

The perceived value of the nursing profession and its future direction

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Abstract

Registered nurses including advanced practice registered nurse practitioners (APRN) are the backbone of the healthcare system. Their responsibilities extend beyond basic patient care to include health promotion, disease prevention, management of acute and chronic illnesses and providing services in anesthesia care and obstetrics. Although nurses represent the largest segment of healthcare professionals and are widely recognized as indispensable collaborators with physicians, they paradoxically occupy undervalued position within the healthcare hierarchy. We have identified several major barriers contributing to the undervaluation, including perceived hierarchy within clinical settings, dysfunctional team dynamics, persistent misconceptions and stereotypes, disparate or absent reimbursement structure that render nursing's contribution to healthcare financially invisible. Hence, it is essential for the healthcare industry to reevaluate the way nurses are valued, both financially and professionally, to ensure that they are empowered to contribute the full extent of their education and training to patient care and the overall effectiveness of the healthcare system. This article examines the major hurdles that may hinder nursing's autonomy and visibility and offers evidence-based strategies to promote the unique value of the nursing profession for improved healthcare delivery and patient outcomes.

Keywords: Healthcare, Nursing value, Advanced registered nurse practitioners, Perceived value, Hierarchy, Autonomy

Introduction

Nurses are key players in the healthcare system ensuring execution of treatment plans, monitoring patient progress, and providing emotional support to patients and their families. As the largest group within the healthcare profession, registered nurses comprise approximately 30% of the healthcare workforce, and their collective impact on healthcare delivery and outcomes is substantial [1]. Their responsibilities extend far beyond basic patient care, especially in the case of advanced practice nurses. They are involved in health promotion, disease prevention, management of acute and chronic illnesses, and providing anesthesia services and obstetric care.

Despite providing these various services, unlike physicians, undergraduate nurses face a fundamental challenge in that they do not directly generate revenue through billing for services [2]. In addition, APRNs are often victims of provider discrimination and are being reimbursed at a lower rate for identical services that physicians provide [3,4]. Furthermore, a systematic review by Vece *et al.* reported that some discriminatory policies even restrict NPs' patient access, direct billing, and direct reimbursement [3]. In many practice settings, APRNs such as nurse anesthesiologists are required to turn over their national provider number to the physician who collects the reimbursement and then pays the nurse anesthesiologist an hourly wage. A recent systematic review by Cortez and Somers *et al.* identified several systemic barriers including limited autonomy, policy constraints, and lack of reimbursement equity, affecting APRN worldwide [5].

These financial dynamics may create a skewed perception of nurses' value within the healthcare hierarchy and contribute to what has been termed the "invisibility" of nursing work. Several studies suggest that the lack of direct billing for nursing services may lead to lower compensation, limited resources, and reduced influence in decision-making processes compared to physician counterparts, and an underestimation of nursing's economic contribution to healthcare organizations [3,4,6,7].

Recent data suggest that this financial structure not only creates practical disadvantages but also perpetuates a perception that nurses are less important team members [8–10]. The study by Weiss *et al.* suggests that when nursing services are not separately billed or valued in financial accounting systems, their contributions become invisible in the economic framework of healthcare, leading to a systematic undervaluation [11]. This undervaluation of nurses undermines their professional standing and impacts patient care quality and safety. This notion is supported by Zwarenstein *et al.* that when nurses are not recognized as equal partners in the healthcare team, their ability to collaborate effectively with physicians and other healthcare professionals can be compromised, leading to communication breakdowns and suboptimal patient outcomes [12]. Consistent with this finding, several studies demonstrate that communication barriers disproportionately affect individuals lower in the organizational hierarchy, who may feel less empowered to speak up with critical input, potentially compromising patient safety [13–15]. Furthermore, the National Academies of Sciences, Engineering and Medicine's landmark report, "The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity, emphasizes that achieving health equity requires nurses to practice to the full extent of their education and training and to be recognized as essential partners in healthcare delivery and policy development [7].

This article aims to examine the major hurdles that hinder

full recognition of nursing's value, including perceived hierarchies, misconceptions, educational underestimation, autonomy constraints, and reimbursement challenges and propose evidence-based strategies and future directions for elevating the nursing profession's visibility and impact.

