Regulating in the Public Interest: The Quality of Nursing Care

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Proponents of market competition in health care have been critics of health planning and health regulation, government functions seen as interfering with the realization of the benefits of market efficiency. In AHPA however, we see government oversight as essential to providing the discipline that markets need, and to realizing the benefits that markets have to offer for everyone in American society.

In 1999, AHPA published a statement on health policy which states, in part:

The reliance on market competition for "healthcare reform" is a political and economic experiment which is resulting in dislocations throughout society. The challenge to public policy is to facilitate the development of a responsible marketplace, one in which the sought-after benefits of competition are realized. To achieve benefit from this process for all residents, it is necessary for legislators to take a more active role in shaping the transformation of the market. Government is obligated to exercise sound stewardship of the public's resources, much of which it controls as the primary payer of services. Healthcare is a social good like safety and education which, in a democratic society, requires intelligent government oversight in order to balance competing needs and priorities.

The question for us is how best to demonstrate to our critics the primacy of the role of government oversight through planning and regulation in securing broad benefits for the public's health. I believe that the clearest case for this can be made when we address the quality of health care, for health care quality is a value commonly understood and held in high regard by legislators, health care providers, and the general public alike.

In a previous article ("Regionalization for Quality: Certificate of Need and Licensure Standards," accessible at http://www.ahpanet.org/research_articles.html#regionalization), I presented a case for government planning and regulation in fostering superior medical care resulting in better patient outcomes. The subject then was specialized hospital services, with the focus on surgeons and their hospital teams. Now, I'd like to look at general clinical services in hospitals and nursing homes, with the focus on nurses.

Nursing and the Quality of Health Care

Researchers looking at hospitals are increasingly finding close relationships between the quality of medical outcomes and the quantity and quality of professional nursing care. For example, a study by Prescott (1) found "substantial evidence linking RN staffing levels and mix to important mortality, length of stay, cost and morbidity outcomes." (p.197) A study by the American Nurses Association (2) found an inverse relationship between nurse staffing and hospital lengths of stay, and between patient morbidity indicators for preventable conditions and registered nurse skill mix.

In nursing homes, staffing by nurses is much more directly related to quality of care and quality

of life for residents. In a landmark study, the Institute of Medicine (3) found that nurse staffing ratios, and staff mix in particular, are most closely related to better outcomes for nursing home residents. The most significant variable in the studies the IOM reviewed was the ratio of RN hours to total staff hours per resident day. (pp. 147ff) One study by Cohen and Spector (4) calculated that "addition of half of an FTE RN (about a 10 percent increase in RNs on average staffing) would save about 3000 lives annually.

In a follow-up study, the IOM had this to say about nurse staffing:

Abundant research evidence indicates that both nursing-to-resident staffing levels and the ratio of professional nurses to other nursing personnel are important indicators of high quality of care, and that the participation of registered nurses in direct caregiving and in the provision of hands-on guidance to nurse assistants is positively associated with quality of care. Several studies have shown the importance of nursing management by professional nursing staff and gerontology specialists in making improvements in quality of care. (5) (p.12)

Magnet Hospitals

The American Nurses Association has established standards for nursing excellence that are based on the research linking nursing practice with better patient outcomes. It then identifies hospitals and nursing homes that meet its standards and certifies them as Magnet Hospitals through an application procedure which must be renewed every four years. These facilities have adopted a management philosophy with the highest standards for nurse administration and for the growth and development of nursing staff. To date, 27 hospitals and one nursing home have been so designated. Eight of these hospitals are in New Jersey.

The IOM (1996) summarized the findings of studies that compared Magnet Hospitals with control hospitals: "These findings indicate that lower Medicare mortality rates, as well as improved work-related well-being for RNs, are linked to hospital organization characteristics that result in RNs having: (1) more autonomy to provide care in their professional roles and within their areas of expertise; (2) greater control over what other care givers do in the patient care environment and over resources; and (3) well-documented and well-developed professional relationships with physicians." (6) The IOM concluded that "the magnet hospital study indicates that the preferred organizational structure is one in which the hospital management sees its primary responsibility as delivering patient care and therefore both places a high value on the quality of nursing services and actively supports the professional role of nursing services." (p.120)

The Need for Government Oversight to Ensure the Public Interest

In the 1990s, hospitals laid off thousands of nurses in response to market pressures, hoping to largely replace them with much cheaper aides. However, hospital patients were becoming sicker and hospitals soon had to abandon this approach and acknowledge that RNs were even more essential to hospital care than previously. Meanwhile, the economy opened ever more lucrative opportunities to the nurses who had been laid off. The nurses who remained became overburdened with greatly increased patient loads, responsibilities, and paperwork. Hospital

nurses began to experience stress levels that often made it impossible to continue their commitment to the professional ethos that had always motivated them to look after the best interest of their patients.

