Nursing in the United States

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It's exciting to be a nurse in the United States today-there are so many opportunities. But, it is also a time of turmoil in the health care system, a time when the same changes that bring opportunity can create uncertainty and discomfort.

To understand nursing in the United States, it is necessary to look at the overall health care system and some of the social, economic, and cultural changes occuring. I'd like to review this with you as well as sharing with you some of the anticipated changes for the near future. I'm sure that you yourself will readily see some of the concerns and opportunities these present for u.s. nurses.

POPULATION

Of the approximately 227 million people in the United States, over 83 percent are white but the tide of immigrants from Asia, Africa, South America, Mexico and the Carribean islands has added an increasing number of non-white people to the population that did not exist when most of the immigration was from Europe. This cultural diversity brings new dimensions to American life, but because the assimilation of these people seems to be more difficult, there are also some problems, not the least of which is health care.

There have also been other major changes in population patterns. The number of one-parent families has more than doubled since 1971; most are headed by women, most of whom are separated or divorced. Proportionately, the highest number are black. The average household size is 2.72 persons, down from 3.14 about ten years ago, contributing factors are relatively low birth and marriage rates, although this is increasing again; high levels of separation and divorce, and a 78% increase in those living alone.

Another significant change is the populations age structure. In about the last ten years, there has been a strong shift to more young adults and elders and a drop in the number of children. Those 65 old and over increased by over 32 percent and is still growing. Women are in the majority in almost all states and make up 60% of those over 65. Both education and occupation seem to affect the birth rate of women, with the better educated and those in professional and managerial positions having a fertility rate of less than half that of all women; about 20% said they expected to have no children. Although the overall birthrate of the United States has declined after the spectacular 20 year population explosion after World

War II, the fact is that the already poor, undernourished, undereducated and underemployed are having the most children. In addition, many of these are poor, often black, teenage, unmarried mothers who despite an increase in abortion, continue to have children. Adolescent sexuality and pregnancy are considered major health and social problems in the United States, with the U.S. rate of teen-age pregnancies among the highest in all developing countries. One out of 10 female teens has a baby before age 18. The result is an adverse effect on the young parents' educational attainment and economic self-sufficiency, with similarly adverse effects on the infants' physical health, cognitive development, social/emotional development and school achievement.

HEALTH STATUS

According to health statistics, the health status of the U.S. population, is, as a whole, better than ever. Some years ago, a noted public health physician said :

> Our society is now creating our most signigicant health difficulties. As a matter of fact most of the major health problems awaiting our attention appear to be man made··· As man has conquered infectious disease, perhaps more through an improvement in his standard of living than through science. The background of the health problems of our current and future age is increasingly made up of our growing cigarette-smoking habituations, our alcohol-centered socializations, our high-fat high calorie routine diet, our swift and dangerous motorcars, our smoke-belching factories, our heavily polluted waterways, our pesticide-dependent agriculture and our steadily increasing exposure to ionizing radiation.

Public health experts still agree that these factors, products of people's *choices*, whether as individuals or society as a whole, have serious effects on U.S. health. However, others say that technological and lifestyle changes that have occurred in the past eight decades have improved, rather than, hurt. Americans' health. Like the KNA, the American Nurses' Association is involved in influencing the government to improve health conditions (including envir onment) for the public.

A report of the Ameican Council on Science and Health states that the life expectancy of the newborn is now 75.5 years with females continuing to have the longer life span. The leading causes of death are: heart disease (although this has declined in the last few years); cancer; cerebrovascular disease; accidents, particularly motor vehicle; chronic obstructive pulmonary diseases and allied conditions; pneumonia and influenza; diabetes mellitus; chronic liver disease and cirrhosis; althera-sclerosis; and suicide. Of communicable diseases, only sexually transmitted infections have increased in recent years, but there is public health concern because some parents are neglecting to have their children immunized against childhood illness.