The Current State: Evidence of Nursing's Undervaluation

Before examining the specific barriers, it is important to establish the current state of nursing's perceived value. While nurses have been voted the most trusted profession in the United States for over two decades, this public trust paradoxically coexists with professional undervaluation within healthcare systems [16]. Two recent systematic reviews examining societal perceptions of nursing revealed that while the public primarily views nursing through the lens of direct patient care and compassion, the profession's leadership capabilities, clinical expertise, and autonomous decision-making abilities remain largely unrecognized [5,17]. This gap between trust and recognition of expertise reflects a fundamental disconnect in how nursing is perceived versus how nurses function in modern healthcare delivery.

The economic invisibility of nursing further compounds this issue. Despite nursing representing the largest workforce in healthcare and contributing substantially to patient outcomes quality metrics and cost savings, these contributions often remain financially unquantified in traditional healthcare accounting systems. This creates a paradox where nursing is simultaneously essential yet economically invisible and trusted yet professionally undervalued.

Hurdles to Realizing the True Value of Nurses

Realizing the true value of nurses is essential for optimizing healthcare delivery and improving patient outcomes. Several hurdles currently hinder the recognition and appreciation of nurses' contributions, as illustrated in **Figure 1**.



Figure 1. Contributing factors that hinder the true value of nursing profession including historical hierarchies, misconceptions, stereotypes, lack of autonomy, representation in leadership and direct billing for nursing service, and inadequate public awareness.

Perceived hierarchy between nurses and physicians

Hospitals are commonly operated with parallel management systems consisting of administrative and clinical hierarchies. The perceived hierarchy in the clinical setting significantly impacts the dynamics of healthcare teams particularly affecting nurses' professional autonomy and voice [8,9]. This notion is corroborated by Jameson *et al.* that traditional hierarchies suppress nurse voice and innovation, while organizations embracing collaborative leadership see improvements in team dynamics and clinical care [10]. In a traditional hospital setting, a hierarchical structure often exists, with physicians at the top, followed by APRNs e.g., as nurse practitioners, midwives and certified registered nurse anesthesiologists, registered nurses (RNs) and licensed vocational nurses (LVN) (Figure 2). While this hierarchy reflect differences in education level, scope of practice, and regulatory authority, it frequently perpetuates an antiquated idea that physicians automatically occupy a higher position even where education and scope of practice are comparable [8]. The physician hierarchy wields significant power over important decisions regarding the current and future direction of the hospitals while nursing leadership enjoys much less authority. This power imbalance between nurses and physicians can lead others in the interprofessional team to view nursing's role as subservient to physicians. As a result, it creates situations where nurses' clinical judgement and expertise are overruled, causing tension, frustration and potentially compromising patient care.

The language used in healthcare settings reflects and reinforces this hierarchy. For example, the common term "physician orders" can be problematic, implying a command structure that may pressure nurses to blindly adhere to physicians' requests, even when these contradict their own clinical judgment. The hierarchical culture within healthcare organizations, where physicians hold positions of authority and nurses are expected to follow their directives, perpetuates this dynamic and may discourage nurses from advocating for their own expertise and contributions to patient care [18]. This hierarchy extends beyond the nurse-physician relationship, potentially hindering interprofessional collaboration and obstructing information flow among pharmacists, allied health professionals, and other team members [9,10].

Misconceptions and stereotypes of nursing

Misperceptions and stereotypes of nursing persist despite the significant advancements in the profession. One of the most pervasive stereotypes is that nurses are merely assistants to physicians, taking orders rather than making critical decisions in patient care. This traditional view fails to recognize the valuable contributions nurses make as autonomous healthcare professionals and collaborative partners in care delivery. Recent research examining nursing's public image confirms that while nursing is respected for caregiving, its intellectual, scientific, and leadership dimensions remain underappreciated. A 2023 qualitative study critiques the traditional "heroic" view of patient care, revealing that nurses' leadership skills and decision-making abilities are largely unrecognized and undervalued by the healthcare system [19]. Moreover, this misperception undermines the autonomy and expertise of nurses especially APRNs, who are highly trained healthcare professionals capable of independent decision-making and complex care management [20,21].

Additionally, nursing has historically been associated with femininity and caregiving, perpetuating the notion that nursing is a nurturing profession primarily for women, rather than a highly skilled, evidence-based profession requiring advanced clinical reasoning [22,23]. This harkens back to an earlier period when nursing functions were performed by nuns and other religious figures due to the intimate nature of some aspects of care, and nursing was not considered a noble profession but rather one associated with lower status [23]. For instance, nurses are often portrayed in media as performing bed baths and medication administration, rather than engaging in complex clinical decision-making and patient advocacy [23]. While these basic tasks are important aspects of nursing care, they represent only a fraction of the multifaceted role nurses play in modern clinical setting.

