Nursing: Thoughts on Nursing Service and Identification of the Service Offered

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Economic dimension of nursing care

Nursing care, whether provided in the hospital or community setting, has a cost and has economic implications.

In a consumer society, it is important to make some determinations about the monetary value or the market value of care. What kinds of care are valued in economic terms? Just as is done for many other products, one could establish stock certificates for nursing care. One could then distinguish among:

The care to which a high market value is accorded: that is, care requiring a high level of specialization and heavy technology either for diagnosis of illness or treatment of it. This kind of care would have a high monetary value not only because of the equipment required, but also thanks to the prestige which it confers. The high cost of this care is the result of the complex technology and the value placed on super-specialization, the cost of the necessary studies, and utilization of this specialization which, in most cases, results in an action isolated from a general context.

The care which requires little time and only basic skills (not a high level of preparation or complex techniques), and which can easily be multiplied; for example, injections, simple dressings, some specific aspects of basic hygiene. The economic value of this care would be based on the large number and frequency of tasks performed. It would be valued because of the efficiency of the repetition of stereotyped tasks. This kind of care would become a consumer product and the body itself would become an object for consumption.

The care which takes into account the most fundamental basic needs: the habitual and daily care necessary to maintain life, and that one can no longer provide for oneself if one loses one's autonomy. This care is based on observation and on the perception of what is important in order for life to continue from day to day. This care calls for significant action linked to the problem or problems of life which are posed. This care would be the lowest ranking in the market. In the community setting, this care is the lowest paid—if paid for at all; as for hospital services, there has never been an attempt to evaluate the worth of this care.

In fact, this care requires the greatest quantity of energy and work, but as it is related directly to women's work, it is not taken into account in any economic study and it is considered care of a minor nature which does not require any particular competence. There is contempt for this care, yet one would certainly be astonished with the result if one could evaluate the cost of the innumerable hospitalisations which are due to a lack or insufficiency of care in the home, or its inappropriateness, or its inadequacy in helping the patient fulfil his basic needs for maintenance of life—the need to do shopping, to prepare meals, to dress, to get up, to maintain contacts with other people. One would also be astonished with the result in evaluating the usefulness of simple treatment and care in limiting the development of the illness and the degenerative process to which it leads.

It is indispensable not only to provide this kind of care, but also to communicate it to others, in the sense of helping people to learn and to understand. This basic but indispensable care requires much more knowledge than it would at first appear. It requires time and energy.

But a question remains—how to evaluate what is invisible and does not show in the statistics of the social and economic structure, because it is part of the ordinary process of everyday life? How can one turn the question around in order to evaluate the elements of everyday life and what it can cost a country when these are not taken into account?

One could also look at the cost of care from the point of view of the groups within the population who have most access to it and to what degree they actually benefit from this care. Several studies carried out over the last few years have demostrated the inequality of access to care, and have shown that the most privileged groups within the population are those which have most access to care. However, these studies need to be further refind, because even though some groups may be able to use the services of health institutions more easily than

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others, they are perhaps misled as to the real value which they derive from this care, including nursing care. The care which is offered to them is, in general, in the form of curative care.

The economic implications of nursing care remain for the time being difficult to measure. However, certain indicators can open the way to a degree of estimation. The basic parameter in this field is energy—for which we will never be able to evaluate fully the total economic and social impact in relation to the choices of sources of energy and their use.

In the field of care, including nursing care, there is a close link between the energy spent for care, and the vital energy that this care liberates. Vital energy is the energy which utilizes all that exists or all that remains of the life potential in relation to the degenerative process. In other words, is there an acceleration of wear or loss to the detriment of gain within the context of the interdependent biological, psychic, and social dimensions of life?

Certain curative measures utilize a great deal of energy and produce very little. It is the same in relation to the utilization of a large number of medications which not only do not stimulate the vital forces within the person, but maintain his state of illness or prevent him from reacting, while other therapeutic forms or other techniques could stimulate his physical and psychic energies and help him regain those things which are meaningful in life.

