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PERCEPTIONS OF HEALTH PROFESSIONALS ON CONCEPTS CLINICAL ECONOMICS AND PATIENT ADVOCATE

PERCEPÇÕES DOS PROFISSIONAIS DE SAÚDE SOBRE CONCEITOS DE ECONOMIA CLÍNICA E ADVOGADO DO PACIENTE

PERCEPCIONES DE PROFESIONALES DE LA SALUD SOBRE LOS CONCEPTOS DE ECONOMÍA CLÍNICA Y ABOGADO DEL PACIENTE

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Objective: to understand the perspective of health professionals on the concepts of Clinical Economics and Patient Advocate. Method: a qualitative study with health professionals. Data were collected in June/2017 from the question: What is your perception of the concept of Clinical Economics and Patient Advocate? Qualitative data were analyzed using the Collective Subject Discourse. Results: the speeches pointed out that it deals with innovative, challenging and applicable proposals for nursing and health care. Patient Advocate and the Clinical Economics concept can support the decisions of the health team/service managers. The ideas can enhance the integration of the teams, resolve conflicts, bring together different professional categories and mitigate the risks of legal, financial and ethical responsibilities regarding health care. Conclusion: the concepts was understood as fundamental and applicable, since the organization survive with adequate human, financial and material management.

Descriptors: Nursing. Patient safety. Health economics. Patient care team.

Objetivo: compreender a perspectiva dos profissionais de saúde sobre os conceitos de Economia Clínica e Advocacia do Paciente. Método: estudo qualitativo com profissionais de saúde. Os dados foram coletados em junho/2017 a partir da questão: Qual a sua percepção sobre o conceito de Economia Clínica e Advocacia do Paciente? Os dados qualitativos foram analisados pelo Discurso do Sujeito Coletivo. Resultados: os discursos apontaram que se trata de propostas inovadoras, desafiadoras e aplicáveis para a enfermagem e a saúde. O Advogado do Paciente e o conceito de Economia Clínica podem subsidiar as decisões dos gestores da equipe/serviços de saúde. As ideias podem

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potencializar a integração das equipes, solucionar conflitos, aproximar diferentes categorias profissionais e mitigar os riscos de responsabilidades legais, financeiras e éticas em relação à assistência à saúde. Conclusão: os conceitos foram entendidos como fundamentais e aplicáveis, uma vez que as organizações sobrevivem com adequada gestão humana, financeira e material.

Descritores: Enfermagem. Segurança do paciente. Economia saudável. Equipe de atendimento ao paciente.

Objetivo: comprender la perspectiva de los profesionales de la salud sobre los conceptos de Economía Clínica y Defensa del Paciente. Método: estudio cualitativo con profesionales de la salud. Los datos fueron recolectados en junio/2017 a partir de la pregunta: ¿Cuál es su percepción del concepto de Economía Clínica y Defensa del Paciente? Los datos cualitativos fueron analizados utilizando el Discurso del Sujeto Colectivo. Resultados: los discursos indicaron que se trata de propuestas innovadoras, desafiantes y aplicables para la enfermería y la salud. El Defensor del Paciente y el concepto de Economía Clínica pueden apoyar las decisiones de los gestores de equipos/servicios de salud. Las ideas pueden mejorar la integración del equipo, resolver conflictos, unir diferentes categorías profesionales y mitigar los riesgos de las responsabilidades legales, financieras y éticas en relación con la atención de la salud. Conclusión: los conceptos fueron entendidos como fundamentales y aplicables, ya que las organizaciones sobreviven con una adecuada gestión humana, financiera y material.

Descriptores: Enfermería. Seguridad del paciente. Economía sana. Equipo de atención al paciente.

Introduction

Global social phenomena have brought changes in people's lifestyles, longevity, mass immigration, demand for health services and economic crises that have influenced access to and provision of health services.

Regarding only chronic diseases, estimates pointed out that by 2030, this group of diseases will represent 70% of death in the global disease burden[1], 76% in Brazil and this number tend to worsen due to association with Covid-19. It is known that comorbidities such as, for example, a mental health disorder are associated with the increase in the cost of care for patients suffering from chronic diseases[2].