There is disagreement as to whether the U.S. infant mortality rate is higher than in some other industrialized nations, but there *is* evidence that low birth weight is a factor. Infant mortality for blacks is nearly twice that of whites. Cancer is the leading cause of death in

children, but since the 1960's more school age children have died from accidents and violence than from disease. The death rate of adolescents has risen in the last 20 years with the chief causes being accidents, homicide and suicide. There is also concern about drug addiction and sexual diseases. Cancer, the leading cause of natural death accounts for only 5% of all deaths in this age group. In the middle age group, accidents are also the leading cause of death, with the death rate of men twice that of women. Most women die of cancer (chiefly breast and genital); men, of heart disease, cancer, homicide, and suicide (besides accidents). The death rate of the over 65 group has dropped since 1950, primarily due to a drop in heart-disease. Cancer deaths increased. About 75 percent of the mortailty in this group is due to heart disease, cancer, and stroke. Most older Americans are reported to maintain their vigor and independence, although they feel that their health is declining. However, the fact that the old are living to become older means that when they do become ill, many, especially women, are not able to care for themselves. Today the population in nursing homes, for instance, is made up primarily of women over 75.

One other change in the U.S. population is attitudinal, rather than physical. People are demanding (and taking) the right to participate in decisions that affect them. This is especially true of health care. There is evidence that the public wants enough information about health care alternatives to make choices to suit themselves, including no treatment—the right to die. At the same time, in this so-called "consumer revolution", they demand qualified, competent practitioners to give the care they have selected. American health practitioners' licensing presumably guarantees the public minimum safe and effective practice. No more will protection of the incompetent practitioner by his or her colleagues be tolerated.

Nurses who have had to deal with these situations, are now facing head-on, the implications of these changes for themselves as professional practitioners. In the one instance, they are working with their patients/clients to see that they get needed information and are being supportive as hard decisions are made. More than ever, they are committed to teaching the client, encouraging independence, self care and health living. In the other instance, we see nurses/who, recognizing their responsibilities, are involved in peer evaluation, continuing education, some of our states require evidence of continuing education for relicensure professional discipline and programs of rehabilitation for impaired nurses-a matter of accountability that is part of professionalism.

OTHER TRENDS

There are other trends that have affected U.S. nursing. An obvious one is the dramatic advance of technology and science, especially the computer: which is beccming an innate part of both health care delivery and education. I'm sure that later this week hearing more about the technological advances in medical care that also have had considerable impact on nursing.

Finally, we cannot underestimate the influence of the women's movement in the U.S. which has not only changed the self-concept and operating mode of many women nurses,

but is bringing to nursing young women who are a far cry from the meek, unsophisticated, obedient working class high school graduate who once entered nursing. The modern assertive nurse expects nursing to be a career, not just a job, expects to combind that career with home and family; sees herself as equal to other health professionals, including physicians, and demands autonomus practice and professional respect as well as reasonable wages and benefits. And more than likely, she will not flee from the field if all this is not forthcoming, but will stay and fight. In some cases that means utilizing the art of negotiation; in others, confrontation, including collective labor action and strikes. But perhaps we should go back a step.

NURSING EDUCATION

Who are the nurses of the future in the United States? Today we are competing with other fields for the very intelligent 18 year old woman, fields that were once not generally open to women. But basides these candidates, we are attracting more men and both men and women with other degrees. Sometimes I wonder how they can choose the program best for them.

Nursing education in the United States often appears incomprehensible to nurses in other countries, and indeed, many Americans would agree. There are two nursing licenses in the United States, the registered nurse (RN) which is mandatory for practice in every state, and the practical or vocational nurse (LPG or LVN), not mandatory in all states. Both are acquired after passing (different) licensing examinations administered by the state nursing boards with questions selected from a national pool. (A major advantage here is that nurses may move from state to state, and except in rare circmstances, can become licensed in another state without taking the examination again).

The route to these examinations is relatively simple for the LPN-generally a one year educational program in a vocational or technical school. But to become an RN, the educational choices are varied and confusing: a two year associate degree program; a two to three year hospital-based diploma program with no degree (the original nursing education program); a four year baccalaureate; and less frequently, a master's program for those who already have baccalaureates in another field, and standing by itself, the nursing doctorate program at Western Reserve University that also leads to licensure. Since all of these graduates will hold the same RN license, but obviously have different preparation, it is easy to see why the public, the employers, and nurses themselves wonder who does what. Add to this the fact that some licensure laws have a special category for clinical specialists or nurse practitioners!

As of now, several trends are evident. First, that baccalaureate education for professional practice is a dictum that is beginning to be accepted. One result is that many RNs without baccalaureates in nursing are proceeding to acquire the degree, and this, in turn, is creating changes in nursing education, as will be desribed later. The second inevitability is that a second type of nurse is being identified—a technical nurse, which would include all those less

than baccalaureate. My prediction is that the PN programs will fade away and those potential students will eventually be entering A.D. programs. Naturally, nurse licensure will then be changing. Whether the titles will remain the same, with different educational requirements or whether the titles will also change is already being discussed.

