Éditorial/Editorial

Since the late 1990, Canadian provinces and territories have been moving towards the baccalaureate degree as the minimum educational requirement for registered nurses (RN) to enter the profession. Today, all provinces and territories, except for Quebec, have this requirement. Several arguments have justified this upward shift. First, research has shown that patient outcomes are better when care is provided by baccalaureate prepared nurses. For example, a study by Aiken et al. in 2003 found that an increase of 10% in the proportion of university prepared RNs resulted in a 5% decrease in both patients mortality and failure-to-rescue rates. Similarly, a community home nursing study by O'Brien-Pallas et al. in 2002 found that patients' knowledge and behavior scores improved drastically when cared by university prepared RNs. Second, the acuity of hospitalized patients has increased considerably in light of technological advancements; and many have complex health issues requiring additional education and skills to manage conditions and provide appropriate care. Third, RNs are required to work with other healthcare professionals, many of whom are university prepared. For example, physicians have a Medical Doctorate; psychologists are prepared at the master's or PhD level; pharmacists are moving towards a Doctor of Pharmacy Degree (by 2020) as the minimum educational requirement for entry to practice; and physiotherapists in Ontario are prepared at the master's level since 2012. Therefore it is important that RNs have an education that is better aligned with that of other health professionals, facilitating collaboration and bringing equal credibility to nursing. Furthermore, university prepared RNs are better equipped to work autonomously. Autonomy is especially important for the essential roles RNs are now playing in primary health care and overseeing patients with chronic illnesses.

Conversely, as hospitals are asked to contain cost and reduce spending, RNs, because of their large number, become the primary target of budget cuts. As a result, and regardless of the evidence presented above, there is a trend where hospitals are replacing RNs by less costly licensed practical nurses (LPNs). While it has been argued that LPNs do have their place in the healthcare system, they need to be employed in situations where they are the most appropriate provider to deliver care, not because they cost less. Furthermore, what is discouraging about this trend is that not only does it affect RNs' sense of worth and morale, it can negatively affect relationships between regulated nurses who are now competing with each other for jobs. Being care for by the wrong health care professional may also compromise patient outcomes, and

ultimately increase cost by increasing length of stay and readmission rates. It seems that when it comes to budget and finances, the best evidence is not necessarily taken into account.

I believe that if we are serious about managing healthcare cost, we need to look at the needs of patients, where those needs can most appropriately be addressed and by whom. We also need to ensure that there is sufficient funding available so that the appropriate healthcare provider is available to care for patients and to meet their needs. As service delivery models move from hospitals to the community, RNs are well placed to make a difference and provide cost-effective services. However, to do so RNs need to be “valued”, not “priced”.

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