Chapter Objectives

1. Identify global trends linked with nursing practice.
2. Describe changes in global demographics and how they influence health.
3. Define vulnerable population, health disparities, health equity, and social determinants of health.
4. Analyze gaps between current health care trends and individual, family, and societal health and illness needs.
5. Explain links among individual, family, community, and population health and illness experiences.
6. Explain the role of the nurse in family care coordination.

Chapter Concepts

Environments of care
Globalization
Health disparities
Health equity
Population health and illness
Social determinants of health
Urbanization

Chapter Introduction

Chapters of this Instructor Manual have some additional information to supplement things found in the 15 chapters. You might find some information useful for planning content to teach, create
learning activities, or incorporate into student evaluation. Some information might serve as background or theoretical supports for students. Each chapter’s materials include an additional case study, learning activities, NCLEX type questions, and Internet resources. The Instructor Manual also includes four separate chapters aimed at nursing faculty that will be teaching family focused nursing care. These chapter titles are:

- Transforming Nursing Education
- Using Essential Guidelines to Build Nursing Curriculum
- Using Simulation to Teach Family Focused Care
- Moving to a Family Focused Teaching Practice

This first chapter describes some current trends relevant to nursing practice and begins laying a foundation to understand the changing needs and potential ways to envision nurses’ work. Throughout the first textbook chapter, students are encouraged to consider trends, identify the things society really needs, and encourage inquiry about what characterizes best practices in ever-changing environments. Some myths about family involvement in health and illness care delivery need to be examined. Beginning ideas about family focused care are introduced and ideas to build upon are laid as a foundation.

**Changing Trends Influence Health Care Delivery**

This first textbook chapter aims to provide nursing students an overview of some driving forces linked with current health care concerns. The trends suggest things to consider as they learn about various national and international factors that influence ways nursing is practiced and care delivered. Trends such as global perspectives and international concerns, aging populations, and rising health care costs are described. Increasing numbers of persons with multiple chronic illness conditions and the associated costs are of great concern. Technological, informational,
and even surgical health enhancements provide consumers with new, but costly choices. Elective surgeries for beauty and obesity are accessible options. The nation’s growing numbers of elderly will likely mean that even sicker people are being cared for in family households for longer time periods. Future consumer needs will vary from those experienced just a few decades ago.

The business and finance of health and illness is in flux. Rapidly rising health care costs and extravagant expenditures often mean health and illness care is unaffordable to many of the nation’s people. Informatics and changing technologies in medical and health care practices introduce continual change that require flexibility, ongoing education, careful monitoring. The largest number of elderly people ever cared for by health care systems is sure to increase the demands. Things like prevention, focus on lifestyle behaviors, and ways to help people better self-manage their diseases at homes and in communities is of concern. Complex care needs of chronically ill persons are not being fully met. Changes place stress on working nurses as they are expected to do more with less.

Despite many social changes, the length of workday, staff availability, and ways new nurses are prepared remains much the same. Many pressing concerns are linked with ways students learning to practice nursing. For decades, students have been primarily prepared to assume employment in acute care settings. Over the last few decades, many have called for change in the ways nursing students are prepared and ways nursing is practiced. Students need to learn increasing amounts of information. They need to learn to evaluate care outcomes, provide quality care, meet employer and consumer expectations, be leaders and advocates in a changing practice field, and practice safely in error free environments. Some questions to ask are: What should nursing practice look like in this information and technological age? How can nurses shape their practice to best meet changing consumer needs? In what ways can nurses assume
leadership roles in advocating for needs of those seeking and needing care? What do nursing students need to learn as they are prepared for evolving health care delivery systems?

Nurses say that patients and their families are valued, but how well have nursing students learned to effectively communicate and form partnerships with individuals and family units? Some professional nursing staff still argue about things like family visitation, the importance of family presence, visiting hours, and appropriateness of family inclusion in specific procedures. Worries about privacy, confidentiality, time management, and nurse uncertainty about appropriate actions to take often result in neglect or avoidance of family care. The textbook *Family Focused Nursing Practice* is about gaining and using a *think family* attitude. It intends to help faculty and students identify practical ways nursing education and practice can be altered to more efficiently and effectively satisfy societal needs.

