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95-96 NURSE TRAINING AMENDMENTS OF 1978

GOVERNMENT AMENDMENTS

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HEARING

BEFORE THE

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KANSAS STATE UNIVERSITY

SUBCOMMITTEE ON

HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON

INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

SECOND SESSION

ON

H.R. 11434

(And All Identical Bills)

BILLS TO AMEND TITLE VIII OF THE PUBLIC HEALTH SERVICE
ACT TO EXTEND FOR TWO FISCAL YEARS THE PROGRAM OF
ASSISTANCE FOR NURSE TRAINING

H.R. 512 AND H.R. 2797

BILLS TO AMEND TITLE VII OF THE PUBLIC HEALTH SERVICE
ACT TO PROVIDE FOR THE MAKING OF GRANTS TO APPROPRIATE
COLLEGES AND UNIVERSITIES TO ASSIST THEM IN
ESTABLISHING GRADUATE PROGRAMS FOR NURSES IN
GERIATRICS AND GERONTOLOGY

H.R. 2799

A BILL TO AMEND TITLE VII OF THE PUBLIC HEALTH SERVICE
ACT TO PROVIDE FOR THE MAKING OF GRANTS TO APPROPRIATE
COLLEGES AND UNIVERSITIES TO ASSIST THEM IN
THE ESTABLISHMENT AND OPERATION OF PROGRAMS FOR
THE TRAINING OF NURSE PRACTITIONERS TO PROVIDE
PRIMARY HEALTH CARE IN NURSING HOMES

MARCH 20, 1978

Serial No. 95-96

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- American Association of Colleges of Nursing, Eloise Lewis, Ed. D., F.A.A.N. president.
- American Association of Nurse Anesthetists:
 Booth, Michael, C.R.N.A., chairman, education committee.
 Fevold, Nancy, deputy executive director.
 Williamson, Kenneth, consultant.
- American Hospital Association:
 Gehrig, Leo J., M.D., senior vice president.
 Logue, Patrick, regional legislative assistant.
- American Nurses' Association:
 Blakeney, Hazle, R.N., Ed. D., chairperson, commission on nursing education.
 Holleran, Constance, director, Government relations.
- Health, Education, and Welfare Department:
 Foley, Henry A., Ph. D., Administrator, Health Resources Administration, Public Health Service.
 Lashoff, Joyce C., M.D., Deputy Assistant Secretary for Health—Programs, Public Health Service.
 Scott, Jessie, R.N., Director, Division of Nursing, Bureau of Health Manpower, Health Resources Administration, Public Health Service.
- Nation League for Nursing, Dorothy Jean Novello, R.N., Ph. D., past president.
- National Student Nurses' Association, Valerie Lewis, on behalf of.

NURSE TRAINING AMENDMENTS OF 1978

MONDAY, MARCH 20, 1978

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m. in room 2322, Rayburn House Office Building, Hon. Richardson Preyer, presiding [Hon. Paul G. Rogers, chairman].

Mr. PREYER. The subcommittee will come to order.

This morning the subcommittee begins its consideration of H.R. 11434, the "Nurse Training Amendments of 1978", legislation which would extend the Nurse Training Act for 2 fiscal years.

Prior to 1964, Federal programs to support nursing education were fragmented and directed primarily toward the education of public health nurses. Growing concerns, however, with respect to a severe national shortage of nurses, prompted a report and recommendations by the Surgeon General's Consultant Group on Nursing to expand the Federal role in nurse education and training. Guided by the recommendations of the consultant group, the Congress enacted the Nurse Training Act of 1964, which consolidated and expanded the existing nurse training authorities into a consolidated program of support.

This act and succeeding acts broadened the purposes for which funds could be awarded to schools of nursing. The Nurse Training Act of 1975, which would be extended by H.R. 11434, is oriented toward four national purposes: to increase the supply of active nurses, to improve the quality of nursing education and practice, and to improve access to a nursing education by individuals from disadvantaged backgrounds.

There is no administration bill before the subcommittee. Instead, there is a budget request similar in nature to those of the previous administration which would all but terminate the Federal role in nursing education. Alternatively, legislation sponsored by most of the members of the subcommittee would extend the 1975 Act through fiscal year 1980. This legislation would continue Federal support of nurse training and would afford the subcommittee an opportunity to examine carefully alternative approaches to assuring the quality of nursing education as well as the areas in which the level of Federal support should be expanded, reduced, or eliminated.

Because the authorities under the Health Professions Educational Assistance Act of 1976 also will expire at the end of fiscal year 1980, the enactment of H.R. 11434 would enable the subcommittee to analyze and evaluate the Federal role in the education of all health

professionals and determine the appropriate response to national health care needs of the 1980's. We will be pleased to work with this administration in mutual efforts toward this end.

Mr. PREYER. Dr. Carter?

Mr. CARTER. I am pleased to be a cosponsor for this legislation, to extend the Nurse Training Act for 2 years at the same total authorization as current law. In fact, I would be willing to put in a cost increase to adjust for the inflation rate.

As you know, Mr. Chairman, over the years, I have been a strong supporter of the nursing profession. I have worked with you and the subcommittee to develop legislation to support their training. As a physician, I have had first-hand knowledge of the important role that nurses fill in the health care field, particularly in my district the nurses are an outstanding example of how nurse midwives have provided needed help to the communities in that area.

Now, with enactment of the rural health clinics legislation, which provides for reimbursement of services provided by nurse practitioners and physicians assistants, we expect that the access to health care will be greatly improved. Personally I want to continue our assistance for nurse training.

Thank you, Mr. Chairman.

Mr. PREYER. Thank you, Dr. Carter. You certainly have been a good friend of the nurses in this country through the years.

Without objection the text of H.R. 11434, H.R. 10468, H.R. 10813, H.R. 10845, H.R. 10873, H.R. 11619, H.R. 512, H.R. 2797, and H.R. 2799 will be placed at this point in the record.

[Testimony resumes on p. 12.]

[The text of H.R. 11434, H.R. 10468, H.R. 10813, H.R. 10845, H.R. 10873, H.R. 11619, H.R. 512, H.R. 2797, and H.R. 2799 follow:]

1 to be made to a section or other provision of the Public
2 Health Service Act.

3 SEC. 2. Section 801 (relating to authorizations for con-
4 struction grants) is amended by inserting after "for fiscal
5 year 1978" the following: "and for each of the next two
6 fiscal years".

7 SEC. 3. (a) Subsections (a) and (b) of section 805
8 (relating to loan guarantees and interest subsidies) are
9 each amended by striking out "1978" and inserting in lieu
10 thereof "1980".

11 (b) Subsection (e) of such section is amended by in-
12 serting after "in fiscal year 1978" the following: "and in
13 each of the next two fiscal years".

14 SEC. 4. Subsection (f) of section 810 (relating to
15 capitation grants) is amended by inserting after "fiscal
16 year 1978" the following: "and for each of the next two
17 fiscal years".

18 SEC. 5. The first sentence of subsection (d) of section
19 820 (relating to special project grants and contracts) is
20 amended by striking out "and" after "1977," and by insert-
21 ing before the period the following: " , \$20,000,000 for the
22 fiscal year ending September 30, 1979, and \$20,000,000 for
23 the fiscal year ending September 30, 1980".

24 SEC. 6. Subsection (b) of section 821 (relating to
25 advanced nurse training programs) is amended by inserting

1 after "for fiscal year 1978" the following: "and for each
2 of the next two fiscal years".

3 SEC. 7. Subsection (e) of section 822 (relating to nurse
4 practitioner programs) is amended by striking out "for fiscal
5 year 1978" and inserting in lieu thereof "each for the fiscal
6 year ending September 30, 1978, and for the next two fis-
7 cal years".

8 SEC. 8. Subsection (c) of section 830 (relating to
9 traineeships) is amended by inserting before the period "and
10 for each of the next two fiscal years".

11 SEC. 9. (a) Subsection (b) (4) of section 835 (relat-
12 ing to loan agreements) is amended by striking out "1978"
13 and inserting in lieu thereof "1980".

14 (b) Section 837 (relating to authorizations for student
15 loan funds) is amended (1) by inserting before the period
16 in the first sentence "and for each of the two fiscal years",
17 (2) by striking out "fiscal year 1979" and inserting in lieu
18 thereof "the fiscal year ending September 30, 1981", and
19 (3) by striking out "October 1, 1978" and inserting in lieu
20 thereof "October 1, 1980".

21 (c) (1) Subsection (a) of section 839 (relating to dis-
22 tribution of assets) is amended by striking out "Septem-
23 ber 30, 1980, and not later than September 30, 1977" and
24 inserting in lieu thereof "September 30, 1981 and not later
25 than December 30, 1983".

1 (2) Paragraph (1) of such subsection is amended by
2 striking out "1980" and inserting in lieu thereof "1983".

3 (3) Subsection (b) of such section is amended by
4 striking out "1980" each place it occurs and inserting in lieu
5 thereof "1983".

6 SEC. 10. (a) Subsection (b) of section 845 (relating
7 to scholarship grants) is amended (1) by striking out
8 "next two fiscal years" in the first sentence and inserting in
9 lieu thereof "next four fiscal years", (2) by striking out
10 "1979" and inserting in lieu thereof "1981", and (3) by
11 striking out "1978" and inserting in lieu thereof "1980".

12 (b) Subsection (c) (1) of such section is amended (1)
13 by striking out "next two fiscal years" in subparagraph (A)
14 and inserting in lieu thereof "next four fiscal years", (2)
15 by striking out "1978" in subparagraph (B) and inserting in
16 lieu thereof "1980", and (3) by striking out "1979" in
17 such subparagraph and inserting in lieu thereof "1981".

