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## Implications for Nursing Involvement in Health Care Reform: An International Comparison

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Running Head: NURSING INVOLVEMENT IN HEALTH CARE REFORM

Implications for Nursing Involvement in Health Care Reform: An International Comparison

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Implications for Nursing Involvement in Health Care Reform: An International Comparison

*Introduction*

Healthcare is an ever-changing field that is constantly developed through technology and research. This is true not only in the United States, but in every country in the world. With the changes that modify healthcare over time, new roles for healthcare professionals are developed. The adaptation of these roles to deliver the highest standards of care and changes in protocol is essential in providing the best care possible to patients. The evolution of healthcare throughout time is a fascinating journey through history. At this point in time, however, there are many differences between the health care offered in different countries. To understand this, one must look deeper into the history and culture to discover the dynamics of change for any particular country. In this paper, a comparison of two countries' approaches to deliver healthcare services to their people and the practice of professional nursing will be presented. The report is based on a study abroad course where data were gathered about the two countries and included a ten day tour of Slovakia meeting many healthcare leaders and nursing students. A pictorial presentation of this report is attached (See Appendix) as evidence of the comparisons between the two health care systems. The United States of America and the Republic of Slovakia are two countries that have particularly interesting healthcare delivery and nursing practice evolutions that are changing with current reform initiatives.

Not only are these two countries faced with healthcare reform initiatives, but recent health care reform goals worldwide address improving access and quality of care and decreasing healthcare costs (Reinhard, New Studies, 2009). To achieve these goals, the current barriers to success must be addressed. One major barrier to access is a lack of skilled health care providers, such as nurses and primary care physicians (Rother & Lavizzo-Mourey, 2009). As a result,

insufficient staffing creates an environment for poorer patient outcomes. Poor outcomes and mistakes are costly. Therefore, the goals of health reform are interrelated, and can be addressed by changing the workforce to fit the needs of the times. Throughout history, healthcare has always been a fluid field due to its changing knowledge base and constant innovations. This is how changing times creates changing roles for the health care workforce. In order to keep up with the changes, health care reform also needs to be as fluid.

### *History*

To understand where Slovakia's healthcare is today, one must look at the history of the people which includes a long history of domination by other countries that surround the land area currently known as the Slovak Republic. In 833 A.D., Slavic people founded the Great Moravian Empire, of which they are very proud (CultureGrams, 2005). The Slavs were taken over in 907 A.D. by Hungarians. In 1526, they were overtaken by Austrians. In 1918, after World War I when the Austro-Hungarian rule fell apart, Slovaks joined with the Czechs. This political change was supported by the Slovak-Americans who had immigrated to the USA in between 1890 and 1915 and led by a Slovak national hero, Milan Rastislav Štefánik who died when his plane crashed during one of his many trips to and from the USA. This movement formed a long standing relationship between the two countries which continues today. In 1938, Slovakia declared independence from Czechs while Hitler was annexing their lands. They became allied with Germany throughout World War II. When Germany was defeated in 1945, however, the Czechoslovak Republic was reinstated. In 1948, Communism took over and forced Stalinization and persecution soon followed. Communism reigned until 1989 and nationalism emerged for the Slovaks. In 1993, the Slovaks were finally declared independent from the Czechs in a peaceful negotiation referred to as "The Velvet Revolution" (Slovakia Health Comparison, n.d.). To this

day, Slovakia is its own democratic nation. Their president elect represents political stability for the democracy (National Human Development Report, 2000). The prime minister acts more as the President of the United States does, making political decisions and changes in the political and legal system, while the President of Slovakia acts as a figurehead for appearances. This history impacted their healthcare in many ways, from education of healthcare professionals, standards of care, and the system of universal healthcare.

The Slovaks have been fighting for their independence for hundreds of years (CultureGrams, 2005). When they were under the rule of many other more powerful nations, an atmosphere of suppression and oppression developed for the Slovaks. Gaining their independence in 1993 was the start of a new era. Just recently, in May of 2004, Slovakia joined the European Union (The European Union, 2001). While ruled by many other nations, Slovakia has kept their system of universal healthcare throughout several different rulers and so it remains today.

In any country, the healthcare system is supported by and much healthcare is delivered by nurses. In Slovakia, the education of nurses has changed dramatically. In the Communist era, young women were chosen very early in life and were taught throughout their primary and secondary education what they needed to know to become a nurse. There was no degree involved and the pay was low. Now, due to the standards set by the European Union, nurses are required to have a three year degree upon finishing high school (The European Union, 2001). However, their social rank has not improved much, despite the additional tertiary education required. This is very different from nursing in the United States, where nurses are the number one most trusted occupation, and have a significantly higher pay.

