impact of policies aimed at cost effectiveness in healthcare. In order for nurses to influence and shape decisions, it is essential that they clearly understand how policy is made and implemented, and its wider context. Without this understanding of policy development, nursing will not be included in the process (ICN 2005a).

Nurses also need to work outside of the health sector to share their insights on the design of homes and community environments that help maintain independence and avoid risks that can result in trauma. For example, placing electrical plugs at waist height rather than floor level can make it easier for those with balance problem to function longer in their homes. The use of colour to enable people to avoid slips and trips can play a part in maintaining independence and avoid the need for health services.

Improving the quality of healthcare and access to health services depends on the extent to which the over 16 million nurses around the world are mobilised to be cost effective and care effective. It also depends on providing current knowledge and information to the nursing workforce on key issues such as financing, health policy and decision making process. As the largest healthcare profession, nurses are key to leading change from the frontline towards equity, universal health coverage and ultimately towards improved health outcomes globally.

"Each of you must join the debate, secure a seat at the policy table and make the voice of nursing heard. Without that voice, policy will be incomplete."

Judith Shamian, ICN President 2013-2017
ICN Biennial Report, 2012-2013

In order to strengthen health systems, nurses need to be adequately prepared to help shape policy, work effectively in interdisciplinary teams, plan and manage health services, involve communities and key stakeholders in healthcare planning and delivery, and lobby for increased resource flow to health systems (ICN 2005b).

As such, nurses must be strategically positioned to provide creative and innovative solutions that make a real difference to the day-to-day lives of patients, health systems, communities and the profession.

That is why nurses are essential partners for governments and other funders in securing and assuring care effective, cost effective health systems.

ACTION POINTS

At your clinical workplace:

- Find out the cost of essential supply and equipment used in your setting.
- What can nurses do to reduce the cost of health care in their daily practice?

At national level:

- What are the current cost constraints facing nurses in your country?
- How can nurses address these?

The next chapter will address healthcare financing models and efficient use of resources to provide quality care.

Chapter 2

Healthcare financing

We can't solve problems by using the same kind of thinking we used when we created them – Albert Einstein.

The issue of healthcare expenditure continues to be centre stage on the agenda of various countries and a number of financing initiatives have been implemented to meet the health needs of populations within the constraints of finite resources. Healthcare financing aims to fulfil the cost related to human resources for health, technology for diagnosis and treatment, medicines and other expenditure. To this end, health financing has three key elements: to raise sufficient money for health; remove financial barriers to access; and make better use of the available resources (WHO 2010b).

Achieving quality care at low cost will require nurses' leadership for change so they continue to be cost effective and care effective professionals. A proper understanding of the processes and mechanisms of health financing is fundamental to nursing's leadership and advocacy for health equity and universal health coverage.

Principal financing models for healthcare

Health financing and provision of healthcare are more effective if they are closely linked. Financing mechanisms need to allow universal access to care without putting a heavy burden on the poor. This means putting in place a sound financing model that removes barriers to access - such as out-of-pocket payment, distance and travel time to the health facility - and to high quality care.

There are several ways of financing mechanisms for healthcare services (WHO 2010b; Macdonald 2009). These include:

Tax-based financing: This is the most widely used model of financing in most of sub-Saharan Africa and South Asia. In this model, health services are paid for out of general government revenue such as income-tax, import duties, and tobacco and alcohol taxes. In general, this mechanism is pro-poor. However, concerns with quality of care and access to care may discourage the poor from using health services.

Social insurance financing or pooled funding: In this mechanism health services are paid through contributions to a health fund such as those by employees and employers. This ensures that the financial risk of having to pay for healthcare is borne by all members of the pool and not by the individuals who get ill. Membership is compulsory, but for some groups such as the self-employed, it may be voluntary.

Private insurance: People pay regular premiums related to the cost of providing services to them. This may mean people who are in high health risk group pay more and those at low risk pay less. This model is mostly found in developed countries where there is some form of national health system such as Canada and the UK. The rich still take additional insurance in order to obtain private services or to access services not covered by the national health system. Membership is voluntary.

User fees or direct payments: In this mechanism there is no insurance or mutual sharing of cost and people make out-of-pocket payment directly for the healthcare services they use. Making people pay at the point of delivery discourages them from using services, particularly health promotion and

disease prevention services, and encourages them to postpone timely visits to seek healthcare. This system may also push people into financial difficulties.

Regardless of which model is used, all must be underpinned by quality of care. If people perceive that the healthcare is of poor quality they are unlikely to use it. In making choices about the different financing mechanisms, it is important to remember that people should be at the centre of care. After all, it is the people who provide the funds required to pay for health services through taxes, contributions and donations. And the main reason for raising funds is to improve people's health and welfare. Health financing is a means to an end, not an end in itself (WHO 2010b).

Table 1. Major trends in healthcare financing

Trend	Objectives	Countries
Introduce or increase user fees to tax-based systems	<ul style="list-style-type: none"> - raise more revenue, more efficient use of resources - create greater accountability to consumer 	Many countries in sub-Saharan Africa
Introduce community-based health insurance systems currently based on user fees and tax revenues	<ul style="list-style-type: none"> - reducing financial barriers created by user fees - encourage more efficient use of resources - raise more revenues 	Thailand, Indonesia, India, Tanzania, Uganda
Shift from tax-based to social health insurance type systems	<ul style="list-style-type: none"> - create independent, sustainable source of health finance - raise more revenues 	Thailand, Eastern Europe, Ghana, Nigeria, Zimbabwe
Consolidate multiple state insurance funds	<ul style="list-style-type: none"> - increase equity and prevent fragmentation - increase administrative efficiency 	Mexico, Columbia, other Latin American countries

Adapted from: Bennett & Gilson (2001)

Focusing on the poor

When financing universal health coverage, it is important that policies are 'pro-poor' and should not exclude those who cannot contribute or make insurance contributions. The important elements of a 'pro-poor' healthcare financing system are (Macdonald 2009):

- contributions to costs of healthcare are linked to ability to pay
- the poor are protected from financial risk associated with illness
- services are accessible - including geographical accessibility and quality

To achieve universal health coverage, financing systems must enable people to use a continuum of health services – health promotion, disease prevention, treatment and rehabilitation – without financial hardship. However, in many countries, millions of people cannot use health services because of direct payments at the time of service or are impoverished because of out-of-pocket payments. Prepayment mechanisms such as pooling of funds remove financial obstacles and thus increase access to services in times of need (WHO 2010b).

How much do health services cost?

In order to decide how much to invest in healthcare, it is important to know how much services cost. A recent WHO estimate of the cost of providing key health services suggests that the 49 low-income countries surveyed would need to spend just less than US\$ 44 per capita on average, rising to a little more than US\$ 60 per capita by 2015 (WHO 2010b). This estimate includes the cost of expanding health systems to deliver a mix of interventions. It also includes interventions for noncommunicable diseases and the health-related MDGs namely, reducing child mortality, improving maternal health and combatting HIV/AIDS, malaria and other diseases. This means that low-income countries can afford to provide coverage of key health services in a cost effective way.

Efficient use of resources

As noted in Chapter 1, the cost of healthcare is rising globally and it is important that the available resources are used in a cost-effective and care-effective way. Wasteful spending accounts for a substantial amount of healthcare resources. For example, in the United States up to US\$ 1.2 trillion, or half of all healthcare spending, is the result of waste (PwC Health Research Institute 2010). An Institute of Medicine (IOM) report estimated unnecessary health spending totalled \$750 billion in 2009 alone (IOM 2012). The biggest area of waste, particularly in the USA, is what is known as 'defensive medicine', which involves ordering of inappropriate or unnecessary tests and procedures to avoid being sued by healthcare consumers (Thomson Reuters 2009). Other factors that contribute to wasteful spending include failure to adhere to medical advice and treatments by patients (IOM 2012; Sabate 2003).

The European Healthcare Fraud and Corruption Network (EHFCN) says that of the annual global health expenditure of about US\$ 5.3 trillion, a little less than 6 percent, or about US\$ 300 billion, is lost to mistakes or corruption (EHFCN 2010). While most countries fail to use the available resources, some countries lose more than others because of poor procurement, irrational use of medicines, or inefficient use of human and technical resources. The varying levels of inefficiency means that some countries achieve higher levels of coverage and better health outcomes than others with the same resources. For example, Brazil, Chile and Costa Rica each spend over US\$ 400 per capita on health; but life expectancy in Brazil is 72 years compared to 78 years in the other two countries (Chisholm & Evans 2010).

The method of paying healthcare providers and the rates they are paid influence their behaviour. It can create economic signals, or incentives, that affect provider decisions about the range of services including prescribing of medicines and diagnostic tests. The right incentives can direct provider behaviour toward achieving health system goals such as improving quality of care and expanding access to priority services or use resources efficiently. On the other hand, some payment methods encourage healthcare providers to waste resources while increasing their income. For example, fee-for-service payment methods create incentives for providers to deliver more services so they can increase their income. Similarly, capitation methods, which reimburse the healthcare provider a fixed amount per patient for a defined set of services, create incentives for providers to enrol more patients so they can maximise their income (Özaltın & Cashin 2014; Chisholm & Evans 2010).

Many health systems fail to isolate nursing costs but rather include them as part of the room ratio, yet we know from research that survival and complications leading to additional costs are tied to nursing care; hence understanding how nurses are deployed is critical in pursuing care effective and cost effective systems. Policymakers should therefore adopt payment methods and set payment rates so the incentives align with the objectives of the health system, such as being more responsive to patients and using resources more efficiently.

Major causes of inefficiency

The major sources of inefficiency in health systems include (Chisholm & Evans 2010):

- overuse of brand-name medicines and underuse of generic products
- use of substandard and counterfeit medicines
- overuse of supply and equipment, investigations and procedures
- inappropriate or costly staff mix, unmotivated workers
- inappropriate hospital admissions and length of stay
- medical errors and poor quality of care
- waste, corruption and fraud
- inefficient mix or inappropriate level of strategies such as funding high-cost, low-effect interventions when low-cost and high-impact options are unfunded

Worldwide, it is estimated that over half of all medicines are prescribed, dispensed or sold inappropriately (WHO 2010c). Irrational use of medicines can take different forms: multiple prescriptions or poly-pharmacy, over-use of antibiotics and injections, failure to prescribe in accordance with clinical guidelines, or inappropriate self-medication (Holloway & van Dijk 2010). To add to the inefficiency, it has been estimated that half of all patients fail to take their medication as prescribed or dispensed (Sabate 2003), which leads to waste and inefficiency of the health system as well as increased antimicrobial resistance.