[H.R. 512, INTRODUCED BY MRS. LLOYD OF TENNESSEE ON JANUARY 4, 1977; AND

H.R. 2797, INTRODUCED BY MR. DUNCAN OF TENNESSEE ON FEBRUARY 1, 1978,

ARE IDENTICAL AS FOLLOWS:]

A BILL

To amend title VII of the Public Health Service Act to provide for the making of grants to appropriate colleges and universities to assist them in establishing graduate programs for nurses in geriatrics and gerontology.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That part E of title VII of the Public Health Service Act
4 is amended by adding at the end thereof the following new
5 section:

6 “GRANTS FOR THE ESTABLISHMENT OF GRADUATE PRO-
7 GRAMS FOR NURSES IN GERIATRICS AND GERONTOLOGY

8 “SEC. 776. The Secretary may make grants and enter
9 into contracts with public or nonprofit colleges and universi-

- 1 ties for the purposes of developing graduate programs for
- 2 nurses in geriatrics and gerontology.”.

95TH CONGRESS
1ST SESSION

H. R. 2799

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 1, 1977

Mr. DUNCAN of Tennessee introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend title VII of the Public Health Service Act to provide for the making of grants to appropriate colleges and universities to assist them in the establishment and operation of programs for the training of nurse practitioners to provide primary health care in nursing homes.

- 1 *Be it enacted by the Senate and House of Representa-*
- 2 *tives of the United States of America in Congress assembled,*
- 3 That part E of title VII of the Public Health Service Act
- 4 is amended by adding at the end thereof the following new
- 5 section:

1 "GRANTS FOR THE ESTABLISHMENT AND OPERATION OF
 2 PROGRAMS FOR THE TRAINING OF NURSE PRACTITION-
 3 ERS TO PROVIDE PRIMARY CARE IN NURSING HOMES

4 "SEC. 776. (a) The Secretary may make grants to and
 5 enter into contracts with public or nonprofit private entities
 6 for the purposes of developing or operating programs for the
 7 training of nurse practitioners with special emphasis on
 8 nursing homes and the care of the aged.

9 "(b) As used in this section, the term 'programs for
 10 the training of nurse practitioners' means educational pro-
 11 grams which meet guidelines prescribed by the Secretary
 12 in accordance with paragraph (c) and which have as their
 13 objective the education of nurses who will on completion
 14 of their studies in geriatrics be qualified to effectively pro-
 15 vide primary health care.

16 "(c) On or before March 1, 1975, after consultation
 17 with appropriate educational organizations and professional
 18 nursing and medical organizations, the Secretary shall pre-
 19 scribe guidelines for programs for nurse practitioners. Such
 20 guidelines shall, as a minimum, require—

21 "(i) a program of classroom instruction and super-
 22 vised clinical practice directed toward preparing nurses
 23 to deliver primary health care;

1 “(ii) a minimum course of study of one academic
2 year of which at least four months must be classroom
3 instruction; and

4 “(iii) a minimum level of enrollment in each year
5 of not less than eight students.

6 “(d) No grant may be made or contract entered into
7 to plan, develop, and operate a program for the training of
8 nurse practitioners unless the application for the grant or
9 contract contains assurances satisfactory to the Secretary
10 that the program will upon its development meet the guide-
11 lines which are in effect under section (c) ; no grant may be
12 made or contract entered into to expand or maintain such
13 a program unless the application for the grant or contract
14 contains assurances satisfactory to the Secretary that the
15 program meets the guidelines which are in effect under such
16 section.

17 “(e) For purposes of making payments under grants
18 and contracts of this section there are authorized to be
19 appropriated \$5,000,000 for the fiscal year ending June 30,
20 1975, and \$7,500,000 for the fiscal year ending June 30,
21 1976.”.

Mr. PREYER. Our first witness today is Dr. Joyce C. Lashoff, Deputy Assistant Secretary for Health Programs, Office of the Assistant Secretary for Health, and I believe she is accompanied by Dr. Henry Foley, the Administrator, Health Resources Administration; and Jessie Scott, Assistant Surgeon General.

We welcome you this morning and would be glad to hear from you at this time.

STATEMENT OF JOYCE C. LASHOF, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH—PROGRAMS, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY HENRY A. FOLEY, PH. D., ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, PUBLIC HEALTH SERVICE; AND JESSIE SCOTT, R.N., DIRECTOR, DIVISION OF NURSING, BUREAU OF HEALTH MANPOWER, HEALTH RESOURCES ADMINISTRATION, PUBLIC HEALTH SERVICE

Dr. LASHOF. Thank you very much, Mr. Preyer. I appreciate the opportunity to appear before you this morning.

I would like to take a few minutes just to summarize the main points of my formal, prepared statement, which I am submitting for the record [see p. 14].

By way of background, the present nurse training authorities began in 1956 with traineeships for nursing teachers, administrators and supervisors. With the 1964 legislation, the authorities expanded to include institutional and student assistance at all levels.

This was done because of the very obvious need for additional nurses at that time.

From 1956 through 1977, almost \$1.4 billion of Federal funds was awarded for student traineeships, loans and scholarships, for construction and basic support for nursing education programs, and for projects to improve nursing education and recruitment.

There are reliable indications that we may now have an adequate number of nurses to support our current health care delivery system. This is a goal which the Federal Government has been striving to achieve over the past decade. Since we appear to be nearing that goal, the administration feels that this is the appropriate time to provide more selective Federal support for nursing education. In order to make the best use of scarce, Federal health dollars, it has been necessary to make some hard and difficult decisions in this area.

The administration proposes extensions only to the existing special project and nurse practitioner authorities with authorizations of \$7.5 million and \$13 million respectively in 1979 and such sums as may be necessary in 1980.

Mr. Chairman, for the last few months, the Department has been conducting a major review of its support for health professions training. We hope to complete that review later this year and we believe the results will teach us a great deal about the ways all our Federal health care programs affect the supply of health professionals.

While we have identified only two clear and present needs for federally subsidized nurse training, we believe any additional proposals must logically await the results of that study and we look forward to sharing that study with you and working with you for future legislation.

I will be happy to answer any questions.

[Dr. Lashof's prepared statement follows:]

STATEMENT

BY

JOYCE C. LASHOF, M.D.

DEPUTY ASSISTANT SECRETARY FOR HEALTH-PROGRAMS

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am pleased to have the opportunity to discuss with you today H.R. 11434, a bill which would extend Federal nurse training authorities for two years, through fiscal year 1980.

The present nurse training authorities, as contained in title VIII of the Public Health Service Act, are administered in the Health Resources Administration of the Public Health Service. Accordingly, I am accompanied by Dr. Henry A. Foley, Administrator, Health Resources Administration and Ms. Jessie Scott, Assistant Surgeon General/Director, Division of Nursing, Bureau of Health Manpower, Health Resources Administration.

Mr. Chairman, I would like to review briefly the history of the present nurse training authorities. In 1956, legislation was enacted to establish the professional nurse traineeship program to provide traineeships for the advanced training of nurses to serve as teachers, administrators, and supervisors. The nurse training authority was extended and expanded by the Nurse Training Act of 1964 which provided broad authorities for a balanced program to assist nurse training institutions and nursing students at each level of training of registered nurses: baccalaureate degree, diploma (hospital schools), and associate degree (junior college).

The last major revision of the nurse training authorities was made by the Nurse Training Act of 1975. Under these various laws and amendments, the Federal government has provided substantial support for nursing education. From 1956 through 1977, almost \$1.4 billion was awarded for student traineeships, loans, and scholarships; for construction and basic support for nursing education programs; and for projects to improve nursing education and recruitment. Partly as a result of this support, there has been a marked increase in the supply of nurses in recent years. Ten years ago there were about 600,000 full-time equivalent active nurses in the United States, or just under 300 per 100,000 population. The most recent estimates (January 1977) show that the number of active full-time equivalent nurses may have increased to more than 850,000, or about 395 per 100,000 population.

The outlook is good for sustained growth in nurse supply. This growth is indicated in part from the fact that graduations from nursing education programs have increased even more sharply than overall nurse supply in recent years (having more than doubled since the enactment of the Nurse Training Act of 1964). In addition, an increased proportion of the nurse population is actively employed in nursing today. For example, in 1966 about 67% of the registered nurse population was employed in nursing, whereas today the proportion active is estimated to be about 72%.

Nurse training assistance under title VIII of the Public Health Service Act has also been influential in improving the quality of educational programs for nurses, as evidenced by the increase in national accreditation of nursing schools. From 1964 to 1976 the percentage of associate degree (junior college) programs that were accredited by the National League for Nursing, the nationally recognized accrediting body, rose from 4 to 46 percent; of baccalaureate programs, from 71 to 80 percent. While diploma programs declined in number in this period, 90 percent of those that continue are now accredited.

Another change in nurse manpower supply attributed in part to Federal nurse training support in recent years is the increased numbers of nurses who are prepared for administration, supervision, teaching, and clinical nursing specialties. Nurses are also being prepared to render primary care in nurse practitioner programs.

Under current conditions the Nation no longer needs to accelerate the total output of professional nurses. There will be an increase in the proportion of nurses preparing themselves for specialized care, for community-based care, and for the administration of cost-effective nursing services. One important area of specialization, especially as new mechanisms for financing health care services are developed, will be the demand for nurses in expanding roles in the delivery of primary care.

Mr. Chairman, as we consider the appropriate role for the Federal government in nurse training development and support, we are concerned

that nurse training problems be dealt with as elements of related Federal education and training policy generally. For example, we need to consider whether, given the current and future projected supply of and demand for nurses, the need for Federal support of undergraduate nurse training can be met through needs-tested undergraduate support in the Office of Education.

The Administration opposes extending the full range of current authorities and proposes extensions only to the existing special project and nurse practitioner training authorities, with authorizations of \$7.5 million and \$13 million respectively in 1979 and such sums as may be necessary in 1980. These extensions would focus Federal nurse training support in fiscal years 1979 and 1980 on areas of greatest national need. Moreover, we wish to emphasize that nursing undergraduate students will continue to be eligible to apply for Office of Education needs-based student assistance programs which total over \$4 billion in the President's 1979 budget, including the Basic Education Opportunity Grant, Supplementary Education Opportunity Grant, Work Study and Direct Student Loan programs. In addition, a limited number of National Health Service Corps scholarships will be available to support nurse training. The large increase in the number of nurses as well as in the nurse/population ratios over the last decade appear to be adequate to meet projected needs when viewed from the current national perspective. We recommend that the Subcommittee's focus now be on the remaining problems: geographic maldistribution and the expanded role function for nurses.

