The Interaction between Politics, Doctors and Nurses.

Paul De Raeve, RN, MScN, MQA
General Secretary of the European Federation of Nurses Association (EFN)

Introduction

The nursing care process and medical practice are two different professions, having two different educational processes and generating different outcomes. Unfortunately, nursing education and with it the nursing profession, is perceived as a 'lower education' although in many European Countries, nursing education is located at University level. The Bologna Treaty will speed up the process by which nurse education completes its move into higher education. Next to the perception of inequality in education is the even bigger gap between the political leadership of nurses and doctors. This affects the continuity of care, the quality of care, the reform and sustainability of the social security and health care system and the outcome of health care delivery for the European citizens. Currently, political leadership relates to status, authority and power. But authority is no longer self evident in society. In recent political debates reference is made to the arrogance and corporatism of the 'health professionals'. George Bernard Shaw, the Irish dramatist and author once wrote that "All professions are a conspiracy against the laity" (Act 1, The Doctors Dilemma). Nevertheless, in most health care settings nurses are 24 hours on 24 hours with those who need care. The communication with the doctors, even in the most difficult working conditions, is organised in such a way that the continuity of care and the best outcomes are guaranteed. Nurses take responsibility for this but do not get rich on it. In the new Member States, this nursing care process is carried out for less 200€ gross salaries a month and even worse, in some cases nurses are not paid for several months at a time. There are fundamental problems here that need to be addressed.

Strategy

In order to obtain health care reform based on criteria such as harmonisation, competition, accountability, effectiveness and solidarity, doctors, nurses and patients need to develop strategies for the construction of valid partnership relations. Exploring these partnerships requires the identification of effective leaders who are skilled in developing and implementing policy in different areas of the health system. It is important to develop effective strategies where all partners have equal opportunities and equal authority.

These partnerships need to focus on job performance, in a way that will lead to improving the health gain of patients/clients. Job performance is a function of the capacity to perform, the opportunity to perform, and the willingness to perform (Blumberg & Pringle, 1982).

The *capacity to perform* relates to the degree to which an individual possesses task-relevant skills, abilities, knowledge and experiences. Unless a nurse knows what is supposed to be done and how to do it, high levels of job performance are not possible. Clear occupational profiles, job descriptions and changes in new occupational profiles in relation to efficiency in work, quality in service and work conditions are needed as well as continuing training modules. The main points about improving the performance capacity in practitioners are to develop:

- qualifications and personal skills continuously in order to make changes;
- the capacity to be critical reflective about personal practice and
- the willingness to be constructive in the acknowledgement of the existing problems.

These problems need to be addressed in unity necessitating dialogue in the decision-making process and between all staff layers. Feedback, both vertically and horizontally, is needed to break down existing barriers and make better use of the manpower and at the same time as creating better workplaces.

The quality and extent of education and training in leadership influences the capacity to perform disproportionately. Most health care organisations react to cost pressures by looking at the cost of labour. Registered nurses are the primary target area for cutbacks in an effort to streamline expenses while remaining competitive. The lack of nurses gives the opportunity for substitution with minimally trained unlicensed assistants to provide direct patient care, such as basic care, and, in some cases, even performing complex high-risk, technical procedures. Within the nursing workforce, the theme of cost containment, leading to the substitution of 'expensive' nurses for 'cheaper' care assistants or aides, has become increasingly apparent in recent years in many countries (Buchan & O'May, 1999) and will influence the capacity to perform in clinical and political leadership. It also has a direct effect on the capacity of an organisation to respond flexibly and strategically to change and reform.

Having the *opportunity to perform* is an important ingredient of strategic change and reform. Nurses may lack the opportunity to perform not because of poor equipment or outdated technology, but because of poor decisions and outdated attitudes within leadership. In many settings, nurses are not at the decision table and in many European countries other toolkits, such as financing systems based on nursing data, have been developed to create an alternative decision-making process. Nurses and their patients pay a high price for this. In relation to other health care professions, 80% of the nursing care process relates to patient care. Unfortunately, only 45% goes directly to the patient due to administrative and grey-zone activities. Therefore it is essential, when designing new structures or systems, to include nurses and nursing in the decision-making process in order to get the full picture on care. Diagnosis related groups (DRGs-APDRGs) and economically derived quantitative data are insufficient for developing, evaluating and implementing policies.