This leads to a very interesting point about what Slovaks value in terms of social rank. From talking with several college-level nursing students, Slovaks value hard work and education (B. Masarykova, personal communication, May 17, 2009). The old tradition of valuing education and professional achievements is still visible when meeting people for the first time. For example, if one would pronounce them self a "doctor" or a "Registered Nurse" they would be given more respect and attention than someone who had not achieved a degree. This is common all across Slovakia, because this is how the social rank was determined in the past. The group identified as holding the lowest social rank are the "Roma's" or "Gypsies" who are viewed as lacking initiative and many are unemployed and generally do not have much formal education. Recently however, the social rank is changing with the introduction of a free market economy (CultureGrams, 2005). There is a transition toward valuing wealth as power and away from education as a social distinction which will change the current social rank.

The shifting social ranking and values affects the Slovakian field of nursing in that their social status would have potentially grown more if the educational requirements for nurses increased before the introduction of the free market. Since nurses earn small salaries in Slovakia and the societal values are changing to value wealth, their social status is predicted to be slow to rise, if at all. Once again, this is very different from nursing in the United States, where nurses are in demand and respected for their knowledge and skills.

While Slovakia's nurses do not have the political status that nurses in the United States have, there is one place where they are treated as equals. This is within the *International Council of Nurses* (ICN), of which both the United States and Slovakia are members (National nursing, 2009). This council has been a worldwide governing body for the nursing profession since 1899. The goals of the ICN are to unite nurses worldwide, to advance the nursing profession, and to

advocate for health policy (About ICN, 2009). Each member country's primary nursing organization chooses its national representative to be on the *Council of National Representatives* for the ICN. The United States' national nursing organization is the *American Nurses Association* (ANA) and Slovakia's is the *Slovak Chamber of Nurses and Midwives* (National nursing, 2009). Representatives of these organizations are united within the ICN to promote the nursing profession and advocate for their patients' right to access to quality health care. This organization is politically significant for Slovakia, because of the lack of political power and social rank that nurses have in the health care workforce. Within the ICN, Slovakia has access to the political power of nurses around the globe.

### *Lifestyle and health*

Lifestyle encompasses aspects and behaviors that make up a way of life. Lifestyle choices are dictated by one's values and can trend and vary between geographic locations, cultures and families. They can also significantly impact health. Lifestyle factors can include transportation, nutrition, alcohol consumption, smoking, drugs, and employment.

Transportation for Slovaks is different than in the United States. The Slovak Republic has an extensive public transportation system that includes busses, long distance and local trains, trolleys, and streetcars. While many families own a car, most people use the extensive public transportation system or walk due to the high gas prices. In the United States, the minority of people use public transportation; most people drive cars. The exception to this is in major metropolitan areas in the United States, where parking is difficult and it is more efficient to utilize public transportation. Both countries struggle with the price of oil, as does most of the world. The implications this has for the health of Slovaks is that they walk more and drive less. Because walking is a healthier lifestyle choice than driving a car everywhere, this has a

positive effect on their health. Working exercise into ones everyday life rather than a separate trip to the gym makes it more likely to happen, and therefore it is a more effective regimen.

Differences exist in the nutritional approach in the two countries. Traditional Slovak cuisine includes less processed and prepared foods, relying on meals prepared at home and include cheese, dumplings, potatoes and meats. While a wide variety of foods are available in the USA, American food tends to be more processed and purchased prepared rather than cooked at home. American's are known for including "fast food" in their diets which includes hamburgers, hot dogs, pizza, and French fries. Slovakia's family-style dinners are high in fat similar to fast food style dinners in the United States. While fast food is available in Slovakia, and healthier family-style dinners are available in the United States, they are in the minority meal in the respective country. The health implication of this is that while the traditional Slovak foods are high in fat, they far surpass greasy supersized fast food meals in a nutrition test. A very large contrast between the two countries is that many companies in Slovakia provide a paid hot meal for their workers, rather than the unpaid lunch period in the US where many workers opt for a "fast food" meal or a restaurant prepared meal. In another contrast, the Slovaks eat less food with high sugar content. Desserts, when served, are less sweet than US desserts and are served at special occasions and holidays primarily. One similarity is the consumption of chocolate which is found with great variety in Slovakia. Therefore, as a generality, a typical Slovakian eats a healthier diet than the typical American.

Alcohol consumption is a big problem in Slovakia and in the United States. In 2004, the rate of alcohol consumption was 12.4 liters per person in Slovakia, compared with the United State's 8.5 liters per person (Total reported alcohol, 2004). However, this measures "adults" as being fifteen and older. This is a significant factor, because the legal drinking age in Slovakia is

eighteen, while in the United States it is not legal to drink until one's twenty first birthday.

Therefore, fifteen to twenty one year olds' consumption in the United States, and eighteen to twenty one year olds in Slovakia are either being underreported or not reported at all, which makes the measurement not comparable against each other. It is safe to say that alcohol is much more accessible in Slovakia than in the United States. Some argue that learning to drink responsibly from an earlier age actually decreases the incidence of alcohol abuse (Frantz, 2007). In both the United States and Slovakia, alcohol is a major health issue that should be addressed with education to increase awareness of the negative effects of drinking on the body.