Another common misconception is that all nurses have similar level of education and perform similar duties [24]. Soheili *et al.* reported persistent misconceptions shape the public image of nursing, including the belief that all nurses have the same education level and job functions, which negatively impact nurse recruitment,

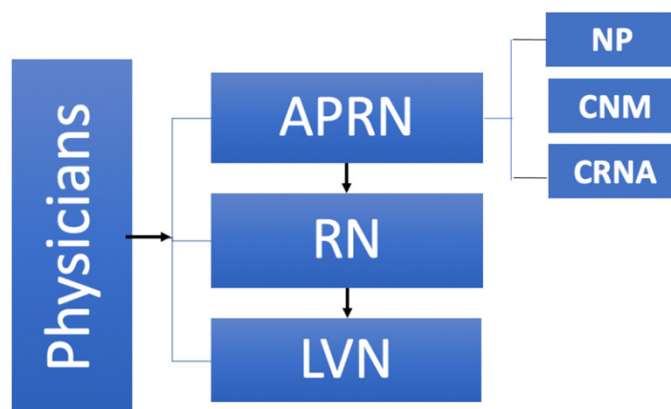


Figure 2. Flow chart depicting the hierarchical relationship in the clinical setting. Traditional healthcare hierarchies have often placed physicians at the top, relegating nurses including APRN, RN and LVN to subordinate roles. APRN represents Advanced Practice Nurses including Nurse Practitioners (NP), certified Nurse Midwives (CNM) and Certified Registered Nurse Anesthesiologists (CRNA); RN represents Registered Nurses and LVNs represents Licensed Vocational Nurses.

recognition, and satisfaction [24]. In reality, nursing encompasses a wide range of roles, specialties, educational level and practice settings, each requiring specialized knowledge and skills [5]. From emergency room nurses advancing to master or doctoral prepared acute care, family, or adult/gerontology nurse practitioners; critical care nurses to doctoral prepared nurse anesthetologists; or obstetric nurses to master or doctoral prepared certified nurse midwives, the nursing profession offers diverse career paths tailored to individual interests and passion, all requiring substantial education and clinical expertise.

Educational requirements and professional recognition

A major misconception contributing to undervaluation is that nursing requires less skill and education compared to other healthcare professions, particularly medicine. This misconception fails to recognize the rigorous and multifaceted nature of contemporary nursing education, which encompasses advanced medical science, theoretical knowledge and extensive hands-on clinical experience. Nurses are trained to assess, diagnose, and treat patients while providing emotional support and patient education.

As nursing responsibilities have expanded and healthcare settings have become more complex and demanding, advanced education and rigorous training have been implemented to ensure optimal patient outcomes [7,22]. For instance, as of 2022, all students matriculated into accredited certified registered nurse anesthetologist (CRNA) programs must pursue doctoral level education [25]. Minimum admission requirements include a baccalaureate or graduate degree, RN or APRN license, and at least one year of full-time critical care nursing experience including demonstrated knowledge of physiological and pharmacological principles, independent decision-making, and advanced monitoring interpretation skills [25]. Upon completion of a nurse anesthesiology program, graduates have an average of 9,369 hours of clinical experience, including 733 hours during their baccalaureate nursing education, 6,032 hours as a critical care registered nurse, and 2,604 residency hours during their doctoral nurse anesthesiology program [25]. Similarly, other APRN specialties have transitioned or are transitioning to doctoral programs, with many programs targeting completion of this transition by 2025 [26]. Despite this extensive education and having been voted the most trusted profession in the United States for 20 consecutive years, nursing is not accorded commensurate authority or professional recognition [4,16]. The disconnect between public trust, educational preparation, and professional authority is particularly evident in primary care, where there is an increasing need for providers, especially in underserved areas. APRNs have demonstrated the ability to provide excellent primary care comparable to the physician counterparts in quality, patient satisfaction and health outcomes [4,27]. Yet, in most states, they face legal requirements for physician supervision even when physicians are remotely located [28]. This supervision requirement discourages NPs from establishing practices where services are most needed [28,29].