**Global Trends**

Today’s health and illness concerns are not influenced by single factors, but by a complex maze of interdependent factors not easily isolated. The place where people live affects health and illness. Family households, neighborhoods, and local communities are intricately connected to a larger world. Nurses need a consciousness of interlocking factors as they give individuals care.

**Natural Resources and Environment**

Environment, whether natural or man-made, is increasingly linked with health and illness. Global trends influence effect the planet’s food, water, energy and environmental resources. The Natural Resources Defense Council (NRDC), a nonprofit environmental action group, has a mission is to protect natural resources—wild life and places—of the planet. NRDC does this by using science findings from research to create policies and laws to protect and keep the environment safe and healthy for all living things. According to the NRDC (2011), climate
change affects health in six ways (i.e., air pollution, extreme heat, infectious disease, drought, flooding, extreme weather). Populations most vulnerable to health problems due to climate change include children, the elderly, and the poor (United States Global Change Research Program, 2009). Where people live matters!

For example, air pollution is worsened in rising heat, increasing the number and intensity of ‘bad air’ days and are especially threatening to persons with asthma and other respiratory tract conditions. Asthma prevalence in persons of all ages in the United States increased 12.3% from 2001 to 2009; it is more prevalent in children than adults, women than men, blacks than whites, and those living below the federal poverty level income (Centers for Disease Control and Prevention [CDC], 2011). These data point to inequalities in health or health care among groups of people--differences in health outcomes, this is often referred to as health disparities. Health disparities often occur in high risk groups (e.g., minorities, children, women, poor). Rising asthma prevalence in these groups is associated with increased exposure to respiratory tract irritants such as environmental tobacco smoke, outdoor air pollutants, and increased pollen burdens (Gilmour, Jaakkola, London, Nel, & Rogers, 2006). Some risks are associated with communities and households of families. Box 1.1 provides information about ways families can protect themselves against air pollution health threats.
Box 1.1 Tips to Protect against Air Pollution Health Threats*

- Check news reports on the radio, TV, or online for pollen reports or daily air quality conditions. Or visit EPA's Air Now website [http://www.airnow.gov/] for air quality info.
- If you or someone in your family has allergies or asthma, on days when pollen or ozone smog levels are high, minimize outdoor activity and keep your windows closed.
- Shower after spending time outdoors to wash off pollen that may have collected on your skin or hair.
- Wash bedding and vacuum frequently to remove pollen that may settle in sheets and carpets.

* Natural Resources Defense Council (n.d., “Air pollution”)

Global Infectious Disease Threats

According to the World Health Organization (WHO, 2011a), in 2008, four of the top 10 causes of death in low- and middle-income countries were infectious diseases; whereas, infectious diseases accounted for only one of the top 10 causes of death in high-income countries. New and reemerging infectious diseases pose threats to human health globally and cause costly periodic disruptions in trade and commerce, political instability in developing nations and tensions in developed nations (National Intelligence Council [NIC], 2000). Foodborne illnesses and infections acquired while hospitalized--nosocomial infections--also pose threats. In the United States, increased amounts and types of imported foods and the growth of virulent microbes (e.g., staphylococcus aureus) resistant to antibiotic treatments are concerns (NIC, 2000).

Increases in international travel, immigration, return of military or other personnel from overseas assignments, and the globalization of food supplies are ways infectious diseases enter
Tuberculosis (TB), HIV/AIDS, hepatitis, and malaria are top causes of death worldwide (NIC, 2000). Since 1973, more than 30 new infectious agents have been identified including Ebola virus, hepatitis C virus, Human Immunodeficiency Virus (HIV), Borrelia burgdorferi (responsible for Lyme disease), Helicobacter pylori (involved in peptic ulcer disease), and HVN1 (causes influenza) (NIC, 2000). Scientists estimate that the next pandemics, epidemics in many parts of the world at once, will come from organisms yet to be identified (NIC, 2000). Eased connections among the world’s people provide unusual ways for infectious agents to spread. Nurses need to be aware of concerns linked with globalization (Box 1.2).