The economy of the United States and Slovakia both have been in turmoil for some time. Unemployment had skyrocketed in Slovakia, jumping from only 1.5% in 1990 to 14.6% in 1994, to 16.2% in 1999 (Highlights on Health, 2001). More recently, in 2006 the unemployment rate was 13.3% (Slovakia Unemployment, 2009). This is similar to recent trends in the United States where unemployment seems to be rising without an end in sight. According to the Bureau of Labor Statistics, the national unemployment rate is 9.4%, but for areas like Detroit, Michigan, unemployment is as high as 17%, according to the Bureau of Labor Statistics (Current Unemployment, 2009; Metropolitan Area Employment, 2009). Due to the amount of power the United States of America has, their economic turmoil is affecting the entire world and it is anticipated that the effects of this recession will be seen for many years to come.

Slovakians have a higher than average number of smokers; 32%, compared with the European Union's rate of 28% (10 Health Questions, n.d.). This is a primary concern of healthcare professionals, as it is a risk factor for some of the most prevalent diseases in Slovakia, including heart disease and lung cancer. Slovakian life expectancy, according to the World Development Indicators database, is 71 for males and 75 for females (Highlights on Health,

2001). The higher morbidity and mortality rates for men are an indication that men do not seek healthcare as often, and they engage in more risky behaviors and occupations, as well as bad habits. Examples of bad habits include excessive alcohol intake and smoking. According to UNICEF, the obesity rate in Slovakia is high at 22.4% (Highlights on Health, 2001). This is most likely due to the high intake of fats, and low intake of fruits and vegetables. This also contributes to the high incidence of heart disease.

The United States has a much lower than average number of smokers, about 21.4% according to the World Health Organization (American Health, 2009). Similar to Slovakia, the United States also has a high incidence of heart disease and cancer, but perhaps better treatment, because they rank lower than Slovakia for deaths by these diseases. Life expectancy is 75 for males and 78 for females, according to the CIA World Factbook (2009). The most astounding statistic is that the obesity rate for the US is 30.6%, the highest of any nation.

While the leading causes for death among adults in Slovakia relate to lung cancer and heart disease, there is a different breakout for youth. A major health risk factor for Slovakian youth is drug addiction (National Human Development, 2009). A lecture on substance abuse in Slovakia from Dr. Maria Chmelova highlighted the major drug-related problems that currently exist (personal communication, May 11, 2009). These problems include the increase in experimentation among youth, due to a high accessibility among youth in schools. The drugs that are increasing in popularity currently are heroin and cocaine. Chmelova's suggestion for deterring this increasingly prominent problem is intervening with around the age of twelve with education about the drugs. Also, offering support and encouragement to youth can deter the need to seek out another form of coping, like illegal substances. Already there are many programs, like the National Program of Fighting Drug Abuse, that aim prevention strategies at the

educational system in order to combat the high accessibility of drugs. A similar program in the United States is D.A.R.E. - Drug Abuse Resistance Education. This demonstrates similar risks for the youth of these nations. There are also treatment programs available in Slovakia, in a Center for Placement of Drug Addicts (M. Chmelova, personal communication, May 11, 2009). This center offers a six week rehabilitation program covered by the national insurance policy and access to physicians and psychiatrists for medical attention and support. Both the United States and Slovakia have drug problems with youth, with similar prevention strategies.

Slovakia and the United States have some significant education points that can be shared with each other. The United States have done an admirable job decreasing smoking, while Slovakia still struggles with this area. Conversely, the United States has a staggering amount of obesity, while Slovakia has a lower incidence. Overall life expectancy is higher in the United States, so this could be another learning opportunity for Slovakia, as far as better care in hospitals and increasing prevention education for disease.

### *Healthcare*

The obvious difference in healthcare between the United States of America and Slovakia is the funding for healthcare. In Slovakia, there is national health insurance, and it is mandatory for everyone in the whole country to have health insurance (CultureGrams, 2005). The insurance is paid by the employer, the individual who is working through taxes, and by the government. Prices are negotiated between the insurance companies and the doctors; the government has no control over the costs (Kovac, 2009). However, the government does have an important role in the healthcare insurance world. They are involved with administration and enforce a guarantee of healthcare insurance (Highlights on Health, 2001). These systems work concurrently to provide adequate healthcare insurance to the citizens of Slovakia.

Slovakia's health insurance covers basic care and necessary medical interventions. Some items are not covered, or are partially covered, like psychotherapy and acupuncture (Highlights on Health, 2001). Standards of care are mandated by law and are based upon quality and effectiveness. There are also a small percentage of privatized health insurance companies that cover additional items, such as cosmetic surgery (Kovac, 2009). Currently, there is a trend moving from public to privatized health insurance coverage. The major difference between Slovakia and the United States is that Slovakian health insurance covers one hundred percent of the population, not for every medical service, but for the ones that are pertinent to health.