On the other hand, rational use of medicines that focuses on essential medicines can reduce expenditure on medicines. For example, the Sultanate of Oman published a national formulary with increased focus on essential medicines. A more responsible approach to the use of medicines consistently saved 10-20 percent of the forecasted medicines expenditure between 2003 and 2009 (WHO 2012c).

Similarly, rational use of human resources such as task-shifting or task sharing can result in substantial savings. To illustrate, in South Africa, task shifting of antiretroviral treatment from doctors to primary-care nurses has shown care by nurses improved TB detection, increased white blood-cell counts, weight gain and better treatment compliance at a lower cost (Fairall et.al 2012).

Healthcare inefficiencies and poor quality care

Inefficiencies and waste of resources in healthcare can also occur because of poor quality care that results in adverse events such as medical errors, hospital-acquired infections and pressure sores, thus increasing hospital stays and cost of healthcare.

Medical errors

Medical errors are a serious threat to patient safety. They are often a result of weak health systems that are poorly staffed or poorly managed. Medical errors can lead to longer hospital stays and thus inflate the cost of healthcare as well as the cost to the patient and family due to pain and suffering or even death (WHO 2005). Reporting of adverse events is crucial to detecting problems in patient safety. However, reporting is not an end in itself; it is a means of improving patient safety through learning from mistakes and changing the organisation's safety culture. An effective patient safety reporting system must be non-punitive, with no shaming and blaming of those who report errors. And the information must be disseminated to others so there is learning from mistakes and changes in practice (WHO 2005).

The problem of medical errors is huge and one-fourth of adults with health problems in Australia, Canada, New Zealand, and the USA and one-fifth in the UK reported they had experienced a medication error or medical error in the past two years (Blendon et al. 2003). In the USA serious preventable medication errors occur in 3.8 million inpatient admissions – costing approximately US\$ 16.4 billion annually - and in 3.3 million outpatient visits each year – costing US\$ 4.2 billion annually (Massachusetts Technology Collaborative and NEHI 2008). In its report *To Err Is Human*, the Institute

of Medicine estimated 7,000 deaths in the USA each year are due to preventable medication errors (IOM 1999).

Overall reduction of medication errors requires a multipronged approach, ranging from financial incentives to organisational and care delivery improvements that address the root causes of errors.

Healthcare acquired infections (HCAI)

The global burden of HCAI remains unknown because of the difficulty to gather reliable data. However, some studies show that HCAI prevalence in mixed patient populations is about 7.6 percent in high-income countries. The European Centre for Disease Prevention and Control (ECDC) estimated that 4,131,000 patients are affected; and there were approximately 4,544,100 episodes of HCAI every year in Europe. The estimated HCAI incidence rate in the USA was 4.5 percent in 2002, corresponding to 9.3 infections per 1000 patient-days and 1.7 million affected patients. Data on the burden of HCAI in the developing world is scanty. However, studies in healthcare settings with limited resources reported HCAI rates that varied from 5.7 percent to 19.1 percent with a pooled prevalence of 10.1 percent (WHO 2011).

HCAI results in prolonged hospital stay, long-term disability, and increased resistance to antimicrobials, a financial burden for health systems, high costs for patients and their families, and excess deaths. In Europe, HCAs cause 16 million extra days of hospital stay and 37 thousand deaths with an annual financial loss estimated at €7 billion. In the USA, HCAs cause 99,000 deaths annually, with a financial loss of US\$ 6.5 billion in 2004 (WHO 2011).

It is clear that HCAs cause much preventable burden of disease and death with huge financial losses. They must be treated as a priority patient safety issue and tackled using comprehensive approaches and with nurses as the backbone of infection prevention, patient safety and system efficiency.

Pressure sores

Pressure sores are a patient safety and a quality of care issue. In the UK an analysis of the cost of treating pressure sores showed that it varied from £1,214 (category I) to £14,108 (category IV). Costs increase with pressure sore severity. It is clear that treatment of pressure sores represents a significant cost burden in the UK, both to patients and to healthcare providers (Dealey et al. 2012).

In the USA, 2.5 million patients develop pressure sores per year with an estimated financial loss of US\$ 9.1-11.6 billion per year. The cost of individual patient care ranges from US\$ 20,900 to US\$151,700 per patient with pressure ulcers. The average length of stay for patients with pressure ulcers was 14.1 days compared to five days for those with no pressure ulcers (Russo et al. 2008).

Hospital-acquired pressure sores are not simply the fault of the nursing care, but rather a failure of the entire health care system. While the prevention of pressure ulcers is a multidisciplinary responsibility, nurses play a major role and they are in a position to be cost effective and care effective. Without concerted effort, the cost is likely to increase in the future as the population ages.

What can nurses do to improve health system efficiency?

Nurses as a force for change have opportunities to improve efficiency and reduce waste. In collaboration with other health professionals and decision-makers, nurses and other health professionals can:

- improve prescribing guidance, information, training and practice
- educate individuals and communities on detection and surveillance of counterfeit medicines
- develop and implement clinical and evidence based best practice guidelines
- implement task-shifting and other ways of matching skills to needs
- Adhere to and champion infection control procedures, improve hygiene standards in hospitals; provide more continuity of care; undertake more clinical audits
- monitor hospital performance and use the data to guide clinical decision
- reduce administrative burdens
- evaluate and incorporate into policy evidence on the costs and impact of interventions, technologies, medicines, and policy options

Nurses are at the core of the health system providing cost effective and care effective services, however, the current global nursing shortage will continue to be a major challenge to run health systems efficiently.

ACTION POINTS

- What are the main health financing models in your country?
- Do the health financing models promote universal health coverage?
- What are the major reasons for wastage of health resources in your setting?
- What can nurses do to reduce wastage and improve efficiency in their day-to-day practice?

In Chapter 3, we will look at how nurses can be more cost effective and care effective through access to the latest synthesis of evidence and the necessary skills to pursue quality and cost effective change, including team care, effective communication and optimising health system performance.

Chapter 3

Be more “care effective, cost effective”

Unless we are making progress in our nursing every year, every month, every week, take my word for it we are going back – Florence Nightingale.

The ICN has a long-standing history of leading nurses to be care effective and cost effective. Through its publications, position statements, projects and conferences, ICN implements its agenda of knowledge transfer and competency development in the nursing population worldwide. One of ICN’s five core values is *Visionary Leadership* which is realised, among other things, through its Leadership for Change and Leadership in Negotiation projects and the ICN-Burdett Global Nursing Leadership Institute.

The escalating cost of healthcare globally requires that measures be taken to contain cost to levels that the countries and governments can afford and sustain. Cost-containment pressures underscore the need to better understand how healthcare and nursing resources can be optimally used. Nurse managers and leaders need to use approaches and tools to achieve cost-containment; while at the same time achieving desired care outcomes. One such method is cost effectiveness analysis.

Defining cost effectiveness and care effectiveness

Health services are delivered within the constraints of financial and human resources and it is important that the cost of healthcare and its benefits are fully considered. We often hear of nurses as being “cost effective” and “care effective”. And an understanding of these terms is vital in guiding decision-making for optimum use of resources.

Cost effectiveness analysis (CEA) enables decision-makers to quantify health benefits in terms of “health” rather than in monetary terms measured in health outcomes; such as number of diarrheal diseases prevented, life-years saved, or improved quality of life (Neumann 2005). It is used to determine which intervention achieves a specific outcome with less cost by comparing two or more healthcare interventions. For example, a cost effectiveness analysis can be done to compare immunisations given by physicians with those given by nurses to determine which group achieves better outcomes with less cost. Another example can be comparing two drugs for hypertension to determine which drug produces desired outcome at less cost.

The interventions are compared in terms of their costs and of their health outcomes or health benefits. The intention is to achieve healthcare outcomes with fewer resources, which leads us to a related concept of “care effectiveness”.

In analysis of cost effectiveness, we also need to consider “care effectiveness” which means care that is based on scientific evidence and produces the intended results or outcomes (Newhouse & Poe 2005). In reference to nurses, care effectiveness is the extent to which health problems are solved and the degree to which outcomes are achieved. If we add cost effectiveness to this definition, it means nurses achieve the intended health outcomes at less cost, with quality as an underpinning element.

As individuals and as members and coordinators of health teams, nurses bring people-centred care closer to the communities where they are needed most, thereby helping improve health outcomes and the overall cost effectiveness of services (WHO 2010d).

Effective service delivery for “care effective, cost effective” healthcare systems

Primary health care and people centred health care

The ICN Code of Ethics for Nurses affirms nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering (ICN 2012b). Nurses also have a fundamental role in providing equitable health services encompassing a continuum of care that are people- and family-centred, evidence-based and continually improving in quality.

Noncommunicable chronic diseases, such as heart disease, cancer, chronic respiratory diseases and diabetes, and mental health problems, are the leading cause of mortality and disability in the world (Lozano, R. et al. 2012, Vos T et al. 2012). Nurses are knowledgeable about the common risk factors for NCDs – tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets. And nurses are the bedrock of success of behavioural changes in individuals and communities through health promotion and disease prevention interventions. By using a life-course approach to health promotion and disease prevention that extend from early years to old age, nurses can help reduce the heavy burden of disease and the associated cost of healthcare. Nurses have also a key advocacy role in redesigning health systems to focus on health promotion and disease prevention.

International evidence suggests that health systems based on strong Primary Health Care (PHC) orientation have better and more equitable health outcomes, are more efficient, have fewer health costs, and can achieve higher user satisfaction than those whose health systems have only a weak PHC orientation.

Pan American Health Organization
(2007)

To this end, it is important to remember that primary health care (PHC) is the preferred and effective means of delivering essential health services at a cost which governments and communities can afford (WHO 2008a). A national healthcare system is more effective when it is based on PHC encompassing a range of publicly funded essential and universally accessible and equitable health services to the population. This approach calls for shifting the focus of healthcare from hospital-based to community-focussed, cost effective interventions that can be delivered by nurses. As the Commission on Macroeconomics and Health (CMH) affirmed, close-to-client health services can be delivered by nurses at a cost of about US\$ 34 per person using a PHC approach (CMH 2001).

Yet, health systems globally have largely concentrated on hospital and tertiary care and the effectiveness and safety of primary care has been given less attention (Iha 2008). This has resulted in high-cost and ineffective health systems with poor health outcomes.

