Diana Bantz
Ann Wieseke
John Horowitz

Perspectives of Practicing Nurses on Ethical Issues In Health Care Economics

Perspectives of nurses working in seven hospitals across the United States are described. Most nurses believed that all people should have equal access and quality of health care. However, most nurses were unwilling to pay more taxes or donate time to achieve these goals.

In the United States, questions are being raised about who will receive which health care resources, at what cost, and who will pay for them (Donley, 1993; Mundinger, 1994). There has not been any scientific study that specifically asks nurses their views on these ethical-economic questions.

This study was designed to explore beliefs of nurses on ethical-economic issues they encounter, or potentially may encounter, in their practice settings. The following research questions were investigated:

1. Have registered nurse staffing patterns been affected by the decreased amount of funds available for health care?
2. Has the quality of nursing care been affected by the limiting of health care resources?
3. Should taxpayers be expected to cover the cost of health care for those who cannot pay?
4. Is there a relationship between personal sacrifice variables and responses to questions about who should pay for and/or receive health care?
5. Who should receive care? Does allocation of resources differ according to age, condition, compliance, or setting?
6. Should nurse practitioners/advanced practice nurses be allowed to provide preventive and promotive care equivalent to that of physicians in certain settings to reduce health care costs?

DIANA BANTZ, PhD, RN, is Assistant Professor, School of Nursing, Ball State University, Muncie, IN.

ANN WIESEKE, DNS, RN, is Assistant Professor, School of Nursing, Ball State University, Muncie, IN.

JOHN HOROWITZ, PhD, is Assistant Professor, College of Business, Ball State University, Muncie, IN.

Method

Sample. A convenience sample of registered nurses (RNs) at seven hospitals selected from across the United States was used for this study. The pool of RNs was drawn from staff and service administration. The entire RN population from the participating institutions was accessed after receiving permission from hospital research committees or nursing administrators. Approval was received from the Ball State University Human Subjects Review Board.

A cover letter was included with each questionnaire explaining the purpose of the study. Subjects were informed that there were no risks involved in either participating or not participating in the study. Anonymity was maintained by not asking for any personal identification, such as name or social security number. Subjects were informed that returning the completed question-

naire was interpreted as consent to participate.

Institutions participating represented a full range of hospital classifications. Three hospitals were large-sized metropolitan trauma centers with each having over 800 beds. Two other hospitals, each having over 300 beds, were located in middle-sized communities and provided secondary and some primary level care. Two hospitals, situated in small rural communities, provided secondary and tertiary level care and had less than 200 beds each.

Instrument. A 27-item questionnaire designed to evaluate nurse perspectives in relation to ethical issues and health care economics was developed for this study. Items were drawn from knowledge gained in a previous study that measured RNs' knowledge of health care economics and the relationship to nursing practice (Wieseke & Bantz, 1992), as well as from a review of the ethical-economic issues identified in the current health care literature (Buerhaus, 1994a; Mundinger, 1994; Joel, 1984; Hicks & Boles, 1984). Part one of the questionnaire contained 19 Likert-style items. This section of the questionnaire investigated RNs' perspectives in relation to equal care for all patients regardless of condition or setting, taxpayer paying for health care, use of nurse practitioners/advanced practice nurses to perform health promotion and health prevention activities, and the relationship between staffing and patients' risk of complications. Part two of the questionnaire contained eight forced-choice items that measured staffing patterns, willingness to provide care on personal time without recompense, and agreement to pay more taxes to ensure access to and equal quality of care for all individuals.

Psychometric properties of the instrument were examined. Internal consistency reliability for the total scale was estimated to be 0.82 by means of Cronbach's alpha statistic. Acceptable internal consistency reliabilities also were estimated for each of the five subscales that measured equal care across conditions ($r = .86$), taxpayers paying for care ($r = .86$), risk of complications ($r = .89$), use of nurse practitioners/advanced practice nurses ($r = .77$), and equal care across settings ($r = .77$). The subscale, equal care across conditions, includes items that query both whether all patients in the nurse's hospital actually receive equal care across conditions and whether the nurse believes that patients should receive equal care across conditions. Items in the subscale, equal care across settings, refer to care provided in an ideal setting and that received in the nurse's actual employment setting.