If the Nation is to meet its health care needs at reasonable cost, Mr. Chairman, Federal nursing and health professions programs must be structured so as to be more targeted and thereby make the maximum possible contribution to the goal of adequate health care within constraints on available funds and expert knowledge. The Public Health Service is currently conducting a major review of its support for health professions training, with the aim of developing a new legislative proposal covering various Department programs affecting health manpower training. We hope to complete this review in 1978.

We have been looking not only at how the health professions programs help meet our needs, but also at their relationship to other Federal programs or policies that affect the supply of health professionals. The implications of various types of health care financing schemes to affect the supply and distribution still need to be considered. Finally, we must take into account the effects of health professions programs on future health service costs.

That concludes my prepared statement, Mr. Chairman. My colleagues and I would be pleased to try to answer any questions you may have.

Mr. PREYER. We will look forward to that study. Do you know when that might be available?

Dr. LASHOF. By June if we can keep at the rate we are going.

Mr. PREYER. Thank you.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

How many programs in the nursing division have had final regulations approved?

Dr. LASHOF. Please repeat that?

Mr. CARTER. How many nursing programs have had final regulations?

Ms. SCOTT. We have final regulations for financial distress grants and for nurse practitioner grants. We have, in process, the regulations for all of our other programs.

Mr. CARTER. I believe in a February newsletter it was reported that only 1 of 10 programs had final regulations.

Ms. SCOTT. Final regulations for nurse practitioners were published, Mr. Carter, and at that time we invited additional comment on only one section of the nurse practitioner regulations. That was section 57.2414C(2), having to do with requirements to be a registered, licensed nurse in order to participate in training for nurse practitioners.

Mr. CARTER. What?

Ms. SCOTT. To be enrolled in a nurse practitioner training program, we believe that the nurse should be licensed to practice in order to take advanced preparation.

Mr. CARTER. Everybody thinks that. Is there a controversy about that?

Ms. SCOTT. There was some discussion about the use of the word "for" in the legislation. There was some feeling that it could mean that you are a registered nurse after the training and so it was an interpretation, really, of that phrase.

Otherwise, the nurse practitioner regulations are final.

Mr. CARTER. That sounds like a matter of semantics.

Do you have a sufficient number staff for the programs authorized under the Nurse Training Act?

Dr. FOLEY. Yes, Mr. Carter. As you know, we centralized some of the staff and are in the process of filling those positions in the divisions within the Bureau of Health Manpower. We have a sufficient number of staff at this time.

Mr. CARTER. I understand that nurse anesthetists may be seeking Federal support for their training. What is your reaction to such a proposal?

Ms. SCOTT. As we moved along with our professional nurse traineeship programs since the late 1950's and the introduction of further support for nursing education, there has been some discussion about whether or not anesthesia is a nursing specialty or a medical specialty. The nurse anesthetists who are studying anesthesia and the anesthetists programs are not located in schools of nursing. We have not supported them under the nurse training authorities.

Mr. CARTER. But we do have nurse anesthetists.

Ms. SCOTT. Yes, but their training programs are not in the School of Nursing, and the nurse training act provides primarily support for programs in schools of nursing.

Mr. CARTER. In fact, I have seen some very good ones.

Ms. SCOTT. I do not think there is any discussion about how good they are or how well they serve.

Mr. CARTER. You do not want to permit them to go into this field through Federal support, is that correct? Would you withdraw support for them in this area, in helping them become nurse anesthetists?

Ms. SCOTT. We would not be withdrawing support in that we have not supported them.

Mr. CARTER. Will you continue your support for them as nurse clinicians?

Ms. SCOTT. If they were classified as nurse clinicians who provide direct nursing care.

Mr. CARTER. Within which fields in the nursing profession do you see the greatest need for additional personnel? Clinical, administrative, or what?

Dr. LASHOF. I think we see the greatest needs in the nurse practitioner area, the clinical aspects of the practice of nursing, community health nursing and geriatric nursing.

Mr. CARTER. Do you have any nurses working as clinicians who are working in coronary-care units?

Dr. LASHOF. Yes, we have the specialist clinical nurses working in intensive coronary-care units.

Mr. CARTER. Does that require training?

Dr. LASHOF. Yes, it requires special training over and above the standard program.

Mr. CARTER. Cardiac surgery. What about capitation? Would you reduce it completely?

Dr. LASHOF. The administration's budget for 1979 does not provide for capitation funding for the nursing schools.

Mr. CARTER. Do you think we have enough nurses?

Dr. LASHOF. The data appears to show that we have an adequate supply of nurses, given the current financing and health delivery system.

If there were major changes in our financing system, or in our method of delivering medical care, then that would change the picture. But the projections at this time, given our current system, are that we have an adequate supply.

Mr. CARTER. We went from 800,000 to 895,000, is that correct?

Dr. LASHOF. No. From 600,000 to 854,000.

Mr. CARTER. I feel that we still do not have enough nurses in the rural areas in particular. Why do you think we should not give this capitation to our schools of nursing?

Dr. LASHOF. Let me respond to both parts of that question. I think you are quite correct that there are not enough nurses in certain areas; that is a geographic distribution problem that is not necessarily solved by just producing more nurses; in our advanced nurse training regulations we do want to address the problem of geographic distribution. That was one of the additions to those regulations.

In terms of the capitation funding, I am not sure that it is a question whether we want to do it, but rather it is a budgetary question; one has to make some hard choices about the allocation of scarce resources, considering the supply situation and the purpose of the capitation program to expand enrollments, other things got a higher priority.

Mr. CARTER. There is a shortage of nurses. We simply do not have enough.

I deplore the fact that you wanted to cut the capitation. I, for one, am going to support it and I trust that the members will go along with me. In fact, I noted HEW is cutting capitation across-the-board for every other group, when we know that we do not have a proper distribution of nurses, or physicians, or physicians assistants, or nurse clinicians. We just do not have it.

What are you going to do about this distribution problem if you are going to cut down on the number of nurses whom we assist to graduate in this country? How are you going to address this problem of maldistribution?

Dr. LASHOF. I think that we do think that there is maldistribution, as I said before. We do not believe that capitation has been successful in addressing that problem.

Mr. CARTER. By your own numbers we increased the number of nurses to 854,000.

Dr. LASHOF. There is no question that capitation was an extremely important and effective measure for increasing the supply of all types of health manpower. The question now is having what appears to be an adequate supply with that problem, is capitation the ideal methodology when dealing with the problem of maldistribution?

A major purpose of the study that I referred to is to look into that problem in some depth and come up with some alternative mechanism of dealing with the geographic maldistribution.

Mr. CARTER. We have had this problem for years and nothing is being done about it. You say we are going to plan to do it; we have been wanting to plan to do it for years. Let's get the job done.

How many different agencies of the Federal Government now supply assistance to nurses?

Dr. LASHOF. Certainly—the Office of Education as well as the Public Health Service; the Department of Defense; the Veterans' Administration.

Ms. SCOTT. The Office of Education has some eligibility for people enrolled in institutions of higher education. The Department of Defense, through the Army, Navy, and Air Force Nurse Corps provide some assistance to nurses for graduate education. The maternal-child health services, as well as other areas in the Public Health Service itself.

Mr. PREYER. If the gentleman would yield?

Mr. CARTER. Yes.

Mr. PREYER. You mentioned the National Health Service Corps and you mentioned that scholarship program in your statement as a source of support for nursing students. How many scholarships have been awarded to nursing students under that program?

Dr. LASHOF. We will have to check that number and submit it for the record.

[The following information was received for the record:]

In fiscal year 1977, 77 nurses received scholarships.

Mr. PREYER. Could you also, for the record, let us know how many you anticipate awarding this year?

Dr. LASHOF. Yes, sir.

[The following information was received for the record:]

In fiscal year 1978, it is projected that there will be 385 recipients of such scholarships.

Mr. CARTER. I believe, according to their statement, Mr. Chairman, this year they are requesting training for 1979, there is a request for 13 nurse practitioners.

In answer to the distinguished Chairman's question, you said how many nurses have been placed in the National Health Service Corps? How many?

Dr. FOLEY. We said we would have to supply that for the record. We do not have that figure. [See preceding page.]

Mr. CARTER. While you are doing that, I wonder if you could indicate where they received their training?

[The following information was received for the record:]

BACCALAUREATE NURSING

<u>SCHOOL</u>	<u>NO. OF STUDENTS</u>
California State College - Sonoma	1
California State University - Fresno	1
California State University - Hayward	1
University of California - San Francisco	1
Loretto Heights College	2
University of Northern Colorado	1
Catholic University of America	1
Georgetown University	2
University of Illinois Medical Center	1
Kansas State College of Pittsburg	1
University of Kansas	1
Towson State College	2
Fitchburg State College	1
Mercy College of Detroit	1
University of Minnesota	1
St. Louis University	1
Columbia University	1
Cornell University Medical College	1
Roberts Wesleyan College	3
SUNY at Binghamton	1
Wagner College	1
Case Western Reserve University	1
Ohio State University	1
Thomas Jefferson University	1
Clemson University	1
Medical University of South Carolina	1
Incarnate Word College	1
Brigham Young University of Nursing	1
University of Vermont and State Agric College	1
George Mason University	2
Radford College	1
Pacific Lutheran University	1
Seattle Pacific College	1
University of Washington	1
TOTAL	40

PUBLIC HEALTH NURSE

<u>SCHOOL</u>	<u>NO. OF STUDENTS</u>
University of Alabama - Birmingham	3
Arizona State University	1
University of Arizona	1
University of Colorado Medical Center	3
Catholic University of America	1
University of Minnesota	1
University of North Carolina - Dept. of PH Nursing	2
Case Western Reserve University - School of Nursing	1
TOTAL	13

NURSE-MIDWIFERY

<u>SCHOOL</u>	<u>NO. OF STUDENTS</u>
Yale University School of Nursing	4
University of Illinois - College of Nursing	2
Columbia University - School of Nursing	2
TOTAL	8

NURSE PRACTITIONER

<u>SCHOOL</u>	<u>NO. OF STUDENTS</u>
California State University - Long Beach	1
University of California - San Francisco	2
University of Colorado Medical Center	1
Yale University - School of Nursing	2
University of Illinois College of Nursing	1
University of Kentucky College of Nursing	1
University of Minnesota	1
University of Missouri Kansas City	2
SUNY at Stony Brook	2
University of Rochester	1
Vanderbilt University - School of Nursing	2
TOTAL	16

Dr. FOLEY. We will get that for you, too, as well.