Box 1.2 Ways to Address Nursing Concerns Linked with Globalization*

<table>
<thead>
<tr>
<th>Recommended actions to address the recruitment and employment of foreign-educated nurses in the U.S. are:</th>
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<tr>
<td>• Invest in targeted foreign-educated nurses in the U.S. nursing workforce.</td>
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<td>• Promote baccalaureate education for nursing practice entry.</td>
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<td>• Synchronize nursing education curricula.</td>
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<td>• Educate undergraduate and graduate students about global health.</td>
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<tr>
<td>• Create a national system to monitor and track inflow of foreign-educated nurses, country of origin, work settings, education, and license.</td>
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<tr>
<td>• Establish an international body to coordinate and advise on international workforce policies.</td>
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* Nichols, Davis, & Richardson, 2011

Infectious Illness

The most common infectious illness to affect travelers is diarrhea from foodborne or
waterborne organisms (WHO, 2012a). Some illnesses have vaccines that can be taken before travel to prevent an infection. Recommendations and precautions for travelers to all parts of the world to reduce health risks can be found on the WHO (2012a) website in a downloadable book, *International Travel and Health*. In the last decade, increased travel resulted in national concerns about epidemic bed bug infestations at low-budget and upscale hotels. Bed bugs are not just found in hotel rooms, they are everywhere (e.g., airplanes, subways, movie theaters, locker rooms, stores, even hospitals). They reproduce quickly, live for a long while without feeding, and even the cleanest persons are susceptible. The concern goes beyond individual travelers because these bugs are transported into households via luggage and affect entire families.

Influenza poses other health risks. New strains get introduced through exposure to others with the disease. It is not uncommon to see people in Asian nations wearing surgical masks when they use public transportation. In 2009, an influenza A (H1N1) pandemic occurred. Data gathered from 80,000 patients in 19 different areas revealed that those most at risk for hospitalization were children under 15 years of age, while those most at risk of dying were those over 65 years (WHO, 2011b). Findings showed that those with severe influenza had more chronic illnesses and obesity was an unexpected risk factor. Some required intensive care admission and died. Nurses need to identify and intervene with those at greatest risk for poor health outcomes and consider implications for family, household, and community risks.

**Infectious Diseases and Antibiotic Use**

A long time concern is the inappropriate use of antibiotics to treat infections that have resulted in the growth of microorganisms resistant to drug therapy (Lehne, 2013). One example of this is multi-drug resistant TB. According to the WHO (2012b) *Tuberculosis Fact Sheet*, about 8.8 million new and relapsed cases of TB were reported in 2010. In this year, an estimated 1.4
million people died from TB. Dr. Paul Farmer details his experience of the TB epidemic among the people of Haiti in the book *Mountains Beyond Mountains* (Kidder, 2003). Rather than base treatment of drug-resistant TB using a utilitarian approach (i.e., what is good for the many outweighs what is good for the one), he focused on treating one case at a time—working with the individual and the family living with the infected person. Evidence showed that caring for one person and those sharing the dwelling rather than many positively influenced health outcomes and altered conventional thinking about best ways to treat TB when resources are limited.

Warnings about inappropriate use of antibiotics have been given for decades (Hamilton-Miller, 1984). This drug class is for bacteria only and should not be used for conditions caused by viruses (e.g., influenza, common cold, upper respiratory conditions). Proper use of antibiotics (e.g., take only when prescribed, complete full prescription, throw away unused drugs, do not share medicines) has long been recommended. It is likely that as much as 50% of prescriptions written for antibiotic use may be unnecessary (Hicks, 2013). However, individuals often demand access to these medications, physicians often prescribe inappropriately, and the needed directions are too often ignored. The result is the growth in concerns about antibiotic resistant bacteria. The problem of MRSA (methicillin-resistant staphylococcus aureus) has long been know as a threat to the sick and elderly, but is a growing problem.

