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Visibility of nursing in policy documents related to health care priorities

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Abstract

Aim: To explore the visibility of nursing in policy documents concerning health care priorities in the Nordic countries.

Background: Nurses at all levels in health care organisations set priorities on a daily basis. Such prioritization entails allocation of scarce public resources with implications for patients, nurses and society. Although prioritization in health care has been on the political agenda for many years, prioritization in nursing seems to be obscure in policy documents.

Methodology: Each author searched for relevant documents from their own country. Text analyses were conducted of the included documents concerning nursing visibility.

Results: All the Nordic countries have published documents articulating values and criteria relating to health care priorities. Nursing is seldom explicitly mentioned but rather is included and implicit in discussions of health care prioritization in general.

Conclusion: There is a need to make priorities in nursing visible to prevent missed nursing care and ensure fair allocation of limited resources.

Implications for nursing management: To highlight nursing priorities, we suggest that the fundamental need for nursing care and what this implies for patient care in different organisational settings be clarified and that policymakers explicitly include this information in national policy documents.

KEYWORDS

missed nursing care, nursing visibility, policy documents, prioritization, rationing

1 | INTRODUCTION

Issues related to prioritization in health care have been discussed among policymakers in the Nordic countries for decades (Hofmann, 2013) and are of ongoing political concern worldwide (WHO, 2014). Even though nurses function as gatekeepers of nursing (Jones, Hamilton, & Murry, 2015) and engage in prioritization at the bedside every day (Suhonen et al., 2018), prioritization in nursing seems to have limited visibility. Additionally, a debate on prioritization in nursing appears to have been almost absent from the public discourse and from policymaking, and it also is rarely discussed within the nursing profession (Tønnessen, 2011). Recently, however, prioritization in nursing has been subject to scrutiny by nurse scholars (Scott et al., 2018; Suhonen et al., 2018), but the extent to which nursing care is visible in policy documents concerning prioritization in health care is unknown. Hence, in this paper, we elucidate and give examples of the ways in which nursing is visible in overarching policy documents concerning health care priorities that are currently in force at the national level in the Nordic countries. That is, we aim to determine whether and how nursing care is mentioned, for example explicitly and/or implicitly, in national documents such as legislation and official governmental reports concerning health care priorities.

1.1 | Background

The demand for nursing services is growing due to a growing number of people with complex health conditions, multiple chronic diseases and comorbidities. This makes prioritization in health care more complex and challenging (WHO, 2014). Furthermore, new challenges concerning prioritization in nursing care will emerge as the discrepancy between available resources and patients' needs is expected to increase (Phelan, McCarthy, & Adams, 2018). Additionally, problems of allocation will become more difficult and complex as technological and medical possibilities evolve. Hence, deciding how to set priorities will be a major cause of concern in nursing for nurses at the bedside, nursing management and leadership, as well as for policymakers.

Suhonen et al. (2018) describe prioritization in nursing as complex decisions made by different professionals in diverse positions on several different levels in all parts of a health care organisation. Several studies have shown how nurses set priorities and ration access to care, both in hospitals and in municipalities, on a daily basis (Lake, Germack, & Viscardi, 2016; Zuniga et al., 2015). Nurses set priorities at the bedside, on the ward and at the organisational and societal levels. These decisions concern which patients should receive nursing care, what resources are allocated to care services and how care is delivered (Suhonen et al., 2018). Nurses sometimes have formal responsibility for prioritization, namely as part of their job description rooted in legislation, such as granting nursing services through administrative decisions (Tønnessen, 2011). Research indicates, however, that nurses mainly set priorities in an informal and implicit manner, like when prioritizing between nursing tasks and patients' different fundamental needs for help during a shift (Alderman et al., 2018; Jangland, Teodorsson, Molander, & Muntlin Athlin, 2018; Scott et al., 2018). Hence, nurses have an extensive impact on people's access to care and the provision of nursing to individual patients without these prioritization processes and decisions being either explicit or transparent. In democratic countries, it is important to make prioritization processes and decision-making regarding rationing explicit and open to public scrutiny (Broqvist, 2018; Daniels, 2008). One place to start is to determine whether and how national policy documents address prioritization within nursing care.