In the United States, health care is mostly privatized, with several government-paid programs geared toward specific populations. The unfortunate thing about privatized healthcare insurance is that it is only available to those who can afford it, leaving many under and uninsured. Overall, privatized insurance coverage cost is shared by employers and by individuals. As previously mentioned, there are some social programs available, including Medicare, Medicaid, Military, Veteran, and Indian Health Services. Medicare provides some coverage for the disabled and adults over the age of sixty five (Your Medicare, 2009). There are three parts to Medicare, Part A covers inpatient hospital, home care and hospice, Part B covers outpatient doctor visits after the client pays a yearly deductible, and Part D helps cover prescription medications. Medicaid is a program to help increase access to care for those living on a limited income (Medicaid Eligibility, 2009). The United States Military provides medical benefits for each active, reserve, guard, veteran, retiree, and family. These benefits include housing, educational assistance for self and family, employment services, tax credits, disability compensation, and much more (Military.com, 2009). Indian Health Services provides medical coverage for American Indians and Alaskan Natives (Indian Health, 2009). This program targets

the elimination of health disparities by providing indigenous members of the United States with access to their own hospitals, health care professionals, and other health care services. Even with these programs in effect to help eliminate health disparities among the vulnerable members of our society, tens of millions of Americans are still uninsured, and many more are underinsured. Comparing this with Slovakia's coverage of one hundred percent of their citizens, the United States has a long way to go in providing access and coverage.

Contrary to some preconceptions of nationalized health care, it is competitively based. Providers are ranked based upon their fulfillment of personal and technical criteria, as well as quality indicators (Highlights on Health, 2001). Because individuals have free choice of provider, and the providers compete against each other, this system sets the stage for successful healthcare professionals to succeed, and to weed out untoward providers.

Healthcare is different in Slovakia than it is in the United States. Their job roles are much more distinct, and there is less collaboration between healthcare professionals caring for a patient (Highlights on Health, 2001). Each healthcare professional acts as their own entity in the patient's care, which can lead to discontinuity. For example, the doctors do not collaborate with nurses when making decisions about patient care, even though nurses may have additional insight into what the patient needs. The concept of a healthcare team, rather than separate healthcare professionals is one that the United States healthcare possesses, to a greater extent. Here, nurses have a responsibility to advocate and case-manage with other professionals to create continuity of care. This is something that could be shared with and implemented into Slovakian healthcare professions.

Healthcare reform is not a stranger to the United States, but is a controversial topic. The issue is increasing government involvement in a capitalist country, versus not changing a system

that allows millions of people to remain uninsured and fall into debt from healthcare bills. There is a lot of criticism and opposition on both sides of the issue, but leaving things the way they are is detrimental to the health of the millions of underinsured and uninsured citizens.

### *Nursing*

As aforementioned, the evolution of professional nursing in Slovakia has been especially rapid in the recent past, with the addition of the three years of college-level education requirement to become a nurse, consistent with the European Union standard for professional nursing at the baccalaureate level preparation (The European Union, 2001). In addition to the basic preparation for nursing, there are also three year master and doctoral nurse degrees (Learning Structures, n.d.). The licensure requirements are also different between Slovakia and the United States. In Slovakia, it is voluntary to be registered with the *Slovak Chamber of Nurses and Midwives* (2008) and it is not required to have a license. However, licensure gives the nurse greater freedom to practice autonomously. The *Slovak Chamber of Nurses and Midwives* supports, manages continuing education, research, and provides legal services to all nurses and midwives who are members. Therefore, it is beneficial for Slovakian nurses to become a member of this organization.

In United States history, Clara Barton, an army nurse during the Civil War, recognized a need for organized nursing schools beyond a diploma (History of Nursing, 2009). Since then, Yale, Columbia, and the University of Michigan developed nursing schools, all during the early 1900's. These rudimentary programs have evolved into modern-day programs including an associate's degree, which takes two to three years, a bachelor's degree, which takes four to five years, masters programs which can take another two to three years, and doctoral programs require additional years of school (History of Nursing, 2009). In the United States it is required

for nurses to have a license, or at the very least, to be working under another registered nurse while working on licensure. In the United States, 'registration' and 'licensure' of nurses are synonymous, if the nurse has a license, then the nurse is registered.

Midwifery in Slovakia is separate from any nursing profession. Schooling is separate from any university or higher education institution and lasts three years (Supporting the Development, 2004). The learning is split up to half theory and half practice. The Slovakian midwife works with an obstetrician, and only with normal, low risk deliveries. The midwife does not conduct any diagnostic testing for abnormalities, care of the newborn or home care (Supporting the Development, 2004). All midwives work in a hospital setting. Their degree of autonomy is pretty low, as they work under the delegation and supervision of an obstetrician, comparable to a registered nurse specialized in caring for the obstetrical patient in the US (Supporting the Development, 2004).