Mr. CARTER. Will I find the same pattern that I found previously, that most of these students go to Georgetown and George Washington? I trust that we will find a majority of them spread out through the areas where the nurses, upon graduation, would be likely to stay.

Dr. LASHOF. I would doubt that we would find this same pattern, because the reason that resulted in Georgetown—we will look at it specifically and submit it for the record.

Mr. CARTER. They are the most expensive schools in the country. I have good friends there.

Dr. LASHOF. Of course, as you know, it is because they are the most expensive that we get the most applications from there and it is not that we go out trying to recruit them from there.

Mr. CARTER. The purpose of the scholarship program is not to send them to the most expensive schools, but to let them graduate and go to places where they are needed. Our problem is distribution, as you have admitted. If you bring them into an urban area, they are going to stay in an urban area.

Dr. LASHOF. Our problem, sir, is that we do not recruit them to go to school and we do not send them to school. We give scholarships to the students who are in school.

Mr. CARTER. As you know our physicians are recruited for the scholarship program and are "matched" at HEW. I think it is wrong for the "matching" to be done there. I think that the scholarship should be allocated according to the States needs, through the States.

Dr. FOLEY. Dr. Carter, having arrived recently, I have begun to look at that. I do have Dr. Martin's assurance that he is working closely with the States and, in fact, we are going to push that further. We share your concern. We think there should be a linkage to the State government as well as what is appropriate in some States.

I will give you my assurance that we are pursuing that rather rigorously right now in making sure that Dr. Martin's statements work towards implementation, as well as just a statement.

Mr. CARTER. Mr. Chairman, I want to thank you.

Mr. PREYER. Let me ask you, generally on the question of geographical maldistribution of nurses: Does that pattern follow pretty much the pattern of the geographical maldistribution of doctors? Do they tend to congregate at the large medical centers and the larger towns rather than rural areas?

Dr. FOLEY. We find, Mr. Chairman, some convergence and, because of that, we are now in the process of designating the shortage areas comparable to the National Health Service Corps service areas because of the convergence. We see much more similarity than dissimilarity in that area.

You will have a situation where you have nurses in some of the rural areas, for example, in the West where I come from, where they will be out there where physicians, and dentists, and other health professionals are not.

Excluding those factors, I think that the shortage problem in the inner city and rural areas is fairly close. Rather than confusing the

general public, we are pushing to bring the definition of those shortage areas together so that we can appropriately place not only nurses, but other health professionals, leading more to team concepts out there in the shortage areas, in the inner city and rural areas.

Mr. PREYER. Thank you.

Along another line of questioning, we heard from the deans of a number of our schools of nursing about the problems they have had with advanced nurse training regulations which were published January 24, and one question that they have been concerned with is, does the Department intend to delete the clinical area designations?

Ms. SCOTT. Under the proposed rules for advanced nurse training, the six areas selected for attention had to do with clinical areas of practice, as well as functional areas of practice. The clinical areas of practice have to do with geriatrics, maternal-child health, community health, adult nursing, acute care nursing and medical surgical nursing as well as the functional areas of administration, supervision, and teaching.

The functional areas are identified in the law itself.

Mr. PREYER. I take it, then, that the answer is no to that question? You do not intend to delete the clinical area designation?

Dr. FOLEY. No, we do not.

Mr. PREYER. I would think that to delete that would go beyond Congressional intent and conflict with it. Is there not a shortage in all clinical specialties?

Dr. FOLEY. Mr. Chairman, to be perfectly candid on this, the data that we are working with is data from 1972 that has gone through several reiterations, 1974 and updates, and it is rather nonexact, to say the least. We think there is adequate supply out there but I think we are into a numbers game and, depending on whose interpretation of those numbers it is would answer your question.

We think there is a sufficient number of supply in the clinical specialties that can be handled in other avenues than the ones we have indicated.

Mr. PREYER. Statistics do not always lie, but they seldom voluntarily tell the truth.

Dr. LASHOF. I think part of the problem, of course, in this statistical number, what we really said there, given these areas, there are some that clearly seem to need more people than others, and we singled out geriatric nursing, community health nursing and maternal and child health nursing as being those with a shorter supply and whether the others are as completely adequate or not, but they seem to be more adequate than those three areas and we felt we had to give priorities within these areas.

Mr. PREYER. I believe the thing that concerns nursing and concerns the subcommittee is that the law does not specify the clinical specialties, and therefore, the feeling is that the administration is going beyond the intent of the law to single out certain specialties as being in short supply in relation to others.

Dr. LASHOF. We understand the concern. It is a question of interpretation of what the law provides for us and it was our view that the law asks the Secretary to define those specialties and they were

defined and then, within that, he had the leeway to set priorities when the dollars could not fund everything. We understand their concern, and their responses are now under review. These did go out as NPRM's. We had 200 responses; those are being analyzed and will be very thoroughly discussed in the Department before the final regs come out.

Mr. PREYER. I think that the administration has publicly concerned its plan, shifting to a different area, to have a national health insurance bill that will phase in a variety of services over the next few years and plan to have that ready for Congress by late this summer.

As a part of your planning for the various options—and this may be something you will want to look up for the record—have you done thorough health manpower need projections for each option?

Dr. LASHOF. I do not think that we have done thorough ones for all of the various options for national health insurance. We did do some projections for what would be the need for a fairly comprehensive range of benefits and what impact that would have on manpower.

We have also done some projections of what the impact would be if there were a marked increase in health maintenance organizations and, jumping ahead, there is no question that a national health insurance program that had much more comprehensive benefits or a major shift towards health maintenance organizations, would increase the demand for nurses and we would have to increase the supply.

However, it was felt that we had to deal with the reality at this point in time; if any of those go forward, then our manpower analysis proposals would have to be adjusted accordingly.

Mr. PREYER. What are the professional nursing projections for a comprehensive plan say, 5 years after its enactment? There again, this may be something you may want to submit for the record.

Dr. FOLEY. We have done that study; we will submit it for the record. We have several alternative models we have used to look at with the national health insurance assumption present in those models.

[The following information was received for the record.]

Requirements for full-time equivalent registered nurses in the United States
as a whole, according to various health system changes for selected years 1980-1985

Health system changes	Full-time equivalent registered nurse requirements		
	1980	1982	1985
Combination of "more liberal" National Health Insurance plan, extensive "role reformulation for registered nurses" and "high" RMO growth	1,173,000	1,276,400	1,450,300
"Role reformulation for registered nurses"			
"Low"	878,500	930,000	1,012,700
"High"	951,600	1,038,100	1,190,400
RMO enrollment growth			
"Moderate"	870,400	918,600	995,200
"High"	867,500	914,100	987,600
National Health Insurance			
"Less" liberal	919,500	971,700	1,055,100
"More" liberal	1,031,800	1,087,300	1,176,100
None of these health system changes	873,600	923,400	1,003,100

Source: Doyle, et al., The Impact of Health System Changes on the Nation's Requirements for Registered Nurses in 1985, Division of Nursing, HHA, PHS, DHEW Publication No. HHA 78-9, 1978. In press.

Mr. PREYER. Then those various models would also show the manpower needs for a more limited plan, I take it, such as a catastrophic insurance plan.

Dr. FOLEY. Basically, our models look at the assumption of universal entitlement, Mr. Chairman, not the question of specific proposals that have been up here on the Hill. We could, in fact, if directed, go back and massage that data in terms of specific proposals, like the catastrophic coverage.

Mr. PREYER. We would like to get those projections. I guess the basic point, which you indicated earlier, is that you now have an adequate supply of nurses in your judgment barring some change in the system of delivery, and the Administration has indicated that there is going to be some change in the system.

You mentioned you are in the process of your review of all of the health policy considerations, which has not been completed yet, which raises the question with all of these ongoing reviews and possibilities of new approaches, that we have not gotten the information from them yet.

Is it not premature to cut out funds right now? You may have to come back and do over again everything that we have been doing right now.

Dr. LASHOF. As I indicated, I think that the problem is that, with budget priorities now, we have to deal with the situation as it now exists. Although we do project changes, we feel that it is realistic at this time; as much as we may feel strongly and the administration does feel strongly that we wish to move ahead with the national health insurance and will have a bill, we do not know what will happen to the bill in Congress. We do not know how long that will take and it was felt that, given our budgetary constraints, we had to deal with the situation as is.

As that situation changes, we are prepared to come back in keeping with those changes.

Mr. PREYER. The subcommittee may give you time to conduct your review without embarrassment of cutting off funds.

Mr. Walgren?

Mr. WALGREN. I would just like to explore briefly, the President's request seems to contain so many zeroes in terms of funding, and I understand you say in your testimony, on page 3, "We no longer have a need to accelerate the total output of professional nurses," but I am concerned when you change from accelerating the total output to, really, providing zero money in a number of different programs that the quality of the nursing training would not be maintained.

I am just wondering how you justify going from a substantial input to zero. How is the quality of nursing training going to be maintained under these kinds of funding appropriations?