However a crucial issue now/and for the immediate future is clear designation of the competencies of each kind of nurse. These have been delineated by both the National League for Nursing and the American Nurses' Association. Now the National Council of State Boards (made up of representative of the licensing boards) is funding a study whose primary focus will be job analysis of the entry level RN, but will also examine "the roles of the LPN and advanced nurse clinician in long term, acute care and ambulatory care settings in the areas of service, administration, education, and research." The expected result is "a comprehensive model of nursing practice."

I know that Ms. Ferguson will, later in the program, tell you about nursing care delivery in the United States, so I will not add any more detail now, but you can see that she will have just as complex a situation to describe as I.

Meanwhile to put things in some perspective: the AD programs are now growing at the greatest rate, and the diploma programs are declining in number. However, currently, in the workforce, about 50% of the nurses have diplomas, 20%, AD degrees, 21% nursing baccala ureates and about 3% other baccalaureates.

The further steps in nursing education are the graduate degrees. Our first graduate degrees were in administration or education with little attention to clinical practice. Then in the 1960s, we began to concentrate on clinical specialty education, and skills in administration and education were by-passed. So we had expert clinicians with no teaching expertise and administrators who could not hold their own with other health administrators. Now, I'm happy to say, we are recognizing the need for highly competent nurse administrators, the equal of other administrators with, at the least, a nursing focus (there is some disagreement as to whether the top nurse administrators also need clinical expertise, but almost everyone agrees that the clinical manager does). How the educator adds teaching skills to an already full clinical education program is still a problem, and many faculty learn on the job—for better or for worse. About 5% of employed nurses hold a master's degree, with almost half being clinical nurse specialists or nurse clinicans. The others are educators, administrators; some are nurse practitioners (NP) and nurse midwives (NMW). I must comment that the nurse practitioner educational situation is particularly odd because when that role emerged, about fifteen years ago, most were trained in short certificate programs or on-the-job by physicians. Now the overwhelming trend is to a master's degree with NP teachers, so here too we have an educational mixture. These nurses with advanced training are invaluable in primary health care, but, with our emerging oversupply of physicians, they are finding themselves in direct competition with some physicians. Their problem is receiving reimbursement for nursing services. While some physicians are working collegially with NPs, others are dong their best to prevent NPs/from being reimbursed for their services, and in some

cases, are strongly opposing their independent practice (that is, without physicians supervision.) The confusion in NP's education whether or not they are certified (a voluntary process) for specialty practice, and how their scope of practice is defined under the law are all big issues in nursing practice. However, specialization at the graduate level is increasing well as in the practice area on-the-job for other nurses. This has also resulted in a proliferation of specialty nursing organizations.

Approximately .2% of employed U.S. nurses hold doctoral degree—that is, under 3000. Most doctorates are PhD's from non-nursing programs; the most common major is education. Now nursing doctorate programs are springing up, most concentrating on clinical study and offering either PhD's or a type of Doctor of Nursing Science (DNS) degree. The need is great, for a number of reasons: nurse faculty in institutions of higher learning must have the same educational qualifications as faculty in other disciplines and now they do not; nurse administrators in complex health care centers are finding doctorates necessary; and, of course, nursing research is an imperative, and must be conducted and led by prepared researchers. You will be hearing more about the kind of research done throughout this program. But, in our eagerness to educate nurses in doctoral programs in *nursing*, we realize that, given the small numbers of nurses with doctorates and the diversity of opportunities that they have, there is a danger of creating weak doctoral programs because of the lack of enough qualified faculty. However, a national report, expected to have considerable influence in federal funding of nursing education has given priority to graduate education and nursing research. Meanwhile, the interest in nursing research is increasing, not only in the universities, but also in clinical settings, where there may be a nurse researcher employed or a partnership with nurse researchers from a university program. This is not yet common, but growing.

I would be remiss in discussing nursing education if I did not mention some of the "alternate" educational patterns.