Antibiotics, wonder drugs that prevent suffering and death, have been hailed as a most important medical intervention of modern times. However, for decades concerns about misuse have been expressed. A growing outcry is now occurring about the increased antibiotic use in livestock production as a means to get animals to market faster. In 2001, the WHO organization called for wiser use of the drugs to:

- Better inform patients appropriate drug use and quit pressuring doctors for prescriptions
Better informed doctors prescribe only drug needed, not just the newest or best

- Avoid overlap in use of antibiotics
- Hospitals use procedures to monitor drug effectiveness
- Antibiotic use in food production (e.g., livestock, poultry) be curtailed

The Animal Drug User Fee Reauthorization Act of 2013 requires that the Food and Drug Administration annually report on how many antibiotics are sold for use on industrial farms. Recent findings indicate that 80% of antibiotics or 30 million pounds sold in the U.S. are used for animal agriculture. The Physicians for Social Responsibility identify this as a risk to human health because growing evidence links antibiotic-resistant infections in humans to overuse of antibiotics in animal agriculture. A report titled *Antibiotic Resistance Threats in the U.S., 2013* indicates that the problem of antibiotic resistance needs to be addressed from farm to table. A study that looked at swine crop field exposure from that proximity to swine manure application and livestock operations was associated with MRSA and soft-tissue infection (Casey, Curriero, Cosgrove, Nachman, & Schwartz, 2013).

New concerns are rising about a super-bacteria -- carbapenem-resistant enterobacteriaceae (CRE), a life threatening bacteria resistant to most antibiotics, even the most powerful (CDC, 2013). CRE appears to have the capacity to transfer resistance to other bacteria that would not normally be a threat and cause them to be untreatable. This bacteria is easily transferred through physical contact, often found in hospitals and long-term care facilities, and especially a risk for those in compromised physical conditions. While health care workers can easily transfer these organisms, family members can also introduce this to each other if they are not aware of good hand washing or isolation techniques. Nursing students need to be aware of wide spread risks associated with infectious diseases and antibiotic use that extend outside the hospital walls and
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involve places where families live.

HIV/AIDS

the HIV/AIDS epidemic. Estimates from 2010 show that 34 million people worldwide had
HIV/AIDS, 1.8 million people died of AIDS-related illnesses, and 2.7 million more became
newly infected (WHO, 2011b). Africa is most affected, with 72% of the global total of 1.8
million deaths. Only 35% of pregnant women got tested for HIV in 2010. The WHO report
indicates that novel community-based approaches to HIV testing need to occur—individual
testing in health facilities is insufficient. Although antiretroviral drug therapy is effective in
decreasing HIV/AIDS mortality rates, women, children, and the poor continue to have less
access to these drugs For instance, in 2010, only 23% of children worldwide who would benefit
from antiretroviral therapy received it (WHO, 2011b). A great problem is that medical treatment
and drugs alone do not address the social and cultural patterns that put individuals and families at
risk and leave children as orphans as their parents die from this disease.

In the U.S., HIV is spread mainly through unprotected anal or vaginal sex and through
the sharing of drug-use equipment. Some racial or ethnic groups are at higher risk than others.
African Americans are at highest risk with about 44% of new infections despite facts that they
represent only 12-14% of the population (CDC, 2010). However, other factors are also important
to consider (e.g., stigma, discrimination, finances, education, geographic region). Other high risk
populations of concern are correctional inmates, health care workers, poor or disadvantaged, and
sex workers. While men that have sex with men are at greatest risk (63%), but heterosexual
contact is also a concern (25%). Young people, aged 13 to 24, comprise 16% of the U.S.
population but accounted for 26% of all new HIV infections in 2010 (CDC). This disease affects
families in many ways, but nurses are often ill-prepared to address disease risks or management (Vance & Denham, 2008).

The spread of infectious diseases often results from human behavior or lifestyles, those occurring at the individual and family level. Nurses can play huge roles in facilitating changes linked with wellness, disease management, and prevention. However, nurses must be aware of risks individuals, families, and communities have for infections. Nursing education has largely focused on the problems related to individuals, but failed to give adequate attention behavioral or lifestyle needs outside acute care settings. Understanding the meaning of connectedness among people, family units, and the larger community are critical for education nurses provide to those in their care.