Nursing’s commitment to primary health care is embodied in the **ICN Code of Ethics for Nurses** first adopted in 1953 and regularly revised which affirms that **“nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering.”**

ICN (2012b)

Primary health care in most countries is provided by nurses who have a unique opportunity to put people at the centre of care, making services more effective, efficient and equitable. Nurses often live within the communities; understand the local culture and language which gives them a unique perspective of the health problems and health needs. It is this presence of nurses at the forefront of health care providing a continuum of care that is a defining characteristic of nursing (ICN 2008b). Nurses are the cornerstone of healthcare delivery that is focused on person-centeredness, continuity of care, comprehensiveness and integration of services which are fundamental to holistic care.

Expanding nursing practice to increase access and quality

Many countries are seeking to improve healthcare delivery by reviewing the roles of health professionals, including nurses, as developing new and more advanced roles for nurses could improve access to care (OECD 2010).

Advanced nursing practice: More and more countries are exploring or introducing nurses practicing in advanced roles. ICN defines advanced practice nursing as *“A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master’s degree is recommended for entry level”* (ICN 2009a).

Due to changing population demographics, increasing costs and challenges with access to care, more countries are giving consideration of introducing advanced practice roles in an effort to reduce costs and increase patient access and patient satisfaction.

Evaluations show that using advanced practice nurses (APNs) can improve access to services and reduce waiting times. APNs are able to deliver the same quality of care as physicians for a range of patients, including those with minor illnesses and those requiring routine follow-up. Most evaluations find a high patient satisfaction rate, mainly because nurses tend to spend more time with patients, and provide information and counselling (OECD 2010).

Nurse prescribing: An innovative yet increasingly common advancement in health care delivery is the introduction of registered nurse prescribing. Nurse prescribing has the potential to save costs for the patient (transport, time and money) and for the health system as a whole by freeing up doctors’ time to see more acute and complex patients; and by reducing acute demand and hospital admissions by timely treatment in the community. In addition, it can increase access particularly in underserved areas and for disadvantaged groups, increase consumer choice, and provide for efficiencies in resource management (ICN 2009b, Kroezen 2012). International evidence supports the safety of nurse prescribing, and indicates it has generally been seen as positive as evidenced in a literature review (Latter & Courtenay 2004) and systematic review (Van Ruth et al 2008).

Effective management for “care effective, cost effective” healthcare systems

The desire for cost effectiveness and care effectiveness stimulates reform of health systems in order to achieve health outcomes at affordable and sustainable cost. In today’s complex health systems, no single health profession can claim ownership of knowledge that could contribute to health. That is why there is a need for collaborative practice between different health professions so their competencies are integrated to provide holistic care (ICN 2004; Bower et al. 2003). Thus, there is renewed interest in discovering better ways to deliver health services that best meet the health needs of individuals, families and communities. In an era of increased consumer demand, shifting disease patterns and increasing chronic disease, providing quality, cost effective care, calls for a more coordinated, team-based approach for which nurses are well positioned.

Team approach

Team approach offers a viable solution to the service delivery challenges facing healthcare systems worldwide. Teamwork is now expected, with collaboration at its core. However, despite the growing awareness of potential benefits of the team approach to care, many healthcare organisations lack effective teamwork, with negative consequences on patient outcomes (Lemiex-Charles & McGuire 2006). The barriers to team approach and collaborative practice have been attributed to several factors including lack of structure, lack of system support, competition, professional hierarchy, frequent changes in staff due to shift-work and patient transfers that make coordination and teamwork complicated (ICN 2004; Storch 1994).

Team approach can be effective in the delivery of comprehensive primary health care services as well as for episodic and continuous care of specialised patient populations (Bower et al. 2003). Nurses are vital to the continuity of care and to coordination of services provided by different health

professionals in which inter-disciplinary relations and communication are important. However, some research indicates that the relationship between physicians and nurses is frequently poor. And poor nurse-physician relationships can increase risk of adverse events, errors and poor patient outcomes (Rosenstein & O'Daniel 2005; IOM 1999). On the other hand, improving relationships, coordination of care and teamwork reduces errors and improves quality of care, patient outcomes and patient safety (IOM 1999). For example, a positive nurse-physician relationship is one of the attributes of the Magnet hospitals that produce an empowering environment and job satisfaction in nurses resulting in quality care (Laschinger et al. 2003).

As the main providers of PHC services in most countries, nurses understand the advantages of integrated healthcare delivery and the need to adopt and strengthen collaboration and partnerships. On the front lines every day, nurses are leaders in multi-disciplinary healthcare teams across many settings. The interdependency among healthcare providers is at the core of collaborative practice and integration of competencies. Collaborative practice goes beyond the physician-nurse relationship to include other professionals such as pharmacists, physical therapists, occupational therapists, social workers, psychotherapists, and others. The mix of disciplines in a given collaborative practice will vary in focus and priority in response to different cultural contexts and local circumstances (ICN 2004). Through professional collaboration, there is shifting and sharing of tasks, and integration of knowledge for provision of person-centred care.

The team approach is the cornerstone of person-centred healthcare and nurses have a major contribution to the functioning and effectiveness of health teams. In today's complex healthcare delivery systems, it is impossible for a single professional group to provide a continuum of person-centred care and consultations, linkages and referrals are needed to achieve coordination and continuity of care (ICN 2004). Nurses are the glue that keeps the health system intact with competence to manage the dynamics of team interactions. That is why health systems need to be redesigned to optimise the contribution of nurses to health teams in general and to person-centred care in particular.

Effective communication: Effective communication is a cornerstone of patient safety and quality of healthcare. On the other hand, ineffective health team communication is the root cause for nearly 66 percent of all medical errors (Institute for Health Care Communication 2011). Research evidence indicates that there are strong positive relationships between a healthcare team member's communication skills and a patient's capacity to follow medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviours (Institute for Health Care Communication 2011).

Effective communication among healthcare team members influences the quality of working relationships, job satisfaction and impacts on patient safety. And when communication about tasks and responsibilities are done well, there is a significant reduction in nurse turnover and improved job satisfaction because it facilitates a culture of mutual support (Lein & Wills 2007).

If patients do not understand their diagnosis and the importance of prevention and treatment plans, or cannot access healthcare services because of communication problems, adverse events may occur resulting in harm and wastage. It is equally important that the nurse understand the patient. There is evidence that patients' perception of the quality of the healthcare they receive depends on the quality of interactions with their healthcare provider (Wanzer et al. 2004).

Given the importance of effective communication in improving patient safety and quality of care, as well as job satisfaction of team members, the need for communication skills in nurses and other health professionals must be given high organisational priority.

Learning together to work together for better health: The undue focus on hospital-based education and professional segregation do not prepare health professionals for team work and leadership in today's health systems (Frenk et al. 2010). One of the promising solutions can be found in interprofessional education (IPE), in which students from different health professions learn together at some point during their education (WHO 2010d). Effective IPE enhances respect among the health professions, eliminates negative stereotypes, and fosters a patient-centred approach in

practice (Reeves et al. 2008). In order for team approach and collaborative practice to be effective, it is important that educational institutions provide opportunities for learning together.

Pooling problems; sharing solutions

Nurses are in an ideal position to identify and address problems that can contribute to the development of a more care effective and cost effective system. By bringing nurses together to identify both the problems they face and the solutions they have tried, a rich resource can be unlocked (Benton et al. 2003). While individually, nurse leaders faced more problems than they had solutions but, collectively, the group had a wider range of solutions than the numbers of problems being faced. By facilitating short, solutions-focused meetings, new insights can be released and change initiated.

Nurses' role in management for effective healthcare systems

Nurses' role in effective management for "cost-effective" and "care effective" health systems involves a broad spectrum of actions including supply management, combatting counterfeit medicines and antimicrobial resistance and preventing over-prescribing of medicines.

Supply management: As the cost of healthcare continues to rise, nurses are expected to play an active role in managing healthcare resources including equipment and supplies. Nurse managers have a significant role in resource allocation and budget decisions. At the same time, nurses must use supplies and equipment effectively and should be aware of how much supplies cost and how waste occurs. For example, wearing gloves while making beds is wasteful; and this may lead to shortage when gloves are needed most, such as when changing wound dressings or other procedures requiring a high degree of infection control. Nurses must recognise when supply and equipment is inadequate and when patient safety is endangered as they have an ethical duty to lobby for needed supplies (ICN 2012a).

The judicious use of supplies and use of the right product are essential for cost effective care. However, nurses must guard against "false economy" with use of supplies. For example, the reuse of single-use equipment, such as syringes or catheters, may seem economic but it can lead to infections, thereby increasing the cost of healthcare (Ellis & Hartley 2005). In particular, reuse of syringes can result in such serious and long-term problems as Hepatitis B, Hepatitis C and HIV infections (Centers for Disease Control and Prevention 2011) and patient safety must be considered first rather than saving costs. The nursing and purchasing departments must communicate to determine the best product for the intended use; and a supply chain management system needs to be in place to ensure that the right supply in the right quantities is delivered at the right time for a reasonable cost (Ellis & Hartley 2005; McMahon et al. 1992).

A key concern of managing supplies is to ensure adequate stocks to provide appropriate services. Lack of resources in healthcare settings has serious consequences for the quality of care and for the practice environment of nurses and other health professionals.

Combatting counterfeit or fake medicines: Nurses are concerned with cost effectiveness, care effectiveness, quality of care and patient safety. The growing presence of counterfeit or fake medicines is a serious threat to patient safety, as the work of the health team and the quality of care will be compromised or even endangered by fake medicines. Counterfeit medical products are not only unsafe and ineffective; but they can result in wasted resources and missed opportunity to treat or prevent a disease (World Health Professions Alliance 2011).

Counterfeit medical products increase cost of healthcare by causing added burden of disease and even death; endanger public health by increasing the risk of antimicrobial resistance; and damage patients' trust in health professionals and health systems. That is why ICN has joined forces with other global health organisations, to raise awareness about the dangers of fake medicines. The Fight the Fakes (www.fightfakes.org) campaign aims to mobilise organisations and individuals in the fight of the under-reported, yet growing crime of fake medical products.

Nurses are on the frontlines of healthcare, administering and, increasingly often, prescribing medicines, particularly in primary healthcare settings. They are well positioned to monitor drug effects and side effects and must be vigilant for signs of counterfeiting such as improper packaging and labelling. Nurses have also a key role in educating the public about the dangers of buying medicines through the Internet via non-legitimate online pharmacies or on the streets from unauthorised sources.