Dr. LASHOF. Let me add, one of the aspects of the thinking here was that these programs were starting to increase the supply, as a Federal priority, the goal was to increase the supply. Once one has reached the state where we are producing, or turning out, or graduating the number necessary, then the question comes, is it the Federal role to maintain that? Since these are associate of arts and

baccalaureate programs, should they not be maintained at the local and State levels as are all other programs in the associate of arts and baccalaureate level?

Is the Federal role to do at the baccalaureate and associate of arts level in Nursing what it does not do for teaching or most other fields?

There was a real reason for the Federal Government to move in at a time that we had a shortage. Once there is not a shortage, is there a clear reason for the Federal Government to do the funding, or is it not the responsibility of the local and State governments to pick up and maintain that quality?

The administration's position is that the latter is correct.

Mr. WALGREN. Did I understand that these assumptions were made on the basis of universal entitlement?

Dr. FOLEY. The assumption that we made here was not universal entitlement. The assumption is that were there to be national health insurance, it would be a program of universal entitlement.

The figures we are dealing with, as Dr. Lashof testified earlier, not with the assumption of national health insurance. It is on the status quo at this particular moment in time.

We have the figures, if there were national health insurance with universal entitlement, and we will provide that to the committee.

Mr. WALGREN. The assumptions are based on the status quo. Do you see no shortage of the nurses and the status quo situation?

Dr. LASHOF. We see geographic problems, We see problems of shortages in nurse practitioner areas, community health nursing. But, in terms of the basic nursing, overall supply of nurses, we do not see shortages with the status quo delivery system, status quo financing system.

Mr. WALGREN. How are you addressing the geographic distribution—I am sorry if you covered this—how are you addressing that?

Dr. LASHOF. In the advanced nurse training regulations, there is priority consideration given to programs addressing geographical distribution. We are looking at it in a broad study that we mentioned earlier.

Our feeling was that capitation is not a successful way to address it and we must find other methods. Scholarship priority and health service corps programs, traineeships, and nurse practitioner programs are trying to address the geographic problem.

We know that we do not have a solution to that yet, and it is one of the issues we are going to be addressing fairly thoroughly in our overall manpower studies for nurses, physicians and other health practitioners.

Mr. WALGREN. As to quality, appropriated for fiscal 1978 under advanced nurse training there is \$12 million and under traineeships there is \$13 million. Am I correct in thinking that both programs are for literally advanced nurse training. Both have been zeroed out so we are essentially making a \$25 million cut in our effort to provide advanced nurse training, and that is a question that is just not quantity at all.

My question is then, are we in a position to reduce the advanced nurse training effort that we are making by \$25 million? That, I

gather, would be quality over and above the basic nurse training that all nurses going through the system would receive.

In fact, I am not quite familiar with the flows here, but I have with those two programs. On this sheet is appropriated, in fiscal 1978, a total of \$25 million and contemplated to be authorized for fiscal 1979 is a total of \$50 million, so we are making a \$50 million cut from what was authorized, or contemplated to be authorized, in fiscal 1979 in what I would term advanced nurse training.

I would like to know why the estimates of HEW led to the belief that we would do without that?

Dr. FOLEY. Mr. Walgren, I think, quite straightforwardly, the estimates, the basis for that cutback was not the estimate with regard to the advanced nurse training. It was made because of budgetary restraints vis-a-vis the Office of Management and Budget. They were not estimates for the reduction in advanced nurse training.

I would separate that out from the capitation issue. We think the issue of the funding for capitation and quality that you asked about would occur at the State level reflected in increased tuition, approximately \$150 per student to cover at the AA and BA level.

We think most colleges and community colleges as well, knowing that there is a job market that these students will go into, will, in fact, support the training of nurses in their particular schools.

I do think in the advanced nurse training, it is not an estimate in regards to whether they are needed or not needed. It is a question of the constraints of the budget allocation.

Mr. WALGREN. All right.

Then the question I would have, what is the other side, what is the greater priority? From the viewpoint of HEW, did you see those dollars going into some other HEW program or to some other health program and were you told that if you put more dollars in that other program, they had to come out of the dollars in your own area?

Dr. LASHOF. Yes.

In developing an overall budget for the "H" of HEW, we are given an overall mark within which all of our programs were ranked in priority order and if there were no ceiling, then everything we might like to do could be included. Given a ceiling, one has to balance one program against another and saying, if this is the total dollars you can have, where do they go?

We opted for increases this year in community health centers, in family planning and maternal and child health. Those kind of direct service delivery programs took priority over some of the training and manpower programs.

There is no question, if you look at the overall budget, that manpower cutbacks were chosen rather than—in order to, really, expand some of the health service delivery programs to underserved populations, rural and urban, in this country in an effort to attack problems of infant mortality and access to care, in the hopes that the educational system and local and State sources would be able to pick up some of the slack in the manpower.

But clearly, we are attacking the problems that we were facing in family planning, maternal and child health, community health centers.

Mr. WALGREN. Can you tell me what the net reduction in training and manpower was that was then shifted to delivery programs?

Dr. LASHOF. We can give some rough idea.

Overall, the PHS budget does go up this year, despite the cut-backs in certain areas. I can submit to you for the record a summary table that shows you where all of the increases in our budget are and where all of the decreases are. We prepared it for the Appropriations Committee and would be happy to send you that kind of table.

[The following information was received for the record:]

PUBLIC HEALTH SERVICE
1979 Congressional Budget
(\$000)

February 8, 1978

	1977 APPROPRIATION CONFORMANCE	1978 APPROPRIATION CONFORMANCE	1979 PRESIDENT BUDGET	INC/OSC 1978 APPROPRIATION
(b) Dental health education				
(1) FGM grants.....	5,500	3,500	2,000	-1,500
(2) Dental extensiers.....	2,200	2,000	2,000	—
(3) Educational develop. and application..	2,300	500	—	-500
Subtotal.....	8,000	6,000	4,000	-2,000
(c) Nursing				
(1) Institutional assistance				
a. Operation grants.....	40,000	30,000	—	-10,000
b. Advanced nurse training.....	9,000	12,000	—	-12,000
c. Nurse practitioner.....	9,000	13,000	13,000	—
d. Special projects.....	15,000	15,000	7,500	-7,500
e. Financial diaries.....	—	—	—	—
Subtotal.....	73,000	70,000	20,500	-49,500
(2) Nurse teaching facilities				
a. Grants.....	—	—	—	—
b. Incentive subsidies.....	—	—	—	—
Subtotal.....	—	—	—	—
(3) Student assistance				
a. Loans.....	22,500	22,500	—	-22,500
b. Scholarships.....	9,000	9,000	—	-9,000
c. Travel grants.....	13,000	13,000	—	-13,000
d. Loan repayment.....	3,000	1,500	—	-1,500
e. Fellowships.....	1,000	1,000	—	-1,000
Subtotal.....	46,000	47,000	—	-47,000
(4) Educational assistance				
a. Research grants.....	5,000	5,000	—	-5,000
(5) Congressional reports.....	—	—	—	—
Subtotal.....	5,000	5,000	—	-5,000
(d) Public health.....	20,520	16,500	8,000	-7,900
(e) Allied health.....	24,000	19,500	7,500	-11,000

Mr. WALGREN. I think that would be helpful.

Thank you, Mr. Chairman.

Mr. PREYER. Dr. Carter?

Mr. CARTER. Just one question. I notice, in looking over your proposed authorizations, we see a tremendous cut from last year's appropriation of \$119.5 million down to your request for \$20.5 million. Is that not correct?

Dr. LASHOF. That is correct.

Mr. CARTER. That includes nothing for advanced training, correct?

Dr. LASHOF. Correct.

Mr. CARTER. \$13 million for nurse practitioner training, special projects, \$7.5 million.

Nothing for construction, nothing for subsidies, no loans, no loan repayments, no traineeships and no scholarships. Actually, so far as nursing is concerned, you almost demolish the program, except for nurse practitioner training and special projects.

I understand from a little reading that I have been doing, there has been some difficulty going on over in HEW regarding this funding cut with the nursing group. Is there an argument about whether nursing support should be reduced so much?

Dr. LASHOF. Well, I think, as I answered Mr. Walgren, when one develops the overall budget, one has to rank all of the programs and give priority within a dollar ceiling and there has been discussion at all levels as to what those priorities are.

Every group feels that their particular interest is a priority, but the Department, as a whole, has to make some tough choices, as we indicated earlier.

Mr. CARTER. In this case, we do not need a nurse training program at all?

Dr. LASHOF. I think that our view is that we do not need such a program, but are there other State and local resources to pick it up.

Mr. CARTER. There is no support for them at all?

Dr. LASHOF. At the Federal level.

Mr. CARTER. You testified that more trained nurses are active today than in the past. What do you feel is responsible for this?

Dr. LASHOF. There is no question that the program that has been carried out to make these funds available has been an extremely successful one in increasing the number of schools, the number of graduates, and the number of nurses that we have today.

Mr. CARTER. Again, I would ask you, what are the priorities above the nurse training program?

Dr. LASHOF. I think the same answer that I gave to Mr. Walgren, that we chose this time to emphasize expansion in community health centers, rural health delivery initiatives, family planning programs, maternal and child health programs in the hope that the local and educational institutions would pick up some of the slack in the manpower area.

Mr. CARTER. We do not need any nurses

Dr. LASHOF. I cannot reiterate more that we feel that we need nurses. The question is where the priority and funding should come forth to pay for them.

Mr. CARTER. You are not preparing them for this. You propose to expand the community health center program, but you won't have the nursing power to staff these centers.

Well, thank you so much.

Dr. LASHOF. Thank you.

Mr. PREYER. Thank you.

I hope, along the lines that Dr. Carter was questioning you, that the Secretary will give some thought to adequately staffing expanding community health services, maternal and child health programs and the programs that you wish to expand.

Thank you very much for being with us today and we appreciate your being here.