The costs provided in Brazil by the Unified Health System (public funding), only for the care of patients with cardiovascular diseases in 2015, reached 9.6 billion dollars[3]. And a significant part of the expenses are with curative actions, concentrated in hospital, outpatient care and medications for the treatment of chronic diseases[4].

However, it is worth mentioning that economic costs are only one face of the prism, which involves the suffering of the sick and, invariably adds to the disability caused by chronic diseases, loss of quality of life and the occurrence of premature deaths.

Faced with this scenario, the lack of resources increased and impacted the quality of health systems globally, so it was necessary to review the choice of health care and treatments, not only due to new expenses, but mainly to those that already exist. Regarding to health, it is necessary to reflect that the expenses must be compared first with the benefits/results for the patients and for the health system in a clinical-economic analysis. This approach opens up new perspectives for linking acceptable costs (financial costs, consequences of procedures and the comparison between costs and consequences) with the desired additional health benefit[5].

In this sense, it is recurrently perceived that the core of traditional economic assessments has been directed to aspects that involve only the clinic and the performance of the technology, that is, if it reaches the indicators of safety, effectiveness, efficiency, effectiveness and cost -effectiveness, indispensable premises, however it is necessary to include in these analyzes the economic impact on the budget of individuals and their families[6] and to verify the acceptance of the risk-benefit of health interventions.

Thus, there is a real need for training so that health professionals can acquire skills not only to perform effective and safe clinical procedures,

but also to become reflective professionals, aware of the impact that their decisions have on life and on systems and services patients[7].

The skills needed by health professionals, based on a clinical-economic approach, aim to improve the decisions made, through shared agreements (professional-patient-family), increasing their perception of values and preferences in relation to clinical procedures and treatments of health. In this line, Porzsolt proposes the formation of a new actor in health in a reflection called "Clinical Economy and Nursing"[8].

The proposal in question is the "Patient Advocate", based on the concept "Clinical Economy", which proposes to use economic ideas in health services. In this case, the meaning of the word economy assumes: A) the costs that must be accepted, whether they be hospitalization, side effects, the risk of treatment or financial costs; B) the consequences, such as the benefit. Something that the patient will get back as a solution to their health problem and; C) alternative forms of assistance, which consists of comparing costs and consequences[7].

Based on this idea, it is argued that health care can be promoted with this framework, not only from the perspective of the health professional, but as a structure assumed by managers and administrators. Among health professionals, nurses have adequate credentials to support their actions according to the definition of "Clinical Economics", given their training and their competence to develop expanded care, contextualized and focused on patients' needs, as seen that in his field of practice he articulates and integrates the care of different health professionals[9].

To act as a "Patient Advocate", based on the "Clinical Economy" concept, the nurse requires specific curricular training, Global social phenomena have brought changes in people's lifestyles, longevity, mass immigration, demand for health services and economic crises that have influenced access to and provision of health services.

It is argued that the nurse's practice is centered not only on treatment or on the technology used, but on the evaluation of the process, adherence, effectiveness and safety of clinical measures for the benefit of the patient. Recalling that empathy, a holistic view and humanized thinking when addressing the health-disease process for comprehensive care permeate the professional practice of nurses.

It is assumed that nurses are professionals with the profile to act as "Patient Advocate" and, therefore, urgently need to specialize in clinical economics, knowledge / skills that should preferably be within the scope of these professionals' practice.

Considering that the "Patient Advocate" is a theoretical proposal anchored in the concept of clinical economics, which is a robust conceptual framework for health care planning, added to the theoretical framework of care, it is raised as a premise that it will find acceptance with professionals of health.

Thus, the aim of this study was to understand the perspective of health professionals on the concepts of Clinical Economics and Patient Advocate.

Method

A qualitative approach study with health professionals who participated in the 1st International Seminar on Clinical Economics and Patient Advocate, in May 2017, in the city of Foz do Iguaçu, Paraná, Brazil, which has a population estimated at 256,088[10].

The criteria of inclusion for the participation of the health professional was to have participated in the Seminar mentioned above and to work in the municipality in the health network, private or public. Professionals who were on vacation or leave from work at the time of the interview were excluded. Forty health professionals who participated in the referred Seminar were contacted by email or call phone. Of these, 20 agreed to participate.