Issues such as resource allocation, rationing of nursing care and fundamental need for nursing care, omission of nursing care and nursing tasks left undone or missed have become a growing concern in nursing, as have the consequences they entail for patients, family members and nurses (CA 15208 memorandum, 2014). Research shows how nurses at the bedside are constantly forced to prioritize, deciding which nursing services and interventions to provide and which to leave out (Ausserhofer et al., 2014; Jones et al., 2015). Furthermore, nurses experience prioritization as difficult choices, and some priorities seem to infringe on fundamental values of nursing (Halvorsen, 2009; Tønnessen, 2011). Research indicates that nurses experience moral distress when having to ration nursing care (Choe, Kang, & Park, 2015). Furthermore, other studies find higher mortality rates in patients due to missed nursing care (Ball et al., 2018), and there is a growing awareness of the tension between the rationing of nursing care and the human right to a minimum standard of health care services (Tønnessen, 2011). Hence, prioritization affects patient outcome and can lead to ethical problems and dilemmas. It is thus important not only to study the impact prioritization has on nursing practice, but also to explore possible ways of making the prioritization processes easier for those involved, namely nurse providers and nurse managers.

Fair distribution is a main goal of the allocation of public resource based on egalitarian and universal values such as justice and equality (Daniels, 2008; World Health Organization, 2014). Thus, it is important to determine whether and how national policy documents such as legislation, official governmental reports and white papers describe prioritization in nursing. Studying such policy documents will provide insight into how governments plan to spend and allocate public resources for nursing. By examining such documents from the Nordic countries—countries that have been working on prioritization for a long time—we may determine the visibility of this issue and shed light on prioritization in nursing. While there are some analyses of prioritization processes in selected Nordic countries, these mainly involve priorities related to medical diagnoses and treatment (Hofmann, 2013). As a point of departure, policy documents regarding health care are normative and most commonly concern all health care personnel. Thus, it is unknown whether and how nursing is addressed in policy documents in the Nordic countries. In this study, we searched these documents to see whether and how nursing is

TABLE 1 Priority setting processes in the Nordic countries—a brief overview

Denmark
Denmark has discussed priority setting since the 1970s. The Danish government prioritizes through 'macro-prioritization' (distributing the state budget to various sectors) and 'treatment-prioritization' (distributing financial resources to 'new' treatments or 'packages,' e.g. cancer). Medical technology assessment institutes are often involved in the assessment process. The choice of treatment for particular patients is the responsibility of the health professionals working at hospitals in the particular regions, or at the local medical clinics or medical centres in the municipalities, and relies on clinical judgement
Finland
In Finland, discussions about priority setting started in 1992, and the first report appeared in 1994. The National Advisory Board on Social and Welfare and Health Care Ethics (ETENE) discusses general principles and ethical issues in the field of social welfare and health care. In 2014, the government appointed a Priority Setting Advisory, the Council for Choices in Health Care (PALKO), a permanent body that judges whether or not treatment and care options should be provided for all on demand. PALKO works in conjunction with the Ministry of Social Affairs and Health with the goal of issuing recommendations on services that should be included in the range of public health services. Health care is organised into and steered by five health regions and twenty hospital regions. The health regions have responsibility for health care priorities within their regions based on the principles from ETENE. Finland is in the process of reorganising the health regions, which may imply changes for health care and priority setting
Iceland
Discussions on policy for health care services in Iceland started in 1986, and governmental guidelines for fair distribution of health care services were implemented in 1998 and are still in use. The government prioritizes health care by distributing the state budget to various sectors based on legislation and policy papers. Health professionals are responsible for organising services and individual treatment in line with national regulations and guidelines. In 2001, Iceland published a governmental policy paper for health care goals and priorities, and a new one is being prepared
Norway
In Norway, priorities in health care have been steered on a national health–political level since 1987. The current policy papers from 2014, 2015, 2016 and 2018 set forth and discuss criteria for prioritization in health care. The 2018 paper refers to priorities in primary care, while the others focus on hospital care. Health care managers and health professionals in clinical settings are obliged to follow the national criteria in practice and when setting priorities and planning health care activities. In 2014, the National System for Managed Introduction of New Health Technologies within the specialist health service was established, designating the process and authorities for making decisions regarding new treatment and medicine at the national level
Sweden
In Sweden, health care priorities are steered by a governmental commission. In 1996, the Swedish government agreed on an ethical platform for health care priorities, and the guidelines made then are still in use. The main responsibility for health care services, including how to allocate resources and priorities in health care, was given to the counties and municipalities, based on national values and principles. In addition, a priority centre was established at the University of Linköping, which has been important in developing a national model for multidisciplinary health care priorities