Willingness to perform is the third factor and relates to the degree to which an individual both desires and is motivated to exert effort towards attaining particular levels of job performance. This concerns the personal choice of the individual, but the motivation is influenced by factors such low pay, stress, workload, poor image and working conditions. A change in the gender balance among junior doctors in Western Europe saw more women coming into medical practice. Their requirement of time out for family reasons is a new factor in workforce planning. They are also seeking job-sharing and/or part-time work opportunities. This produces challenges to the

current career progression pathways and they are therefore more likely to change career or retire from the service because the conditions of employment do not suit family responsibilities. This is equally the case for nurses.

Ingredients for performance

There are two significant challenges to encouraging good job performance and they will determine the success or failure of the described strategies.

Firstly, the design of data/information exchanges mechanisms needs to be linked to the development of networking and critical evaluation of what health professionals are doing. The decision-making process within health care settings, which is still highly normative, is step by step shifting to "informative" decision making (De Raeve, 1998, 2001). Information about nurses and doctors, nursing and medicine is required to inform health policy, to study and improve the quality and effectiveness of patient care, and to manage the human resources, including workforce planning and education. Medical and nursing data have a higher impact on budget determination due to the diversity of patient population (age, demographic features, pathology, and patient's need of care) and variation in patterns of care (different nursing care, medical treatments). Outcomes of clinical care for similar patients' shows large variations among individual providers, nursing units, hospitals and even regions and countries, even when the material, financial and human resources employed are the same (Saltman, R. & Figueras, J., eds, 1997). The performance in relation to patient care cannot depend only on quantitative indicators. If qualitative data have no place in policy development and political leadership, the health sector will end up with problems of retention and recruitment of nurses and doctors which will seriously effect the capacity of health services in all Member States. Qualitative data and evidence are needed to support arguments and proposals.

Secondly, the need for 'capacity building', through education is crucial, if health care performance is to be guaranteed. Research indicates that nurses are attracted to, and retained in their work because of the opportunities to care for people, to develop professionally, to gain autonomy and to participate in decision-making, whilst being fairly rewarded (Aiken & Havens, 1999). Nurses are the largest occupational group in the health sector and are a significant partner in policy development. Their inclusion ensures citizens', consumers' and patients' health and safety is taken into account. The problem being faced is that political and health care structures are rigid and difficult to change. One response to this is the decision of the Italian Presidency (second half of 2003) to focus on medicine and telemedicine as an objective for the health sector so as to improve the output of health care systems.

Nursing provides essential services and nurses are knowledgeable about client needs. Nurses have an expertise in negotiation on a daily basis and develop strong collaboration between different partners in care, 24 hours on 24 hours. Where the reason for collaboration is clear, an effective partnership will mean choosing partners carefully for their credibility, skills, past record of achievement, shared values and objectives (ICN, 2003). Partnership is the involvement of staff in decision-making, social dialogue and non-hierarchical co-operation between staff layers. A *sine qua non* is that this co-operation demands flexibility and the breaking down of the walls between different organisational levels. Despite the continuing emphasis on nurses' involvement, the ability to involve nurses is still not commonly achieved.

What holds nurses and nursing back from being active in policy?