Regarding the sample size and its representativeness, in qualitative research the number of people interviewed is not so important, and it is necessary to observe some points, such as: using instruments that verify the diversity and internal characteristics, certifying that the target audience and place for the data collection bring subjective materials to be analyzed, know the interactions and pay attention to the other related groups, in addition to gradually associating the findings with the theoretical framework[11].

Data collection was occurred in the June/2017 period and was started through the following question: "What is your perception of the concept of Clinical Economics and Patient Advocate?", besides identification data such as sex, age, place of work, time of performance and professional qualification.

The interviews were carried after the previous contact to expose the topic and accepted by the health professional, in a room with only the interviewer and the interviewee. The interview responses were recorded and later transcribed by the researcher.

For the identification of the participants, the letter P (for Participant) was checked, followed by the number corresponding to the sequence of the interviews (P1, P2 ... P20). These had an average duration of 20 minutes.

For the analysis of qualitative data, the Collective Subject Discourse (DSC) technique was used, which is a form of data analysis, which represents collective thinking, in which a synthesis discourse adds the content of similar discourses emitted by different people so that each subject contributes to the construction of the DSC. It consists of a technique of tabulation and data organization and is based on the theory of Social Representation. It represents a change in qualitative research because it allows one to know the thoughts, representations, beliefs, and values of a collectivity on a given subject using scientific methods[12].

According to the same authors, four methodological figures or DSC operators called Key Expressions (ECHs), Central Ideas (ICs), Anchorage (AC) are used for the construction of the DSC. As for the size of the group researched in the DSC methodology, the minimum number for participants in a survey is the minimum, that is, itself[12].

This research, with unidentified participants, meets the Resolutions of the National Health Council / Ministry of Health of Brazil 466/2012 and 510/2016.

Results

Of the 20 professionals who participated in this research, 14 were female, 15 were nurses, 14 worked in the public health system, with an average length of service for 10 years.

Most of the participants who agreed to participate in the study were nurses. This can be justified, probably, because nurses agree with the "Patient Advocate" proposal, based on the concept of "Clinical Economics", which qualifies them to exercise a new and challenging act-action competence in health.

When analyzing the data, three discourses-syntheses and respective central ideas were identified, regarding the investigated theme, as described below.

Discourse-summary 01: In the speeches on the general perspectives on the concepts CE and PA, it was possible to identify four central ideas.

Ideia Central 01A: Challenge and Difficulties

As DSC of this CI, we have:

Considered as an immense challenge, but innovative proposals focused on taking care/care in nursing and health. Referred that in the day to day the reality is another, but that in the future one can live in a society in which the nursing is more valued and has more autonomy, particularly for acting in defense of the patient.

Ideia Central 02A: Insertion Locations

As DSC of this CI, we have:

Concepts that can be used in Hospital Care, but also in Primary and Secondary Care.

Ideia Central 03A: Future Perspectives

As DSC of this CI, we have:

Manifested the expectation to learn these innovative and thought-provoking concepts that relate to the nurse's doing.

Ideia Central 04A: Nursing Empowerment and Academic Training

As DSC of this CI, we have:

It is considered timely to introduce such concepts as a sub-area of nursing education as an emerging theme in a society that has increasingly demonstrated in questionable values that target individual interests rather than collective interests, Which aims at a monetary profit and not humanitarian profit.

Discourse-summary 02 In the speeches about the perspectives about the concept of CE, according to the understanding of the participants, three central ideas were identified.

Ideia Central 01B: Importance of Concept

As DSC of this CI, we have:

Fundamental concept and applicable in the day to day professional. Increasingly, institutions need to be more efficient in using their financial, human and material resources. Managing these resources in a sustainable manner and in line with best practices is what keeps a company active in the market.

Ideia Central 02B: Insertion among health professionals

As DSC of this CI, we have:

It is a process that occurs in addition to the financial aspects, but mainly, in the scope of the relationships between the interdisciplinary team, particularly nurses and physicians, as well as the relationship of these with the users/patients under their care.

Ideia Central 03B: Expected Perspective

As DSC of this CI, we have:

The importance of the medical, ethical and epidemiological perspective, emphasizing the indispensable methodological rigor, care with risks with errors or bias; The importance of information, ethics, and safety in research and professional practice.

Discourse-summary 03: The speeches that deal with general perspectives on PA concepts, present two central ideas.