explicitly and/or implicitly mentioned. Even though the Nordic countries were early in developing processes for prioritization, the visibility of nursing in these documents has not been studied.

In the Nordic countries, all citizens have an equal right to publically funded health care services, including nursing. Citizens are covered by national tax systems, collective public insurance systems or other regulations taking care of their rights to health care, with the added possibility of additional cover by private insurance. However, the Nordic countries have different approaches to organising their regulation of prioritization. In Table 1, we give a brief overview of the approaches in each Nordic country.

1.2 | Aim

The aim of this study was to explore nursing visibility in policy documents relating to health care priorities in the Nordic countries.

Nursing visibility refers to whether and how nursing care and/or nurses are mentioned and/or described explicitly or implicitly in the documents. Explicitly means being mentioned directly in the text, and implicitly means when nursing care, nursing priorities or nurses are included as part of health care priorities and/or health care personnel in general. Policy documents refer to overarching policy documents in force from the government, such as legislation or other official documents forming health care policy on the national level with regard to health care priorities.

2 | METHODOLOGY

This study uses a document analysis approach as we seek to understand how policy documents address issues around nursing care in health care priorities (Prior, 2003). Using documents as material, we must take into account the intent of the document and the context in which it is produced (Flick, 2018; Prior, 2003). The documents used in this study are official documents forming national policy concerning priorities in health care. These documents are important in that they reflect political and governmental ambitions and values. Analysing policy documents is relevant as they address public health issues by revealing political goals and legitimating measures and actions concerning public health care services recommended by policymakers (Flick, 2018).

When using documents in research, we must critically consider their quality, namely their authenticity, credibility, representativeness and the meaning (Flick, 2018). Policy documents usually fulfil the criteria for authenticity and credibility because they are primary documents, originals, which implies accuracy as well as reliability in terms of expressing the political goals of the government. Representativeness relates to typicality, and the included documents are all typical policy documents (see Table 2) expressing national policy and/or legislation of each country involved in the study. Meaning here refers to the intended meaning of the documents, which in this case is policy related to priorities in health care on a national level.

2.1 | Material, search and selection

Each author was responsible for searching databases of current interest and selecting relevant policy documents in their respective countries. For an overview of searched databases, see Appendix S1.

Through the search, we identified various documents. Since the aim of this study was to explore how nursing is visible in policy documents at the national governmental level, we excluded documents at the county and municipality levels, ethical codes of nursing and clinical medical guidelines relating to treatment of various patient groups with specific medical diagnoses.

2.2 | Description of the included material

The policy documents included are national-level documents from the Nordic countries, in force as of 2018, regarding priorities in health care with political obligations for follow-up. In Table 2, we give an overview of the included documents from each country, presenting the documents' name, type and applicability level and/or setting in the health care organisation.

