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THE FUTURE MARKETPLACE, REGULATION OF HEALTH CARE PROVIDERS, AND EDUCATION OF NURSES

Part II

by

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Introduction

The title of this joint paper, combining marketplace, regulatory, and education issues proves that speakers tend to speak about what they want to speak about rather than what they are asked to speak about. Having been asked to speak about nursing credentialing, I said I wanted to speak about educational remapping, so the title was generously but awkwardly stretched to accommodate this intransigence. To match Lori and Clem's generosity, I will discuss credentialing briefly and then move on to talk about the revamping of the education system required for *a responsible future*. (By the way, I favor responsible future over the terms preferred or alternative future. Responsible seems less self-serving than preferred and more positive than alternative.) Also, as a gesture of recognition and appreciation, not generosity, I wish to acknowledge my co-author on the education segment of this project, Dr. William Holzemer. Finally, as to opening amenities, I wish to apologize that this paper could not be circulated to you in advance of the conference.

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Credentialing

Lori Andrews has discussed the history of nursing practice regulation and then gone on to identify factors, such as physician supply, chronicity, costs, computers, and consumerism, possibly affecting the future marketplace and regulations. She has identified alternative licensing strategies, including (1) joint practice committees, (2) legally condoned physician delegation to nurses, (3) specialty certification, (4) use of standard protocols, and (5) the most honest and direct, but difficult, route of expanding the legally defined scope of nursing practice. She has also rather fearlessly mentioned institutional licensure, anathema to nurses, and so-called consumer licensure, in which the client is deemed qualified to judge as to whether we are safe practitioners. And she has forecast a dark but likely future with outside forces constricting the nurse's role and autonomy. She has also forecast a preferred future in which nurses aggressively use these factors she has identified to their advantage in gaining more professional responsibility and independence. This would be accomplished either through an expanded law or within a competitive environment of a voluntary certification, consumer choice system.

As to these futures, for several reasons I tend to be less sanguine about the last option, i.e., an essentially deregulated system. It seems to me that the forces favoring

deregulation in this country would have to be in power a long time before they could overcome the opposition of tradition and the medical lobby. And it has seemed to me that political ideology swings like a pendulum in this and other free nations, with the strokes only varying in degree and interval, not in their inexorability. The medical profession, in the meantime, may occasionally take some buffeting from the executive, legislative, and judicial branches; from regulatory agencies, such as the FTC; and most recently from industry, but nevertheless seems to prevail in both liberal and conservative times. Also, I can attest from our experience in California that organized nursing itself will probably oppose any free-for-all system, admitting alternative health providers to the field. We will become as protective as the physicians, because while we may not have as much as we want, we are among the "haves" with regard to regulatory authority.

I am inclined to believe we are going to have to slug it out in the legislative halls and the courts to gain favorable laws and interpretations of those laws. Corporations and third party payors, seeking less costly alternatives in their health plans, may also give us some support in pushing out the scope of practice boundaries.

In focusing upon the external environment, Lori Andrews has not mentioned the very engrossing credentialing issues within the profession. I am speaking of the efforts to redefine educational requirements and accountability in

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licensure, differentiating between the baccalaureate and the associate degree prepared nurse, probably absorbing the practical nurses with the latter within a technical category. Controversy rages around titling and definitions of practice for the two groups and will undoubtedly again be the center of debate at the ANA House of Delegates meeting later this month in Kansas City. On the one hand there are those preferring only to tinker with the present system, preserving the RN and LPN licenses, just upgrading the education tc the baccalaureate and associate degree respectively. Others are willing to open up the nursing practice acts widely to more sweeping changes--new credentials, new definitions of practice and accountability.

The Credentialing Study that I chaired in 1977-79 recommended state licensure for the professional nurse and national, voluntary registration for the associate degree graduate. The position paper on nursing regulation unanimously adopted by the International Council of Nurses (ICN) on June 15, 1985 recommends only one category of statutorily regulated nurse in each country. The paper further recommends, as to title, that the word "nurse" be reserved for that single category. Accordingly, auxiliaries would be variably regulated by non-governmental means. The ICN position goes on to recommend certification by the professional association, not governmental regulation, for specialists. Also, the U.S. Council of State Governments has endorsed the concept of applying licensure to no more

than one category in a field (Shimberg & Roederer, 1978).

