

Invisible economics of nursing: analysis of a hospital bill through a Foucauldian perspective

Karen B. Lasater BSN RN

Doctoral Fellow, School of Nursing, University of Pennsylvania, Philadelphia, PA, USA

Hospital bill: invisible economics of nursing

Health care is expensive and becoming increasingly more so. USA spends significantly more of its gross domestic product (GDP) on health care compared with other countries. In 2009, USA spent 17.4% of GDP on health care expenses, while the second largest spender, the Netherlands, spent 12% of GDP (OECD, 2011). The current state of health care spending in USA is unsustainable and threatens the fiscal well-being of the nation (Antos *et al.*, 2012).

Nearly a third of all USA health care expenditures are spent in the acute care hospital setting. In 2012, it is estimated that approximately \$880 billion was spent in hospitals (Kocher & Emanuel, 2012). Nursing care services are the most intensely used hospital services by acute hospital inpatients yet are poorly economically measured (Knauf *et al.*, 2006). After a patient is discharged from a hospital, he or she receives a hospital bill that is intended to represent the cost of the services provided to him or her during that particular hospital visit. The line items on the hospital bill function to capture the value of the care provided throughout the duration of the inpatient stay. For example, each physician or specialist visit is billed at a particular rate depending on the diagnosis-related group (DRG) under which the patient is admitted. Allied health care professionals who are not employed by the hospital, such as physical and occupational therapists, also independently bill for the time spent providing services to the patient.

Correspondence: Ms Karen B. Lasater, Doctoral Fellow, University of Pennsylvania, Claire M. Fagin Hall, 418 Curie Boulevard, Philadelphia, PA 19104-4217, USA. Tel. (+1) 413552 8143; fax: (+1) 215573 2062; e-mail: karenbl@nursing.upenn.edu

Nurses are an anomaly in the current inpatient billing system. Rather than bill for the actual services provided to the patient or the amount of time spent providing nursing care, the cost of nursing is embedded into the line item for room and board, which is the same fixed cost for every patient receiving the same level of care within a particular institution. In other words, all patients cared for on a given unit are billed the same room and board charge regardless of the actual amount of nursing care the patient utilized during that hospitalization.

Historically in USA, the majority of nursing care was provided in a patient's home. Nurses billed patients directly for services. However, when medical advances in the early 20th century caused more patients to seek care in the hospital setting, nurses followed patients from the home into the hospital (Welton & Harris, 2007). This created a competitive economic relationship among hospitals, physicians, and nurses. Nurses became hired as employees of the hospital, thus resulting in the billing of nursing services as hospital room and board (Welton & Harris, 2007). Hospital staff nurses' lack of visibility, as an economically valued provider, is largely a product of the historical impact of hiring nurses as employees of the hospital. Consequently, nursing's lack of representation on the hospital bill is problematic for the perception of nurses as financially valuable health care providers.

The loss of economic visibility of nursing is problematic for multiple reasons. Hospitals generally consider nursing an expense rather than revenue generating because hospitals are not directly compensated for nursing care in the same way they are compensated for physician or other allied health services. Therefore, hospitals are motivated to cut costs by rationing nursing care rather than investing in aligning nursing care intensity with individual patient

needs (Aiken, 2008). The deficiency of nurse-specific data by which to bill makes nursing literally and figuratively invisible in terms of political and financial decision-making capacity within the health care sector (Watson, 2009). Identifying the actual economic value of nursing services and changing policy to directly reimburse hospitals for nursing services will positively impact patient outcomes, improve nursing professionalism, and create a more accurate measure for hospital reimbursement (Welton *et al.*, 2006; Aiken, 2008).

In New York, hospitals are incorporating nursing intensity weights (NIWs) as a method of reflecting the quantity and quality of nursing services provided based on DRGs (Knauf *et al.*, 2006). Welton & Dismuke (2008) argue that billing based on nursing intensity metrics will not result in larger or smaller hospital reimbursements but more accurate reimbursements that appropriately reflect the actual nursing care provided. They find that NIWs improve the accuracy of hospital billing by incorporating nursing factors not previously measured (Welton & Dismuke, 2008).

Despite this evidence, there are several criticisms of NIWs. Among these criticisms is the concern that billing based on NIWs not only requires a precise measurement of the type and extent of nursing care but also requires a more elaborate billing code system that captures nursing services (Welton & Harris, 2007). Documenting and coding NIWs also pose an additional nursing administrative burden. Others question whether NIWs fundamentally capture the entirety and complexity of nursing work (Finkler *et al.*, 2012). NIWs measure the tasks of nursing and facilitate a common public misconception that nursing is inherently task oriented rather than an intellectually complex profession that cares for the physical, psychological, and social well-being of people (Finkler *et al.*, 2012).