As indicated in the table above, all the Nordic countries have national policy documents about priorities in health care or including priorities in health care. The included documents, however, display great variation in terms of scope, content, topics and applicability level and/or setting in the health care organisation. The documents include laws, regulations based on laws and governmental expert reports, as well as guidelines from National Advisory Boards. Although the included legislation does not focus on health care priorities per se, aside from the Norwegian regulation relating to prioritization in specialized services, it impacts health care priorities in general in its respective country.

The differences between the Nordic countries in terms of what documents were included may imply variations in how each country implements prioritization in their health care organisations (as also shown in Table 1). For example, the material from Finland consists of five overarching acts and one national body, whereas the material from both Norway and Sweden includes one piece of legislation and four governmental experts' reports. Hence, it is important to note that documents included are the documents we found relevant at the national level in each country. More specific guidelines at the county or municipality level might exist, as is the case in Denmark, although these are excluded in line with the aim of the study. Moreover, all the Nordic countries have passed legislation relating to health care, patients' rights and health personnel. However, these acts are not included from all the countries, as in some cases we considered other documents more relevant in relation to prioritization in health care.

2.3 | Data extraction and analyses

Each participant read the included documents from their own country looking for whether and how nursing is visible explicitly and/or implicitly in the documents. To ensure validity and reliability in the data extraction process, the authors discussed as a group and agreed upon what to look for in the texts. First, we searched each text for expressed values, criteria and definitions of priorities and examined what and how nursing was visible explicitly and/or implicitly. Next, we agreed on relevant search words for priorities in nursing, which terms to use in each country and how to understand the meaning of each term. Then, we examined all the documents using the predetermined search terms. Finally, we had to find a valid translation into English. Translated into English, the search words used are *caring*, *nursing*, *nursing care*, *nursing and care*, *prioritization* and *priorities in nursing* (see Appendix S2, which includes both the native and the English words).

3 | RESULTS

The analyses elucidate that nursing is rarely explicitly visible in the national documents; that is, nursing or nurses' responsibility in prioritization is seldom mentioned in concrete terms. Most often, nursing is implicit, that is included in health professionals' responsibilities or related to health care priorities in general. First, we present overarching common features for the Nordic countries concerning nursing visibility in the documents. Second, we present areas where nursing is explicitly and/or implicitly visible, supported by examples extracted from the texts.

3.1 | Common features and nursing visibility

All the Nordic countries have documents describing explicit criteria for prioritization and underlying values (see Appendix S3), as well as defining priorities in health care, although without specifying nurses or nursing in particular. The documents mainly focus on priorities in health care in general and include all health care personnel. All countries define priorities in a similar way and emphasize that prioritization ranking something that is useful in advance of something else that is also useful. Furthermore, prioritization entails finding ethical and acceptable ways of saying no to patients in need of well-considered medical treatment and care because other patients' needs have to be preferred. The definitions also reveal that prioritization in health care is a concept with many dimensions, including balancing of values and decision-making, often used in regard to delivering resources and medical treatment among different patient groups.

3.2 | Explicit and implicit visibility of nursing

In the following, we show how and in relation to which areas nursing is explicit and implicit in the documents (Table 3):