Ideia Central 01C: Current Scenario

As DSC of this CI, we have:

There is a need for a good training with knowledge of the nurse in this area of clinical economics, adequacy of curricula in universities, as well as dissemination and acceptance by the multidisciplinary team, mainly by doctors and companies providing health services. In our culture, „medical knowledge and act" still prevails with great force. The nurse's view differs from the doctor's view. Questioning a doctor and requiring him to explain his actions and decisions, entails great possibilities of disagreements and discomforts. But we have to agree that the most qualified professional is nurses.

Ideia Central 02C: The importance of the Concept

As DSC of this CI, we have:

Patient Advocate can support decisions either from the health team or from service managers. From a strategic point of view within the institution, its work may integrate teams, resolve conflicts, bring different professional categories closer together and mitigate the risks of legal liabilities.

Although the analysis methodology used is that of the Collective Subject Discourse, a single report by a nurse interviewed drew attention to define so well the role of this professional in the current scenario, that it was considered necessary to present this discourse here: "'From my experience of nurse practitioner, I observed in a non-systematic way that, in most cases, it is in nursing that the patient places his trust. Many even ask the nurse to talk to the doctor, because the doctor passes so fast that the patient is afraid to forget. And then we take responsibility and commitment to resolve that issue for the patient. These situations are frequent in nurses 'professional lives'".

Discussion

The general concepts of the participants point to the understanding of the clinical economy and of the nurse (patient's lawyer), still in a superficial and broad way, but with a sign of the innovative aspect of these terms in nursing and health. However, the difficult implementation of these concepts in practice, is mainly due to the lack of appreciation of the patient's opinion and the incipient professional autonomy of nurses to make decisions in defense of the patient, linked to the dependence of the physician-physician model centered[13].

There is a gap in research on how nurses deal with decision-making, even though these have an impact on quality and safety in patient care. Understanding this process contributes to the planning of support interventions. It is

already known that chronic exposure to stress negatively affects the health of nurses as well as the decision-making process[14].

In the current scenario, decision-making is still under the exclusive responsibility of the doctor, who also experiences moral suffering when making decisions, particularly for ethical challenges. Although in some countries, such as the United States, United Kingdom, Ireland, Finland, Australia and New Zealand, there has already been an expansion in the professional skills of nurses, granting greater autonomy to them, as this professional is already authorized to prescribe medication. In a study published in 2019, it showed that 52% of nurses and midwives agreed that expanding these skills would increase the prestige of this professional and autonomy for these professionals influences decision making[15].

However, decisions that consider patients' wishes are associated with less suffering from the doctor and can be targeted for patient-centered interventions[16] with the participation and performance of the patient's nurse advocate. Therefore, the nurse-patient-doctor interaction can also result in quality and effectiveness in the model and process of care and patient care.

Regarding to the places of insertion of the clinical economy and the nurse-lawyer (patient's lawyer), as they are concepts under construction, their applicability is perceived as possible in the different care scenarios, be it basic, specialized or hospital. According to the above, it should be noted that the author of the terms directs the use of the terms mainly for the hospital environment, but is not limited to it. And, when addressing the financial aspect of health institutions and services, it is not limited to discussing private ones[8].

It is considered that the patient's nurse advocate, supported by clinical economics, has similar ideas to that discussed in health advocacy for users of public services, whose propositions consider technical, scientific and relationship knowledge among other professionals and patients for the development of nurses 'autonomy, still incipient[17,13], with a view to also strengthening citizenship and patients' rights[17].

However, it goes further. Clinical economics considers that the financial aspect of institutions and services may be a matter of survival, according to the profit logic, but the clinical economy of the patient has a value related to meeting his needs, especially when the health results are clearly perceived by the change in health status, which can also be quantified if evaluated by longitudinal studies. Therefore, the value of a health service, from the patient's point of view, is a perceived value, whose opinion should take priority when considering the ethical principle of patient autonomy[18].

It is important to consider that this value does not have an absolute and static dimension, as it depends on the context in which it occurs and may change over time[18], affected by movements and counter-movements inherent to human complexity and the universe of health.