I suspect that neither the Credentialing Study nor the ICN recommendations for only one licensed nurse will be followed in the U.S. Having made what I believe to have been a serious mistake in licensing two categories mid-century, we cannot seem to retreat. The forces of precedent and protectionism are too strong. Moreover, the proliferation of state certification of Heinz 57 varieties of specialists seems to be unstoppable. This so-called "seconding licensing" of specialists is a pocketbook issue, as well as a status issue, with reimbursement policies as a strong motivating force.

Since we are encouraged to speak of preferred futures, I vote for licensing only the professional nurse and for voluntary registration and institutional certification for auxiliaries, with accountability through the licensed nurse. I couldn't agree more with Lauren Leroy about the crippling stratification that has occurred. Chaos in the credentialing system has provided no guidance for the marketplace. Furthermore, I favor the voluntary certification of specialists. I have taken the liberty of bringing with me some copies of the recommendations of the ICN Project on Nursing Regulation. As the Project Director, I must say that these recommendations represent my preferred future. I am one who prefers a universal order and identity for the profession. I believe that the power to expand and solidify our role in health care and health policy is

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available through education and through regulatory simplicity, clarity, and unity.

Education

The Problem

Now I wish to explore the uncharted future, i.e., educational remapping required to achieve nursing's avowed or chosen or official future. First, let me tell you how I have come to use the phrase educational remapping, since it is of my own invention. It is anecdotal in orgin.

The term derives from my impression that nursing is like the Vermont farmer who, when queried by a passing motorist as to how to get to his destination, scratched his head, pondered lengthily, and grudgingly advised, "I wouldn't start from here"? This attitude--our attitude--is one we can't afford. It is guaranteed not to get us to Montpelier or the moon or wherever we choose to go.

In our thirty-year stream of books, pamphlets, editorials, position papers, resolutions, policy statements, and national plans on educational goals for the profession the words are clear and compelling. Strangely, the only numbers in those professional documents are the years--the years 1980 and 1985 in which the goal of the baccalaureate for professional practice was to have been achieved by the magic of retitling and licensing. These documents do not speak of numbers of types of nurses needed to meet health care needs or numbers of nursing schools and their annual productivity. This denial suggests that we may not intend to start from here. But, of course, we must.

Let's talk numbers. Bill and I are prepared to open the discussion in simple fashion, by comparing broadly developed national projections on nursepower supply (S) with nursepower need (N), by educational level, for the year 2000. Our current rate of productivity from the variety of nursing education programs is the route to destination S, projected supply. How much must our course be altered if we are to proceed instead to destination N, projected need? *A course correction in educational mapping must become the centerpiece for a national plan to reach our chosen destiny.*

Figure 1 shows conceptually the need for educational remapping, reflecting that the course of productivity of technical nursing personnel must be adjusted downward and the course of productivity of professional nurses upward. I say conceptually, rather than specifically, because the data sources are mixed and not entirely comparable, as will be explained. The xed out lines, our current trajectories, will lead to Destination S, projected supply. The solid lines, the course corrections, would lead to Destination N, projected need. The actual gaps between the two are undoubtedly greater than shown, because of our conservative approach throughout and because projections for LVN/LPNs supply were based upon substantial underestimates of the current supply.

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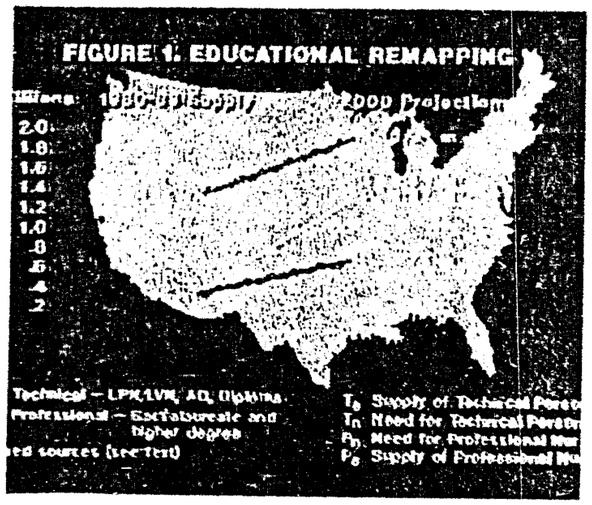

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Supply:

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U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing (unpublished, 1985). National sample survey of licensed practical/vocational nurses. From a telephone conversation with the Department of Research, American Nurses' Association, on June 26, 1985.

Projection:

Department of Health and Human Services (1984). Report to the President and the Congress on the status of health personnel in the United States. Washington, D.C.: Author.