I am sure that your position is not a particularly comfortable one, but you have supported yourselves very well.

Our next witnesses are members of a panel, Miss Valerie Lewis of the National Student Nurses Association; Dr. Dorothy Novello, past president, National League for Nursing; Dean Eloise Lewis, who is appearing here as president of the American Association of Colleges of Nurses; and Hazle Blakeney, chairperson of the American Nurses' Association.

We are glad to welcome all of you here this morning and I extend a special warm welcome to my fellow townspeople, Dean Lewis.

We are ready to proceed in any form that you want to. Who will lead off?

STATEMENTS OF HAZLE BLAKENEY, R.N., ED. D., CHAIRPERSON, COMMISSION ON NURSING EDUCATION, AMERICAN NURSES ASSOCIATION, ACCOMPANIED BY CONSTANCE HOLLERAN, DIRECTOR, GOVERNMENT RELATIONS (ANA); ELOISE LEWIS, ED. D., F.A.A.N., PRESIDENT, AMERICAN ASSOCIATION OF COLLEGES OF NURSING; VALERIE LEWIS, ON BEHALF OF NATIONAL STUDENT NURSES' ASSOCIATION; AND DOROTHY JEAN NOVELLO, R.N., PH. D., PAST PRESIDENT, NATIONAL LEAGUE FOR NURSING

Dr. BLAKENEY. I am Hazle Blakeney of the Commission on Nursing Education for the American Nurse Association. Mr. Chairman, in the interests of time, I will just highlight my statement stressing the nursing manpower situation aspects in particular.

Mr. PREYER. Without objection, your entire statement will be made a part of the record [see p. 39].

Dr. BLAKENEY. Thank you.

My colleagues will then focus on specifics of the legislation and on related issues.

As this committee well remembers, the 1975 Nurse Training Act has had a stormy history. A pocket veto, followed by a signed veto which was successfully overridden in the House by 384-43 and, in the Senate, 67-15, was its beginning. Since then, it has been an uphill battle to get funds and regulations to carry out its programs.

With your continued help, we feel the Nurse Training Act has been very successful.

Mr. Chairman, we appear before you today to urge prompt enactment of H.R. 11434 to extend for two fiscal years these programs of assistance to nursing schools and to nursing students. As we stated when the bill was introduced, several studies pertinent to future needs for support of nursing education are now underway. One study is being conducted by the University of Wisconsin to develop recommendations for credentialling within the nursing profession.

Another is the WICHE [Western Interstate Commission on Education] study on nursing needs. A third issue under study is the future education for entry into nursing practice.

Before addressing specific provisions of H.R. 11434, I would like to summarize the status of national nursing resources, an essential component of the country's health care services.

Currently, there are an estimated 1,018,000 registered nurses engaged in the practice of nursing as compared with 815,000 in 1973. Some of those practice part-time.

Trend data substantiate the fact that proportionately more nurses are active in practice today than ever before. The American Nurse's Association is pleased to see that the nurse anaesthetists are testifying today also, for we are well aware that there are no funds available to them at this time.

In a recent unpublished paper prepared by the manpower department of the American Nurses Association, it was found that, at the present time, there are no hard data to suggest that there is an excess of registered nurses in the United States.

Although there are sporadic rumors about registered nurses in specific cities being unable to find employment, overall, nationwide, despite the marked increase in graduations from basic nursing programs, employment opportunities continue to absorb essentially all who seek employment in nursing.

The employment opportunities have grown, as the supply of registered nurses has grown. A review of selected, available data is instructive.

In our 1976 survey of hospitals, two-thirds of directors of nursing responding to the question reported difficulty in recruiting registered nurses. Almost 70 percent of those reporting recruiting difficulties indicated it was due to a shortage of registered nurses.

Large medical centers have full-time recruiters to fill nursing positions. Employment opportunity advertisements in professional journals and newspapers continue to document unfilled budgeted positions, and agencies that place part-time registered nurses have grown in number and size.

Nursing job fairs are being held in cities throughout the country. At a recent fair in New York, a representative from the Texas Hospital Association was quoted in the March 8 New York Times as saying, "We represent 700 hospitals, and we have 5,000 nurse vacancies to fill."

Hospital data collected by the American Hospital Association and analyzed by the American Nurses Association show that during the time period of 1972 to 1976, registered nurse employment by hospitals increased 26.4 percent!

We believe this increase reflects the increasing intensity and sophistication of nursing care required by hospitalized patients. The number of days of hospitalization continue to be cut as a result of utilization reviews, and so forth, so the patients need for care in that shorter stage and much greater than even 10 years ago.

Home health agencies also have increased demand for nursing staff. Again, patients go home sooner, are sicker, and require more extensive and more frequent visits.

The nursing profession continues to be concerned about nursing shortages which exist in certain geographic areas.

We are deeply interested in supporting innovative programs which will offer incentives to nurses to relocate to these areas.

As this committee knows, we strongly supported capitation eligibility requirements that encouraged schools to establish outreach programs in underserved areas. Many schools are doing this, but we still hope to see more move in that direction.

The problem of influencing health professionals to locate in underserved areas is a complex one which relates to the availability of appropriate health facilities, the existence of a professional support system which includes opportunities to interact with peers and continuing professional development opportunities, and the availability of reimbursement for services rendered, or a salary, which is at least competitive with other areas.

We are heartened by trend data reporting that baccalaureate graduates, nurse practitioners, and minority nurses are providing care in underserved parts of the country.

Future requirements for nurses, as well as other health manpower, will be greatly influenced, of course, by the form which national health insurance and/or Federal programs take. The health delivery system is currently in a state of change, with accompanying uncertainties.

It will probably remain so until clear policy and priority emerges at the Federal level. A comprehensive national health insurance program, plus increasing coverage with HMO's and additional expansion of nursing rolls will, as estimated in the previously referred to Wiche study, require a 110-percent increase in the number of professional nurses needed!

In addition, public health departments report an increasing need for nurses to do cancer screening, hypertension screening, and followup and to increasingly provide services to handicapped adults.

Regardless of what form national health insurance will assume in the future, be it catastrophic coverage, or population-specific coverage, we believe that the need for nurses will be increased. We believe the need for such increases will be most acute in geographically underserved areas and in long-term care and ambulatory care, where the introduction of Federal insurance payment systems could stimulate the demand for services.

Nurses tend to differ from other health groups in that we estimate need on the unmet health needs of the public that can be met by nurses.

In 1980, we believe that the situation will be more predictable, and that the studies currently underway within the Government and

the profession will yield information upon which rational new initiatives for public support for nursing education can be proposed.

The Americans Nurses' Association supports H.R. 11434. We comment on each of the provisions in our full statement.

It is essential that present support be continued. As was noted when legislation for extension of the Nurse Training Act was introduced, it is important to avoid any abrupt change in the funding for some 1,400 nursing programs and nearly a quarter of a million nursing students.

Any such change could disrupt careers of many students and create havoc in nursing schools which have expanded and made many other substantial changes in order to meet Federal requirements for funds.

Time must be allowed for evaluation of potential changes in the health delivery system and evaluation of nursing care studies. All groups involved have agreed, for sometime, that a priority for Federal aid for nursing education is improvement of the quality of nursing care through advancing the educational preparation of nurses in leadership positions.

Although there have been continuing increases in the number of nurses with advanced preparations, a critical shortage still exists. The ANA recommends that graduate programs be characterized by pluralism, diversity, and flexibility and be responsive to the emerging health needs of society. The recently published proposed HEW regulations for advanced training grants would make such diversity impossible.

Therefore, we urge you to clarify your intent for those prepared in master's, doctoral, and postdoctoral programs.

Mr. Chairman, we would like to voice our concern at the administration's proposed elimination of the National Advisory Council on Nurse Training. That Council is necessary to advise and consult with the administering agency on policies affecting programs and evaluations of the effectiveness of the use of Federal resources.

We believe that the National Advisory Council on Nurse Training is essential to the effective administration of this legislation, and we strongly urge its continuation. We ask, though, that you look at its composition. Vacancies have been allowed to exist for long periods of time, and the annual change in students on the Council makes their contribution quite limited.

We ask the committee to move for speedy enactment of H.R. 11434.

I thank you for the opportunity to express our views on this legislation and my colleagues will continue.

[Testimony resumes on p. 56.]

[Dr. Blakeney's prepared statement follows:]

AMERICAN NURSES' ASSOCIATION

Testimony On

H.R. 11434

Nurse Training Amendments of 1978

March 20, 1978

By

Hazle Blakeney, R.N., Ed.D.

To

Subcommittee on Health and Environment

Committee on Interstate and Foreign Commerce

U. S. House of Representatives

I am Hazle Blakeney, Chairperson of the American Nurses' Association Commission on Nursing Education and Chairperson of the Career Development Department of the University of Maryland School of Nursing.

Mr. Chairman, we appear before you today to urge prompt enactment of H.R. 11434 to amend Title VIII of the Public Health Service Act (Public Law 94-63) to extend for two fiscal years the program of assistance to nursing schools and nursing students. As was stated when the bill was introduced, several studies pertinent to future needs for support to nursing education are now underway. One study is being conducted by the University of Wisconsin to develop recommendations for credentialing within the nursing profession. Another is a WICHE study of nursing needs. A third issue under study is the future entry into nursing practice.

Before addressing specific provisions of H.R. 11434, I would like to summarize the status of national nursing resources, an essential component of the country's health care services. The Congress is to be commended for actions taken in the past to expand and improve this necessary and valuable resource for meeting health care needs of people. Past legislative enactments have made a difference.

Currently there are an estimated 1,018,000 registered nurses engaged in the practice of nursing as compared with 815,000 in 1973. Of that 1,018,000, about two-thirds work full-time. Trend data substantiate the

fact that proportionately more nurses are active in practice today than ever before.