In this sense, an economic analysis is necessary for clinical-economic decision-making for decision making and adequate clinical behavior by health professionals, considering that this decision must be made by the patient and the family. To assist them in this decision-making, nurse Y (patient's advocate) is understood as a tool[8] or strategy to increase transparency and efficiency in health care, which makes this nurse essential in the structure of health institutions[19].

In order to conduct the reasoning of the nurse (patient's advocate), the economic analysis must be discussed and thought with the patient and his family, who must consider the "costs" of hospitalization, the side effects and the risks of treatment or refusal and the monetary costs; the "consequences" of those choices or refusals; "alternative forms of action", which means comparing the costs and consequences of at least two or more options, as well as the refusal of one or all of the options[8].

When it comes to the financial aspect of health institutions and services, it is not limited to discussing private ones. It is understood that health does not recognize borders, neither sectors nor specialties nor custom, which means that managers, politicians and health professionals, mainly nurses and doctors, are co-responsible

for guaranteeing access to health, care and well-being. -be of quality for people, both in public and private services. The way to reach them is that they can vary[8].

The clinical economy, in the aspect of insertion among health professionals, moves and stimulates the relationships between health professionals /people, mainly nurses and doctors, towards better patient care practices, the latter being the main one. recipient. However, the benefit of the practice of "good nursing" is not particular for the patient, nor the focus of attention of the health team, nor the relationships of health professionals are limited to doctors and nurses, since in circularity of the care / care process, patient and family, professionals, institutions and services are integrated and connected in order to promote the health care of a larger group[20].

In the logic of clinical economics, "good nursing" is more valuable than many high-tech solutions, which require high costs with material resources, since nursing care is fundamental for the care of people. The nurse, a priori the nurse, can be a promoter of greater care, the care of the collective, a collective that involves taking care of several people (from the patient/ client family, from their own peers - the nursing team, the multi-professional team, institutional environment, among others) and multiple dimensions that involve direct (care) and indirect care (management of human and material resources). Therefore, nursing care is considered essential for the good care of people.

Nursing care is patient-centered and most institutions have nursing professionals 24 hours a day, with the full presence of a nurse (s). These professional (s) are responsible for knowledge of pathology, treatment, definition of care and nursing prognosis (necessary for the Nursing Process), but they also have knowledge of life history, emotional, spiritual and social needs and physical, which go beyond the knowledge inherent to the diagnosis and medical and nursing prescriptions. However, although this knowledge is essential for the provision of clinical nursing care, there is still insufficient knowledge by nurses about the Nursing Process, although its mandatory use in professional practice, to systematize nursing care[21]. A challenge to be overcome by the patient's nurse advocate.

In this sense, nurses need to overcome challenges inherent to their professional practice and, based on their knowledge, question, inquire, worry about everyday situations to promote care and ensure patient safety, valuing mainly what it is important and necessary for the patient and their family, at that moment, with respect to their choices, although, for this, it involves risks that can be controlled. Therefore, nurses need to be prepared to initiate and dialogue with members of the health team itself in the face of conditions or definitions that, in some way, contradict the patient and family's desire, by identifying the definition of behaviors, treatments or interventions that are not compatible with the best scientific evidence or good care practices, or that may compromise patient safety.

As a perspective, the greatest interest must be in the health and care of the patient, according to their particular interests and needs, as well as their family, and not the institutional interest, profit, the hurry. For this, the nurse must advocate for the patient and not for the institution or the interest of some. The excellence of the clinical economy can be sustained by the adherence of health organizations to the culture of human care, not only linked to profit. This care is linked to the guarantee of information, safety and ethics, not only in professional practice, but also in the execution of research involving people.

In order to count on this nurse who questions and asks, it is necessary to have a "good nursing education", as this professional needs to be prepared for his academic career, since graduation. Your training can be continued and deepened at the graduate level for "good nursing" as a practice and professional care.

It is necessary, in the universe of institutions, the "good nurse manager", who articulates the management of care linked to patient safety and the quality of services, concomitant with cost management, which in the current scenario are still immense in service burden on public and private health systems. Thus, it is necessary to

articulate multiple factors, the most fundamental, which guarantee customer satisfaction, the best health results, but also the financial survival of health institutions and services.

In the search for excellence in care, in the effectiveness of actions and in patient safety, it is necessary to adequately dimension the nursing team[22] and the respect for autonomy nurses so important needs to be ensured by institutional managers. Increasing teamwork brings positive results not only on job satisfacton, but also on care delivery[23].