Habitual and daily care for the maintenance of life, delivered in a routine and systematic way, uses up great quantities of energy without liberating any, either for the care-givers or those receiving care. This is because of the passive way in which care is given; care has lost its significance and is, most often, disconnected from the emotional support which releases affective energy.

Care, including nursing care, borrows and mobilizes energy. Care is a vehicle of energy; therefore the balance between the sources of energy utilized and the nature of the health problems seen in the context of life needs to be determined. The fragmentation of problems, disconnected from the total context, can only lead to wastefulness and a poor utilization of energy.

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Social dimension of nursing care

Nursing care is meaningful only if one is aware that it takes place within a social context which it affects and which at the same time conditions it.

The service offered by any trade or profession affects society and leaves its mark on the direct or indirect beneficiaries of the service as well as those providing the service (Bertaux).

Whether because of the technologies utilized, the type of social hierarchy created, the institutional forms established, the equipment developed or the social impact of the provision of care, nursing has a broad social influence, even if one is not conscious of this influence or even if it can be perceived but furtively.

Technology

We have experienced the extent to which technology influences the kind of care that we give. "Technology is not neuter; it reflects and determines the relationships between the producer and the product, the worker and his work, the individual and the group and society as a whole, man and the environment; technology is the matrix of the balance of power, the social relationships in production and the hierarchical division of tasks. The choices made by society have always been imposed through the choice of technologies" (Bosquet).

Technology is the basis of professional images. The evaluation of the nursing role and the related social model can be determined through such images: the nurse and the bed-pan, the nurse and the thermometer, the nurse and the needle, the nurse and the intensive care unit.

These images are transmitted by the media—illstrations in pamphlets and books, beginning with those for children, which all play a role in forging the public's image of the nurse. This image is reinforced today by radio and television.

This image, in turn, has given birth to a social model of the nurse, and conditions a whole series of motivations in light of what professional practice in its many variations can be.

Technology and categorization of patients

In line with the development of investigative and curative techniques, health institutions changed from bein polyvalent to being specialized.

Hospital services are organized around the investigative and curative techniques, with the result that people who face different problems in life but who have similar symptoms are all grouped together. These people have their illness, or their organ, in common...and this is how services for gastro-enterology, nephrology and ophthalmology, or services for people with tuberculosis, or cancer, developed.

This organizational model is so predominant that even when the technologies are not totally refined, or when they have been far surpassed by the human problem, they remain in place; for example, services for alcoholics and drug addicts.

This organization of services around technologies creates a social profile of patients and of health personnel. Patients lose everything which normally creates their identity—the social status which is accorded in line with their civil status, their profession or their belonging to various

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social groups. They assume a "patient" identity which takes over—in space, time and relationship—their lives. The category of illness in which they are classified confers upon patients the identify which they must assume.

In the same way, nursing personnel and faced with the great difficulty of being confronted with a same type of illness—cancer, or rheumatism—and of having to concentrate on a pathological process of which they are distrustful, because the illness process is isolated from the total meaning of the way of life of which it is a part.

Both patients and nursing personnel find themselves in a Kafkalike situation. There is an accumulative process based on the illness which disconnects care from the context of life and makes it an alienating experience. There is much more diversity for personnel providing care outside of institutions and they can see the person within the context of his daily life. Within the hospital setting the technological possibilities are much more striking and disturbing.

Technology and hierarchy of nursing personnel

Based on technologies, techniques and their economic and social value, a whole vertical structure or hierarchy of nursing personnel has been built.

There has been a progressive sub-division of tasks into noble or less noble tasks, or subordinate tasks, and they have been distributed to various levels of personnel as technologies have developed. These changes were the basis for the creation of a whole process of recognition according high esteem for the capacity to provide curative care of a highly technological nature, or the capacity to manage the assignment of tasks. Because of this, there are two ways to rise in the professional hierarchy:

specialization (either technical—for example, assistant in anaesthesiology—or based on an age group of patients—for example, pediatric nurse);

—supervision or teaching.