CURRENT EMPLOYMENT

In a recent unpublished paper prepared by the Manpower Department of the American Nurses' Association, "An Assessment of the Current National Labor Market for Registered Nurses," it was found that at the present time there are no hard data to suggest that there is an excess of registered nurses in the United States. Although there are sporadic rumors about registered nurses in specific cities being unable to find employment, overall, nationwide, despite the marked increase in graduations from basic nursing programs, employment opportunities continue to absorb essentially all who seek employment in nursing. The employment opportunities have grown as the supply of registered nurses has grown. A review of selected available data is instructive.

The unemployment rate for registered nurses in 1977, as measured by the Bureau of Labor Statistics was 2.6 percent, well below what is considered a full employment rate. In that same year unemployment for females 16 years and over was 3.6 percent.

In an American Nurses' Association 1976 survey of hospitals, two-thirds of the directors of nursing responding to the question reported difficulty in recruiting registered nurses. Almost 70 percent of those reporting recruiting difficulties indicated it was due to a shortage of registered nurses.

Large medical centers hire full-time recruiters to fill nursing positions; employment opportunity advertisements in professional journals and newspapers continue to document unfilled, budgeted positions; and agencies which place part-time temporary registered nurses have grown in number and size. Nursing "job fairs" are being held in cities throughout the country. At a

recent fair in New York, a representative from the Texas Hospital Association was quoted in the March 8 New York Times as saying that "We represent 700 hospitals, and we have 5,000 nurse vacancies to fill." A recruiter from Tennessee was quoted as saying that she had 50 openings for nurses in intensive care and medical surgical nursing.

With the recent change in immigration regulations, fewer foreign nurse graduates will enter the country for the purpose of employment. The decrease may be as many as 4,000 per year.

There continues to be a belief among some employers that nurse shortage problems can be solved by the recruitment of foreign nurse graduates. Data from a 1970-1972 survey conducted by the American Nurses' Association and funded by a contract from the Division of Nursing of the Health Resources Administration, DHEW, revealed that five states, New York, Michigan, California, Illinois and New Jersey, received 75 percent of the applications for licensure from foreign nurse graduates.

The survey also documented gaps in foreign nurse graduates educational preparation which created problems in obtaining state licensure. A low percentage of foreign nurse graduates passed the state examinations for registered nurses on their initial attempt.

Based on a deep concern about the employment opportunities for foreign nurse graduates especially those unable to fulfill licensure requirements and the quality of nursing care provided by foreign nurse graduates, American Nurses' Association and the National League for Nursing jointly funded the Commission on Graduates of Foreign Nursing Schools. The purpose of this Commission is to provide a pre-immigration screening examination for foreign nurse graduates and to maintain current information on the status of foreign schools. The first examination is to be offered overseas in 1979. The cost

of development of the examination was partially underwritten by the Division of Nursing, HRA, DHEW. Continued financing for this endeavor is being studied at this time.

The facts indicate that while a very high percentage of registered nurses participate in the work force and are employed in nursing, newly graduated nurses continue to be able to find employment in nursing within a very short period of time after graduation. This plus the unemployment data suggest a current shortage, not an oversupply of registered nurses.

Hospital employment data collected by the American Hospital Association and analyzed by the American Nurses' Association shows that during the time period of 1972-1976, registered nurse employment by hospitals increased by 26.4 percent of 112,413 full-time equivalent positions. We believe this increase reflects the intensity and sophistication of nursing care required by the hospitalized patients. The number of days of hospitalization continue to be cut as a result of utilization reviews, etc., so the patient's needs for care in that shorter stay are much greater than even 10 years ago.

Home Health agencies also have increased demands for nursing staff. Again, patients go home sooner, are sicker and require more extensive and more frequent visits.

The increased demand for services is further substantiated by the change in ratios of registered nurses to licensed practical nurses employed. In the reporting year of 1975-1976, 7.7 full-time equivalent registered nurses were added to hospital payrolls for every full-time equivalent licensed practical nurse. This in contrast to 1972-1973 and 1973-1974, where 3 registered nurses full-time equivalent were employed for every licensed practical nurse. The increase in the utilization of registered nurses again reflects patient care needs and the changes in health care being delivered. These changes were not

brought about by an increase in hospital beds or average daily census as both decreased during this same period. Several studies are in process to study the cost factors of this increased use of registered nurses and the data seems to support the hypothesis that costs are lowered when the ratio of RN's to other nursing staff is lowered.

GEOGRAPHIC DISTRIBUTION OF NURSES

The nursing profession continues to be concerned about nursing shortages which exist in certain geographic areas. We are deeply interested in supporting innovative programs which will offer incentives to nurses to relocate to these areas. As this committee knows, we strongly supported capitation eligibility requirements that urge schools to establish outreach programs in underserved areas.

The problem of influencing health professionals to locate in underserved areas is a complex one which relates to the availability of appropriate health facilities, the existence of a professional support system which includes opportunities, and the availability of reimbursement for services rendered or a salary which is at least competitive with other areas. We are heartened by trend data reporting that baccalaureate degree graduates, nurse practitioners and minority nurses are providing care in underserved parts of the country. The implementation of the Rural Health Clinic Reimbursement Law (P.L. 95-210) should do much to stimulate the utilization of nurses as primary care providers in these areas.

ACADEMIC PREPARATION OF NURSES

Any consideration of the adequacy of nursing personnel resources must include not only the numbers of those employed but also the level of educational preparation as related to established criteria for fulfilling specific positions and functions.

The 1963 Surgeon General's Consultant Group on Nursing established criteria for determining needs for nurses serving in various capacities. Utilizing these criteria, the Western Interstate Commission on Higher Education, as part of its work on the project, "Analysis and Planning for Improved Distribution of Nurses" and based on current utilization of nurses, tested the appropriate educational mix for registered nurses employed in 1972. They found that there should have been more than five times as many nurses with master's or doctoral degrees as there actually were in 1972 and that the number of registered nurses with baccalaureates should have been more than twice the actual number.

The orderly transition of education for nursing to institutions of higher education is observable in the increasing numbers of baccalaureate and associate degree programs in nursing and the decrease in the number of diploma programs. As of October, 1976, there was a total decrease of 3 percent in enrollment of students in initial programs of nursing over the previous year. This represents a 6.8 percent decreased enrollment in diploma programs; an increase of 3.2 percent in associate degree programs and an increase of 4 percent in enrollment in baccalaureate programs.¹ The 1974-1975 admissions to nursing programs showed an overall increase of 3 percent, a 4.4 percent decrease in diploma program admissions and increase of 5.7 percent in associate degree programs and 4.2 in baccalaureate programs over the previous year.

Although percentage gains in the number of nurses with graduate education preparation is encouraging, the actual number fall significantly below the needs and goals set by the profession and the Federal government. The number of nurses receiving master's degrees in nursing has been increasing slowly each year. In the 1965-1966 school year, 1,279 master's degrees were awarded, while in 1974-1975 the number had increased to 2,694 and in 1975-1976 to 3,437. In 1974-1975, 74 nurses were granted doctoral degrees from programs located in nursing education components of universities. Disappointingly, graduations at the doctoral level decreased to 62 in 1975-1976, although this compares favorably with the 14 such degrees conferred in 1965-1966. In spite of these increases in the numbers of nurses prepared at the graduate level, there is still a great dearth of nurses with master's, doctoral, and post-doctoral preparation to fill positions of leadership in education, nursing practice, supervision, administration, and research. It seems to be difficult for some people to understand that nursing is a complex field requiring extensive knowledge of both the physical and social sciences.

Advances in biomedical research require well-qualified nurses to care for patients benefiting from new surgery or other means of treatment.

The following is a projection of the registered nurse supply through 1990 by educational levels made by the DHEW Division of Nursing in its First Report to Congress, required by the Nurse Training Act, 1977:

"Preliminary projections of the registered nurse supply indicate that by 1990, the number of those available for employment would range between 1,467,000 and 1,541,000. About 62 percent of these would have as their highest educational preparation associate degrees or diplomas; 33 percent, baccalaureate; 5 percent, master's or doctoral."

If these projections are correct, even by 1990, the educational preparation of the registered nurses will not meet the anticipated educational requirements for the nursing work force.

NURSING STAFF REQUIREMENTS

In a recently published position paper, Nursing Staff Requirements for In-Patients Health Care Services, the ANA Commission on Nursing Services took the position that no one numerical concept, specific formula, or ratio can be applied generally in in-patient health care facilities because of the multitude of variables which might be taken into account. The following are examples of the kinds of investigations that are currently underway regarding acuity of care patients require and nursing utilization.

1. The GRASP Project in North Carolina is studying pre-admission classification of patients based on nursing care needs.
2. Massachusetts Eye and Ear has developed preliminary information relating to the costs of nursing care in specific diseases and patient problems.

3. The Consultant firm of Ernst and Ernst in concert with the Evanston Hospital tried a time and motion study and found it too task-oriented. They then moved to approach cost accounting via the PCU (patient care unit). The PCU was designed around a nursing process model with five components: (1) assessment, (2) planning, (3) implementation, (4) teaching-counseling-support, and (5) discharge planning-evaluation. Part of the project is to look at the influence of levels and types of nursing on length of time performance. Modular nursing is a variety of the brand of nursing concept. Variables to be considered will be elements of the nursing process, quality, and a time (efficiency) approach (mode of delivery) to care, levels of practice and staffing mix. Quality will be assumed to be constant as measured by the Joint Commission on Accreditation of Hospital's patient care evaluation procedure.

The Division of Nursing, HRA, through its comprehensive contract with WICHE to study nursing resources, has devised a national model and state models which make it possible to project nursing needs and resources based on analysis of factors affecting nursing requirements and availability of personnel. A report to Congress was due February 1st, 1978 but has not yet even been submitted.