To improve cost-effectiveness and healthcare access, the Institute of Medicine (now the National Academies of Science, Engineering and Medicine) examined nursing's role and offered recommendations including removing barriers that prevent nurses from practicing to the full extent of their education, training and competence [30]. In addition, the IOM has called for nurses to function as equal partners with physicians and other healthcare

providers as a key strategy to advance quality healthcare [30]. The National Academy of Medicine's "Future of Nursing 2020-2030" report reinforces these recommendations, emphasizing that nurses must be enabled to practice at the top of their license and function as full partners with physicians and other healthcare providers as a key strategy to advance health equity and quality healthcare [7]. This report specifically identifies scope of practice barriers as a critical obstacle to addressing healthcare disparities and achieving equitable access to care [7].

Autonomy and independence

Autonomy and independence are fundamental principles that empower nurses to deliver high-quality, patient-centered care and contribute to positive healthcare outcomes. Autonomy enables nurses to make informed decisions about patient care based on their clinical judgment, expertise, and knowledge of evidence-based practices. Studies have shown that increased nurse autonomy correlates with improved patient outcomes, including reduced mortality rates, fewer complications, and higher patient satisfaction scores [21,31,32].

Nurses, including APRNs such as nurse practitioners, certified nurse midwives, and CRNAs, are trained to assess patient needs, formulate evidence-based care plans, and adapt interventions as necessary to optimize patient outcomes. Autonomy enables nurses to advocate effectively for their patients' rights, preferences, and best interests. As primary patient advocates within the healthcare system, nurses ensure that patients' voices are heard, concerns are addressed, and autonomy is respected in care-related decision-making processes. Critically, nurses' autonomy and independence expand access to essential healthcare services, particularly in underserved and rural communities experiencing physician shortages. APRNs play a crucial role in bridging gaps in primary care delivery by providing comprehensive, cost-effective, and culturally competent care to diverse populations. Studies have demonstrated that states with full practice authority for NPs have better healthcare access, particularly in rural areas, without compromising quality of safety [28,31].

Interestingly, autonomy complements rather than contradicts collaborative practice. Evidence shows that autonomy enables nurses to contribute their unique perspectives, expertise, and skills to interdisciplinary healthcare teams [5,33]. Specifically studies found that nurses collaborating with physicians, pharmacists, therapists, and other professionals develop individualized care plans, coordinate services, and optimize patient outcomes through shared decision-making and mutual respect. A systematic review by Stalpers *et al.* shows that when nurses practice with autonomy within collaborative teams, patient outcomes improve significantly, including reductions in hospital-acquired infections, pressure ulcers, and length of stay [34].

By promoting autonomy and supporting nurses in their practice, healthcare organizations can maximize the contributions of nurses to achieving positive health outcomes and advancing patient-centered care goals. Autonomy and independence are essential for nurses, including APRNs to fulfill their roles as trusted healthcare professionals, patient advocates, and drivers of quality care delivery. The evidence clearly demonstrates that enabling nurses to practice autonomously within their scope improves healthcare access, quality, and cost-effectiveness while enhancing professional satisfaction and retention.

Reimbursement structures and financial recognition

The nursing profession must differentiate itself from other healthcare professions to better demonstrate its unique value to the public and within healthcare systems. Understanding the historical context of nursing reimbursement illuminates how current financial structures contribute to nursing's invisibility. In the 1920s, nurses in the United States were paid directly by patients, making their contributions economically visible and valued. However, a fundamental shift occurred in the 1930s when nursing care became bundled into hospital room rates, effectively separating nursing services from direct revenue streams. This bundling created a legacy that persists today, with nursing services subsumed within hospital overhead rather than recognized as distinct, billable services. This financial structure has contributed to the persistent undervaluation of nursing work and provides little incentive for hospitals to invest in optimal nurse staffing levels, as nursing costs appear as expenses rather than revenue generators.

Value-based care presents both opportunities and imperatives for recognizing nursing's contributions. In value-based care models, where reimbursement is increasingly tied to patient outcomes, quality metrics, and patient satisfaction rather than volume of services, nurses' roles become critically important. Research demonstrates that nursing care quality directly impacts the metrics most valued in these models, including patient safety outcomes, readmission rates, patient experience scores, and care coordination effectiveness [27].