TABLE 2 Included documents

Country	Name of document	Type of document	Applicability level and/or setting
Denmark	Danish Health Act of 16 June 2005.	Legislation	All health care services
	Danish Ministry of Health, 2016. *Principles on prioritization of medicine at hospitals*	National guideline	Primary sector
	Danish Ministry of Health, 2008. *National strategy for Medical Technology assessment. Better basis for planning and prioritization in the health sector*	National strategy paper	All health care services
Finland	Finnish Health Care Act No. /1326	Legislation	Specialized and primary health care
	Finnish Act on the Status and Rights of Patients 785/	Legislation	All health care services
	Finnish Act on Supporting the Functional Capacity of Older Population and on Social and Health Services for Older Persons 980/	Legislation	Primary health care and health care settings where older people are taken care of
	Finnish Health Care Professionals Act 559/	Legislation	All settings
	Finnish National Advisory Board on Social Welfare and Health Care Ethics (ETENE)	National recommendations on shared values base in health care	All settings
	Finnish Parliamentary Ombudsman,	Legislation	All settings
Iceland	Icelandic Ministry of Health and Social Security, 1997	Legislation	All health care services
	Icelandic Law on Health Care Services, 2007	Legislation	All health care services
	Icelandic Health and Social Security Ministry, 1998. *Priority setting in Health Care*	Official governmental report	All health care services
	Icelandic Health and Social Security Ministry, 2001. *Healthcare plan until 2010: Long-term healthcare goals*	Official governmental report	All health care services
Norway	Norwegian regulation relating to the prioritization of specialized services. FOR-2000-12-01-1208	Legislation: Regulation according to Act	Specialized services
	Norwegian Ministry of Health and Care Services 2014. *Open and fair—priorities in the healthcare services.*	Official governmental report	Specialized services
	Norwegian Ministry of Health and Care Services, 2015a. *Principles for priority setting in health care. Summary of a white paper on priority setting in the Norwegian health care sector.*	Official governmental report	Specialized services
	Norwegian Ministry of Health and Care Services, 2015b. *In dead earnest. Seriousness and prioritization*	Official governmental report	Specialized services
	Norwegian Ministry of Health and Care Services, 2018. *First things first. Priority principles in primary health care.*	Official governmental report	Primary care
Sweden	Swedish Health and Medical Care Law	Legislation	All health care services
	Swedish Ministry of Health and Social Affairs, 1995. *Difficult choices in healthcare.*	Official governmental report	All health care services
	Swedish Ministry of Health and Social Affairs, 2001a. *Priorities in health care—Perspectives for politicians, profession and citizens.*	Official governmental report	All health care services
	Swedish Ministry of Health and Social Affairs, 2001b. *Death concerns all of us: Dignified care at the end of life: Final report.*	Official governmental report	All health care services
	Swedish National Audit Office, 2004. *Guidelines for priorities in healthcare*	Official governmental report	All health care services

3.3 | Areas where nursing is explicit

Areas where nursing is explicitly mentioned in the text relate to (a) fundamental nursing care and resource allocation and (b) end-of-life care.

3.3.1 | Fundamental nursing care and resource allocation

Fundamental nursing care and resource allocation is explicitly mentioned a few times in Norwegian and Swedish documents. One

TABLE 3 Areas of nursing visibility in national policy documents

Explicit and implicit inclusion of nursing	Nursing areas
Nursing is explicitly mentioned	• Fundamental nursing care and resource allocation • End-of-life care
Nursing is implicit	• Responsibility for knowledge-based prioritization • Prioritization based on values and rights to care • Ethical dilemmas in health care delivery

Norwegian document reflects nurses' responsibility to prioritize between tasks when providing fundamental nursing care:

> *In nursing homes, nurses and assistant nurses must prioritize in terms of what should be given first priority. Mouth care for one patient, or making sure that another patient gets breakfast on time? […].Time is often limited: Who should get the care first? How much time should be given to each patient? If you use much time on one patient, another has to get less.*
>
> *(NOU 2018:16, p. 80)*

In the Swedish document titled 'Difficult choices in healthcare,' it is suggested that nursing is as important as medical treatment in prioritization of patients (SOU, 1995:6, p. 195). This document treats nursing explicitly, capturing important dimensions of the complexity of nursing care, without addressing what this entails for nursing priorities:

> *Nursing: to satisfy human and personal needs and in so doing defend the individual's own resources to preserve or recover optimal health, as well as to meet needs of care at the end of life. Nursing is a thread through all care and constitutes a complement to treatment. It requires engagement and knowledge of science as well as of human character.*
>
> *(SOU 1995:5, p 108)*