**Nurses and Non-communicable Diseases**

Some concerns linked with non-communicable diseases immediate and continuous actions. All facets of disease management are not controlled through technology. Things like information, self-care skills, motivation, and support are as important to individual outcomes as medical management, drugs, and evidence based practice. Non-communicable diseases often require alterations in routine behaviors and lifestyles of persons diagnosed and their interacting family household members. Individuals and family members are challenged as they try to understand prevention, care management, and access to unrelated health care systems. Teaching students to think and act in proactively can assist individuals and family units recognize potential risks, provide timely, information, instruct in skills to manage clinical conditions, and help access needed supports.

Modifiable risk factors can be addressed, but many individual characteristics (e.g., age, sex, race, genetics) are non-modifiable. Students need to know about both sets of these factors.
They need to work within their scope of practice and recognize limitations between can and cannot be done to resolve modifiable factors. For example, food products often include refined starches, sugars, salt, unhealthy fats, and chemicals. Consumption of processed foods and meals eaten outside the home can be less nutritious than home prepared items. Todays families often cook little, eat few fresh fruits and vegetables, and eat several meals outside the home weekly. Economic growth and technological inventions have led to sedentary lifestyles and increases in overweight and obese persons. Nurses that view these as modifiable factors can be intentional as they collaborate with individuals and family units, set goals, plan strategic actions, support and commend positive behavioral changes to manage modifiable factors.

Tobacco use has been strongly connected to many non-communicable diseases and is a modifiable risk factor. Americans are using fewer tobacco products, but other nations are consuming more. In 2009, 16% of U.S. adults were daily smokers compared with the median of 21.5% of 13 industrialized nations in the Organization for Economic Cooperation and Development (OECD) (Squires, 2012). Other things like hypertension, high cholesterol, and high blood glucose serve as indicators of intermediate risk and call for immediate modifiable lifestyle changes. Students that understand needs for family focused nursing care can address risk modifiable factors linked with disease in ways that are informative and supportive. Instead of viewing non-communicable diseases from only episodic or curative perspectives, nurses can be proactive in prevention, care management, and adoption of healthy lifestyle behaviors.

Nurses care for those suffering from disease, disability, genetic disorders, child maltreatment, domestic violence, substance abuse and mental illness. Resources to help individuals and families differ vastly around the globe. Stable countries with plentiful resources do not always uniformly deliver services to all populations, inequities and disparities exist.
Widespread international concerns about global health and wellbeing led nearly 200 member states of the United Nations (UN) commit to working together and combatting poverty, disease, hunger, illiteracy, destruction of the environment and improvement of women’s lives by combating discrimination. The result is an agreement called *The United Nation’s Millennium Declaration* that contains eight specific goals (Box 1.4). Nursing organizations have responded with specific plans to address these targets. For example, Sigma Theta Tau International aims to encourage nurses worldwide to lead and participate in the eight goals, particularly those that relate to population health. As students are taught about nursing care, it will be useful to help them see through a family lens and understand the complex needs of non-communicable diseases for individuals and family units.

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<th>Box 1.4 United Nations Millennium Development Goals and Targets*</th>
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<td>· Worldwide eradication of poverty and hunger</td>
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<td>· Global education to at least elementary level</td>
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<td>· Empowerment of women through gender equity</td>
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<td>· Reduced child mortality</td>
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<td>· Improved health of mothers</td>
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<td>· Treatment of infectious diseases such as HIV/AIDS, malaria</td>
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<td>· Protection and improvement of environment</td>
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<td>· Partnerships for global development</td>
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**Obesity as a Leading Risk for Disease**

The rise of obesity is a major national and global concern. Obesity is a leading risk factor linked with non-communicable diseases and an underlying factor for diseases such as type 2 diabetes, cardiovascular diseases, cancer, stroke, and other life-threatening illnesses. Over the last three decades, waistlines have expanded and surgical procedures such as gastric bypass have increased. While a body mass index (BMI) of 18 to 24.99 is considered healthy, those with a
BMI in the 25 to 29 range are considered overweight and those over 30 are obese. People often underestimate their weight and overestimate their height. It is reported that 1 in 10 American people will be obese (42% overweight, 11% severely obese) by 2030 (Fickelstein, Strombotne, Chan, & Krieger, 2012). This report suggests that obesity is related to about 9% of annual medical costs and costs about $147 billion per year. Risks are associated with numbers of fast food restaurants per person in a geographic area, consumption of calorie dense foods, large portion sizes, and sedentary lifestyles. Healthy lifestyle includes needs for vigorous physical activity, less screen time, diets rich in nutrient dense fruits and vegetables, and adequate sleep. Lifestyle factors, family behaviors, knowledge and access to health care affect disease risks.