“As CEO of the International Council of Nurses, I know how important the trust of patients is to nurses who want to do their best and see their patients recover quickly. If they receive a fake medicine, they may lose faith and confidence in healthcare professionals who try to help them”.

David Benton, Fight The Fakes (2013)

Patients and the public have a high trust and confidence in nurses as illustrated by the *Gallup Honesty and Ethics Poll* in the United States. In 2013 and for many years before that, the Gallup Poll showed that a high percentage of the American public rated the honesty and ethical standards of nurses as either “high” or “very high” (Gallup 2013). By targeting counterfeit medicines, nurses are in a prime position to help ensure the safety of patients and restore the public’s trust in healthcare.

Another important nursing role related to medicines and to cost effectiveness is the prevention of multiple uses of prescription drugs or polypharmacy.

Management of multiple prescriptions: In the era of co-morbidity where people are living with multiple chronic conditions, a significant number of patients often take multiple prescription drugs. Nurses know that it is a challenge to manage older patients with chronic diseases, who often take multiple prescriptions, see different doctors and may get conflicting medical advice and prescriptions.

Too many medicines per patient – poly-pharmacy – is a form of irrational use of medicines which results in wastage of resources and widespread health hazards (WHO 2012d). In the UK, estimates suggest that from 1995 to 2010 the number of patients taking 10 or more medicines trebled (Duerden et al. 2013). Taking numerous prescription drugs has negative consequences and can lead to adverse events such as drug interactions. However, it remains a challenge and has proved to be difficult to prevent. Integrated care is now widely accepted as the way forward in caring for people living with multiple conditions.

Interventions to prevent poly-pharmacy and promote rational use of medicines include: (WHO 2012c)

- training of physicians and others who prescribe medicines
- use of clinical guidelines
- development and use of national essential medicines list
- establishment of drug and therapeutics committees in districts and hospitals
- supervision, audit and feedback to health professionals
- public education about the dangers of poly-pharmacy
- avoidance of distorted financial incentives to prescribers so they are not motivated to give more prescriptions for financial gains

There is need for more engagement with patients to ensure that medicines are taken in the way that prescribers intend. This requires education of patients to ensure that they understand the benefits of taking the prescribed medicines and avoid situations where medicines are wasted. Nurses at the frontline of care in the hospital and community settings can play a key role in this education. This means changing patients’ behaviour and also changing the prescribing behaviour of physicians’ and other healthcare providers.

Effective health workforce for “care effective, cost effective” healthcare systems

It is essential that the health workforce is planned according to the needs of the population. The appropriate staff mix must be sought to deliver necessary health services. One of the major constraints to tackling global access to essential healthcare services is a serious shortage of health workers. “Task shifting” or “task sharing” is one way to address this challenge. Task shifting is a process of delegation of tasks to less specialised health workers.; By reorganising the workforce and sharing of responsibilities, task shifting provides a viable solution for improving healthcare coverage and allows for efficient use of human resources (WHO 2008b).

As previously mentioned, evidence shows that a higher number of qualified nurses is associated with reductions in patient mortality and adverse events (Aiken et al, 2014). Conversely, an extensive research in England showed the more healthcare assistants employed, compared to registered nurses, the higher the rate of deaths in hospitals while a greater number of nurses per bed was associated with lower rates of death after a treatable complication (failure to rescue) (Griffiths et al. 2013).

With regards to educational level, the evidence suggests that an increased emphasis on bachelor's education for nurses could reduce preventable hospital deaths. (Aiken et al. 2014).

In planning for effective health workforce, incentives are an important means of attracting and retaining staff as well as motivating and improving their performance. Incentives can be positive, negative, financial or non- financial, tangible or intangible (ICN 2005a). Non-financial incentives - in the form of autonomy of work, flexible hours and scheduling, recognition of work, coaching and mentoring, and career development - also play an important role in workforce performance (Mathauer & Imhoff 2006).

Failure to consider an appropriate incentive system could result in unfavourable results such as staff attrition and higher organisational costs. For example, the implementation of improved pay for public sector health workers in Uganda and Tanzania is reported to have resulted in an internal migration of health workers from faith-based facilities to government services, leaving many areas where only faith- based services were available to poor and underserved communities (Dambisya 2007). Similarly, when Ghana introduced allowance for overtime work for doctors and nurses with a disparity in the allowance for nurses; there was resentment among nurses which was considered to have increased their migration (Pooja 2007).

The chronic underinvestment in the health sector, combined with poor employment conditions and policies, such as low remuneration; heavy workloads and exposure to occupational hazards have resulted in deterioration of working conditions in many countries. There is clear evidence globally that this has a serious negative impact on the recruitment and retention of health professionals, the productivity and performance of health facilities, and ultimately on patient outcomes (ICN 2013a).

Under these negative working conditions, it is unlikely that nurses will perform at their optimum and thus the desired health outcomes are unlikely to be achieved. As such, this unhealthy work environment pushes nurses away from their countries to seek better working conditions and better remuneration elsewhere; thereby worsening the nursing shortage in their home countries. In fact the major reasons driving migration are lack of support from supervisors; non-involvement in decision making; lack of supplies and equipment; lack of promotions; and heavy workloads (Kingma 2008; WHO 2006). One solution to improve the situation is to introduce workplace innovations known as “positive practice environments” (PPEs). These are settings that support excellence in practice and decent work. In particular, PPEs strive to ensure the health, safety and well-being of staff, support quality patient care and improve the motivation, productivity and performance of individuals and organisations (ICN 2013a). Some of the benefits of PPEs include lower rates of absenteeism and turnover, increase in staff morale and productivity, and improved work performance (ICN 2013a).

Fostering a sense of communication and leadership in the work environment produces a positive feeling toward the workplace and improves the satisfaction of staff (Registered Nurses Association of Ontario 2006). Nurses reported more positive job experiences and fewer concerns with care quality in hospitals with better nurse practice environments (Aiken et al. 2008). The study also found that patients had significantly lower risks of death and failure to rescue in hospitals with better care environments.

For example, the Magnet hospitals demonstrate clear leadership that enhances quality patient care, nursing excellence and innovations in practice. Magnet hospitals are characterised by autonomy, control over practice environment, and positive nurse-physician relationships. As a result of the positive work environment, Magnet hospitals are able to avoid nursing shortages and staffing problems (Joint Commission 2005).

Nurse leaders and policy makers are challenged to provide positive practice environments as a means of improving workforce performance and quality of care through a combination of financial and non-financial incentives that are responsive and effective in meeting policy objectives related to recruitment and retention.

Determining nursing resource allocation

Internationally nursing is not well represented in hospital reimbursement, despite being the largest healthcare profession, and despite being a major cost component of the hospital budget (Sermeus et al. 2008). As indicated in the previous chapter, many health systems fail to isolate nursing costs but rather include them as part of the room ratio. Understanding how nurses are deployed is critical in pursuing care effective and cost effective systems as research has shown that survival and complications leading to additional costs are closely tied to nursing care. However, general staffing levels and allocation of nursing personnel are likely to be influenced by a hospital's financial resources and how nursing is addressed in the reimbursement system.

In most countries there is no adjustment for a nursing care case mix in the hospital financing system, although there is a significant variability in nursing intensity and direct nursing costs between and within similar adult medical/surgical units (Welton et al. 2006). Nursing intensity is the amount of direct and indirect patient care activity required to carry out the nursing function and the factors that have an impact on the level of work required to perform that activity (Morris et al. 2007). Under the umbrella of intensity of nursing care fall the concepts of nursing workload, patient acuity and time taken to administer patient care.

In order to ensure nursing representation in healthcare finances and to measure the intensity of nursing care, patient classification systems for nursing care have been developed. However, these systems are often applicable to specific nursing speciality and do not seem to find wide applications.

As part of its commitment to the development of nursing, ICN has developed the International Classification for Nursing Practice (ICNP) since 1989. ICNP is a terminology or controlled vocabulary that allows nurses worldwide to document their practice in similar ways. This improves communication, makes it easier to share information, and allows data to be re-used for other purposes, such as:

- demonstrating or projecting trends in nursing practice
- allocating resources according to need
- influencing health policy

As such, ICNP is an essential tool for nursing (ICN undated).

A literature review showed that countries such Denmark, Italy, the Netherlands, Portugal, Spain, and the US reimburse nursing as a part of a general 'room and board' fee, without going further into specific nursing care characteristics (Laport et al. 2008). This means that differences in nursing hours delivered are not addressed. However, use of a fixed daily room rate in the USA showed there was an underestimation of nursing costs by 32.2 percent (Welton et al. 2006).

Most countries that adjust for nursing care use an average nursing resource weight per Diagnosis Related Group (DRG), by clustering patient stays into groups that are homogeneous in terms of clinical characteristics and resource use. A relative weight represents differences in hours and minutes of care on a pre-specified level such as a patient level, DRG level, or nursing ward level. It summarises resource consumption as a function of nursing time needs. For example, on a DRG level, a DRG with a relative weight of 4.0 is four times more nursing resource intensive than a DRG with a relative weight of 1.0. Examples of an average nursing resource weight per DRG can be found in the systems used in Australia, Canada, New Zealand and Switzerland (Laport et al. 2008).

Nursing cost allocation studies provide the necessary information to develop such average nursing resource weights in most of these countries. The averaging method, however, does not take the variability of nursing intensity within DRGs into account (Welton & Halloran 2005).

Nursing minimum data sets (NMDS) have been developed in a number of countries to provide an accurate description of nursing care and nursing resources. For example, in Belgium a nursing weight system exists based on Belgian-NMDS (B-NMDS), used to classify inpatient days into 28 zones to adjust budget allocation for differences in nurse staffing requirements that take into account patient dependency, severity of illness, complexity of care and time taken to provide care. The standard times for each category of the patient classification system can be determined by using the B-NMDS instead of laborious time measurement methods (Sermeus et al. 2008; Sermeus et al. 2009).

The B-NMDS has high potential for nursing management applications and allocation of resources to reflect nursing intensity.

ACTION POINTS

- Think of ways you can be care effective and cost effective. What would you change to achieve these?
- What are the challenges you face to become care effective and cost effective?
- How will you mobilise support to bring about the change?

The next chapter will highlight evidence-based value of nursing for care effective and cost effective health systems by providing varied examples from different countries.

Chapter 4

Value of nursing for “care effective, cost effective” healthcare systems

The key to unleashing the organisation’s potential to excel is putting that power in the hands of the people who perform the work – James M. Kouzes.