We have commenced in simple fashion, neither challenging nor refining the gross figures, because it seems important to avoid getting bogged down in methodological arguments, data fine-tuning, regional differences, ideological stances, or other distractions from the bold realities we face--or have not faced--in charting our course for the future. This stark beginning is to rivet our attention upon the nature and magnitude of the educational redirection required to achieve our objectives.

Without entering the debate about licensing and titling, the assumptions we make about our common educational goals are these:

> Preparation for professional nursing will be a minimum of a baccalaureate degree in nursing.[1]
>
> Preparation for technical nursing will be the associate degree in nursing and practical/vocational nursing will merge into technical nursing through educational and/or credentialing means. Diploma programs will close or convert or merge into one of the two collegiate levels of nursing education.

The facts that must be dealt with in pursuing those goals are (1) the existing and projected nurse supply at current "entry" levels (LVN, ADN, BSN, or higher[1]), (2) the output of schools preparing nurses at those levels, and (3) the projected need for nursing personnel in the future.

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[1]It is acknowledged that professional nurses are also being prepared in generic master's (M.N.) and doctoral (N.D.) programs. For convenience the baccalaureate is used throughout the paper to designate these professional entry degrees.

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Need and supply projections. In examining data from a variety of sources, we have discovered an alarming degree of consensus among the projections for supply and need for nursing personnel in the years ahead. However, as has been said, these projections have not been examined in relationship to the productivity of nursing educational programs or the professional goal of entry to nursing practice at the professional and technical levels. We have combined data from three existing sources to provide a framework that will challenge the profession to remap the nursing educational programs in this country. The projections of supply and need utilized do not equate to the population of nurses, but rather to full-time equivalents (FTEs) of practicing nurses, because some licensed nurses do not practice and others only part-time. Therefore, the projected supply may be inadequate to meet the need.

The first data source, Clem Bezold's primary reference, was the 1984 Report to the President and Congress on the Status of Health Personnel in the United States (Department of Health and Human Services, 1984). As has been indicated, this report provides manpower projections for all the health professions for the years 1990 and 2000. The nursing section utilizes a manpower projection technique developed by the Western Interstate Commission for Higher Education (WICHE). The projections are based upon estimated population trends, requirements for nursing personnel across settings such as hospitals, clinics, schools, home care

industry, etc., analyzed by required level of educational preparation for each type of nursing position. The report provides both lower and upper bound projections based upon differing ratios of nurse to population. The lower bound estimate is a conservative estimate of the required nurse: population ratio and was selected for the analysis presented in this paper. Therefore, the conclusions drawn should be viewed as conservative and would be significantly more dramatic if the upper bound projections had been utilized. Furthermore, the LPN/LVN supply projections were based upon 1974 survey figures. A recent national sample survey of LPN/LVNs indicates that these figures were greatly underestimated (USDHHS, 1985). I repeat for these two additional reason we may have greatly underestimated the need for a course correction in our education remapping.

The second data source was the American Nurses' Association's (1983) ANA's Facts About Nursing 1982-83. The figures for 1980 nursing personnel supply, excluding LPN/LVN information, were taken from this document.

The third data source was the National League for Nursing (1983), NLN Nursing Data Book 1982. Both accredited and non-accredited programs were included to project the numbers of graduates by type of educational programs. In addition, an attrition factor, based upon NLN's data documenting the small number of nurse graduates across levels of programs who leave nursing, was factored into the projections.

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It was necessary to develop projections of supply and need for technical and professional nurses. In accordance with our assumptions, technical nursing was defined for the future by level of educational preparation at the associate degree level. Therefore, the projected supply and demand for technical nursing was the combination of the supply and demand figures for LPN/LVN, associate degree, and diploma graduates. We recognize that this decision probably compounds our earlier underestimation of the need for professional nurses because many AD and diploma graduates function at a high level of nursing because of the existing uniform licensing examination and common role responsibilities in some settings. Thus we have continued to choose the most conservative approach in developing the estimates used in this paper.

Having given several statistical and technical reasons for believing the proposed remapping to be underestimated, I venture a professional opinion. The alternative changes in the health care system outlined by Clem Bezold and Sarah Detmer suggest to me that a richer mix of professional to technical personnel will be needed. Professional nurses provide greater flexibility for the system: they act more knowledgeably in complex environments and more autonomously in isolated environments. Also, extended care facilities and home health care increasingly require substantial clinical judgment as well as planning and technical skills.