The Institute of Medicine report (2012) titled *Measuring Progress in Obesity Prevention* refutes the idea that obesity is largely the result of a lack of will power by individuals, but a problem centered in policies and environments that are ‘obesogenic.’ Single solutions such as taxing sugar-sweetened drinks or making fresh vegetables available are unlikely to solve the problem. Instead, policies that create incentives for building connecting sidewalks and trails in housing areas, promotion of bicycle commuting, 60 minutes of physical activities in school every day, more healthy dietary choices everywhere, and revised farm policies are directions needing attention. Living in a 24-hour a day seven day a week food carnival with few opportunities for physical activity in usual daily lives is are concerns for families and communities. Nurses need knowledge about family and societal needs tied to health, wellness, disease prevention, and illness management. Nurses can be educators and advocate for changes to improve life quality.

**Globalization and the Medical Workforce**

Globalization in health care is also occurring. The U.S. Bureau of Labor Statistics recently reported that the job growth in the health care sector accounts for one out of every five jobs
created. In 2010, about 209,000 primary care physicians or about one-third of all U.S. physicians managed 51.3% of all clinical visits (AHRQ, 2011). So, about half the business went to one-third of the physicians—those in primary care. According to the American Academy of Family Physicians, primary care is defined as the care done by physicians specifically trained for and skilled in comprehensive first contact and continuing care for those with undiagnosed symptoms, signs, or concerns. This care includes health promotion or maintenance, disease prevention, education, diagnosis, and treatment of acute or chronic illness. Primary care occurs in a variety of settings (e.g., physician office, inpatient care, long-term care, ambulatory care).

Others also provide primary care (i.e., nurses, nurse practitioners, physicians assistants). Needs for registered nurses is expected to grow from 2.74 million in 2010 to 3.45 million by 2020 (Squires, 2012). In 2010, the AHRQ reported the number of nurse practitioners at 55,625 and physician assistants at 30,402. In 2011, numbers of nurse practitioners (NP) reached 180,233 and some projections expect that number to double by 2025 (Pearson Report, 2011). Likewise the numbers of physician assistants is likely to continue to grow with projections reaching 127,821 by 2025 (Hooker, Cawley, & Everett, 2011). However, geographic distribution of primary care providers is uneven with far more practicing in urban than rural regions. Increasing numbers of NPs represents a valuable workforce for the nation, but uniform scope of practice regulations across states, reimbursement for services, and varied work environments need thoughtful investigation (Poghosyan, Lucero, Rauch, & Berkowitz, 2012). Effective use of NPs will also include education that provides them knowledge about ways individuals, families, and communities are interdependent and skills to provide coordinated and collaborative care.

The U.S. has often drawn a workforce from other places and now has many nurses and physicians from other nations. Worldwide demand for nurses continues to exceed the supply and
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the Bureau of Labor Statistics, U.S. Department of Labor (2012) is predicting that an increase of 712,000 nurses will be needed by 2020. This number will be difficult to reach as the Baby Boom generation of nurses fully retires. In 2007, a study found 270 U.S. companies actively recruiting foreign-educated nurses mainly from the Philippines and India (Pittman, Folsom, & Bass, 2010). Nurses share some similar traits, but things like educational preparation, regulation, credentials, licenses, entry into practice, and clinical practice vary considerably among nations. Pathways for becoming a nurse differ and practice expectations and care delivery vary. For example, midwifery is viewed as a separate profession in Australia, but a nursing specialty in the U.S. 

Foreign-educated nurses can face huge challenges as they transition to U.S. health employment settings (e.g., practices differ, language barriers, medication administration, use of technology).