On the other hand, no horizontal hierarchy has emerged up until now which would create and recognize a careerstructure for the nurse providing direct care, whether in the hospital or in community services.

If basic nursing care, the care which contributes to the fulfilment of all kinds of basic needs, is not more highly regarded, if those who provide this care are not recognized at their true value, if the necessity of respecting their competence and allowing them to develop it is not taken into account, then nursing care will always remain underdeveloped and disconnected from basic needs of people.

The multiplication of vertical hierarchical structures may satisfy the corporative needs of the profession, but when it is not based on the development of a well defined competence, on the capacity to understand and to develop nursing, this multiplicity can have a negative effect on those who need care and those who provide it.

The multiplication of hierarchies contributes to the subdivision of tasks and to a distorsion of basic care, and prevents us from recognizing the value of this care, and therefore the value of the work of those who provide it. Therefore, those who provide this care are not recognized by society and there is no professional career structure at the level of basic care.

This lack of a career structure for the nurse remaining in the direct care setting contributes to dissatisfaction in the profession and should be taken into account when looking at the reasons for the scarcity of nursing personnel.

Social role of nursing

Until very recently, a whole economic and social concept of care placed high value particularly in France, on the dual relationship doctor-patient or care-provider/care-receipient, at the expense of an analysis of the factors involved in the health-illness process and without taking into account the people and the groups concerned by a similar type of problem. Therefore, in order to be seen in its true significance which is to "assist to live", and to perceive what contributes to or interferes with the development of life, the provision of care cannot be an isolated act, cut off from the general context. Nor can it be an individual act which takes into consideration only the individual within his own context.

Care becomes a social act which is achieved only if an ensemble of social dimensions are taken into consideration. If the care process is separated from an analysis of what hinders life, there is the risk, in many situations, of masking the basic causes of the problem and encouraging its growth.

In providing care for victims of drug or alcohol addiction, of occupational illness or of social inadaptation, nursing personnel will contribute to maintaining the status quo if they limit their action to caring for the individual. Providing care is not only the blind defence of biological life, but also the mobilisation of energies

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to resolve social problems. The provision of care is not a responsibility for an individual only.

The provision of care presupposes a social responsibility —a responsibility which is not limited to curing symptoms, but which seeks out the reasons for them and ways to mobilise people and groups to combat them. The desire to add a community dimension to care is beginning to take form.

Knowledge, technology, values, economic and social factors—here are a whole series of indicators for nursing which could help to make known the kind and the value of nursing care offered to consumers, based on the basic difference between habitual and on-going care for the maintenance of life, and curative care. However, in order to make use of these indicators we must elucidate and analyze the problems, based on prevailing conditions, for it is not by remaining alone and isolated that we can perceive and understand the care process and, quite simply, live with it. Whether in relation to the progressive mastering of analysis and synthesis, or in relation to the need to express everything which affects the experience of care, discussion in indispensable, both in educational programmes and in the work setting. The care process will be enriched to the degree that the discussion group is permissive and does not create feelings of guilt, and if it is accepted that the provision of care is never, and can never be, a neutral act.

The above-mentioned indicators can serve as key elements for elucidation in the service setting and in nursing research. Research, in order to be as significant as possible, must take into consideration the dialectic between the patient and the caregiver, must bring to light the contradictions, must contribute to discernment of the levels of tolerance in care encountered both by the consumers and the providers of care, and must converge on the economic and social dimensions of care.

Limits to identification of nursing care

Care is a reciprocal act. It can therefore not be the exclusive property of one group of health workers. Care will always be shared among several people and groups. Therefore we must take into account the limits of nursing care.