Table 1, Estimated Need and Supply for Nursing Personnel, indicates that, based upon current trends, by the year 2000 there will be roughly one-half as many B.S.N. and higher degree nurses, one and one-third times as many ADN nurses, and one and one-half the LVN/LPN's required to meet the conservatively projected estimated nursing personnel need. This represents a deficiency of 619,100 prepared at the baccalaureate and higher level; an excess of 297,000 prepared at the associate degree level; and an excess of 204,200 LVN/LPN's. When the associate degree and practical nurses are treated collectively as the technical pool, an oversupply of 501,100, contrasted with the BSN and higher degree shortfall of 619,100, is projected for the turn of the century. The projected need for the year 2000 is for approximately a 1:1 ratio of professional and technical nursing personnel. We shall be 45% on the low side to meet the need for professional nurses; 35% on the high side to meet the need for technical personnel.

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Table 1

Estimated need and supply for nursing personnel - 2000[a]

	Levels of Education	2000 Need (N)	2000 Supply (S)	2000 Nurses per Position (S - N)
Projections for existing levels of education	LPN/LVN	490,300	694,500	1.40
	AD/DIP	937,000	1,234,000	1.32
	BSN and higher	1,371,500	752,400	0.55
Projections for technical/ professional	Technical[b]	1,427,300	1,928,400	1.35
	Professional[c]	1,371,500	752,400	0.55

[a]Sources: American Nurses' Association (1981). ANA's facts about nursing 1982-83 (p. 264). Kansas City, MO: Author. (AD/DIP, BSN and Higher Supply)
Department of Health and Human Services (1984). Report to the President and the Congress on the status of health personnel in the United States. Washington, D.C. (Need)
U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing (unpublished, 1985). National sample survey of licensed practical/ovcational nurses. From a telephone conversation with the Department of Research, American Nurses' Association, on June 26, 1985. (LPN/LVN Supply)

[b]Technical defined as LPN/LVN plus AD/DIP.

[c]Professional defined as BSN and higher.

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The sources of the projected supply figures are the current population (adjusted for attrition) and the educational productivity reflected in Table 2.

Table 2

Numbers of programs, admissions, and graduates by level of nursing education for 1981

	Level of Education			
	BSN	AD	DIP	LPN/LVN
Programs	383	715	303	1,331
Admissions	35,808	56,899	17,494	58,479
Graduates	24,370	36,712	12,903	41,002
Average # of graduates per program	64	51	43	31

Source: National League for Nursing (1983). NLN nursing data book 1982. New York: Author.

Baccalaureate nurses are being prepared at the rate of 24,370 per year, roughly one-half the output of the combined associate degree and diploma schools. Furthermore, practical nursing programs add more than 40,000 to the practice field annually. Here is the ultimate message of this paper: *The "entry into practice" issue may be titling and credentialing; the "entry into practice" problem is that baccalaureate graduates entering practice each year from 383 BSN programs are outnumbered 3.7 to 1 by lesser prepared*

personnel entering the field from 6 times the number of associate degree, diploma, and vocational programs.

Educational Remapping for the Year 2000

Unlike the Vermont motorist, we can now chart the course from here to there. We now have a numerical fix on destination N, projected need, for our educational remapping. Our objective is two-fold:

1. To increase the number of professional nurses by 619,100 above current projections for the year 2000.
2. To decrease the number of technical nurses by 297,000 below current projections for the year 2000.

What corrective strategies are required to alter our course sufficiently to reach this destination?

° First, all nursing education outside of the collegiate system should be discontinued.

° Secondly, practical nursing and associate degree programs should merge and enrollments in associate degree programs increased by 25-40 percent.

° Third, the output of baccalaureate programs should be doubled by opening new programs and/or increasing the enrollment of existing generic and second-step programs.

Meeting the Challenge

Who are the key parties to effecting this change? They range from the national to the institutional level.

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° First, the national organizations--in particular the ANA, NLN, AACN, and AONE--must face the numbers and work in concert to develop and support a national plan to achieve the educational remapping required.

° Secondly, regional and state planning must occur. Master plans for nursing education should name numbers, schools, programs, enrollments, etc.

° Third, schools should operate conscientiously within these master plans.

° Fourth, nursing service directors should develop staffing plans truly differentiating professional and technical nurses and commensurate roles.

° Fifth, the national nursing organizations and state boards of nursing should seek to resolve the licensing and titling issues. However, their effort need not nor should not postpone nor detract from the educational remapping that must proceed nevertheless in order to meet national need projections.

In addressing all of the above challenges, principles and positions are not enough. Let's talk numbers!

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