Evaluating the Consequences of Hospital Restructuring

Aiken, Linda H. PhD*†; Fagin, Claire M. PhD*

Medical Care: October 1997 - Volume 35 - Issue 10 - p OS1-OS4

Preface

Author Information

*From the Center for Health Services and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania.

†From the Department of Sociology and Population Studies Center, University of Pennsylvania, Philadelphia, Pennsylvania.

Address correspondence to: Linda Aiken, PhD, Center for Health Services and Policy Research, University of Pennsylvania, 420 Guardian Dr., Philadelphia, PA 19104-6096.

• References

The Bellagio conference on Hospital Restructuring in North America and Western Europe held in November 1996 brought together experts in the hospital sector, public policy, health workforce, hospital consulting, nursing, medicine, and health outcomes research from the United States, Canada, England, Scotland, Germany, and the Netherlands. The conference endeavored to determine the extent and nature of hospital restructuring across countries with differently organized and financed health care systems, to assess the impact of restructuring on patient outcomes and future national workforce requirements, and to explore the feasibility of international research on the outcomes of hospital reform and restructuring. The impetus for the conference grew out of our long-standing interests and research on the adequacy of the international health workforce (the topic of a 1989 Bellagio international conference also organized by the University of Pennsylvania†), the problems and prospects posed by health system restructuring, and the need for developing a wider range of health-care choices sensitive to consumer preferences, accessibility, cost, and quality.

Nursing shortages have played a prominent role in concerns about quality of hospital care throughout the world. In the United States, public policy interest generally has focused on increasing the supply and availability of nurses to meet growing demands in hospitals. Over the past decade, however, changes in national health systems have begun to reshape the role of hospitals with the goal of reducing expenditure growth by restricting hospital use and achieving greater efficiencies in inpatient settings. As a result, the debate about the adequacy of the nurse workforce has shifted from concerns about recruitment and retention to how many nursing positions can be eliminated without adversely affecting patient care.

Hospital restructuring initiatives, often labeled "patient-focused care," have swept the US hospital sector and are being exported to Canada, Europe, and other parts of the world. Although some of the goals of patient-focused care are laudable and have the potential to improve efficiency and enhance patient satisfaction, the model generally seeks to reduce nurse staffing levels and to substitute less educated personnel for professional nurses. Little if any research is available to know whether hospital reengineering schemes reduce expenditure growth, which is their major aim.
Moreover, there is considerable concern that any savings achieved will be made by nurse staffing reductions that could adversely affect quality of care and patient outcomes in a context in which changes in hospital utilization have resulted in fewer but sicker inpatients.

It is astounding to observe how many hospitals have made major investments in organizational restructuring and work redesign in the absence of empirical evidence of the effectiveness of the initiatives, or their safety. The use of the team concept, which undergirds hospital reengineering, is not new. Teams were the prevailing form of organization of nursing labor in US hospitals from the late 1940s throughout the 1960s. Ultimately it was abandoned by consensus of nurses and management because of the difficulty of successfully separating nurses’ responsibilities from those of auxiliaries under practical circumstances of daily work, and nurses’ dissatisfaction at being held accountable for care they did not control.6 There is no evidence that new team models of work organization have solved the problems that led to the abandonment of team nursing. If anything, the complexity of care and average severity of illness of inpatients suggest that today's nurses will be even more dissatisfied with being held accountable for clinical interventions by auxiliary personnel than in years past. Surveys of hospital nurses' attitudes confirm their widespread dissatisfaction and concern about quality of care.7 Furthermore, no objective data exist on the success of patient care redesign schemes in reducing costs or improving patients’ satisfaction with hospital care, two of the stated goals.

We look, then, for reasons for the success of management consultants in marketing untested, often unsuccessful, and expensive hospital reorganization schemes. A recent analysis of reengineering in corporations and industry points to managers' "pitiful predilection for magic cures" that "promise to control the uncertainty at the heart of their jobs."8 In organizations entrusted with the care of very sick people, experiments designed to improve efficiency need to be put to a rigorous test that at the very least ensures that they do no harm.

Ironically, well-researched, successful models of hospital organization are being dismantled or undermined by the introduction of untested reengineering schemes. More than a decade of research demonstrates, for example, that more than 40 magnet hospitals in the United States organized around a professional nurse practice model have superior clinical outcomes and higher patient and staff satisfaction, at costs no greater than other hospitals.9-12 Encouraged by the success in the United States, a number of countries have taken steps to identify magnet hospitals.13-15 The success of magnet hospitals has been linked empirically to nurse autonomy, nurse control over the patient care environment, and close relationships between nurses and physicians enhancing the exchange of vital information. These are very different concepts from those forming the basis of the multiskilled team approach of patient-focused care that explicitly minimize disciplinary and professional identification. Research can shed light on the relative merits of different forms of hospital organization, as is evident from studies on staff and clinical outcomes of magnet hospitals, intensive care units,16,17 and dedicated AIDS units.18

The impetus for the Bellagio conference resulted from a confluence of research documenting that the organization and staffing of hospitals is related to differences in hospital mortality,9 and to the increasing press coverage and anecdotal evidence that consumers' trust in hospitals was eroding because of the emphasis on cost-cutting.2 Restructuring and reengineering initiatives, despite their popularity with hospital management, have not been embraced by consumers or health professionals.19 Consumer groups in the United States have been vocal particularly in their objections to very brief hospital stays, especially for childbirth and for surgical procedures (including mastectomy). Anecdotal evidence suggests that more patients and families are seeking to hire private duty nurses, a phenomenon not seen in American hospitals for many years. Nurses have been most outspoken about staffing levels in US hospitals, charging that staffing has been reduced to unsafe levels.7 Nurses’ concerns about eroding quality of care often are discounted or dismissed because of their potential conflict of interest in work redesign proposals that eliminate nurse jobs. Physicians have been remarkably distant and silent about the potential and actual negative consequences of hospital restructuring.

We hope this supplement will enrich the debate about how to maintain excellent and affordable hospitals. The articles in this supplement ask the difficult questions about cost-quality tradeoffs in hospital restructuring, and delineate an international research agenda to begin to pursue the answers.20 We are grateful to the extraordinarily talented and dedicated group of experts who participated in the Bellagio conference. These articles demonstrate the depth and scope
of their expertise, as well as their commitment to solve the dilemmas facing the modern hospital. We are pleased to report that the research agenda established in Bellagio, which is discussed in the articles that follow, is underway in the United States, Canada, and the United Kingdom as a first step in understanding the cost-quality tradeoffs in hospital reform.

We are grateful to the Rockefeller Foundation, the University of Pennsylvania International Fund, and the Baxter Foundation for support of the conference and associated activities, and to the Agency for Health Care Policy and Research for support of publication of the conference papers. We also thank Jill Baron and the staff of the Center for Health Services and Policy Research at the University of Pennsylvania School of Nursing for their many important contributions to the success of the conference, and particularly to the editing of this volume. We extend our thanks as well to Duncan Neuhauser for his many useful suggestions that resulted in an improved volume. Finally, we are honored to have an introduction by Kerr White whose international research on health services established the tradition to which we hope this volume contributes.

References


**Section Description**

Hospital Restructuring in North America and Europe: Patient Outcomes and Workforce Implications

© Lippincott-Raven Publishers