One Norwegian document underlines nursing priorities specifically in the context of the intensive care unit (ICU) where the need for staff and nursing priorities are obvious (NOU, 2014:12, p. 120). Otherwise, the responsibility of nurses (and other health professionals) in terms of allocating resources is seldom mentioned in relation to fundamental nursing care. Nevertheless, the Swedish document from 1995, after mentioning priorities set by physicians, makes the point that nurses and other health care professionals have to set priorities every day:

> *The same attention is not paid to the important priorities constantly set in daily nursing care and decided by registered nurses, nurse assistants, mental care assistants, physiotherapists, occupational therapists, medical social workers, dieticians, psychologists, medical secretaries and others. For the individual patients, these types of prioritizations are of great, and in some cases crucial, importance for the quality of care.*
>
> *(SOU 1995:5, p. 63)*

3.3.2 | End-of-life care

End-of-life care in ICU settings is an area where nurses and nursing are mentioned explicitly in Norwegian documents:

> *Dignity and care at the end of life is an important debate. Spirituality, ethics, morality and economics are challenged down to the very core of personal values when facing death, independent of age […]. Critical care nurses often face many ethical dilemmas and have close interdisciplinary cooperation with the physicians in the ICU.*
>
> *(NOU 2014:12, p. 57)*

While this quotation shows nurses' responsibility for providing dignified and holistic care, there is no mention of the complexity of prioritization in these situations. End-of-life care is also highlighted in one of the Swedish documents (SOU, 1995:5, p. 180) in relation to fundamental care and resource allocation, as seen above.

3.4 | Areas where nursing is implicit

Nursing is implicit in descriptions that include nursing and nurses as part of health care professionals' general responsibility for prioritization in health care and/or patients' rights to care, and includes (a) responsibility for knowledge-based prioritization, (b) prioritization based on values and rights to needed care and (c) recognizing ethical dilemmas in health care delivery.

3.4.1 | Responsibility for knowledge-based prioritization

Finnish legislation underlines that health professionals are obliged to provide care based on evidence and health science (Finnish Health Care Professionals Act,). Even though the text is mainly medically oriented, it emphasizes care, pointing in particular to nursing (Finnish Health Care Act No,). One Norwegian document underlines the responsibility health professionals, including nurses, have for making knowledge-based and interdisciplinary prioritizations:

> *Many priorities are made in the encounter between health and care personnel and patients/users. Assessments are made continuously without time to discuss or reflect*

with colleagues. Health and care personnel's medical knowledge and first-hand knowledge of the patient/user is therefore essential to setting good priorities.

(NOU 2018:16, p. 81)

3.4.2 | Prioritizations based on values and rights to care

As shown in Appendix S3, a multitude of values and criteria exist to guide priorities in health care; however, policy documents often refer to patients' rights to care, benefits of care and urgency of care. Finnish legislation states that:

Each healthcare professional must weigh the benefits of their professional activity to the patient and its possible hazards. Healthcare professionals must take account of the provisions concerning patients' rights. Healthcare professionals must always provide help to those in need of urgent care.

(Finnish Health Care Professionals Act, 1994, Chapter 3, Section 15)

Other values mentioned in the documents that are (implicitly) relevant to prioritization in nursing include respecting patients' vulnerability, ensuring patient safety, avoiding emotional damage and harm and developing trust. Areas that are specifically singled out are mainly related to palliation, end-of-life care and community care. As a Norwegian paper exemplifies, nurses play an important role in prioritization in end-of-life treatment:

In end-of-life care, curative treatment and tasks are usually not considered; however, providing good care and palliation is essential. This implies recognition of the patient's vulnerability and caring for integrity and dignity, as well as emphasizing good communication.

(NOU 2014:12, p. 133)

Very rarely, distinctions between medical priorities and fundamental needs are made concerning patients' right to care and financial resources. However, one Norwegian document makes an important distinction relevant to prioritization in nursing and the discussion of missed nursing care.

The committee will emphasize that there is a fundamental distinction between services aiming at treatment and prevention of illness and services aiming at providing for patients' fundamental needs [...]. For the latter, the committee argues that the society must accept the cost necessary to provide a minimum standard of health and care services.

