Are We Just Cost Centers?

WHY IS NURSING CONSIDERED AN EXPENSE TO THE HOSPITAL RATHER THAN A SOURCE OF REVENUE?

BY GENEVIÈVE M. CLAVREUL, RN, PHD

NOT THAT LONG AGO ONE OF THE nursing lists I subscribe to had a most interesting discussion thread that had to do with a conversation a nurse had had with the chief nursing officer. The nurse was bothered after discovering that their hospital viewed nursing as a cost center and not as a source that generated income. The discussion thread continued for many weeks, and as I read the various comments posted by members of the list I recalled that I had mentioned this very topic in a white paper on the nursing shortage that I had written for the County of Los Angeles in 2000, and I thought this would also make for an interesting topic for my column.

There may be a historical explanation. Some of the first nurses were nuns in religious orders who provided nursing care as their act of service. To expect payment would have been unseemly.

RUBBED THE WRONG WAY

Historically nursing has been and is seen as a cost center. When hospitals and other healthcare providers do their budget, the nursing staff is listed as an "item" that must be paid for rather than as an "item" that generates fees or money. But just because we've always done it this way, doesn't mean we have to keep doing it. The key question, however, is how do we change what is accepted as a common practice, and a practice that is neither illegal nor seen as, necessarily, flawed?

The most interesting aspect of seeing nursing as a cost center is that it is actually contrary to how most of the other healthcare providers are seen by hospitals. Doctors and most, if not all, of the various therapists, such as respiratory, occupational, physical, etc., are usually seen and listed as a fee for service, and therefore as generating income for hospitals. So why is nursing an expense to a hospital, and how did this practice become as entrenched as it is now?

On the one hand we have hospitals that must factor in nursing care and all its associated costs while at the same time keeping the budget trim and in line — which often means a struggle between the chief nursing officer (CNO), who gets the appropriate number of nurses to cover each shift, and the chief financial officer (CFO), who keeps the hospital in as much of the black as possible.

Of course one can always make the argument that without nurses to staff the various units, a hospital's main source of income, it's raison d'être so to speak, would slowly grind to a halt; without appropriate nurse staffing doctors would have to limit their admissions, surgeries and other similar procedures, thus strangling the revenue generation pipeline.

THE PAST IS STILL PRESENT

Not sure how ingrained this practice is? Just take a look at the following answer I received when I queried the phrase "nursing + cost center." The third result from the top was a link to WikiAnswers, which provided the following question as its interpretation of my original query: "How is the hospital nursing department a cost center?" It then returned the following response: "in that nurses require a salary and support funding (scrubs, pencils, etc.) and do not directly generate income to the hospital, that department is typically classified as a cost center."

When one reads similar "definitions" I think one can understand how this understanding colors the role of the nurse in today's hospital setting.

So how did we get to such a classification? Could this practice date back to the founding of our profession? Perhaps, especially when you consider that many of those who first provided nursing as a vocation were often nuns belonging to orders that provided nursing care as their act of service. Just as there were religious orders that were renowned for their teaching, so too were there religious orders that dedicated themselves to providing solace to their fellow man through nursing.

When one couples this history with the theory of altruism that often surrounds those in the health profession, one can see how discussing salary or payment for services rendered may be unseemly, as they used to say in polite company. Also, let's not forget that nurses have historically been seen as an adjunct or assistant to the physician. Even today, far too often nurses are viewed as an extension of the service provided by the physician, rather than a separate but parallel field of practice.

Thus it was often left up to the physician, and later hospital administrators, to decide how best to compensate the nurses in their employ. Patients didn't and, I think, still do not see the nursing care they receive as an augmentation to the "doctoring" they receive, therefore nursing is still perceived as a part of the overall package, and thus not generating income.