Regarding nursing, ensuring the best care related to the quality and safety of the patient, nurses Y (patient's lawyer) are perceived as promoters of this care. The letter Y sounds like why and gives a significant questioner to nurses who, based on their theoretical practice, based on scientific evidence, questions of conduct, opinions and medical practices for the benefit of the patient[8]. Questioning a doctor and demanding that he explains his actions and decisions implies possibilities for disagreements and discomfort. However, it is confirmed by the testimonies that the most qualified professional for this function is the nurse[8], since supported by the managers of the institution or service to act in defense of the patient, needing to investigate and question the medical conduct.

In order to act in defense of the patient, it is necessary that the nurse has a high qualification in his area of knowledge, with constant updating in a qualified scientific database to obtain high-level scientific evidence, which can support explanations with the patient and discussion with the medical team. However, excellent knowledge and clinical practice in the specialty is a prerequisite, but it is not enough. Knowledge of clinical epidemiology and basic microeconomics, psychology, ethics and philosophy are also essential[7], in addition to communicational and dialogical skills, respect, empathy, zeal, ethical and moral attitude, among others human attributes that consider multidimensional patient care as a major benefit, regardless of their choices.

According to the above, although the best scientific evidence indicates the best treatment, it is up to this professional to clarify to the patient the risks, benefits, monetary costs, among other conditions involved. Above all, this nurse must ensure that the patient's choice is not influenced by any part. Therefore, impartiality and ethics are fundamental in this process, as well as being resigned to the patient's decisions, although, in particular, they may disagree with them[8]. Thus, considering the ethical principle of respect for patient autonomy must be sovereign, as the desire of family members and doctors is not always correlated with that of patients[24].

Opinions, judgments, theoretical and practical knowledge or scientific evidence must not annul the decision of the patient and his family (if the decision is shared with the patient), which must prevail and be respected. It is worth mentioning that all explanations given to the patient and the decisions taken must be recorded in carefully prepared documentation[8] and signed by all involved.

According to the concept of Y-nurse (patient advocate), unnecessary interventions for patients should be avoided, particularly those that can increase costs. Interventions are necessary when they increase the effectiveness and efficiency of health outcomes, and not to what may be related to higher survival rates[7].

But, one can go further, the patient's lawyer in Y can guarantee the patient's right to choose based on scientific evidence, but also based on his life history, desires, ambitions, needs, perspectives, considering his unit in the multiplicity of experiences of health professionals. This means considering the one in the multiple, that is, that the experience or decision is exclusive to the patient. Although the professional experiences several similar situations in his daily work, each patient is unique. Considering the individuality/uniqueness/particularity of each being, in their context of life, also means practicing "good nursing". They are considered the key element in the influence of their team, with the central purpose of patient health[25].

In addition, when the patient disagrees with the medical conduct, the nurse can mediate the conflict between the patient's desire and the

medical choice, advocating for the patient. For this, it requires talking with the doctor to discuss the benefits and / or risks involved in the established conduct, as well as its refusal. Consequently, this action can bring together the interprofessional dialogue, value the patient's desire and mitigate the risk of legal responsibilities[16].

The nurse's work in Y is based on the best health care, whose questions about treatment decisions must observe the lowest resource costs, especially those that affect the patient, supported by the principles of clinical economics. Therefore, the nurse is responsible for evaluating the process, adherence, efficacy and safety of the clinical practices chosen for the benefit of the patient, not only in the best treatment or technology used. This does not mean replacing a treatment or medication, but to assess the impact of this treatment or medication on the patient's quality of life[19].

The study was limited to interviewing health professionals participating in the referred Seminar, when the concepts in question were presented, and because it is an emerging theme, the statements may have had little depth or reflection in the answers. It is recommended to deepen the concepts of clinical economics and Y-nurse (patient's advocate) through new studies as well as their application and evaluation in different realities.

Conclusion

The speeches pointed out that it deals with innovative, challenging and applicable proposals for nursing at all levels of health care, inserted in the training for nurses and all health professionals, with effective training interrelating ethics, epidemiology and patient safety based on the Patient Advocate and the Clinical Economics.