These limits will always remain difficult to determine. They need to be studied in relation to the dependency-autonomy process; they are linked to age and to events which pose obstacles to life and which must be perceived in relation to the setting and the nature of the problem posed, and of the people who may be called upon to participate: doctors, nurses, therapists.

All those concerned must analyze the situation, perceive who is the "key person" in the situation and who will ensure the coordination of all aspects. This analysis makes it possible to limit the number of persons in order not to disperse the measures to be carried out and in order to determine the level of tolerance and of saturation which can be experienced both by those receiving care and those providing it. This is linked to the nature of care, the kinds of care interventions, their frequency, their intensity, the length of time,

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and in relation to the different biological, psychic and social aspects. Such on-going study will show what can be supported by the person needing care and what can be supported or can no longer be tolerated by those who provide care.

The indicators in the care setting reveal that nursing personnel are subject to all kinds of stress and anxiety which have often been masked, but which are nevertheless quite real. To attempt to negate these stresses leads only up dead-end roads: alienation, refuge in technology, or further sub-division of tasks.

If we can analyze the stress factors and recognize them as an intrinsic part of the care process and then seek ways to compensate for them, we can then reconsider the factors which can make care an alienating experience and rethink how we can create conditions which will contribute positively to care— through discussion, organization of care, adequate working conditions.

Nursing personnel are resource persons for those who are in need and who are facing serious problems in their lives. But nursing personnel also need resource or support persons because they are constantly in contact with problems, suffering, illness, and death over long periods of time and in relation to many people.

Nursing power and its use

Any process of indentification grants power since it contributes to making a service known and consequently accords a value to those who provide it, as well as a role and a status. Everything depends on the nature and the use of this power.

Power is different depending on whether it is based on the development of professional competency or on institutional support without increased competence in relation to care or to the management or teaching of care.

Power, including professional power, can be stifling or liberating. But professional power

can only be justified and have meaning if it is liberating, if it is used for the benefit of those for whom it exists, if it can determine what is important in the lives of people in accordance with their lifestyles, if it recognizes the knowledge of others and enables them to utilize it, if it contributes to increasing their knowledge without destroying what they already know, but rather by adding to it. Power should put skills at the disposal of others, and let people have the possibility and the right to care for themselves insofar as possible.

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Nursing and health policy

All these signs and indicators identifiable in relation to nursing care—bearing in mind the difference between care and cure —can serve as a basis for developing professional policy. Knowledge, technologies, concepts and beliefs, economic and social aspects—all determine the orientations which form professional practice.

To the degree that there is awareness of these choices and options on the part of those who provide nursing care, there is a formulation of professional policy. Based on this policy the professional group can then determine its policies in relation to other social policies.

If the group has not made a choice or is not conscious of the economic and social implications of the care provided and of the care function to which its members contribute, the group members must nevertheless be aware that they are not in any case neutral, as one can too often believe and as one has too often tried to convince us. The group then becomes the vehicle of a policy which it has had no part in setting, but on which it has involuntarily or voluntarily drawn its own conclusions.

"If on the other hand knowledge, values and research are analyzed within the framework of the political inter-relationships, the comparisons between professional and political objectives can assist in evaluating to what degree professional objectives are essentially camouflage or reality. The awareness that a profession has of itself should be based, not on its own conception, but on the role that it plays, as a profession, in the constant changes of political power" (Bitensky). The profession can find itself in the position of supporting political objectives which are foreign to it, all the while believing that they are congruent with the needs of the consumers of care and the values of the profession.

Nursing services can therefore define itself in relation to health policy only if it seeks its own identity and determines its action in relation to a social policy. This cannot be done once and for all and, like life itself, which is a constant projection towards the future, it must be reconsidered in line with evolution.

Like life itself, from which it grows, care constantly needs to be reassessed. Just like life, of which it has been said that it needs to be reinvented, so it is with care—care must be suitable to life, care must give meaning to the lives of those who receive it and those who provide it. Care must let man be the master of his life and his death, from a peaceful birth to a chosen death.

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