Midwifery in the United States is a bit different. First, a Certified Nurse Midwife (CNM) requires a master's level education, which is about two years in addition to a Bachelors of Science in Nursing, which takes upwards of four years. In the US, the nurse midwife is not limited to the hospital setting, but can also practice in a home or birth center (Sonnenstuhl, 1996). Most provide total care, with the potential for a consultation with a physician if necessary. They are able to admit and discharge their patients, without the intervention of an obstetrician or physician (Sonnenstuhl, 1996). Some nurse midwives do not have hospital privileges; this means they do not have access to the equipment of the hospital, like an ultrasound machine or other resources of the hospital without involving a physician. Their overall goal is to support the mother through the prenatal, antenatal, and postnatal periods, and provide care for both the mother and child in these periods (Sonnenstuhl, 1996). Nurse midwives also do family planning,

education about safe sexual practices and pap smears. Nurse midwives in the United States have more extensive education, about an extra three years beyond a midwife's education in Slovakia. Therefore, they granted more autonomy and a more inclusive scope of practice in comparison.

A commonality for nursing in both the United States and Slovakia is the nursing shortage (Sekacova, 2009). It is a worldwide problem. This affects nurses who are currently working by creating a larger patient load. From a broader perspective, this can affect the quality of patient care and can ultimately lead to poorer patient outcomes. This is why it is so important for nurses to advocate for change to address these concerns. Advocating for patients is the role of the nurse and not just in a legal and ethical sense. Nurses need to be politically active in order to shape a system that will improve patient outcomes.

#### *Nursing Involvement in Health Care Reform*

As aforementioned, health care reform goals are by and large universal around the world, to increase access to and quality of care and to reduce costs. Therefore, the following reform ideas can be applied to almost any part of the world. In order to improve patient outcomes and quality of care, all levels of nurses need to be involved. This is because nurses are the health care providers at the bedside and are on the front lines of direct patient care. The education nurses receive can be the difference between whether a surgical patient's complication is caught early or whether a patient develops a nosocomial infection. Therefore, health care reform needs to support nurses in their roles of providing patient care. Several initiatives have been researched for addressing the shortcomings for nursing in the United States' current health care system. These include standardization of nurse-to-patient ratios, addressing the nursing shortage by supporting nursing schools with funding for more students and providing incentives for nurses to

pursue higher education and become clinical and teaching faculty, and adapting and utilizing the nurse practitioner role to help decrease the primary care physician shortage.

One consideration for improving patient outcomes, and consequently reducing cost, is to standardize a favorable nurse-patient ratio. This will be effective because nurses have the education to foresee complications and prevent nosocomial infections that an unlicensed health care worker may not (Rother & Lavizzo-Mourey, 2009). In fact, according to a study by Kane (2007), adequate nursing staff can decrease adverse events by up to 25%. More time with each patient can also mean fewer mistakes, like medication errors, because a large patient load has been found to be a contributing factor of these costly errors (Kleinpell, 2001). By decreasing the sheer quantity of the nursing workload, the quality of care delivered will increase. The nurse will have more time to educate the patients on their disease process and treatment options, provide presence at the bedside, and implement nursing care measures. Some argue that ratios do not take into account the expertise of the nurse, while the charge nurse assigning patients can account for differences in competencies (Nurse: Patient, 2009). Also, no actual tool exists to measure what the exact patient ratio should be, and implementation of this ratio would be difficult, especially if the consequence of not adhering is a fine (Hershbein, 2005). Despite these points, implementing nurse to patient ratios have shown improved outcomes, and should be incorporated into practice. Therefore, in order to improve patient outcomes and help drive down the cost of health care due to errors, standardization of nurse-patient ratios is an important factor to consider.

While nurse-patient ratio standardization may improve quality of health care received, it does not help with access. Access to health care is a worldwide problem, and one that the United States is not immune to. This is where the root of the nursing shortage needs to be investigated.

The problem is not the lack of interest in pursuing a nursing education; as many as 30,000 qualified applicants were turned away in the United States in the year of 2008-2009 (Rother & Lavizzo-Mourey, 2009). This number can reach up to 99,000 if associate and diploma certified nurses seeking baccalaureate degrees are included. These statistics indicate that, at least in the United States, the nursing shortage stems from the lack of capacity in the nursing schools due to clinical site and faculty shortages (Rother & Lavizzo-Mourey, 2009). A way to compensate is to increase funding for simulations, which will decrease the impact of a lack of clinical placement sites for students to gain experience. However, in the United States, educational funding is a component of a state's budget and with the current economy in a recession, major budget cuts across the board are hurting nursing schools (Rother & Lavizzo-Mourey, 2009). Also, more incentives for nurses to further their education by pursuing a master's degree and beyond are essential in developing an adequate supply of nursing faculty to teach at nursing institutions and universities. Additionally, these nursing faculty need to receive a more competitive salary to drive nurses to the teaching positions, as salary for a professor is less than that of an administrative or clinical position (Rother & Lavizzo-Mourey, 2009). Therefore, the incentive for pursuing a career in teaching nurses is low. Addressing these issues by supporting nursing schools all over the United States, and worldwide, is imperative in alleviating the nursing shortage.