As perspectives, it is expected to open up for learning, expand and deepen the theoretical concepts in question, in an academic, professional and scientific environment, to enable/condition nursing empowerment through qualified academic training. Not only for the innovative aspect of the concepts, but also for the important contribution to patient care in a society conditioned by individual interests and profits. Therefore, the concept of clinical economics is understood as fundamental and applicable, since the institutions survive with adequate financial, human and material management.

Collaborations:

1 – conception and planning of the project: Reinaldo Antonio Silva-Sobrinho and Adriana Zilly;

2 – analysis and interpretation of data: Adriana Zilly and Maria Aparecida Baggio;

3 – writing and/or critical review: Reinaldo Antonio Silva-Sobrinho; Maria Aparecida Baggio; Adriana Zilly; Fabiana Colombelli and Franz Porzsolt;

4 – approval of the final version: Reinaldo Antonio Silva-Sobrinho; Maria Aparecida Baggio; Adriana Zilly; Fabiana Colombelli and Franz Porzsolt.

References

1. Malta, Deborah Carvalho et al. Doenças crônicas não transmissíveis e mudanças nos estilos de vida durante a pandemia de COVID-19 no Brasil. Revista Brasileira de Epidemiologia [online]. 2021, v. 24 [Acessado 2 Março 2022] , e210009. Disponível em: <https://doi.org/10.1590/1980-549720210009>. Epub 03 Maio 2021. http://doi.org/10.1590/1980-549720210009.

2. Sporinova B, Manns B, Tonelli M, Hemmelgarn B, MacMaster F, Mitchell N, et al. Association of Mental Health Disorders With Health Care Utilization and Costs Among Adults With Chronic Disease. JAMA Netw Open. 2019;2(8):e199910. DOI:10.1001/jamanetworkopen.2019.9910

3. Siqueira ASE, Siqueira-Filho AG, Land MGP. Analysis of the Economic Impact of Cardiovascular Diseases in the Last Five Years in Brazil. Arq. Bras. Cardiol. 2017;109(1):39-46. DOI: 10.5935/abc.20170068.

4. Silva RM, Caetano R. "Farmácia Popular do Brasil" Program: characterization and evolution between 2004 and 2012 Ciênc. saúde coletiva. 2015;20(10):2943–56. 10.1590/1413-812320152010.17352014.

5. Porzsolt F, Paschke S, Naegler H, Bruch H-P. Die Finanzierung des gesundheitlichen Mehrwerts setzt die Unterscheidung von Qualität und Nutzen voraus. Monitor Versorgungsforschung. [Internet]. 2015 [cited 2020 Jul];4:39-43. Available from: http://www.monitor-versorgungsforschung.de/kurzfassungen/ kurzfassungen-2017/mvf-04-15/Qualitaet_Nutzen

6. Pinto M, Madureira A, Barros LBP, Nascimento M, Costa ACC, Oliveira NV, et al. Cuidado complexo, custo elevado e perda de renda: o que não é raro para as famílias de crianças e adolescentes com condições de saúde raras. Cad. Saúde Pública. 2019;35(9):e00180218. DOI:10.1590/0102-311X00180218.

7. Porzsolt F, Kaplan RM (editors). Optimizing Health-Improving the Value of Healthcare Delivery. New York: Springer; 2006. p. 1-313.

8. Porzsolt F. Clinical Economics and Nursing. Rev. Latino-Am. Enfermagem. 2015;23(6):989-990. DOI: 10.1590/0104-1169.0000.2640.

9. Piexak DR, Backes DS, Backes MS, Tomaschewski-Barlem JG, Devos Barlem EL, Gautério DP. Divergências e convergências entre o cuidado do enfermeiro e o cuidado dos demais profissionais. Rev Cubana Enferm [Internet]. 2017 [cited 2020 Jul];33(1). Available from: http://www.revenfermeria.sld.cu/index.php/enf/article/view/416.

10. Instituto Brasileiro de Geografia e Estatística. Síntese de Indicadores Sociais: Uma Análise das Condições de Vida da População Brasileira. Série Estudos e Pesquisas de Informação Demográfica e socioeconômica. N.27. Rio de Janeiro: IBGE; 2010.