It may be useful to review briefly trends in general higher education before we discuss these other aspects of nursing education. Even though there is public concern for the "drop outs", who do not finish high school and are often highly disadvantaged in the job market, more students than ever are graduating from high school. If they choose to continue their education—their choices are generally a variety of trade schools, 2 year community colleges, or 4 year colleges or universities. Because of the overexpansion of many institutions of higher learning after World War II, a number found that when the baby-boom ended they needed to look for new student markets. This was particularly crucial as federal funding for higher education dropped. At the same time some experts have identified life-long learning as a major trend for Americans. Thus, it was natural that the colleges should seek to attract older students—second careerists and housewives, for instance who sought both short-term courses and degree programs. A particularly significant trend that evolved was the "open curriculum" concept which allowed students to get credit for what they knew either through testing or other documentation. With the new technology, students could learn at home, or at least, away from the main campus by computer, television, or audio and videotapes.

Efforts were made to develop a variety of means for self-study.

This approach spilled over to nursing especially in the last ten years. All of these approaches are being used. Also, there is both an associate degree and a baccalaureate "external degree" nursing program, under the auspices of the state of New York which is accredited by the National League for Nursing. The credits are acquired by transfer of appropriate academic courses from other institutions, and testing, including four performance examinations that involve actual care of patients. Study guides are available from the Regents External Degree Program (REDP) without fee. The written tests are administered at nearly 200 locations, six times a year and the performance tests administered by qualified nurses, are given at five Regional Performance Assessment Centers. (The written examinations are now also available for use by colleges who can given credit for them in their own programs.) The latest version of an external degree is now being developed by the state of California, which expects, eventually to offer a master's external degree.

The external degree approach is not for every nurse. Almost all who make this educational choice are either already licensed nurses (RNs), licensed practical nurses (LPNs) or individuals who have not completed another nursing program. However, over 9000 individual learners are enrolled in the REDP; over 2000 have earned associate nursing degrees since 1975 and nearly 600 have earned BSN degrees since 1979. Most states admit the graduates who seek RNs to licensure examinations and their performance has been good.*

Many unverisity nursing programs have now developed an interest in the vast educational potential of RNs without baccalaureates, and whereas once those RN's felt themselves unwanted and discriminated against as they struggled to hold full time jobs and go to school, they now have many more options, including home study, regional campuses, traveling professors, availability of a choice of evening courses, and challenging exams. Finally, it would be remiss not to note that Sigma Theta Tau is the only honor society for nurses in the United States, and with its 191 chapters on college and university campuses, and its 80,000 members is the second largest nursing organization in the U.S.

NURSING PRACTICE

Where do American nurses practice? The easy answer is; everywhere, but a report of the U.S. government on the most recent survey of nurses (1980) gives us the following information:

1.3 million of the 1.7 million RNs are employed in nursing, about 77% fulltime. More than 96% are female, and over 90% are white, non-Hispanic. The greatest number are between 25 and 44 years old.

PLACES OF EMPLOYMENT (includes both full and part-time):

Hospitals	65.6%	Student Health Service	3.5%

* The Sept.-Oct', 1984 issue of *Nursing Outlook* focuses on the external degree program and other flexible nursing eduction programs that are geared to the RN returning to school for an advanced degree.

Nursing homes	8.0%	Occupational Health	2.3%
Community health	6.6%	Private Duty Nursing	1.6%
Physicians' offices	5.7%	Other	1.7%
Nursing education	3.7%	Not Reported	0.6%

"HANDS-ON" NURSING:

65% are employed as staff nurses and equivalent job titles 58,414 are nurses in specialized direct patient care:

19,070 clinical nurse specialists
16,758 nurse practitioners/midwives
14,580 nurse anesthetists
8,006 nurse clinicians

Of the 1.3 million RNs employed in nursing, 64% spent at least 1/2 of their regular work week in direct patient care.

The average staff nurse salary is about $16,000 a year. Interestingly, that of instructor, clinician, or supervisor is only about $19,000: of nurse administrator in education and service $25,000. Nurse anesthetists have the top average of almost $28,000. Obviously, being national averages, both the low and the high end of the scale are obliterated. For instance a rural area; in a particular region of the country may pay much less in general. I personally know faculty Who are earning close to $50,000 and administrators with salaries of $100,000. But that is clearly not the rule.

At the present time, there is even concern that salaries will be cut or there will be layoffs in health care agencies. The reason/is that, in the United States, we are in an era of tieht cost consciousness in health care.

Our 340 billion dollar health care system has been condemned as an extravagent non-system focused on sick care.