(NOU 2018:15, p. 107)

In general, resources connected to implicit visibility of nursing priorities are mainly mentioned in relation to issues about sufficient staffing and preferred skill mix.

3.4.3 | Ethical dilemmas in health care delivery

All of the included documents seem to avoid identifying ethical dilemmas related to prioritization in health care. One example from the Norwegian documents puts forth a complex ethical dilemma concerning benefit without exploring it further:

At the end of life, there might be profound differences between the care provider's and the patient's valuation of benefit.

(NOU 2014:12, p. 134)

Another example from Sweden (SOU, 2001a:8, p. 98) highlights the distance between decisions made at the political level and the ones closest to patients facing the consequences of prioritization every day:

Those working closest to the patients are therefore deeply affected by the ethical dilemmas that can follow from decisions about selecting and deselecting everyday choices. They are often confronted with almost impossible choices. The personnel are naturally also affected by the prioritizations made at the political level. They are the ones who first come to recognize the effects of decisions made by politicians about changes in resources or in the organization.

4 | DISCUSSION

As the results highlight, the included Nordic documents rarely mention nursing explicitly in reference to health care priorities on a national level; rather, nursing is implicit as part of health personnel responsibilities and health care priorities in general. The fact that nursing is implicitly addressed suggests that nurses and nursing are included and regarded as equally important as other health professionals and health fields when it comes to health care priorities. This implicitness, however, may also imply a need for clarification, which we will elaborate further. Below, we discuss the implications of the findings particularly in the light of missed care.

The fact that prioritization in nursing is mostly implicit in national documents might be because in some of the countries, other documents at the county or municipality level describe nursing priorities in detail. Another reason that nursing is more commonly implicitly included in this documentation might be a biomedical focus on diagnoses and criteria such as benefits and cost of treatment. Patients with diagnoses that require relatively little medical intervention may nevertheless need extensive nursing care. In the

documents, the responsibility of health personnel to ensure patients' rights to care is highlighted, especially concerning end-of-life care and fundamental needs. What this responsibility entails, however, is not elaborated for either nurses or other health care providers. However, as one Swedish government report states, 'health personnel are deeply affected by these almost impossible choices' (SOU, 1995:5). Nurses' important role in these difficult choices, both as gatekeepers and in everyday decision-making, is not sufficiently highlighted in policy papers, and neither are the thresholds for provision of care and accountability in prioritizations. Nurses have a unique position because they assess patients' preferences, and patient need, at the bedside. Therefore, it is of vital importance to describe their competences, tasks and duties when discussing prioritization. This entails visualizing fundamental nursing care and clarifying nurses' responsibility in policy documents and the strategies for prioritization in health care.

We will argue that the lack of visibility of nursing priorities in policy documents is a risk to patient care, as it may perpetuate an invisibility and lack of understanding of substantive, important elements of nursing care. The prevalence of missed nursing care/care left undone highlighted in the literature (Jones et al., 2015), and the types of nursing care most often missed or left undone (Ausserhofer et al., 2014), may heighten this risk and, ultimately, may lead to reduced quality of care and increased morbidity and mortality.

A growing number of research studies indicate that there is a relationship between organisational and environmental variables, care rationing and/or missed care, and patient satisfaction (Blackman et al., 2018; Lake et al., 2016; Papastavrou, Andreou, Tsangari, & Merkouris, 2014). Studies also indicate how prioritizations reduce the quality of care and challenge provision of safe and competent nursing care (Suhonen et al., 2018; Tønnessen, 2011). Several studies underline the serious consequences of missed nursing care and care left undone. Ball et al. (2018) studied post-operative mortality and found that increased nursing workload was significantly associated with missed nursing care and increased morbidity and 30-day mortality. In another cross-sectional study involving a sample of 65 hospitals, Cho et al. (2016) found a correlation between risk of fall injuries and reduced quality of care, RN staff levels and missed nursing care. Findings that correlate missed nursing care and reduced quality of care are also found in other studies (Carthon, Lasater, Sloane, & Kutney-Lee, 2015; Jones et al., 2015; Kalisch & Lee, 2012). A number of studies also emphasize the need to identify thresholds beyond which prioritizations and rationing start to produce negative patient outcomes (Papastavrou et al., 2014; Tønnessen, 2011). These findings underline the need of increased and detailed visibility of nursing care in policy documents, as a measure to reduce and/or prevent incidents of missed nursing care/care left undone, which increasing evidence indicates produces negative patient outcomes.