Another barrier to access of health care worldwide is the lack of primary care physicians (PCPs). For the United States, this means that reform that focuses on increasing health care insurance coverage does not necessarily grant greater access to care. Nurses can be a part of the solution, by adapting the nurse practitioner (NP) role to best suit the needs of the evolving health care system. The nurse practitioner role was created to help address the uninsured and

underinsured population's lack of primary care (Peterson & Sinclair, 1997; Cronenwett, 1995; as cited in Review of Scope, n.d.). Additionally, a study facilitated at Columbia University's School of Nursing concluded that similar patient outcomes and satisfaction with care were found when comparing patients who saw a nurse practitioner for primary care with patients who saw a physician, as long as the NP had the same authority and responsibilities as the physicians (How do Nurse, 2001). Other studies conducted over the last thirty years found similar patient outcomes between NPs and physicians as primary care providers (Sherwood, et al, 1997). Despite this evidence, NPs in the United States are currently only granted autonomy in underserved and rural populations. Therefore, adapting the NP role and scope of practice would be necessary in order to incorporate them into the primary care role. Incorporating nurse practitioners into the primary care role on a worldwide scale is crucial to address the lack of access to care due to the shortage of primary care physicians all over the globe.

### *Implications for nurses*

Nurses need to get involved with health care reform on a global scale by advocating for the rights of their patients. These rights include the right of access to care, the right to good, quality care, and the right to reasonable cost. According to the *American Nurses Association* (2009), there are several ways to get involved here in the United States. First, nurses can write to Congress, and encourage - congressman/woman's involvement in the reform. Secondly, nurses can join a local or online Health Care Reform Team. Start discussions and clear misconceptions with friends, neighbors, and co-workers. Raising awareness can be as easy as using online blogging, e-mails, Facebook, and Twitter. Getting interest and involvement started for others is a great way to increase the impact of nationwide efforts. Encourage involvement in the issue, because repercussions of the reform are likely to affect most Americans, as well as most nurses.

Finally, nurses can join nursing organizations that are actively advocating for reform globally, like the *American Nurses Association*, with its ties to the *International Council for Nurses*. Nurses have the responsibility to be informed and to advocate for their profession and for their patients. Outside of the United States, where the need is so much greater, this is especially important. Also, nurses can get informed about nursing abroad in other countries, and advocate for the profession of nursing worldwide when they may not have the means of doing so themselves.

### *Conclusion*

While it seems that Slovakia and the United States of America are worlds apart, in many ways they are similar. Understanding where Slovakia fits in with the history of Europe helps to bring to light their lifestyle, health, and healthcare. Like Slovakia, the world is constantly changing, and healthcare has to adapt to remain adequate. There is a worldwide struggle with many of the same problems, including inadequate access to health care, poor patient outcomes, and high costs. Involving nurses across the globe to reform health care is essential to its success, because nurses play such a pivotal role in the health care system. Nurses are trained to advocate for the legal and ethical rights of patients. Since every patient has a right to health care, adequate health care with the best possible patient outcomes, with reasonable cost, it is an ethical issue to reform health care to meet these criteria. Nurses need to get involved at the political level, and fight for what is right.

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Appendix: A Health Care Comparison

### Implications for Nursing Involvement in Health Care Reform:

An International Comparison  
Health Care in  
December 2019



### Introduction



- This ten day journey through Slovakia focuses on international comparative health care, reform and implications for the field of nursing
- The reform of health care around the world indicates a lot of change.
- This change needs to envelop the roles of health care workers, to adapt to the needs of the system
- Reform goals worldwide aim at increasing quality and access, and decreasing cost

### Barriers to Health Care Goals

- Lack of skilled professionals, like nurses and physicians, creates an obstacle to improving access to and quality of care
- Short staffing can lead to poorer patient outcomes and mistakes, which can be costly



### Slovak History



- Slovaks come from a long line of oppression, of which they recently escaped by declaring themselves an independent nation.
- Back in the 900's, Slovakia became under the rule of Hungary, and Austria joined that rule in 1526.
- When that fell apart in 1918 (after WW1) Slovakia joined with the Czech Republic.
- During WW2, Slovaks broke free from the Czechs and allied themselves with Hitler.

### Slovak History



- In 1945, when Hitler's regime collapsed, Slovaks found themselves a part of the Czechoslovakia Republic once more
- Next came Communism and forced Stalinization, which lasted from 1948 to 1989
- Finally, in 1993, Slovakia declared itself independent from the Czech Republic
- To this day, they are an independent democratic nation and are free of oppression

### Health Care in Slovakia



- Throughout history, Slovakia has always had universal health care that has provided access to care for its citizens
- When Slovakia joined the European Union, their health care professions had to adapt to the standards of the EU
  - For the field of nursing, this meant a baccalaureate education was required