Vast evidence shows that nursing is a cost effective yet often undervalued and underutilised healthcare resource. As participants in a recent ICN-World Bank Dialogue observed *“nurses are sub-optimally utilized in care delivery, management and policy settings, and are not deployed to full scope in many environments that would stand to benefit from integrated team-based approaches”*. (ICN/World Bank 2014).

Nurses must clearly articulate and demonstrate the value and cost effectiveness of nursing and nursing outcomes to consumers, other health providers and policy-makers at all levels. They must also be able to negotiate and advocate for the resources needed to provide safe care.

Nurses have a responsibility to engage in research and develop innovative models of care delivery that will contribute evidence of nursing effectiveness to planning, management and policy development. As the ICN position statement affirms *“With rising health needs and health care costs, which includes costs associated with the provision of nursing services, nurses must take the initiative in defining, examining and evaluating the health outcomes and costs of their activities (ICN 2001)”*. Dissemination of nursing research on the value and cost effectiveness of nursing is a vital component of advocacy and influencing health policy.

ACTION POINTS

- Think of how you can use available research evidence to improve quality of care. What would you change and how would you go about introducing change?
- How would you go about establishing mechanisms for exchange of nursing and other research to guide your practice?

Nurses deliver health services in schools, workplaces, prisons and other community settings. In the process they promote health, save lives and improve quality of life. But what does this look like on the ground where nurses are implementing cost-effective and care-effective services to a wide range of populations? Below some examples from a number of countries:

Cost effectiveness and care effectiveness of nursing interventions

Nurses are delivering cost effective services in varied settings saving health systems and governments financial and other resources. The literature on nurses and cost effectiveness is vast and varied. These country examples demonstrate the value of nurses in terms of being care effective and cost effective.

Taiwan — Improving mental health: Nurses in Taiwan implemented a hospital-based home care (HHC) for patients with mental illness and these services improved patient outcomes related to psychotic symptoms, social functioning and service satisfaction; compared to the patients in the conventional out-patient follow-up care (COF). The mean cost for the HHC group was US\$ 1,420.6 and for the COF group the cost was US\$ 3,208.2, clearly demonstrating that nurses are care effective and cost effective (Tsai et al. 2005).

Spain — Improving patients' functioning: a home care service model that involved nurse-led case management streamlined access to healthcare services and resources, while impacting positively on patients' functional ability and caregiver burden, with increased levels of satisfaction (Morales-Asencio et al 2008).

United Kingdom — Reducing cardiac morbidity: In 2009-2010, 453 British Heart Foundation Specialist nurses saw a total of 111,645 patients, made 171,449 telephone calls to patients, delivered 9,658 teaching sessions contributing to 8,438 fewer hospital admissions through nurse-led interventions. They saw patients in their own home and in clinics to monitor their conditions, adjust their medication doses and provide information and support. The nurses used a variety of care models: outpatient clinics, home visits, and tele-monitoring. An evaluation of the programme demonstrated that heart failure nurses reduced all-cause admissions by an average of 35 percent, and an average saving of £1,826 per patient was gained after the costs of the nurses have been deducted. There were significant improvements in quality of life and physical health of patients and heart failure specialist nurses have become the linchpin of a co-ordinated multidisciplinary community service to patients with heart failure (Pattenden et al. 2004).

USA — Reducing domestic violence: Families receiving home visits by nurses during pregnancy and when they had infants had significantly fewer child maltreatment reports involving the mother as perpetrator, compared to families that did not receive home visits. Of the women who reported 28 or fewer incidents of domestic violence, home-visited mothers had significantly fewer child maltreatment reports during the 15-year period than mothers not receiving the intervention (Eckenrode et al. 2000).

USA — Planned pregnancy: Women who received home visits by nurses had fewer subsequent pregnancies; fewer closely spaced pregnancies, and fewer months of using financial aid and food stamps. The home visits had enduring effects on the lives of women living in an urban setting (Kitzman et al. 2000).

Japan — Positive mental wellbeing: A study showed that women with post-partum depression who received four weekly home visits by a mental health nurse compared to those who did not, had significant improvement of depressive symptoms, and reported positive benefits from the home visits. Significant differences were observed between those who had home visits and those who did not in terms of increased scores of physical, environmental and global subscales, and the total average score of the WHO quality of life assessment instrument. On the psychological subscale, significant differences were observed between groups. The qualitative analysis of comments about the benefits of home visit revealed four categories related to 'setting their mind at ease', 'clarifying thoughts', 'improving coping abilities', and 'removing feelings of withdrawal from others'. These results suggest that home visits by mental health nurses can contribute to positive mental health and social changes for women with post-partum depression (Tamaki 2008).

Nurse effectiveness in HIV/AIDS care

HIV/AIDS has put a heavy burden on the nursing workforce and on healthcare systems. Nurses are the main providers of care as well as in prevention of infections, combatting HIV-related stigma and improving access to antiretroviral therapy.

USA — Reducing viral load: A study to test the effectiveness of a community-based advanced practice nurse (APN) intervention to promote adherence to HIV and psychiatric treatment regimens showed that patients who were assigned to APNs who provided community-based care management, at a minimum of one visit per week, and coordinated clients' medical and mental healthcare for one year, compared with the control group, had a significant reduction in viral load and increased CD4 count (Blank et al. 2011). This project demonstrated the effectiveness of community-based APNs in delivering a tailored intervention to improve outcomes of individuals with HIV and co-occurring serious mental illnesses.

China — Improving adherence: A study that set out to examine effects of nurse-delivered home visits combined with telephone intervention on medication adherence, and quality of life in HIV-infected heroin users, demonstrated that the group that received nurse-delivered home visits combined with telephone intervention over eight months, compared to the control group, were more likely to report taking their pills and on time. There were significant effects of intervention in physical, psychological and environmental domains of quality of life and depression. Home visits and telephone calls were effective in promoting adherence to antiretroviral treatment and in improving the participants' quality of life and depressive symptoms in HIV-infected heroin users (Wang et al. 2010).

South Africa — Improving health outcomes: A study that examined doctor-to-nurse task shifting showed that nurse-provided care of patients with HIV can be as effective as physician-provided care, and offers some particular benefits. These benefits included significantly improved TB detection, increased white blood-cell counts, weight gain and better treatment compliance. In addition, when nurses, rather than physicians, administered antiretrovirals, survival rates were not negatively affected. The findings show that with very little extra training and support, nurses can deliver HIV care that is just as safe and effective as that provided by physicians (Fairall et al. 2012).

Embracing technology to deliver cost effective care

Nurses have embraced technology to improve access to healthcare and outcomes and cost of care. The evidence shows that care provided using telehealth is of comparable outcome but at less cost than that provided in face-to-face encounters.

Canada — Reducing length of stay: Several examples demonstrate how nurses using technology to care for patients in their homes reduce the length of hospital stays, the number of hospital readmissions and visits to emergency departments.

- A study showed 85 percent fewer hospital admissions and 55 percent fewer visits to the emergency department among people enrolled in a New Brunswick telehealth homecare programme. Telehomecare also reduced the frequency of home care visits that nurses need to make, thereby improving their productivity (Canadian Home Care Association 2006).
- The 24-hour health information and advice services provided by registered nurses across Canada have decreased non-urgent emergency department visits by up to 32 percent, with high levels of satisfaction and low cost (Stacey, et al. 2004).
- Monitoring cardiac patients at home with telehome monitoring technology in Ottawa reduced hospital readmissions among angina patients by 45 percent over a one-year period (Woodend, et al. 2008).

USA — Reaching rural communities: Nurse specialists use telephones to provide follow-up visits to infants with lung disease in rural areas. The programme targets families living in rural areas who often find it difficult to repeatedly travel to a distant medical centre for follow-up care. Evaluation of the programme, believed to be the first application of telephone follow-up care for an infant population, delivers similar developmental and health outcomes as traditional models of care, suggesting that the programme successfully enhanced access without impacting on quality (AHRQ 2008).

Nurse effectiveness in community health and development

Nurses engage in addressing the broader issues of community mobilisation and development as well as in mobilisation for health-related actions including health promotion and disease prevention. While outcomes and cost effectiveness information in this regard is a challenge, the following example demonstrates nursing's role in addressing the social determinants in community health.

Mozambique — Improving lives: A nurse-led project in community development that aimed to improve the lives of women, youth and children involved women's groups by recruiting them as project leaders. After training the women returned to their communities and identified community development committees, collaborated with the committees to identify priority needs and shared information and worked together to address the priorities. The women were designated as *Promoter*s (promoters) of community development and health. The *Promoter*s assumed responsibilities for conducting training, budgeting, conducting field supervision and compiling reports. Evaluation of the project showed that it had a positive impact on the lives of the people in the areas where the *Promoter*s lived. A key lesson learned from the project was that development is like a tree, it must grow from the ground upward; it cannot be imposed from above (Ferrel 2002).

Latin America — Extending coverage: Nurses have a long history of alliances with a variety of health providers and community groups and respond to their needs. Through the implementation of primary health care, nurses have:

- extended coverage, provided essential care and helped to control illness and promote infant growth and development
- worked to improve the health of school children and improved immunisation coverage
- helped to reduce maternal mortality and improved detection of breast cancer
- mobilised communities in deprived areas for sustainable development and helped to set up social support systems (McElmury 2002).

Nurse effectiveness related to substance abuse

Substance abuse prevention is an important area for nursing interventions and research indicates nurses have contributed to this field.

Thailand — Reducing risky behaviour: A study that determined the effectiveness of Motivational Enhancement Therapy (MET) for hazardous drinkers in Primary Care Unit (PCU) settings in rural Thailand, showed that MET delivered by nurses in PCUs in Thailand appears to be an effective intervention for male hazardous drinkers (Noknoy et al. 2010).

Canada — Stopping smoking and addressing alcohol use: Another example from Canada shows that support and education by nurse practitioners leads to consistent results in reducing smoking and alcohol use, shorter hospital stays, decreased hospital admissions and more appropriate clinic visits, thus reducing cost and improving outcomes (Murphy 2005).

Nurse effectiveness related to staffing and educational level of nurses

The work environment presents nurses with complex challenges. Some of these challenges include the skill mix and the workload such that the lower the level of nurse staffing and the heavier the workload, the less favourable patient outcomes. The other issue is related to educational level of nurses and effect on patient outcomes.