Costs of Health Care

Health care costs continue to accelerate around the world, but especially here in the U.S. Health care costs are somewhat ambiguous because it is hard to ascertain how much money is actually spent, what goods and services are bought, and how the quality and value of services compare. Ideas about economics suggest supply and demand can regulate costs, but this seems not the case when it comes to health care. Scarce quantities can produce high demands and high costs, but adequate or even abundant supply often means demands and cost increase. Even when availability increases, cost reductions have not been seen. Health care spending and costs are derived from millions of private decisions, but decisions are also corporate or administrative, employment, and government driven. Things like pharmaceuticals, durable medical equipment, surgeries and treatments, images and tests, professional providers, health insurance, hospitals and clinics, home health and hospice, and public health are just some of the factors that enter into
health care costs. The cost-benefit ratios of all medical expenditures compared to individual clinical outcomes are difficult to measure and evaluate.

In 2009, U.S. health care spending reached about $2.5 trillion with per capita expenses at $7,578 (U.S. Census Bureau, 2012). This amount was 17.4% of the gross domestic product (GDP), far more than any other developed nation. In 2010, $2.6 trillion or 19.2% GDP was spent on health care ($8,402 per person), a radically different amount than spent in 1960 ($27 per person), or 2000 ($1,377 per person) (California Healthcare Foundation, 2012). The Gross Domestic Product (GDP) represents the size of a nation’s economy and is a standard measure to identify national wealth and determine wealth of its citizens are. The GDP does not describe a nation’s wellbeing as other measures provide important information (e.g., literacy, life expectancy, income distribution), it is commonly referred to when factors to compare nations are used. In comparison to the 17.4% spent by the U.S., the Netherlands (12%), France (11.8%), Germany (11.6%), Canada (11.4%), and Mexico (6.4%) spent far less GDP on health care. U.S. health care spending far exceeds all other developed countries.

In the 1990s, it was thought that managed care or managed competition would help the U.S. keep its annual expenditures in line with the growth of the GDP as it appears that ability to pay is a driving factors (Reinhardt, Hussey, & Anderson, 2004). Thousands of payment systems and plan administration plays large roles in U.S. health care costs. Quality adjusted life years (QALYs) are often used to discuss the value of costs (e.g., immunizations and prenatal care are low cost but provide high returns). However, this is in direct contrast to high cost procedures (e.g., diagnostic tests of large populations with low incidence of disease found, futile or heroic medical treatment at life’s beginning or end) that also might be argued by some as actions that increase QALYs. Lack of guidelines about the maximum costs per QALY for private or public
insurers in the U.S. result in huge expenditure differences in treatments for those insured or uninsured. High costs of technologies, prescription drugs, chronic illnesses, and administrative costs are likely to continue as factors underlying high health care costs (Box 1.3).

**Box 1.3 Factors Influencing Choices in Seeking Health Care Services**

Factors linked with health care are numerous and come from many different directions. One option for Americans is medical tourism, international surgical travel, health travel, or global health travel to receive treatments for medical, surgical or dental care in a foreign country. This is one of the fastest growing industries in the healthcare sector and is a positive source of revenue for many nations. Some U.S. companies offer this option to employees and are even willing to pay for travel and medical expenses as the costs are much lower. Several insurance companies have either implemented or piloted programs in medical tourism. While early on this care was primarily care sought for elective procedures (e.g., plastic surgery, cosmetic dental care), it has become the route for many non-elective surgeries (e.g., cardiac surgery, knee and hip replacements). Care standards are generally as rigorous as in North American hospitals and potentials for risks similar to U.S. care facilities. Joint Commission International or some other credible agency or institution accredit many hospitals outside the U.S. Medical malpractice insurance for physicians outside the U.S. are usually significantly lower than they are for physicians in the U.S. Thus, surgery abroad can be as much or more than 60 - 90% less than in the U.S. and individuals often receive treatments from certified physicians originally trained in the U.S. Asian nations such as India, Thailand, and Singapore are also taking the lead in the businesses of medical tourism, but other nations (e.g., Mexico, Costa Rica, Europe) are also attracting attention.
Awareness of illness risks associated with the places people live is important. Families around the globe often contend with malnutrition, lack of clean water, uneven food distribution, vector borne diseases, and scarcities of medical care and supplies. Famine, displaced populations, and political unrest also affect the health and well-being of many; an example is the widespread poverty over decades that has devastated Ethiopian individuals and families (Taye, Haile Mariam, & Murray, 2010). The negative influences of long-term poverty and unrest often continue for generations even after some conditions improve. Culture, tradition, and history of a geographic place influences the lives, health, and illness of those living there for a long while.