### Lobby in Bratislava Hospital with President of Slovak Chamber of Nurses & Midwives



### Social Rank



- Slovakian traditional values include hard work and education
  - Due to these values, and the previous lack of college-level education required for nurses, nursing as a profession has never had much social or political power
- Recent trends toward a free market economy have impacted traditional values
  - Money is now becoming the new prestige
  - Slovakian nurses do not get paid much, so their social rank is not expected to rise as significantly as if education was as highly valued
- In the United States nursing is the most trusted profession, and is held in a higher regard

### Lifestyle and Health: Transportation



- Slovakia has an extensive public transportation system, which a great majority of the citizens use
  - Most families do own a car, but limit use due to the high oil prices
- The United States on the other hand, are more likely to use a personal automobile than public transportation
  - This is the exception in large cities where parking is difficult and mass transportation like subways and buses are readily available



### Lifestyle and Health: Unemployment



- Unemployment is a major issue in both Slovakia (13.3%) and the United States (9.4%)
  - However, in the Detroit Metropolitan area the rate is actually 17.1% w/ auto industry
  - With it come the health risks of living in poverty
    - Malnutrition
    - Exposure: unsafe environments, dangerous neighborhoods
    - Less likely to access health care without insurance (US) which can lead to complex health problems

### Lifestyle and Health: Nutrition



- Slovaks do have a high rate of obesity (22.4%), but not as high as the United States (30.6%)
  - Traditional Slovakian dishes are high in fat
  - Slovaks tend to prepare and eat meals at home
  - Often employers serve hot lunch to employees in Slovakia
- In the United States, fast food is popular, and eating on the go is becoming more and more the trend
  - United States dishes are often fried, and high in sugars and fat

### Lifestyle and Health: Alcohol

- In Slovakia, alcohol is a big problem, because its easy accessibility has youth trying it younger and younger
  - The legal drinking age is 18, but people are rarely carded in restaurants, especially if they're with family
  - Some argue that learning to drink responsibly at a younger age is important
    - 12.4 liters/person/year average (2004)
- In the United States alcohol is a big problem, because it is such a restricted item that it becomes a vice
  - The legal drinking age is twenty one
  - The frontal cortex of the brain isn't fully developed until about the age of twenty; this is where the judgment and reasoning center is located
    - 8.5 liters/person/year average (2004)



### Lifestyle and Health: Smoking

- This is a prevalent issue in Slovakia, with its effects causing many long term chronic morbidities and mortalities
  - Slovakia average: 32%
    - Heart disease and Lung Cancer
  - European Union average: 28%
    - Heart disease and Cancer
  - United States: 21.4%
    - Heart disease and Cancer
- United States has similar primary causes of death, but perhaps better health care, because they rank lower in deaths from these diseases than Slovakia



### Lifestyle and Health: Life Expectancy

- Life expectancy for Slovakia
  - Men: 71
  - Women: 75
- Life expectancy for the United States
  - Men: 75
  - Women: 78
- For both populations, the men's life expectancy is shorter due to not seeking medical treatment as readily and for engaging in higher risk and unhealthy behaviors



### Lifestyle and Health: Substance Abuse



- Substance abuse is a leading cause of death among Slovakia's youth
  - High accessibility through peers from school
  - Leads to an increasing rate of experimentation among youth, often with fatal consequences
    - Heroin and cocaine use is on the rise
  - Prevention: educating youth around the age of twelve in schools, and offering support and encouragement to students to defer the need to engage in unhealthy coping behaviors.
  - National Program for Fighting Drug Abuse in Slovakia
  - Drug Abuse Resistance Education (DARE) is a similar program here in the United States

### Health Care: Funding



- In Slovakia, nationalized health care covers makes insurance coverage a mandatory for for all citizens
  - This is paid by employers, citizens through taxes on their earnings, and by the government (poor)
  - Prices are negotiated between the insurance companies and the physicians
  - Governmental influence mandates that everyone is covered
- Coverage
  - This coverage includes all necessary medical care, as well as some extra services, like day spas and up to three in-vitro fertilizations
  - Exclusions are things like cosmetic surgery, for which privatized insurance would need to be purchased

### Health Care: Funding, cont.



- In the United States, funding is shared between employers and individuals
  - Most insurance is privatized
- Some social programs are available for specific populations
  - Medicare: 65+ or disabled (may expand)
  - Medicaid: limited income
  - Military/ Veterans: active, veterans, families
  - Indian Health Service: American Indians and Alaskan Natives

### Health Care



- In Slovakia, health care professionals act as own entities in a patient's care, they do not work with a mindset of a team
- In the United States, health care professionals try to work as a team (of course there's room for improvement) and case manage to collaborate care for patients with multiple health problems

### Nursing Comparison



<ul style="list-style-type: none"> <li>United States                     <ul style="list-style-type: none"> <li>4 year Bachelor's, additional 2 years for Master's and Doctorate degrees</li> <li>Licensure mandatory</li> <li>Nurse Midwifery is a specialist position, considered a Master's degree, requires additional certification and 2 years education on top of Bachelor's</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Slovakia                     <ul style="list-style-type: none"> <li>3 year Bachelor's, additional 3 years for Master's and Doctorate degrees</li> <li>Licensure not mandatory</li> <li>Midwifery is separate entity than Nursing, and is not affiliated with other higher edu. institutions: Takes 3 years of schooling: half theory, half practice</li> </ul> </li> </ul>
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### Midwifery Scope of Practice Comparison