A national sampling of more than 7000 nurses by the American Nurses Association found that 75 percent of those who responded felt that the quality of nursing care in their institution had declined in the previous two years. Last year, the IOM highlighted the role of medical errors in premature hospital mortality, finding that up to 98,000 hospital deaths per year are attributable to such errors. The U.S. Pharmacopeia maintains a national database for hospital medication errors. In a recent analysis of more than 6000 errors in 56 hospitals, it concluded that "the primary contributing factors to medication errors were distractions and workload increases, many of which may be a result of today's environment of cost containment."

It is out of concern for patients and for their role in caring for them, that so many nurses have left their profession at the very time when need for experienced nurses is increasing. Both that need and the depreciation of the professional environment for nurses result from the same market forces.

In its 1996 Report, the IOM said that Congress should mandate 24 hour RN coverage in nursing homes by the year 2000, and recommended that hospitals expand the use of RNs with advanced training and skills to provide nursing leadership and cost-effective patient care. Federal law specifies that an RN must be on duty for only eight hours per day, seven days per week, and that licensed nursing services be provided 24 hours per day. This has been required since 1987.

In July 2000, HCFA reported to Congress on a study it had been conducting over the previous eight years into the staffing situation in the nation's nursing homes. It sought to define those staffing requirements necessary to provide a minimum quality of care below which quality may be "seriously impaired." It found that what was required was 45 minutes of care per resident day from an LPN or an RN, and 12 minutes of care per resident day from an RN. It reported to Congress that over 90 percent of the nation's nursing homes fail to provide this minimum level of care. (Source: National Conference of State Legislatures)

State Regulation

As of the end of last year, 28 states required some minimum number of hours of nursing care in nursing homes per patient day. Only seven states required RN coverage 24 hours per day, seven days per week. (California, Colorado, Connecticut, Hawaii, Maryland, Pennsylvania, Rhode Island)

On October 10, 1999, California became the first state to require all patient care units in hospitals to meet fixed minimum nurse-to-patient ratios. It requires the State Department of Health Services to adopt regulations that establish minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and hospital units for all general acute care hospitals, acute psychiatric hospitals, and special hospitals. It requires nurse staffing to be determined based on severity of illness, the need for specialized equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the patient care plan

and the ability for self-care and the licensure of the personnel. It prohibits a general acute care hospital, an acute psychiatric hospital, and special hospital, from assigning an unlicensed person to perform nursing functions in lieu of a registered nurse, or from allowing unlicensed personnel under the direct clinical supervision of a registered nurse to perform certain skilled clinical functions including the administration of medication.

Prior to passage of this law, California had set nurse-patient ratios only for ORs, critical-care units, and neonatal intensive care units.

Initially, the State Department of Health Services proposed a staffing level of one to six on general surgical units, giving a nurse an average of ten minutes per hour for each patient exclusive of her administrative duties. The California Nurses Association has proposed one to four, while the hospital association has proposed one to ten.

It was California that gave us HMOs and managed care, and it was in California that nursing experienced its most severe stresses. It is fitting therefore, that California's Nurses Association has become the most progressive and proactive advocate for nursing that we have in this nation, and that California's legislature has first risen to protect one of the key determinants of the quality of care in its hospitals. Similar legislation regulating nurse staffing in California nursing homes was drafted, but it was vetoed by the governor as too expensive.

The author wishes to dedicate this article to Patricia Lynch, RN, one of the multitude of excellent nurses who have maintained their dedication to the highest principles of nursing practice even as their profession has abandoned them.

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6. See Aiken, Linda H., Smith, Herbert L., and Lake, Eileen T. Lower Medicare Mortality Among a Set of Hospitals Known for Good Nursing Care. Medical Care 32:771-787, 1994. This study examined 250 hospitals. Controlling for differences in physician qualifications and patient populations, it found five fewer deaths per 1000 Medicare discharges in magnet hospitals. If these results were applied to Medicare discharges in all hospitals, there could be about 50,000 fewer deaths per year.