USA — Reducing death, pain and suffering: A number of studies have shown that higher numbers and a richer mix of qualified nurses leads to reductions in patient mortality, rates of respiratory, wound and urinary tract infections, number of patient falls, incidence of pressure sores and medication errors (Irvine & Evans 1995; Shields & Ward 2001).

Europe — Better resource usage: A study by Aiken et al. (2014) in nine European countries that aimed to assess whether workload of nurses and nurses' educational qualifications were associated with variation in hospital mortality after common surgical procedures, showed that:

- an increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7 percent
- every 10 percent increase in bachelor's degree nurses was associated with a decrease in this likelihood by 7 percent

These associations indicate that patients in hospitals in which 60 percent of nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30 percent lower mortality than patients in hospitals in which only 30 percent of nurses had bachelor's degrees and nurses cared for an average of eight patients.

Nurse cost effectiveness in school health services

As the examples below show, in countries where school health services exist, nurses provide cost effective care to school children.

USA — Delivering UHC: A study that evaluated the quality and cost effectiveness of healthcare provided in urban and rural elementary school-based telehealth centres, using "plain old telephone system" (POTS) technology. A telehealth school-based model was developed that used a full-time school nurse, half-time mental-health consultant, linked pediatric practice, and linked child psychiatrist via POTS with an electronic stethoscope; ears, nose, and throat endoscope; and otoscope. The results showed that average family savings per encounter were 3.4 hours of work time (US\$ 43), US\$ 177 in emergency department and US\$ 54 in physician costs. Telehealth technology was effective in delivering pediatric acute care to children in these schools. Paediatric providers, nurses, parents, and children reported primary care school-based telehealth as an acceptable alternative to traditional healthcare delivery systems. The POTS-based technology helps to make this telehealth service a cost-effective alternative for improving access to primary and psychiatric healthcare for underserved children (Young & Ireson 2003).

USA — Making economic sense: In recent years many school districts have cut the services provided by qualified school nurses. However, a cost-benefit analysis of school health programmes showed that during a school year, at a cost of US\$ 79 million, school health programmes prevented an estimated US\$ 20 million in medical care costs; US\$ 28.1 million in parents' productivity loss; and US\$129.1 million in teachers' productivity loss. As a result, the programme generated a net benefit of US\$ 98.2 million to society. For every dollar invested in the programme, society would gain US\$ 2.20. Eighty-nine percent of simulation trials resulted in a net benefit (Wang et al. 2014). The results of this study demonstrated that school nursing services were a cost-beneficial investment of public money, warranting careful consideration by policy makers and decision makers when resource allocation decisions are made about school nursing positions.

Quality and cost effectiveness of nurses compared to physicians in PHC

Nurses are the main providers of primary health care (PHC) services in most countries. Their role in PHC includes health promotion, disease prevention, care coordination and prescribing medicines. Studies on effectiveness of nurses in PHC show that outcomes of care are superior or comparable to care provided by physicians. The examples below attest to this reality.

International — Broadening scope of practice: An international systematic review set out to answer the research question: What is the impact of the primary and community care nurse on patient health outcomes compared with usual doctor-led care in primary care settings? The review demonstrated modest international evidence that nurses in primary care settings can provide effective care and achieve positive health outcomes for patients similar to that provided by physicians. Nurses are effective in care management and achieve good patient compliance. Nurses are also effective in a more diverse range of roles including chronic disease management, illness prevention and health promotion (Keleher et al 2009).

Canada, UK and USA — Investing in advanced nurses roles: Similarly, a systematic review of comparison of nurse practitioners (NPs) with physicians in primary health care settings in Canada, the UK and the USA, showed low to moderate quality evidence that patient health outcomes were similar for nurse practitioners and physicians, but that patient satisfaction and quality of care were better for nurse practitioners. Moderate quality evidence suggests that nurse practitioners had longer consultations and undertook more investigations than physicians. No significant differences between nurse practitioners and physicians were found regarding numbers of prescriptions, return consultations and referrals (Horrocks et al. 2002).

England and Wales — Improved patient satisfaction: In a comparison of care effectiveness and cost effectiveness of general practitioners and NPs in PHC, outcome indicators were similar for nurses and general practitioners, but patient satisfaction was higher in those cared for by nurses. NPs were slightly more cost effective than general practitioners (Venning et al. 2000).

USA — Better value for monies: In 2009, the national average cost of an NP visit in the USA was 20 percent less than a visit to a physician. (Eibner et al. 2009). A meta-analysis reviewed the evidence regarding the impact of NPs compared to physicians on healthcare quality, safety and effectiveness. The review covered articles published from 1990–2009 which were summarised into 11 aggregated outcomes. The systematic review showed that outcomes for NPs compared to physicians (or teams without NPs) were comparable or better for all 11 outcomes reviewed. A high level of evidence indicated better serum lipid levels in patients cared for by NPs in primary care settings. A high level of evidence also indicated that patient outcomes on satisfaction with care, health status, functional status, number of emergency department visits and hospitalizations, blood glucose, blood pressure, and mortality were similar for NPs and physicians (Stanik-Hutt et al. 2013).

In a succinct summary of the NP literature Bauer (2010) concluded that every study published in peer-reviewed journals has reinforced the Office of Technology Assessment's 1981 conclusions (LeRoy & Solowitz 1981) that NPs can be substituted for physicians in a significant portion of medical services - ranging from 25 percent in some specialty areas to 90 percent in primary care -- with at least similar outcomes. Not a single study has found that NPs provide inferior services within the overlapping scopes of licensed practice. **No matter what setting, nurse practitioner care has proven to be a high-quality, cost effective means of primary care delivery.**

The various examples show that whether in health facilities, or community settings and homes, nurses deliver cost effective and care effective services. Yet, nurses lack support to implement evidence-based care and there is often a huge lag in using the available research to improve quality and cost of healthcare. Nurses are well positioned to be the primary care provider and act as a gatekeepers and entry point to other levels of health services. To achieve this, the full potential of the nursing workforce must be fully mobilised to create healthy societies in a healthy world.

ACTION POINTS

The above examples are illustrations of what nurses can do 24 hours a day, 7 days a week, 365 days a year. To mark your case success:

- seek out examples from your country.
- compare your practice with best practices.
- set an agenda that drives cost effective care effective services.

Chapter 5 highlights the way forward and outlines an agenda for action for nurses and NNAs.

Chapter 5

Way forward

Role of nurses and NNAs

I think one's feelings waste themselves in words; they ought all to be distilled into actions which bring results – Florence Nightingale.

An agenda for action

Nurses and national nurses associations (NNAs) have a central role in contributing to sustainable healthcare financing and cost as well as care effectiveness. Every day, nurses see the challenges of obtaining resources needed for patient care and for personal protection. Despite the challenges, nurses can develop the skills and confidence to influence and shape health policy.

Nurses deal with life and death situations and they have knowledge and experience in improving healthcare through helping to shape effective health policy. Nursing has a major contribution to make to health policy. Yet, nurses are having trouble getting this message to policy-makers and, in many countries, nurses have not played or been given the opportunity to have an active role in the policy process (ICN 2005a).

The nursing gap in policy involvement can be a major barrier to nursing effectiveness, health team functioning and quality of care. Some evidence suggests that nurses can waste time and energy solving problems of supply and equipment needed in their day-to-day patient care that could be easily addressed through management support and nursing involvement in policy and decision-making (Tucker 2002).

This year's IND theme of *Nurses: A Force for Change, Care Effective, Cost Effective* echoes, a clarion call for action for nurses and NNAs to mobilise individually and collectively to tackle health system financing and achieve quality of care and patient safety in a cost effective way. So what can nurses do for more effective and sustainable healthcare financing?

Through your actions and interactions with policy makers and others nurses need to:

- **Use your experience.** Nurses have a wide range of experiences of working in the health system to build a case for effective financing of health systems. However, experiences should be informed by facts and figures to encourage intelligent lobbying and advocacy.
- **Pool your insights.** Nurses face similar problems. Pool your expertise and gather information on what has worked elsewhere rather than re-inventing the wheel. Apply the solutions within context and with knowledge, vigour and determination.
- **Learn the language of economists** and the type of arguments that convince policy makers of the need for additional funding. This includes an understanding of cost effectiveness, care-effectiveness, cost-benefit, and measuring outcomes of care so you can communicate well with policy makers.
- **Target your arguments** towards the Ministry of Finance as well as the Ministry of Health and do not forget the private sector.

- **Keep informed of developments.** It is important to know what is happening in healthcare financing, access to care, community concerns, and in the country generally. Nurses must keep up-to-date with public issues by engaging in dialogue with others, attending public meetings, reading newspapers and journals.
- **Develop an informed position** for your ideas so as to engage in smart dialogue with others using facts and figures. Emotional arguments on crucial topics such as need for more funds for healthcare, protective equipment or nurse-staffing levels do not make an impact.
- **Write and publish either alone or with colleagues.** Relevant and timely articles in journals, newspapers and magazines can help influence opinion. Keep an eye on current issues that would benefit from a nursing perspective. Collaborate with nurse researchers to obtain evidence to document ideas and discussions.
- **Mobilise public opinion** by participating in grass roots groups and use local radio to reach out citizens. Tell stories that people can relate to.
- **Join special interest organisations** such as patient or consumer groups that match your interests and share your positions. Your contribution might be more effective if presented through a larger group with an established reputation and credibility. Your NNA is a good source of information, support and consultation.
- **Know who the key players are**, such as politicians and officials in local, regional and national government. Visit them your colleagues, but prepare carefully. Develop an agenda and consider what you will present and how you will respond to difficult questions. To be persuasive, you need to be clear and concise in meetings. In addition, support your views with hard data or factual evidence to increase your credibility. Disseminate a brief summary of the issues. Remember to keep regular contact with key stakeholders and policy makers, not just when you need them.
- **Link with the key nurse leaders and networks** that you might work with to have input into policy. For example, nurses in top positions in health ministries are valuable contacts. They are a key ally in getting your message across to the right audience.
- **Establish regular contact with nurses in influential positions.** They may be in policy or senior management positions in departments of health or other health organisations. Sometimes nurses are elected representatives in government at all levels or they may be members of parliament. Nurses are also found in public service organisations, voluntary organisations and non-governmental organisations. These groups can be useful resources to help you achieve your health policy goals.
- **Communicate your position** through ongoing representation in policy-making bodies, lobbying, written or oral submissions, and meetings with people in positions of influence. Remember to keep good relationship with the media.