Implementing performance-based reimbursement models for nursing services can incentivize nurses to focus on delivering care aligned with quality metrics and patient outcomes, such as patient satisfaction, safety indicators, and clinical outcomes. These models encourage nurses to prioritize evidence-based practices and patient-centered care while providing tangible recognition of nursing's contribution to organizational performance. A recent systematic and meta-analysis by Deschenes *et al.* found that under performance-based models, nurses may be more motivated to identify opportunities to streamline workflows, reduce waste, prevent adverse events, and implement innovative care delivery approaches, resulting in optimized resource utilization and reduced healthcare costs over time [17].

Additionally, studies have shown that performance-based reimbursement models encourage interdisciplinary collaboration and teamwork among physicians, pharmacists, therapists, and other healthcare team members to coordinate care effectively for patient well-being [3,6,35]. This is supported by Glazier and Weiss' studies that team-based care becomes more equitable and effective when nursing contributions are financially visible and valued [11,36].

Several evidence-based approaches can improve recognition and reimbursement of nursing services. First, several studies suggest that expanding direct billing capabilities for APRN services and ensuring equitable reimbursement rates at comparable to those physicians would address fundamental financial disparities [3,37,38]. Other studies suggest to develop value-based nursing care models that quantitatively assess and reimburse nurses' contributions to quality outcomes, patient satisfaction, care coordination, and prevention of adverse events to make nursing's impact financially visible [39,40]. This could include specific reimbursement for nursing-led interventions that demonstrably improve outcomes, such as

transitional care management, chronic disease management, and patient education programs [40–42]. Others suggested alternative is to redesign bundled payment models which explicitly recognize and allocate resources for nursing contributions rather than subsuming nursing costs within general institutional expenses [43,44]. Finally, incorporating nursing-sensitive quality indicators, such as pressure ulcer prevention, fall prevention, and infection control into reimbursement formulas would create direct financial incentives for nursing excellence [45].

Redesigning reimbursement for nursing services offers substantial opportunities to incentivize high-quality care delivery and improve patient outcomes while addressing nursing's economic invisibility. However, implementation requires concerted efforts from healthcare organizations, policymakers, insurance payers, and professional associations to design and implement equitable, performance-based reimbursement models. Challenges related to measurement validity, standardization of metrics, provider adoption, resistance from established systems, and overcoming historical precedents must be acknowledged and addressed through evidence-based policy development and stakeholder engagement.

Consequences of the Barrier

The undervaluation of nursing has significant consequences that extend beyond individual nurses to affect patients, healthcare organizations, and the broader healthcare system. Two recent studies reported that when nurses were not recognized or compensated appropriately, workforce retention suffered [24,46]. Particularly, current data indicate concerning trends in nursing turnover rates, particularly among early-career nurses, with estimates suggesting that approximately 30% of new nurses leave the profession within the first two years. This turnover is costly both financially with replacement costs estimated at 1.5–2 times annual salary and in terms of organizational knowledge and expertise loss [46,47]. A study by Yu and Yuk found that patient care quality and safety can also be impacted when nurses were unable to practice autonomously or when their expertise was not fully utilized [48]. Several case reports also support this notion that when nurses face hierarchical barriers that prevent them from speaking up about safety concerns or when their clinical judgment is systematically undervalued, patients are at increased risk [13–15].

Healthcare system effectiveness and efficiency suffer when artificial barriers prevent nurses from practicing to their full capabilities. In areas experiencing physician shortages, particularly rural and underserved communities restrictive scope of practice regulations that require physician supervision limit access to essential care, increasing health disparities and delaying treatment [3,28,31,32]. The recent systematic and meta-analysis by Lee *et al.* found that the economic inefficiency of paying for unnecessary supervision and of not fully utilizing highly trained APRNs contributes to rising healthcare costs without corresponding improvements in quality [49]. In addition, increasing evidence shows that APRNs provide safe and high quality patient care comparable to physician counterparts [4,50,51]. Given the evidence base demonstrating both the safety and cost-effectiveness of independent APRN practice, maintaining restrictive scope of practice regulations represents not only a disservice to the nursing profession but also a policy failure that compromises patient access, healthcare equity, and system sustainability.

Conclusion

Recognizing and valuing the contributions of nurses is essential for fostering a healthcare system that prioritizes patient-centered care, interdisciplinary collaboration, and professional respect. However, it challenges entrenched attitudes and the existing reimbursement system. Thus, policymakers, healthcare leaders, and stakeholders need to work together to improve recognition of nursing services, including those provided by APRNs to ultimately enhance the quality and accessibility of healthcare for all.

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