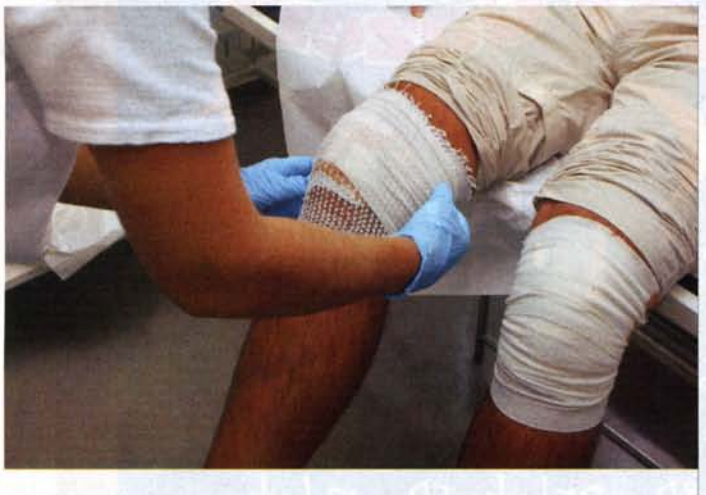
MODEL BEHAVIOR

Of course there would be those who might argue that hospitals do place a monetary value on nursing care. How else would hospitals be able to pay their nursing staff? However, nurses are not salaried with the same methodology as physicians. Physicians are generally not considered employees of the hospital; they are in essence independent contractors, for lack of a better description. Thus physicians are granted "privileges" to work at hospitals where nurses are generally hired directly onto staff.

However, we don't find hospitals insisting that physicians provide the basic tools of their trade. Just as nurses pull items from the hospital's "store" so do the physicians; but hospitals seem to continue to bill these functions differently. Could nurses be billed on a similar model as that of physicians and other fee-for-service healthcare professionals? Why not?

Without nurses the very basic day-to-day care that doc-

Could nurses be billed on the same model as physicians and other fee-for-service healthcare professionals, such as physical therapists?



tors order for their patients could not be carried out, and in all likelihood many patients would find themselves in bad shape for lack of good nursing follow-up and care. The daily nursing care would most likely fall to the patient's family (as is the case in some countries today).

LINKING UP WITH THE CHAIN OF COMMAND

Is there any way to change opinions, from viewing nurses as a "line-item" that generates income and revenue versus one that costs hospitals? All is not lost. This issue is definitely gaining traction in both the real world of hospital management and in nursing academia. For example, a reader recently sent me an excellent, if somewhat technical, article from the *Journal of Nursing Administration* that was published in January 2007. The authors of the article, "Describing Costs Related to Nursing," undertook a valiant effort to break down how nursing costs are attributed, and compared several common nursing costs models.

As more studies are published on this issue I think we'll begin to find nursing move from being viewed as a cost center to a revenue stream. Much of this evolution rests on chief nursing officers and other nurses in the upper echelons of the chain of command (such as chief executive officer, chief financial officer and so forth). As these "opinion leaders" change their outlook this can then filter down through the chain of command. I think that any hospital that tries to redefine the nursing model from cost center to revenue stream will ultimately set in motion a ripple effect that could have long-reaching and positive effects on how the nurse's role is interpreted.

STRIVING FOR SYMBIOSIS

Altering the perception of nurses from cost center to revenue stream will not solve the multifaceted problem that is the nursing shortage, or the dissatisfaction some nurses have with their profession; but it could go a long way to reduce the conflict that surrounds paying for nurses. As nursing salaries are perceived as income for the hospital rather than a drain on its cash flow, a more symbiotic versus parasitic relationship develops.

I know that these terms seem harsh. When you sit down with a group of nurses who have just been informed by hospital administration that cost-cutting measures need to be taken, they know that means dutting nursing hours or staff. (When was the last time a hospital pared down its physician staff?) Thus nursing is parasitic in relationship to this scenario. However, as nursing is elevated to the role of the revenue it generates — because without adequate nursing staff one can not admit additional patients, provide adequate nursing care, minimize negative patient outcomes, etc. — then the role of the nursing staff becomes symbiotic in nature, with each party benefiting from the other.

Nursing is continually evolving, and there is no reason that we cannot also change how nursing is perceived to affect the hospital's bottom line. It's time to evolve into nursing being seen as the revenue-generating stream that it truly is, and when this happens one more puzzle in the nursing shortage/satisfaction problem will be solved. WN

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