<ul style="list-style-type: none"> <li>United States                     <ul style="list-style-type: none"> <li>Can work autonomously, some keep physician on call</li> <li>More autonomy</li> <li>Provide total care: prenatal education and care, antenatal care and coaching and postnatal care and education</li> <li>Family planning education, pap smears</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Slovakia                     <ul style="list-style-type: none"> <li>Work under obstetrician</li> <li>Less autonomy</li> <li>Do not diagnose abnormalities</li> <li>No newborn care or assessment</li> <li>Work on normal/low risk pregnancies and deliveries</li> </ul> </li> </ul>
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### Nursing Shortage



- Nursing shortages are prevalent worldwide, especially in developing countries
- Extensive research in the US shows that larger workloads has adverse effects on patient outcomes, and can increase overall costs due to mistakes and not recognizing a complication early

### Nurse-Patient Ratios



- A strategy that can improve outcomes is to implement a standardized nurse-patient ratio
- Theoretically, this can improve outcomes due to allowing the nurse to be at the patient's bedside longer
- Nurses have the education that other unlicensed healthcare workers do not: this can be the difference between a complication being caught early on, or the prevention of a nosocomial infection
  - This can pay off in a lot of ways that healthcare organizations don't really think about
- This has the potential to increase the amount of education patients receive in the hospital, and decrease the amount of times they are readmitted with the same problem
  - This can pay off in a lot of ways that healthcare organizations don't really think about
- There is also the potential to decrease errors, like medication errors, which can save a lot of money as well

### Nurse-Patient Ratios cont.



- Cons
  - The other side of the issue is that because there is no way to know exactly what the "magic number is", you cannot standardize a set number for all nurses, units, and hospitals
  - The ratios also do not take into account the expertise of the nurse; some nurses are able to handle more patients
    - This can easily be accounted for by the nurse manager on a particular unit, but if standardized ratios are implemented, this will be more difficult
  - Fines for not adhering due to large volumes can hurt hospitals

### Lack of Access: Nursing Shortage



- Tens of thousands of qualified applicants are turned away each year from current nursing programs due to lack of capacity of nursing programs
- This needs to be addressed by incorporating incentives for nurses to continue their education and become faculty, because a lack of faculty is an issue
  - Higher pay should also be addressed, as nurses can make more in clinical work and administration than as faculty at a university
- Also, a lack of clinical placement sites is also an issue, which can be rectified by adding simulations to complement the lecture material and increase the capacity of the class
- This all takes money, which is the biggest issue of all because of how the US economy is struggling; nursing schools receive money and support from the state, and budget cuts across the board are limiting the expansion of the nursing programs

### Lack of Access: PCPs



- The nursing profession is not the only health care workforce that is insufficient, primary care physicians are also in limited supply
- This can only get worse if health care coverage is expanded; the same amount of physicians with millions more patients
- This can be helped by adapting the nurse practitioner role to include more primary care, and not just in the underserved and rural populations, as they are currently
  - Encouraging nurses to become practitioners can help address this lack of primary care providers

### Lack of Access: PCP's cont.



- The Nurse Practitioner (NP) role was originally created to address the lack of primary care in rural and underserved populations
- Studies show that primary care provided by a NP with the same autonomy as a physician have similar outcomes and patient satisfaction
- Therefore, NPs are ready to step up to the plate and increase access to care, as they were originally intended to do
- This is crucial when reform talks are focusing on increasing coverage

### Implications for Nurses



- Nurses need to get involved politically
- Nurses can write to their congressman/woman to educate them on and encourage their involvement in the issue
- They can join their local or national nursing organizations that are actively advocating for the nursing profession already
- They can raise awareness by talking to own family, friends, and colleagues
- Also, nurses are great advocates and need to advocate for nurses in those countries where nurses are not as highly regarded
  - Explaining a clear awareness of how nurses can impact the quality of the health care system is crucial in making a greater impact
  - Rural in countries like Slovakia do not have the political power to create change in their country

### Conclusion



- The United States and Slovakia are two of many countries that are actively involved in reforming their health care
- Every aspect of life affects what the population of a country needs from its health care system, including lifestyle and health behaviors
- Reform goals worldwide are aiming their efforts at improving patient outcomes, increasing access and decreasing cost
- Nursing is a huge factor, because of sheer size of the nursing workforce, as well as their presence at the patient's bedside

### Conclusion cont.



- Supporting the involvement of nurses in the reform is crucial to address the goals of the reform: access, outcomes, and cost
- Nurses can also help increase awareness of the changes that need to happen in order to ensure that the health care reform is a success
- Nurses are a powerful entity of the health care workforce, and need to be on the front lines of this health care reform

Thank you!

Any Questions?