The articulation of what fundamental nursing care is and what responsibilities it entails must, however, come from the nursing profession itself, as nurses are the ones who are competent to make this determination. This will have implications for nursing leadership and policymaking.

The documents emphasize that decisions about priorities in health care should be made in a democratic and fair way following a principle of 'responsibility for reasonable decisions.' The arguments behind a given decision should be made transparent to the people having to live with the consequences, to facilitate both better understanding and the possibility of complaints. Thus, the need for an open discussion about priorities in nursing, and possible criteria to guide these decisions, is evident if the goal is fair allocation of resources.

Moreover, this should involve dialoguing between the various stakeholders that could be affected by these priorities, including citizens (Broqvist, 2018). When nursing priorities remain implicit, important democratic values such as openness and fair and equal access to basic goods and services are threatened. Hence, there is a need for members of the nursing profession, especially nursing leadership, to initiate discussions about prioritization in nursing care and to work out what this responsibility entails for nurses in various positions and settings caring for patients with various care needs and dependencies.

4.1 | Implications

Fundamental aspects of nursing care are complex and difficult to specify and have been discussed for years without any consensus (Feo, Kitson, & Conroy, 2018). According to Feo, Kitson and Convoy, a definition of fundamental care is needed to develop a robust evidence base for clinical practice. One possible way to visualize nursing more clearly could be to use an approach that captures the holistic complexity in nursing needs, such as proposed by Kitson (2018), as a point of departure. In this way, resources allocated to fundamental nursing needs, benefit to the patient and health care cost would become clearer and consequently more visible in prioritizations. To promote this process, nurse managers can have an important role in making sure prioritization in nursing care is addressed in legal and policy documents, as well as taking an active role in leading national initiatives to close the current gap in this area.

5 | STRENGTHS AND LIMITATIONS

Throughout our analysis, we encountered some challenges, which limit this study. There is no database dealing specifically with prioritization; thus, each participant searched the web pages of important stakeholders such as governmental and other national authorities. The included documents vary in terms of scope, content and level of health care organisation at which they apply, which made the analytic process, systematization of results and selection of quotations difficult. Furthermore, it was a challenge to find comparable search words, as each participant needed to search their documents in their own language. To address these challenges and strengthen the study, we are transparent regarding the search words used, databases searched and the documents included in our analysis, in addition to explicitly elaborating our analytic process throughout the manuscript.

The strength of this work is that, despite the challenges, we have managed to describe both the differences and common features in the relevant documents regarding priorities in health care on the national level for the Nordic countries. Our search revealed that nursing is very rarely explicitly mentioned in national policy documents. Thus, we have shown the complexity of health care priorities, as well as the differences between the Nordic countries, and the importance of context when it comes to prioritization in health care.

6 | CONCLUSION

Prioritization takes place every day, and research shows how difficult it is to ensure a minimum standard of nursing care and provide for fundamental needs if prioritization remains implicit. To ensure fair allocation and prevent injustice, prioritization must be open to challenges, including through dialogue with citizens, peer review and scrutiny. The articulation of nursing priorities can start with nursing management explicitly describing nursing needs and consequences of provision of care according to setting, needs and context. It is especially important for health care policymakers to consider making explicit their reasoning behind the prioritization of nursing and care in response to patients' fundamental care needs.

ETHICAL APPROVAL

Ethical approval was not required for this paper.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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