Problems such as this exist in the U.S.. For example, the Appalachian region is the home of about 25 million people living in mostly rural areas in parts of 13 states or 420 counties, only West Virginia is totally in Appalachia. Although things have greatly improved since 1965 when regional poverty and its effects were first recognized, many of these counties still lag far behind much of the rest of the nation. In 2009, per capita income for many families in the Appalachian region was 25% lower than for others in the nation with the very lowest incomes in southern Appalachia (Appalachian Regional Commission, 2011). Many Appalachian counties have long been plagued with lower high school and college graduates, fewer physicians, specialists, and health care resources, and higher rates of cancer, heart disease, stroke, and diabetes than the rest of the nation. Areas of high poverty have been plagued for generations by industries that raped the land of natural resources and created hazards and health risks for people living there. The culture of place influences residents’ health and illness.

Industrial processes also have health implications. For example, when land is cleared for logging or large-scale agriculture, local people find jobs opportunities available in remote areas.
Erosion, contaminated groundwater, shrinking aquifers, air pollution and urbanization can result, all of which have unwelcome health effects. The Dust Bowl of the 1930s was caused by drought coupled with farming methods that did not include practices of crop rotation, fallow fields, terracing, wind-breakers, or cover crops. This ecological disaster resulted in economic, social, and physical damages that affected families. In the nation’s quest for energy, a new dilemma currently is facing communities as hydraulic fracturing or fracking is raising environmental concerns about compromised air quality, water contamination, methane gas, and seismic activity that leads to small earthquakes. A new 2013 film called *Promised Land* shows the conflicts that occur as some people obtain great financial benefits and profit, but others face potential risks.

You might be saying, “this is very interesting, but what does it have to do with nursing?” Nurses living or employed in particular geographic areas must be attuned to the benefits and risks of place that might impinge on health and create risks. Things like global economic developments, war or violence, and industrialization all have effects on the physical and mental health of individuals. As the burgeoning world population grows and more families move from rural areas to cities problems with safe and adequate housing, health care and other needed services may occur (United Nations Population Fund [UNFPA], 2011). Lack of food, poor sanitation, limited employment, crime and disease are well documented by UNFPA. These societal factors might not initially appear as nursing concerns, but global societies create new questions. What are the implications of interdependent relationships for health and illness care of individuals and family units? What are nursing roles linked with societal concerns? What might Florence Nightingale do if faced with these global health and illness care needs?

**Nursing Workforce Trends and Recommendation**

It is critical that the nursing profession educates and retains a high quality global nursing
workforce. Additionally, a shortage of nursing faculty to educate the next generation of nurses is predicted (American Association of Colleges of Nursing, 2012b). In low-resourced nations, nurses are unemployed and underemployed because funds are lacking to pay salaries (Spetz, 2011). The International Council of Nurses (ICN), International Society of Nurses in Genetics (ISONG), Sigma Theta Tau International (STTI), and other international organization such as the International Family Nursing Association (IFNA) play key roles in bringing nurses with common goals from across the globe together. International groups offer nurses ways to share knowledge and resources to address family focused nursing care and other perplexing problems linked with health and illness.

**Chapter Summary**

Health care is driven by many factors. Natural disasters, economic disparities, political upheavals, and other things affect health. Social issues such as poverty, housing and education along with growing scientific evidence and technology are a few things that effect health and illness treatment. In a continually changing world, nurses are challenged to stay abreast of global influences on current trends. The relationships and interdependence of individual and family factors, social health determinants, and household location influence health and illness. Individuals live in families and are part of communities where health care availability may or might not be equitable. The places where families live, learn, work, play, and pray influence health needs and illness risks. The textbook chapter introduces students to some ideas about why thinking family is important and reasons why a family focused nursing approach to care is needed. Family focused nursing involves coordinated care that addresses individual and family unit needs at home, in acute care settings, and the communities where they live.


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