Despite attempts to capture the economic value of nursing services in the hospital, there remain many unanswered questions about the practicality and implications of individually billing health care payers for nursing services utilized during a particular hospitalization. The remainder of this paper examines the absence of nursing care on the hospital bill through

the perspective of 20th century French social theorist Michel Foucault.

Foucauldian analysis

Foucault emphasizes the ways in which discourse, power, and knowledge construct our social worlds by empowering and oppressing certain groups. According to Foucault, discourses are systematically derived norms that determine the importance of a given subject (Foucault, 1972). Collective discourses compose discursive frameworks, which are the sets of unopposed assumptions that enable humans to construct a view of the world in specific ways (Cheek & Porter, 1997). In the context of the hospital inpatient billing system, the hospital bill is a tool through which a dominant discipline, medicine, exerts its power over nursing to control how society comes to perceive the economic value of the nursing profession (Foucault, 1978).

Using a Foucauldian framework, the medical profession can be analysed as the dominant discourse within health care. Foucault does not suggest that the medical discourse be displaced or overtaken by a different discourse, but rather that one recognize how the medical discourse influences and reinforces its dominance through power and knowledge (Cheek & Porter, 1997). It is important to acknowledge that Foucault did not recognize power and knowledge as equivalent concepts, but rather separate concepts that are in constant interaction with each other (Foucault, 1972). In other words, knowledge does not beget power; rather, knowledge and power function within a discourse to influence each other.

A Foucauldian perspective allows one to question how knowledge is created, who has the power to create knowledge, and how knowledge privileges or oppresses individuals and groups (Cheek & Porter, 1997). Brown & Seddon (1996) acknowledge that in health care, medical knowledge is more highly regarded than nursing knowledge. This imbalance in the value of knowledge also creates a cycle of reinforced power imbalance whereby medicine is awarded more power because its knowledge is more highly valued. Because medicine maintains the domi-

nant discourse and its associated power, all truths that comprise reality must be in accordance with the discourse of medicine.

Foucault believes discursive frameworks should be critically analysed and challenged because the dominant discourse and its associated knowledge are strongly influenced and reinforced by people in positions of power and authority (Cheek & Porter, 1997). Dominant discourses are so deeply embedded in social and cultural values that the dominant discourse becomes the one perceived true reality, thereby blinding individuals to the possibility that there could be multiple truths depending on the perspective from which something is perceived (Mellican, 1995).

Dominant forces construct knowledge as an attempt to control or persuade the health care consumer's perception of which health care services are economically valuable. Given this perspective, the hospital bill has evolved as a distorted, socially constructed representation of health care services provided in the hospital. The hospital bill fails to represent nursing care by neglecting to charge for the care as an independent line item apart from room and board. Furthermore, the hospital bill does not illustrate that nursing services are the most heavily used services during a hospital stay (Knauf *et al.*, 2006). The exclusion of nursing services as a line item on the bill negates the fact that nursing plays an important role in providing valuable care to patients. In other words, dominant forces have constructed the contents of the hospital bill in a way that selectively recognizes contributors of patient care and discriminately provides economic credit for the care provided, thus rendering nursing services economically invisible.

Although the hospital bill represents ways in which the nursing profession has been and remains economically undervalued, the hospital bill is also a means by which nurses can free themselves from the covert oppression of the dominant medical model of health care. Foucault describes the concept of emancipation as a means for oppressed individuals or groups to break free from dominant discursive frameworks (Foucault, 1994). According to Foucault, in order for an individual to achieve emancipation, he or she must first become aware of how the dominant discourse affects his or her behaviour and perception

of others. In the context of the hospital bill, this involves critical awareness by nurses and the general public about how nursing's absence from the hospital bill subconsciously perpetuates misconceptions about the relative value of the nursing care compared with medical care.

Second, the individual must use what Foucault describes as 'technologies of self' to create a new way of being by which the individual is able to govern his or her own conduct free from the dominant discourse (Foucault, 1994; McCabe & Holmes, 2009). Technologies of self are the collective techniques applied by an individual to autonomously govern one's own thoughts and behaviour without the influence of dominant societal ideals. Using technologies of self allows the individual to, in a sense, use self-discipline and reflection to become emancipated from the distorted dominant influences. However, Foucault believed that one is never truly freed from the dominant discourses, only consciously aware of the effect of the distorted discourse on one's own sense of reality (Foucault, 1986). The individual employs critical awareness to question the formerly taken for granted reality and thus is freed from the previously accepted distortions of the dominant discourse, enabling the emergence of an alternative world view (Cheek & Porter, 1997).