Designing and implementing a sound health financing strategy involves continuous lobbying and advocacy rather than a one-off action towards a perfect system. The idea is to achieve a win-win situation so your efforts and contribution to health policy benefit health systems, patients and nurses. Building effective health and social policy requires that nurses collaborate with a wide range of stakeholders including patients' organisations, other health profession associations, other sectors such as human rights and women's groups, and others.

Role of NNAs

As the face and national voice of nursing in the country, NNAs have a tremendous opportunity to advocate and reinforce the critical role of nurses in the development of quality health policy and the effective and efficient redesign of health systems that increase access and deliver effective health interventions. As such NNAs are the conscience and moral compass of the profession to whom individual nurses and the public look up to for guidance and leadership on vital health issues and policies. These issues and policies include, access to care, quality of care, patient safety, and safe working environments. Healthcare financing underpins all these issues.

NNAs represent nurses with diverse competencies and resources that can be mobilised for the benefit of the population and the profession. The collective wisdom and knowledge that exists within NNAs is an asset that must be tapped fully. Nurse clinicians, managers, academics and researchers should work in tandem with the NNA leadership to realise the nursing agenda of building healthier societies. In order to achieve this, health financing mechanisms must be factored into the work of the NNA. So what can NNAs do to support effective health policy that supports nurses to function at their optimum and as care-effective and cost-effective professionals? Some of the activities that NNA can address include:

Action 1: Map out the vision. Establishing a vision for the future based on an understanding of the present is crucial, because the decisions that NNAs choose towards cost-effectiveness and care-effectiveness are vital to effective health systems. In order to do these NNAs must involve nurse managers, clinicians, researchers and educators and others such as policy makers and other health profession organisations to map out a vision. The vision should be used as a road map for NNA actions to influence health policy.

Action 2: Conduct situation analysis. The situation analysis should focus on components of healthcare systems including financing, access to care, nurse-staffing levels and challenges, workplace environment, access to supply, equipment and personal protection equipment. The situation analysis does not need to start from scratch as much of this information is available from annual reports of the Ministry of Health and other health facilities. Having the right information is a basis for strategy development and a good starting point for change. Disseminate the information from the situation analysis to NNA members.

Action 3: Use the language of economists and the type of arguments that convince policy makers in issues such as the need for policy changes, the need for additional funding or increased staffing levels. This includes an understanding of cost-effectiveness, care-effectiveness, cost-benefit, and measuring outcomes of care so you can communicate well with policy makers.

Action 4: Be aware of current and emerging government priorities (e.g. addressing universal health coverage, the post 2015 sustainable development goals) and frame your argument in relation to these priorities.

Action 5: Position the NNA as an expert resource on important healthcare issues by developing clear policy positions. Produce printed policy statements that are supported by data from relevant publications, research studies, and respected opinions. Use ICN position statements - such as the ones annexed to this document and those found on the ICN website (www.icn.ch/publications/position-statements/) – as references and adapt to meet local needs.

Action 6: Lobby government and policy-making bodies to ensure that the nursing voice is included, particularly where it is clear that the NNA has an important contribution to make. These include healthcare financing and its impact on access to care, quality of care, patient safety and workplace issues. Decide on the most appropriate strategies for involvement in different policy processes. For example, the NNA could seek formal representation on a policy board or committee; make submissions as part of the policy process; publicise the NNA's position on an issue; or lobby key people. Provide regular briefings to policy makers on key nursing and policy issues and impact on patients, nurses and health outcomes. Use facts and figures to make your point.

Action 7: Be alert to health and public issues, both locally and nationally. Keep track of new policies the government is proposing. Find out about the issues, the policy development process and the approaches to see how the NNA can contribute to better health and social policy. Provide timely response in face-to-face meetings or through written submissions. Ensure that public and written NNA statements are clear and professionally presented.

Action 8: Form strategic alliances with other organisations that share similar vision, positions and concerns as the NNA. Establishing ties is an effective way to increase the impact of submissions and briefings, without compromising the core values of the NNA and the profession. For example, the alliances can be with other health profession organisations similar to ICN's membership in the World Health Professions Alliance (WHPA), which is a global alliance of key health profession organisations ([/www.icn.ch/projects/world-health-professions-alliance/](http://www.icn.ch/projects/world-health-professions-alliance/)).

Action 9: Develop unified positions with other nursing organisations. Unity within the nursing profession is essential to ensure that there is a unified nursing voice on the issues. Nursing organisations must agree to support each other and work together on important issues without losing their individual identities. This must include key messages that need to be agreed and communicated to policy makers. If policy makers receive differing messages from different nursing organisations in the country, they are unlikely to listen to a nursing 'voice'.

Action 10: Educate NNA members on policy issues related to health care financing, cost of health care and access to care. Mobilise members to advocate the association's position, showing strength through numbers and unity. Keep members informed and provide regular feedback to avoid rumours and misinformation. The NNA must identify spokespersons who are dynamic, articulate, well informed and committed to represent it in policy issues. They must be perceived as constructive and knowledgeable, and be prepared to take an active part in discussions. They must also be willing to take guidance from the NNA leadership and provide feedback on major points arising during the policy process.

Action 11: Prepare younger nurses for leadership roles in influencing health policy. Provide mentorship to younger nurses by taking them to policy forums to expose them to the policy process and key players. Guide them to get experiences that can develop their abilities. Support them to take on additional responsibilities to become 'policy activists' related to health financing, the value of nursing, access to care and quality of care.

In all of these, it is important to foster constructive relationships with influential people, including key stakeholders for specific policy issues or important players in the policy environment. The NNA must be seen as constructive and offering solutions. If the NNA is perceived as constructive in the discussions or in its written submissions, it is likely to be involved in policy development and likely to be considered as a key stakeholder in the policy making agenda. It is good to remember that the relationships and meetings must be on regular basis; and not just when the NNA needs something.

NNAs must mobilise their resources and expertise to maximise their role in shaping sound health policy. A clear understanding of the health policy process, as well as a good grasp of the health financing landscape will empower nurses and NNAs to "walk the talk" and lead nursing to be truly a force for change.

Research agenda

Research is often seen as an ivory tower activity and far removed from the daily work of nurses. However, it must be made clear that research is part and parcel of the day-to-day nursing work and that every nurse and every NNA has a key role in nursing research. The nursing agenda for action to influence health policy would be incomplete without production of new knowledge through research, and excavation of existing knowledge through literature review. NNAs are well positioned to mobilise financial and human resources in their membership to obtain new information through research as well as through dissemination of existing research. Shaping effective health policy needs to be informed with robust and research-based evidence.

Nursing faces a challenge in participation in the policy arena. A future nursing research agenda is needed that helps in generating new knowledge on what works and what doesn't in relation to engaging nurses in shaping health policy. For example, what are the barriers, and facilitators of nurse-involvement in health policy? Are these factors internal to the profession or are they externally located? This knowledge is, of course, vital for developing strategies to remove the barriers and to enhance nurse- involvement in policy.

Financial and human resources are limited and research should unravel better and effective ways of promoting health and of preventing disease, and better ways of care and cure. There is a vast body of literature on cost effectiveness and care effectiveness of nursing interventions. This research needs to be made widely available to nurse managers and policy makers. However, a better understanding of optimising the nursing workforce through innovations such as task shifting or task sharing is needed. As well there is need for more research in understanding skill-mix and care outcomes. And nurses and NNAs can contribute to this understanding.

The optimal allocation of resources remains a high priority for nursing and for wider healthcare. Nursing forms the largest part of the global healthcare workforce and nurses are key both to the delivery of healthcare and to health improvement. In order to protect these vital functions (Aiken et al., 2014), robust methods of costing are needed. Nursing terminologies, such as ICNP, that can improve consistency in nursing data collection are important. However, additional tools are needed to make the data meaningful. One example of such a tool is the Belgian Nursing Minimum Data Set (B-NMDS) which is used to inform the allocation of budgets according to nursing need in hospitals across Belgium (Sermeus et al. 2009). The results of ongoing research to link ICNP and the B-NMDS have been encouraging (Hardiker et al. 2014).

Educational levels of nurses and links to quality and outcome of care is another exciting area. Nurses and NNAs can take these issues to help produce knowledge that would guide nursing education policies in their countries. For example, what level of nursing education is more effective for delivering cost-effective services in primary health care, intensive care, emergency departments, etc.? While some NNAs have the capacity to conduct and commission research, others face challenges. However, there is a lot of research that needs to be disseminated. And dissemination of research would be a good starting point for many NNAs.

A research agenda is needed to transform nursing and to empower nurses to be truly "*A Force for Change: Care Effective and Cost Effective*". The future of nursing research is bright; however a lot remains to be done to make nursing, as well as policy issues, evidence-driven. And the collective wisdom, commitment and knowledge of the world's nurses offer hope for advancing evidence-based, quality care for all.

Chapter 6 Conclusion

Nursing is often described as a 'sleeping giant' that should be awakened to realise its full potential. This description is perhaps apt particularly when it comes to involvement in health policy in general and health financing in particular. Nurses are at the core of healthcare delivery but marginalised from contribution to health policy development and decision-making. As shown in the country examples in Chapter 4, there is a growing body of evidence that nurses achieve as good or even better health outcomes in a range of clinical settings; therefore their engagement in policy making is essential. If the energy of the millions of nurses is awakened with the full support of managers and policy makers, and with their full involvement in policy, then nurses would truly be a force for change to transform health systems. If the examples given were systematised and implemented then the financial benefits would be enormous. Care effective, cost effective services could be the universal reality.

Nurses continue to provide care with resilience and versatility often with little or no resources or organisational support. Nursing is also described as the 'backbone of healthcare delivery'. However, it is apparent that this backbone is being chipped away through constant erosion and depletion of energy. A case in point is the depletion of the nursing presence at the headquarters of the WHO (ICN 2013b). Yet, the World Health Assembly, the supreme decision making body of WHO, has repeatedly recognised that nurses are essential to the development of quality health policy and the implementation of effective health interventions. The increasing absence of the nursing voice within Ministries of Health and the WHO needs attention now more than ever.

This year's IND theme of *Nurses: A Force for Change, Care Effective and Cost Effective* is indeed fitting and timely. As shown in the research evidence from the various country examples, nurses are indeed cost effective and care effective professionals. With redesigned health systems and full participation of nurses in policy, the healthcare landscape can be transformed to improve access to care, patient safety and quality of care for all.



Position Statement

Promoting the value and cost-effectiveness of nursing

ICN Position:

Evidence shows that nursing is a cost effective yet often undervalued and underutilized health care resource.