Validity of the instrument was assessed by means of expert review and principal components factor analysis with varimax rotation. Two nurse researchers in the areas of economics and management, two nursing administrators, and three experts in the area of business economics critiqued the questionnaire before it was administered. They concluded that the instrument measured the expected content. Factor analysis revealed five factors that accounted for 67% of the variance in the data with all item loadings revealed as greater than 0.56. No items dual loaded on more than one factor.

Procedure. Questionnaires were mailed to individual hospital liaisons for distribution to RNs employed at the institutions. Questionnaires were returned to agency liaisons via envelopes marked only with the investigators' names and returned to the investigators by bulk mailing. Five-hundred three usable questionnaires of the 2,500 distributed (20%) were returned.

Limitations of this study included a low response rate, possible evaluation apprehension, and the small number of items for each issue. Generalizability of the results may have been modified by the presence of these limitations.

Discussion of the Results

Demographic information requested included area of practice, type of position, years in practice, nursing education, practice setting, age, marital status, number of children, gender, and household income. Eighty-eight percent of the respondents were female (n=444), 3% were males (n=15), and 9% did not indicate their gender (n=44). Ages ranged from 20 to 60 with 59% of the respondents between the ages of 31 and 45 and a mean age of 38 years. Sixty-four percent of the respondents were married, 26% single, 9% divorced, and 1% widowed. Sixty-two percent reported having children. Household income, representative of total economic resources, ranged from $15,000 to over $85,000, with a mean of $56,000. Ninety-eight percent of the subjects worked in a hospital and 80% were employed in staff nurse positions. Forty-nine percent of the subjects reported that they worked in medical-surgical areas, 37% worked in critical care areas, 10% worked in maternal-child areas, and 3% worked in other areas, such as doctors' offices. Eighty-two percent had worked more than 5 years with a range of work experience from new to the profession to 40 years

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in practice. Forty-four percent had at least baccalaureate preparation, while 26% had associate, 18% had diploma, 12% had master's, and 1% had doctoral preparation.

Analysis of the relationships between scores on the subscales was completed using Pearson correlation coefficients. A strong positive correlation ($r = .32$, $p < .001$) was revealed between the belief that taxpayers should pay for health care and a belief that there is and should be equal care across conditions. Thus most nurses felt that equal care should be provided at taxpayer expense for 24-week gestational age infants whether the mother is a 17-year-old crack cocaine addict, a 35-year-old patient who has undergone fertility treatment, or a 24-year-old healthy primipara.

There was a weaker positive correlation between the belief that taxpayers should pay and a belief that there is and should be equal care across settings defined by hospital group ($r = .19$, $p < .001$). Subjects believed that clients were getting equal care and that clients should receive equal care regardless of the type of hospital in which the nurse was employed.

No significant relationships were found between use of practitioners/advanced practice nurses and beliefs related to equal care across settings or conditions. A moderate negative relationship was found between the belief in the use of practitioners/advanced practice nurses and beliefs related to risk of complications because of a decrease in nursing staff ($r = -.20$, $p < .001$). In other words, nurses who believed in the use of nurse practitioners/advanced practice nurses also believed that there was a higher risk of complications for the patient because of a decrease in nursing staff.

Research Question One: *Have registered nurse staffing patterns been affected by the decreased amount of funds available for health care?*

Fifty-eight percent of the respondents reported that a decrease in budget resulted in reduction of nursing staff positions. Fifty-nine percent reported that full-time positions were eliminated and 38% noted staff that left were not replaced. Nurses indicated the lack of adequate nurse staffing is cause for concern and that life-threatening physical complications could result. Weil and Stack (1993) voiced a similar concern stating that "health care reform with a modest decrease in a hospital's resource allocation could have a major adverse impact on nursing service" (p. 205). Nursing personnel in many parts of this country are unable to assume additional patient care responsibilities without hospitals restructuring their nursing and other related activities (Buerhaus, 1994b).

Research Question Two: *Has the quality of nursing care been affected by the limiting of health care resources?*

Overall respondents reported a perception that a decrease in nursing staff increased risk of life-threatening physical complications. In addition, medical-surgical nurses, subjects who were single, master's-prepared nurses, and those who had been in active practice less than 5 years responded that a decrease in nursing staff on their units was more likely to be associated with increased risk of psychological and nonlife-threatening physical complications. Grouping responses by hospital type revealed that those who were employed in large hospitals reported a perception that a decrease in nursing staff increased risk of all three types of complications. Results of this study support statements made by Prescott (1993) that there is evidence linking RN staffing levels and mortality, length of stay, and morbidity outcomes.