The most important reason is the image others hold of nurses as a group. Nurses are perceived to be nice, friendly and hard working, but not powerful. All seats around the decision-making table are accounted for and occupied. Nurses are aware and understand the nature of power, what power they have or could have, and how to use it more effectively. This requires education at all levels. Preparing nurses for policy participation should be seen as part of nursing practice, and nursing education and power should not be avoided or rejected, nor must it be mis-used. Nursing must developed informed positions on key policy issues because a powerful role does not guarantee influence. Nursing must position itself to make effective contributions in the policy arena by holding key positions in government, by representation on key policy committees and by integrating political leadership into day-to-day activities in nursing, both individually and collectively. The nursing profession needs to be owned by nurses and for nurses and the value, even the added value of nursing needs to be on the political agenda. Finally, there are gender related issues. Nursing is a predominantly female profession and clinical and political leadership is linked to time and role conflicts (e.g. working hours) and the undervaluing of nursing by some groups as well as by many nurses themselves, because of the value placed on the position of nursing and women in society. Nurses should not blame others or the policy environment for non-participation or lack of visibility. Nurses must develop proactive strategies for addressing these difficulties in partnership. Most health professions are not homogeneous. There are many very different interest groups. The importance of unity is significant, and the value of diversity is crucial. Teamwork, partnerships, coordination and inclusiveness are essential values to guide policy activities, while at the same time using the uniqueness of different groups to best political advantage.

Conclusion

The two major components to health reform are changes in policy, and changing the structure and processes of health systems and organisations.

Nursing should be involved in health policy development, and political decisions such as the allocation of health resources and priorities for spending. Nursing provides essential services, but is often invisible in contributing to the planning and organising of health care services. In fact, nurses have often been negatively affected by health reform, especially if the main emphasis has been on cutting costs and if medical and economic models drove these reforms. This is reflected in loss of jobs, cuts in nursing budgets, increases in workload, concerns about job security and working conditions, concerns about patient safety and quality of care, inappropriate changes in the level and mix of staff, and lowered job satisfaction and motivation.

Therefore there is an urgent need for the growing involvement of nurses in contributing to health and social policy at national and European level and in acting at the same time as facilitators for implementation of proposed changes. Development, evaluation and implementation of policy at European, national, regional and last but not least, local level, need to be horizontally orientated and not hierarchical. Up till now policy development and implementation have taken place in two different worlds using a top-down approach for implementation. Increased advocacy and capacity building should lead to a horizontal approach.

Health reform brings an expanded need for education. For many years nurses have been equipped with the knowledge, strategies and strength to take up leadership, management and policy roles in nursing and health services in an environment of continued challenge and change. Education for new roles, expanded roles and nurse-led initiatives are needed as a long-term investment for

social policy development at the European level. Individual nurses, groups of nurses, and employers, all have a part in identifying opportunities for nurse-led services and new nursing roles. It is important to monitor and document benefits and outcomes including the cost-effectiveness of nursing interventions. This information can be used by nursing leaders and professional organisations to advocate for policy changes and decisions for the benefit of European citizens' health care systems. In addition, the whole area of incentives and rewards should be assessed against the documented benefits and outcomes. The positive contribution of nurses, and the difference they make, should be promoted more widely, and acknowledged and rewarded in concrete terms. New and expanded roles must be supported by appropriate professional regulation. This helps in the establishment of constructive and equal partnerships.

References:

Aiken, L. & Havens, D.(1999) Shaping Systems to Achieve Desired Outcomes. Journal of Nursing Administration, 29 (2), 14-20.

Blumberg, M. & Pringle, C. (1982) The Mission Opportunity in Organisational Research: Some Implications for a Theory of Work Performance. Academy of Management Review, October 1982, 565.

Buchan, J. & O'May, F. (1999) Globalisation and Health care Labour Markets: a Case Study from the United Kingdom. Human Resources for Health Development Journal, 3 (3), 199-209

De Raeve P. (1998) Approche méthodologique de la mesure de la production infirmière en Belgique - La mesure de la production hospitalière. , ULB, MISS - Maîtrise en Management des Institutions de Soins et de Santé, 87-100.

De Raeve P. (2001) The added value of joining process indicators within hospitals. Transparenz und Klarheit auf dem Weg zum neuen Entgeltsystem in Deutschland. Deutsche Casemix-Konferenz, Konferenzdocumentation, 58-64.

ICN. Globalisation and Health System Reform: Implications and Strategies for Nursing". Unpublished paper, ICN Geneva, 2003

Saltman, R. & Figueras, J., eds (1997) European Health Reform: Analysis of Current Strategies. World Health Organisation, Copenhagen.