Three noted scientists, in looking at today's medical care, held that:

1. Public health measures, social conditions and personal health behavior are the main determinants of health.
2. Our health system is too heavily weighted in the direction of hospital-based medicine and that there is need to give greater emphasis to community-based ambulatory care with a strong preventive component.
3. Many medical measures and interventions are not effective by any criterion. Those measures or interventions that are proved to be ineffective should be abandoned.
4. Many services now provided by physicians can be performed by other health personnel.
5. Iatrogenic illness is fairly extensive and is a very serious concern.
6. Costs in the health sector have risen disproportionately and economies cost controls are warranted.
7. Some health and human services which presently are not available should be provided.
8. There is need for more humane health care.

Few would argue those points, but one not mentioned is access to care. A 1983 report by the Robert Wood Johnson Foundation concluded that the American people have greater access to care than ever before with the majority enjoying access to a personal physician or other regular source of general medical care. The chief complaints were out-of-pocket costs, waiting time to see a doctor and the amount of information provided by doctors and nurses. The poor, the black, and the unemployed, some 12 percent of the population, had serious access problems. That this would probably worsen, given health economics was acknowledged by a presidential commission on ethics, which concluded that "society has an ethical obligation to ensure equitable access to health care for all."

Neither in the Commission nor in the public is there total agreement on that statement, particularly in relation to the next step—access to all the expensive high technology, the world of transplants and artificial parts. Even those who believe that health education and promotion could be the answer to high costs are not optimistic either that there will be adequate commitment to the reality (not the concept) or that change will occur in any great hurry.

In the meantime, citizens of the United States spend more than 10 percent of the Gross National Product on health care—more than any other nation in the world. "Astronomical cost" were the watchwords with the result that hospitals, to begin with, were forced by Medicare/Medicaid* regulation and a new federal budget act into a whole new syetem of reimbursement. And the signs were clear that other health care facilities would soon fall under similar rules. Put simply, prospective reimbursement with DRGs** means that instead of being paid for the costs of a patient's stay after the fact, the *anticipated* cost of the patient's care according to the diagnoses or diagnosis and certain other factors is set, including number of hospital days. If the hospital is able to provide the care at less than that cost, the excess may be kept; if the cost is greater, it has to be absorbed. This means that care has to be effective and efficient, and now, instead of it being an advantage to have longer stays, the opposite is true, indeed crucial.

The public is somewhat ambivalent about all this—people want cuts in costs, including taxes, which pay for many of these services, but they also want full, high-quality health care. Are both possible? They also have some ongoing complaints, besides high costs and access: fragmentation of services, maldistribution of health personnel, overspecialization of practitioners, inadequate quality, depersonalization, and loss of personal control within the system.

Health care experts and policy makers have suggested remedies, but like the economic pundits, their "guesstimates" of future trends are not totally reliable. Some place great faith in some sort of national health insurance, but the difficulty of assessing the cost and outcome of the assorted proposals has made the Congress slow to act, and with opposition in the administration, nothing will happen. Nevertheless, some predictions about the health care of

* Federal(partial) payment of health care for the elderly and poor

** Diagnosis related groups

the future, this from a number of "experts", are, at the least provocative.

1. There will be a growing demand for geriatric services.
2. Successful organizations must be oriented to health, rather than medical care.
3. Hospitals will evolve into "human service" centers, including besides the traditional acute care, fitness, counseling, employment services, personal care, nutrition, family planning and other social services.
4. The patient will play a greater role in health care decision-making.
5. Costs will increase, but the public will demand that health outcomes must justify such expenditures.
6. The individual provider will be replaced to a large extent by the medic-computer.
7. The doctor glut will become greater, and many will shift from private practice to group practice or salaried partners.
8. Increasingly, care will be delivered outside of the traditional hospital setting.
9. The number of hospitals will drop and there will be growth in multi-hospital systems with possibly as much as 70 percent of the health care industry included by 1986. (For-profit groups will grow)
10. Home care will grow dramatically.
11. Workers will pay more of their health care expenses out of pocket and thus will become more conservative in use.
12. For the urban poor there will be a deterioration in the quality of care. By the year 2000, a two-tier system of care will exist—unless there are major changes.
13. National health insurance is likely, with the probable form a combination of public and private programs financed by government, employer, and employee.

The role of nursing in these predictions is clear to you, I'm sure—especially in long term care, home care and primary care. Especially with the economic constraints of today we see the need for the best prepared nurse to care for our public. I refer back to my opening statement—nursing in the U.S. today is a time of challenge and opportunities, not for the faint hearted, but for the courageous, risk-taking professional.