Research Question Three: *Should taxpayers be expected to cover the cost of health care for those who cannot pay?*

Overall subjects agreed that all patients should have access to all types of available health care regardless of ability to pay and that hospitals should provide care for the indigent with taxpayers paying the difference. Subjects with associate preparation, those who were married, and those who worked in critical care or maternal-child areas less strongly agreed with taxpayers paying the costs of health care for those who cannot afford it. Subjects agreed less strongly when asked if they personally would be willing to pay higher taxes to ensure equivalent health care for all. Maternal-child nurses and subjects across all hospitals grouped by size disagreed with using all measures to save a 24-week gestational age newborn across three different conditions (mother is a 17-year-old crack cocaine addict, mother is a 35-year-old who has undergone fertility treatment, or mother is a 24-year-old healthy primipara) regardless of who was paying for the care. On the other hand, subjects across all hospital types strongly agreed that triple bypass surgery should be provided with Medicare paying the majority of cost.

Subjects indicated that there should be universal access to health care regardless of ability to pay. Nurses generally felt that taxpayers should pay for those who

cannot afford insurance to pay for health care. This conflicts with an economic climate that possibly will result in limiting the number and types of treatment.

Research Question Four: *Is there a relationship between personal sacrifice variables and responses to questions about who should pay for and/or receive health care?*

Eighty-three percent of the respondents did not want to pay more taxes to ensure equal care for all and 55% were not willing to donate time to provide care for the indigent. Eight-two percent did not currently donate time and those respondents were less likely to agree that equal care was provided across conditions than those who were willing to donate time. Those who were not willing to donate any time were less likely to agree with taxpayers paying.

Nurses also are very conservative with the amount of time they are willing to donate so that all individuals might have access to health care. A full 82% of the nurses responded that they do not currently donate time to provide health care to the economically deprived and 55% were not willing to consider donating time. Those who were unwilling to donate time were less likely to agree that equal care was provided across conditions than those who are willing to donate time. It would seem that those who donate time are more invested and committed to ensuring that the economically deprived have access and equality of service.

In theory universal coverage is supported. In reality when the sacrifice is directed towards the individual, support declines. This is similar to Browning and Browning's (1994) discussion that when someone else pays for an item such as health care people want both a larger quantity of the item and better quality. For example, if someone else will pay for your automobiles most people would choose to buy a (or several) higher quality automobile such as a Cadillac or BMW rather than the Chevy or Ford.

Research Question Five: *Who should receive care? Does allocation of resources differ according to age, condition, compliance, or setting?*

Medical-surgical nurses, those employed in large hospitals, and single individuals responded that patients should receive equal care across settings; however, they reported that this was not necessarily reality. Subjects across all hospital groups disagreed with providing care for noncompliant clients with diabetes and alcoholism at taxpayer or insurance expense. Maternal-child nurses and subjects across all hospital groups disagreed with using all measures to save a 24-week gestational age newborn across different conditions. Subjects who were employed in large hospitals and who had either bachelor's or master's preparation disagreed that organ transplants should be provided to anyone who needs them; and they disagreed more strongly when the taxpayer would have to pay for the procedure.

When presented with specific clinical situations, the theory that all individuals should receive health care was not supported. Nurses did not agree that anyone who needed a transplant should automatically get one. When presented with the addition of taxpayers paying for the procedure nurses more strongly disagreed that all persons who need an organ transplant should receive them. Nurses employed in large hospitals and who held either a bachelor's or master's degree were more likely to disagree that all in need should be provided with an organ transplant. This may be due to exposure; those in large hospitals may have firsthand experience with transplant patients and those with a bachelor's or graduate education have a broader educational base on which to base their response.

Nurses did not believe that noncompliant chemically dependent or diabetic patients should continue to receive care. This supports the belief that the patient should be accountable for his/her behavior and involved in the care. If the patient is unwilling to make the needed lifestyle changes the resources should be distributed elsewhere. This brings up many ethical issues for nurses and care delivery which have yet to be answered. Who will receive the care? At what cost? Should compliance be addressed when making the decision about who will receive care? Does an individual have the right to receive care for the same condition more than once when lifestyle choices are contributing to poor outcomes?