Both the public, as recipients of hospital bills, and nurses are consumers of the dominant medical model. Through the use of technologies of self and critical awareness, individuals can recognize the oppressive nature of nursing's lack of representation on the hospital bill. Awareness enables the individual to recognize and reject the distorted reality employed by the dominant medical model, thus allowing the individual greater control over his or her own truth and world view.

The addition of nursing as a unique line item on the hospital bill allows for a new world view by expanding the discursive framework beyond the dominant medical discourse, which currently masks nursing's economic value. Rather than identify medicine and nursing as competing discourses, representing nursing care on the hospital bill expands the discursive framework to be a more accurate reflection of the reality of the hospital experience. The addition of nursing to the

hospital bill would help nurses to gain greater economic representation as professionals by expanding the knowledge and associated power of nursing's economic value.

Conclusion

Ostensibly, a hospital bill is a piece of paper presented to the health care payer by the health care provider as a way to represent what services were provided by whom during a particular hospitalization and to request monetary compensation for the provided services. Furthermore, the monetary prices associated with each line item denote the value of the service provided. Nursing's lack of representation as a line item on the hospital bill makes nursing's contribution to care invisible to the public and within the health care arena. This invisibility perpetuates an unfortunate fallacy that nursing care is neither a notable nor valuable service.

An evaluation of the hospital bill through a Foucauldian perspective reveals the dominant and oppressive relationships among health care providers. Analysing the absence of nursing on the hospital bill through a Foucauldian lens allows these inequitable power relationships to be explored and guides future knowledge development related to nursing's professional recognition within the health care community and among the general public. It raises philosophical questions regarding how nursing services should be measured and reimbursed, which disciplines should be responsible for the economic visibility of nursing, and how nursing's economic representation reflects larger values related to professionalism and political influence.

Acknowledgements

The author is supported by a grant from the United States National Institutes of Health (T32NR007104). The author wishes to thank Dr. Therese Richmond for her generous guidance.

References

- Aiken L.H. (2008) Economics of nursing. *Policy, Politics, & Nursing Practice*, **9**(2), 73–79.
- Antos J.R., Pauly M.V. & Wilensky G.R. (2012) Bending the cost curve through market-based incentives. *New England Journal of Medicine*, **367**(10), 954–958.
- Brown C. & Seddon J. (1996) Nurses, doctors and the body of the patients: medical dominance revisited. *Nursing Inquiry*, **3**, 30–35.
- Cheek J. & Porter S. (1997) Reviewing Foucault: Possibilities and problems for nursing and health care. *Nursing Inquiry*, **4**, 108–119.
- Finkler S.A., Jones C. & Kovner C. (2012) *Financial Management for Nurse Managers and Executives* 4th edn. Saunders, Philadelphia.
- Foucault M. (1972) *The Archaeology of Knowledge and the Discourse on Language*. Pantheon, New York.
- Foucault M. (1978) *The History of Sexuality Volume I: The Will to Knowledge*. Penguin, London.
- Foucault M. (1986) *The History of Sexuality Volume 3: The Care of the Self*. Pantheon, New York.
- Foucault M. (1994) *The Birth of the Clinic: An Archaeology of Medical Perception*. Vintage Books, New York.
- Knauf R.A., Ballard K., Mossman P.N. & Lichtig L.K. (2006) Nursing cost by DRG: nursing intensity weights. *Policy, Politics, & Nursing Practice*, **7**(4), 281–289.
- Kocher B. & Emanuel E.J. (2012) Overcoming the pricing power of hospitals. *Journal of the American Medical Association*, **308**(12), 1213–1214.
- McCabe J. & Holmes D. (2009) Reflexivity, critical qualitative research and emancipation: a Foucauldian perspective. *Journal of Advanced Nursing*, **65**, 1518–1526.
- Mellican E. (1995) Breast implants, the cult of beauty, and a culturally constructed 'disease'. *Journal of Popular Culture*, **28**(4), 7–18.
- Watson C.A. (2009) Using nursing intensity for Medicare billing and value-based purchasing. *The Journal of Nursing Administration*, **39**(4), 149–151.
- Welton J.M. & Dismuke C.E. (2008) Testing an inpatient nursing intensity billing model. *Policy, Politics, & Nursing Practice*, **9**(2), 103–111.
- Welton J.M. & Harris K. (2007) Hospital billing and reimbursement: charging for inpatient nursing care. *Journal of Nursing Administration*, **37**(4), 164–166.
- Welton J.M., Fischer M.H., DeGrace S. & Zone-Smith L. (2006) Nursing intensity billing. *Journal of Nursing Administration*, **36**(4), 181–188.