11. Minayo MCS. Amostragem e saturação em pesquisa qualitativa: consensos e controvérsias. Rev Pesqui Qualitativa [Internet]. 2017 [cited 2020 Aug];5(7):1-12. 2017. Available from: <http://rpq.revista.sepq.org.br/index.php/rpq/article/view/82>.

12. Lefèvre F, Lefèvre AMC. Discourse of the collective subject: social representations and communication interventions. Texto contexto - enferm. 2014; 23(2):502-7. DOI: 10.1590/0104-07072014000000014.

13. Sampaio RS. Contribuições do processo de enfermagem e da sistematização da assistência para a autonomia do enfermeiro. Rev Cubana Enferm [Internet]. 2019 [cited 2020 Jul];35(4). Available from: http://www.revenfermeria.sld.cu/index.php/enf/article/view/1777.

14. Shirey MR, Ebright PR, McDaniel AM. Nurse manager cognitive decision-making amidst stress and work complexity. J Nurs Manag. 2013;21(1):17-30. DOI:10.1111/j.1365-2834.2012.01380.x.

15. Zarzeka A, Panczyk M, Belowska J, Mazur N, Lourido BP, Gotlib J. Nurse prescribing: Attitudes of medical doctors towards expanding professional competencies of nurses and midwives. J Pak Med Assoc. [Internet]. 2019 [cited 2020 Jul];69(8):1199-1204. Available from: https://jpma.org.pk/article-details/9289?article_id=9289.

16. Wocial LD, Slaven JE, Montz K, Monahan PO, Hickman SE, Callahan CM, et al. Factors Associated with Physician Moral Distress Caring for Hospitalized Elderly Patients Needing a Surrogate Decision-maker: a Prospective Study. J Gen Intern Med. 2020;35(5):1405-1412. DOI: 10.1007/s11606-020-05652-1.

17. Figueira AB, Barlem ELD, Amestoy SC, Silveira RS, Tomaschewski-Barlem JG, Ramos AM. Health advocacy by nurses in the Family Health Strategy: barriers and facilitators. Rev. Bras. Enferm. 2018;71(1):57-64. DOI: 10.1590/0034-7167-2016-0119.

18. Porzsolt F, Kaplan RM. «CLINECS»: strategy and Tactics to Provide Evidence of the Usefulness of Health Care Services from the Patient's Perspective (Value for Patients). In: Porzsolt F, Kaplan RM. (eds). Optimizing Health: Improving the Value of Healthcare Delivery. Springer, Boston, MA. New York: Springer; 2006. p. 1-9.

19. Silva-Sobrinho RA, Zilly A, Porzsolt F. Development of the nursing profession: From nursing angel to patient advocate. Journal of Nursing Education and Practice. 2018; 8(2):16-22. DOI: 10.5430/jnep.v8n2p16.

20. Baggio MA; Erdmann AL. The occurrence of the care 'of us' in the movements and fluctuations of the interactive processes in the hospital environment. Texto contexto - enferm. 2016;25(1): DOI: 10.1590/0104-070720160000160014.

21. Oliveira MR, Almeida PC, Moreira TMM, Torres RAM. Nursing care systematization: perceptions and knowledge of the Brazilian nursing. *Rev. Bras. Enferm*. 2019; 72(6):1547-53. DOI: 10.1590/0034-7167-2018-0606.

22. Carlesi KC, Padilha KG, Toffoletto MC, Henriquez-Roldán C, Juan MAC. Patient Safety Incidents and Nursing Workload. Rev. Latino-Am.

Enfermagem. 2017;25:e2841. DOI: 10.1590/1518-8345.1280.2841.

23. Kaiser JA, Westers JB. Nursing teamwork in a health system: A multisite study. J Nurs Manag. 2018;26(5):555-62. DOI: 10.1111/jonm.12582.

24. Cardoso RB, Pacheco STA, Caldas CP, Souza PA, Peres PLP, Nunes MDR. Comforting practice for the hospitalized elderly in light of bioethics. Rev. Bioét. 2019;27(4):595-99. DOI: 10.1590/1983-80422019274342.

25. Nunes EMGT, Gaspar MFM. Leadership in nursing and patient satisfaction in hospital context. Rev. Gaúcha Enferm. 2016;37(2):e55726. DOI: 10.1590/1983-1447.2016.02.55726.

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