Research Question Six: *Should nurse practitioners/advanced practice nurses be allowed to provide preventive and promotive care equivalent to that of physicians in certain settings in order to reduce health care costs?*

A majority of subjects regardless of hospital type agreed with use of practitioners/advanced practice nurses to perform equivalent preventive and promotive care to that of physicians in certain settings to reduce health care costs. Examining for differences between specific groups, staff nurses and those who had been in practice for 15 years or less strong-

ly agreed with the use of practitioners/advanced practice nurses as opposed to master's-prepared nurses and those who had been in active practice for 16 to 20 years. The difference in agreement may reflect a lack of understanding of the role of practitioner/advanced practice nurses.

Summary and Conclusion

The current study focused on the link between ethics and the economics of health care, with secondary emphasis on the behavior of the health care market, and the impact of economics on quality of care. Results indicated that practicing nurses believe the health care climate has lead to a reduction in staff positions and a resultant increased risk of complications. Most nurses believed that clients should have access to a wide spectrum of health care regardless of ability to pay and that taxpayers should finance the bill. However, when asked how much more they personally would be willing to pay in taxes to support this goal the majority did not want to pay higher taxes. Thus most nurses support equal high-quality care for all but are not willing to pay higher taxes to achieve this goal.

Conflict also existed for nurses who indicated that they believed all should have equal access to care. When given specific situations related to the patient's condition, age, and compliance, nurses made choices in who should and who should not receive care. Implications are that nurses are willing to ration care based on individual circumstance.

Overall respondents felt that nurse practitioners/advanced practice nurses would provide quality care in a cost-effective manner. However, there were some nurses who felt that advanced practice practitioners would not provide the population with cost-effective quality care.

Results of this study can be used by nurse educators and staff development personnel to discuss how economics affect nursing practice. Issues such as decreased staffing and how limited resources are allocated directly impact nursing practice. Nurses traditionally support the idea that all people should receive high-quality health care; however, nurses did not want to pay higher taxes to achieve this goal. Choices must be made and are now being made about who receives health care. Nurses who have been exposed to, discussed, and examined the issues will be in a much better position to deal with the continuing changes in the health care system.$

REFERENCES

Browning, E.K., & Browning, J.M. (1994). *Public finance and the price system.* Now York: MacMillan.

Buerhaus, P. (1994a). Economics of managed competition and consequences to nurses: Part I. *Nursing Economic$, 12*(1), 10-17.

Buerhaus, P. (1994b). Economics of managed competition and consequences to nurses: Part II. *Nursing Economic$, 12*(2), 75-80, 106.

Donley, Sr. R. (1994). Health care reform: Implications for staff development. *Nursing Economic$, 12*(2), 71-74.

Hicks, L., & Boles, K. (1984). Why health economics? *Nursing Economics$, 2*(3), 175- 180.

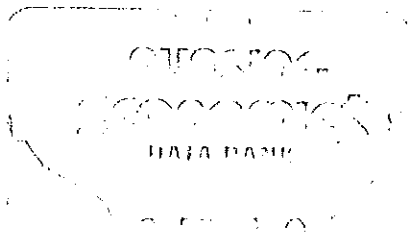
Joel, L. (1984). The economics of health care: Trends and problems. In G. Sorenson (Ed.), *The economics of health care and nursing.* Kansas City, MO: American Nurses Association.

Mundinger, M. (1994). Health care reform: Will nursing respond? *Nursing & Health Care, 15*(1), 28-33.

Prescott, P. (1993). Nursing: An important component of hospital survival under a reformed health care system. *Nursing Economic$, 11*(4), 192-198.

Weil, T., & Stack, M. (1993). Health reform - Its potential impact on hospital nursing service. *Nursing Economics$, 11*(4), 200-207.

Wieseke, A., & Bantz, D. (1992). Economic awareness of registered nurses employed in hospitals. *Nursing Economic$, 10*(6), 406-412.



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Health Care Execs Unprepared for Change

While 99.5% of health care executives and physicians surveyed stated that re-engineering was critical or important to their organization's survival, only 5% said their organizations were fully ready to affect this kind of change, according to a recent survey by Deloitte & Touche. Organizational commitment to risk and change was ranked by 70% of respondents as either the first or second most important factor necessary for re-engineering success. Yet, 92% of respondents said that organizational resistance to change was the highest obstacle they faced in re-engineering.