Nurses must clearly articulate and demonstrate the value and cost-effectiveness of nursing and nursing outcomes to consumers, other health providers and policy-makers at all levels. They must also be able to negotiate and advocate for the resources needed to provide safe care.

Nurses have a responsibility to engage in research and develop innovative models of care delivery that will contribute evidence of nursing effectiveness to planning, management and policy development.

Nursing education, especially management and leadership development programmes, must help nurses become skilled and articulate in demonstrating the value and cost effectiveness of nursing to the health services. Nursing education institutions, and where relevant nursing regulatory bodies, should regularly review curricula to ensure the inclusion of content related to the value and cost effectiveness of nursing.

National nurses associations (NNAs) have an important role in helping determine and influence health and public policy that promotes cost effectiveness and quality of care.

National nurses associations must develop strategies to actively promote the participation of nursing in health service decision-making, nursing and health research, and health and public policy development. This requires developing and supporting strategies for the preparation of nurse leaders who are skilled and articulate, and able to demonstrate as well as promote the value and cost effectiveness of nursing to the health services.

Nurses must assert their professional involvement in policy formulation at all levels.

With rising health needs and health care costs, which includes costs associated with the provision of nursing services, nurses must take the initiative in defining, examining and evaluating the health outcomes and costs of their activities.

Nurses, especially nurse leaders, must have a good understanding of the purpose and nature of health care reform, and the contribution nursing can make at all levels of health care delivery, and in planning, management and policy development for health care services. Where health care reform is in its planning stages, nurse leaders must play a leadership role in policy development related to the appropriateness, nature and purpose of health reform.

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The International Council of Nurses (ICN) and member associations can assist nursing to develop the capacity for dealing with cost-effectiveness in health care, by:

- Promoting the role of nursing as a core resource in cost-effective care and as a critical contributor to decision making on healthcare spending.
- Offering nurses educational opportunities to gain knowledge of political skills, economic principles, budgeting and resource use and cost-effectiveness in health.
- Supporting leadership and management development that includes the role of nurses in resource management, decision-making and policy development.
- Promoting and supporting research and evaluation that links and validates costing methodologies to nursing and health outcomes.
- Encouraging the development of database systems that permit comparison of outcomes across settings to best approaches to care and the most effective design of nursing systems.
- Facilitating information dissemination and interactive networking on cost-effectiveness research, cost-saving strategies and best practice standards.
- Establishing professional networks with relevant stakeholders, to foster collegial collaboration and exchange of ideas and information aimed at promoting quality and cost effectiveness.
- Promoting equity in terms and conditions of service for nurses, to recognize and support their role in promoting cost effectiveness and quality of care in multi-disciplinary settings.

Adopted in 1995

Reviewed and reaffirmed in 2001



Position Statement

Participation of nurses in health services decision making and policy development

ICN Position:

Nurses have an important contribution to make in health services planning and decision-making, and in development of appropriate and effective health policy. They can and should contribute to public policy related to preparation of health workers, care delivery systems, health care financing, ethics in health care and determinants of health.

Nurses must accept their responsibilities in health services policy and decision-making, including their responsibility for relevant professional development.

Professional nursing organisations have a responsibility to promote and advocate the participation of nursing in local, national and international health decision-making and policy development bodies and committees. They also have a responsibility to help ensure nurse leaders have adequate preparation to enable them to fully assume policy-making roles.

Background

Because of their close interaction with patients/clients and their families in all settings, nurses help interpret people's needs and expectations for health care. They are involved in decision-making at clinical practice level as well as in management. They use the results of research and trials to contribute to decisions on quality, cost-effective health care delivery. They conduct nursing and health research that contributes evidence to policy development. Because nurses are often coordinators of care provided by others, they contribute their knowledge and experience to strategic planning and the efficient utilisation of resources.

To participate and to be effectively utilised in health planning and decision-making, and health and public policy development, nurses must be able to demonstrate their value and convince others of the contribution they can make. This may involve improving and expanding the scope of the preparation of nurses for management and leadership, including their understanding of political and governmental processes. It may also involve increasing their exposure through management and leadership roles and positions in both nursing and other health care services, encouraging nurses to participate in government and political affairs, and improving and marketing the image of nursing.

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The International Council of Nurses (ICN) and its member national nurses associations (NNAs) promote and support all efforts to improve the preparation of nurses for management, leadership and policy development. This preparation should be broad and must include the development of knowledge and skills for influencing change, engaging in the political process, social marketing, forming coalitions, working with the media and other means of exerting influence. It must recognise the complex processes and factors involved in effective decision-making.

Professional nursing organisations need to employ a number of strategies to contribute to effective policy development, including monitoring the utilisation of nurses in the workforce; incorporating new models and management strategies; continually marketing a positive image of nursing to key management and policy stakeholders nationally and internationally; disseminating relevant knowledge and research; and, continually developing and maintaining appropriate networks to enable collaborative working relationships with governmental and non-governmental organizations. For its part, ICN will promote and make available information regarding the contribution of nursing in health decision-making and policy development.

Adopted in 2000

Reviewed and revised in 2008



Position Statement

Management of nursing and health care services

ICN Position:

Nursing has a responsibility to contribute to health planning and policy, and to the coordination and management of health services. The International Council of Nurses (ICN) expects nurses to contribute to health policy locally, nationally and internationally through management and leadership roles at all levels and through direct engagement and advocacy by National Nursing Associations (NNAs). The need for excellence in management of nursing and health systems must be actively promoted.

ICN firmly believes that nursing services must be directly managed by nurses. In a situation where there are non-nurse managers whose staff includes nurses, ICN believes that nurse leaders in these situations must have authority to give direction on matters pertaining to professional nursing. In all such situations it is the nurse who is accountable for the scope and standards of nursing practice.

In addition, ICN believes that nurses are well equipped to manage a wide range of health services.

ICN expects nurse managers to receive equal opportunity, preparation and remuneration for management, policy development and leadership as do other health personnel being prepared for senior positions in the health sector.

Background:

The roles and functions of nurse managers are continually being re-defined in the context of health sector change.

Leadership is an essential component of management. It is critical that nurse leaders are well prepared to assume roles as managers in nursing and health care services, in education or in health policy. Nursing leadership includes coaching and mentoring others, and creating the environment for ongoing development and quality care.

Strong nursing leaders support staff in their practice by addressing both professional and clinical issues, promoting job satisfaction and improving the quality of care for health consumers. Specifically, nurses at executive levels play an integral role in the delivery of quality care by providing: strong and effective leadership; social influence; strategic direction; and, authority within an organisation.¹

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¹ Cook M.J. 2001. The attributes of effective clinical nurse leaders. *Nursing Standard*, 15(35), 33-36.

Excellence in the management of nursing and health care services must be actively promoted. Professional nurses associations can strategically influence to ensure that the profession is engaged in health planning and policy

Maintaining networks and linkages with and between key stakeholders is essential to effective leadership and management. Also critical is the ability to continually assess the environment, to monitor performance and to create or adapt to change as required.

Educational preparation for management will vary according to the roles and career paths of nurse managers. ICN has a role in promoting sound education for management and leadership. Professional nursing associations can assist by identifying relevant opportunities and promoting these to their members. Individual nurses must take responsibility for their own education, and develop the ability to plan and manage this strategically.

Nurses need to select appropriate uni- or multi-disciplinary programmes to prepare them effectively for management, policy development and leadership in different settings and at different stages of their professional and career development. Preparation should reflect the importance of continuous learning that is adapted to changing needs and expectations. It should include emphasis on the development of relevant skills and attributes, not just the acquisition of knowledge.

Achievements of nurse managers need to be rewarded in the same ways as other managers. At the same time nurse managers need to demonstrate the benefits of their inclusion in key positions. Appropriate position classifications, equal to other managers at the same level and according to their professional attributes and their level of responsibility, should apply to nurse managers.

Adopted in 2000

Reviewed and revised in 2010



Position Statement

Publicly funded accessible health services

ICN Position:

The International Council of Nurses (ICN) and its member national nurses associations (NNAs) advocate for the development of national health care systems that provide a range of publicly funded essential and universally accessible and equitable health services to the population.

People have a right to equitable health services: promotive, preventive, curative, rehabilitative and palliative. ICN believes that these services should be patient- and family-centred, evidence-based and continually improving in quality measured by agreed benchmark standards and indicators.

Where such services are not publicly funded, ICN believes that governments have a responsibility to ensure accessible health services to the population with focus on vulnerable groups especially those from low socioeconomic groups.¹

ICN supports efforts by national nurses associations to influence health, social, education and public policy that is based on the health priorities for the nation, equity, accessibility of comprehensive and essential services, efficiency (including productivity), cost-effectiveness, and quality care.

ICN views primary health care as the preferred means of delivering essential health services at a cost that governments and communities can afford.²

Accessible, cost-effective and quality services, appropriate regulatory principles and frameworks, standards and mechanisms, and positive practice environments need to be established and applied equally to both private and public health services.

Nurses and NNAs have a responsibility to advocate for such health services, monitor their effectiveness, and drive health policy development, decision-making and implementation to ensure that all people have access to nursing and quality health services.

ICN supports efforts by NNAs to ensure that government policy for publicly funded and accessible health services does not downgrade the level of nursing education required by the complex demands of these services since evidence shows that registered nurses achieve better care outcomes.³

¹ Commission on Social Determinants of Health (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization.

² The World Health Report 2008. Primary Health Care Now More than Ever. Geneva: WHO.

³ Aiken L, Clarke S, Cheung R, Sloane D & Silber J (2003). Educational levels of hospital nurses and surgical patient mortality. *JAMA*, 290, 1617- 1623.

Background

A healthy nation is a vital national resource. A prime goal of each nation must be to achieve the best health status possible for the population within the resources available.

All people should have access to competent nurses who provide care, supervision and support across the range of settings. Health systems need to scale up nursing capacity and encompass a range of strategies that address workforce planning, education, skill-mix, regulatory frameworks and career pathways to ensure effective, efficient and safe health systems.

ICN and member associations need to maintain effective networks with relevant stakeholders to help ensure resource allocation and availability of services are based on needs and priorities, promote primary health care, and consider quality and costs. This includes advocacy for the resources needed to prepare the nursing workforce for the growing burden of chronic and noncommunicable diseases, injuries, disasters and other health challenges facing nations and populations worldwide.

Adopted in 1995

Reviewed and reaffirmed in 2001

Reviewed and revised in 2012

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