POTENTIAL IMPACT OF FEDERAL ACTION

Future requirements for nurses as well as other health manpower will be greatly influenced, of course, by the form which national health insurance

and/or other federal programs take. The health delivery system is currently in a state of change with accompanying uncertainties. It will probably remain so until clear policy and priorities emerge at the federal level. A comprehensive NHI program, plus increasing coverage with HMO's and additional expansion of nursing roles will, it is estimated in the previously referred to WICHE study, require a significant increase in the number of professional nurses needed. In addition, public health departments report an increased need for nurses to do cancer screening, hypertension screening and follow-ups, and to increasingly provide services to handicapped adults and to the elderly.

Regardless of what form national health insurance will assume in the future, be it as catastrophic coverage or population specific coverage, we believe the need for nurses will be increased. We believe the need for such increases will be most acute in geographically underserved areas and in long-term care and ambulatory care, where the introduction of federal insurance payment systems could stimulate the demand for services.

By 1980, we believe that the situation will be more predictable and that the studies currently underway within the government and the profession will yield information upon which rational new initiatives for public support for nursing education can be proposed.²

EXTENSION OF NURSE TRAINING ACT - SPECIFIC PROVISIONS

The American Nurses' Association supports HR 11434, an extension of the Title VIII, PL 94-63 Nurse Training Act of 1975 through 1980, and we would like to comment on each of its provisions. It is essential that present support be continued. As was noted when legislation for extension of the

Nurse Training Act was introduced, it is important to avoid any abrupt change in the funding for some 1,400 nursing programs and nearly a quarter of a million nursing students. Any such change could disrupt careers of many students and create havoc in nursing schools which have expanded and made many other substantial changes in order to meet federal requirements for funds. Time must be allowed for evaluation of potential changes in the health delivery system and evaluation of nursing care studies.

Construction Assistance

The substantial investment of federal funds in construction assistance to schools of nursing since 1971 has been a major factor in facilitating the construction of new facilities and renovation of existing buildings, thus contributing to the marked increase in admissions to nursing schools noted in this period. It has helped to make possible improved teaching methods and has also stimulated more cost effective use of clinical facilities.

As of December 31, 1976, the total number of construction grants approved and funded under the Nurse Training Act of 1975 amounted to \$16.5 million. This represented the last effort to award construction assistance, although \$20 million was authorized for each of 1976, 1977, and 1978. No funds were appropriated for this purpose.

We believe it is most important that funds be authorized for the expansion and renovation of unsafe and/or inadequate facilities which are used for graduate education. The quality of educational programs is being adversely affected in some doctoral and master's programs.

Capitation Grants

We know there are pressures to delete this form of support to nursing schools. However we feel that these grants are vital to many schools of

nursing. Faculty cuts and restricted activity in the "eligibility" projects will occur if these grants are precipitously deleted. Last year some 1,055 schools of nursing received capitation awards.

The outreach into underserved areas of many nursing schools is very encouraging. Abrupt deletion of support will terminate such activity.

Special Projects

We support the increase in authorization for this program. The lack of growth in funding has seriously hampered this section which is the only mechanism to promote changes in teaching, etc.

An increased level of authorization is needed to facilitate growth and expansion of the programs. Creativity in solving local problems has been most encouraging in projects funded through this section.

Advanced Nurse Training

A priority for federal aid to nursing education has been improvement of the quality of nursing care through advancing the educational preparation of nurses in leadership positions. Although there have been continuing increases in the number of nurses with advanced preparation, a critical shortage still exists. Some 60 graduate programs received awards last year.

The First Report to the Congress prepared by the Division of Nursing (1977) underscores the severity of the shortage. That report states:

"Competent administrative leadership is fundamental to assuring quality in the delivery of nursing services and in the education of nursing students, yet only 3.4 percent of the active registered nurses are prepared at the master's level or above, the generally accepted level of preparation for leadership positions."

In a forthcoming publication, Graduate Education in Nursing, the ANA Commission on Nursing Education identifies as the profession's highest priority

the preparation of highly competent leaders to function in diverse roles as nurse clinicians, researchers, theoreticians, teachers, administrators, consultants, public policy makers, system managers and as colleagues on multidisciplinary teams - all to be prepared in master's, doctoral and post-doctoral programs. The Commission recommends that such programs be characterized by pluralism, diversity, and flexibility and be responsive to the emerging health needs of society. The recently published proposed regulations for Advanced Training Grants would make such diversity impossible. Therefore we urge you to clarify your intent for this program.

Nurse Practitioner Programs

In response to a growing demand, nurse practitioner grants were established in 1975 under PL 94-63 to foster the development of programs to prepare nurses to practice in the primary care role. Congress particularly emphasized the need for geriatric nurse practitioners for care of the elderly, a group whose lack of adequate health care has been of increasing concern to all.

In 1974, there were 131 programs to prepare nurse practitioners which graduated 1,503 individuals. Of this number, 311 were from the 45 master's program and 1,192 received certificates from 86 other programs. By 1976, the total number of graduates was expected to be 6,000 to 7,000 according to the Division of Nursing. Increasingly, these practitioner programs are integrated into master's programs. This is an appropriate development.

Most nurse practitioner programs rely heavily on federal support. They are costly to run, requiring many faculty for few students. The potential for increasing federal support is great and could reach as high as six times those currently supported. We have been encouraged by the extent of curriculum innovation in basic baccalaureate and master's degree programs in order to

offer students the opportunity to develop the competencies necessary to provide primary care. Currently, 57 programs are being supported under this section of the law.

The Association hopes that, in the future, such changes in basic educational programs will make it unnecessary to offer non-degree granting continuing education programs to prepare nurse practitioner.

Traineeships, Scholarships and Loans

There has been a steady decline in stipends for both master's and doctoral education because of limited funds and increasing tuition costs. We urgently need clinicians with specialized knowledge in primary, secondary and tertiary care, health planners and coordinators, administrators and faculty. The decline in the number of traineeships available coincide with a decreasing full-time enrollment in graduate programs of nursing. It is estimated that close to half of all full-time students are recipients of partial traineeships (tuition only) although most work at least part-time to support themselves and their families. In the past year 2,400 students received traineeships.

We strongly support continuation of the traineeship awards. We also support continuation of scholarships and loans as currently provided for in the Nurse Training Act. In fiscal 1978 27,000 received nursing loans and 9,000 students received scholarships.

Mr. Chairman, we would also like to voice our concern at the Administration's proposed elimination of the National Advisory Council on Nurse Training. That Council is necessary to advise and consult with the administering agency on policies affecting program and evaluation of the effectiveness of the use

of Federal resources in connection with this program. We believe the National Advisory Council on Nurse Training is essential to the effective administration of this legislation and we strongly urge its continuation. We ask though that you look at its composition. Vacancies have been allowed to exist for long periods of time and the annual change in students on the Council makes their contribution very limited.

We ask the committee to move for speedy enactment of HR 10468. Thank you for the opportunity to express our views on this legislation.

Notes

1

Facts About Nursing 76-77, American Nurses' Association, Kansas City, Missouri, 1978.

2

Provision of data generated from 1977 American Nurses' Association Inventory of Registered Nurses, HRA, DHEW, Contract #230-76-0279.

Design for selection of National Sample of Registered Nurses, American Nurses' Association Statistics Department, sponsored by the Division of Nursing, HRA, DHEW, Contract #231-76-0085.

American Nurses' Association Study of Credentialing in Nursing, conducted by the University of Wisconsin-Milwaukee, completion date: January, 1979.

Second Report to the Congress, from the Secretary of Health, Education and Welfare on the Supply and Distribution of and requirements for Nurse as required by Section 951, Nurse Training Act of 1975, Title IX, Public Law 94-63, due in 1978 will address issues surrounding the preparation and practice of nurses and implications for Federal assistance to nursing education.

Mr. PREYER. Thank you very much.

I would like to comment on that last statement, on the National Advisory Counsel on Nursing. I am the chairman of another subcommittee which has the jurisdiction over that bill. I think I can assure you that it will not be eliminated.

We have looked into it. We are confident that it is needed.

STATEMENT OF ELOISE LEWIS, ED. D.

Dr. LEWIS. I am here today representing the American Association of Colleges of Nursing, which represents over 200 accredited institutions with baccalaureate and higher degree programs in nursing, and we are in full support of H.R. 11434, the extension of the Nurse Training Act.

Further, the AACN urges full support and quick passage of H.R. 11434 in order to assure stability in the planning and management of critically needed nursing programs throughout the country. The future health of our country is dependent in large part on the continued Federal support of nursing programs.

Nurses represent the largest aggregate and most consistent providers of health services. Nurses are providing primary health care to many sectors of our society and have been responsive to changing demands in the health care area. It is important to assure that a sufficient number of nurses with adequate preparation will be available to serve the Nation's health care needs over the next several years.

Extension of the Nurse Training Act for 2 years as proposed in H.R. 11434 will provide sufficient time for completion of the various manpower and credentialing studies in nursing which are currently in progress. Results of these studies along with other data on major health problems and delivery systems will provide the basis for the formulation of a revised proposal for Federal support in nursing.

The need for continued support of all programs contained in H.R. 11434, with a priority emphasis on graduate training in nursing, is clearly evident from the data recently obtained in a study conducted by the AACN on the needs and resources of schools of nursing. Forty-eight percent of the schools surveyed indicated that curtailment or loss of Federal funding would necessitate elimination of a program.

Approximately three-quarters or 73 percent of the schools indicated that a loss of Federal support would necessitate a significant lowering of enrollment in one or more of the baccalaureate or higher degree programs. Creation of such a situation would be highly counterproductive in our attempts to provide more equitable access to a higher quality of health care.

In order to assure adequate numbers of qualified professional nurses, many more graduates are required from baccalaureate and graduate programs. At the present time, less than 20 percent of the total registered nurse population has earned a baccalaureate or higher degree in nursing. Baccalaureate graduates are prepared as primary health care providers to place emphasis on prevention, health teaching, education for self-care, and maintenance of good

health in acute or ambulatory settings. Graduates of master's programs are prepared as advanced practitioners in primary care, clinical specialists, managers of nursing care, and nurse educators.

Data from the AACN study indicate that institutional support for baccalaureate programs in the form of capitation is urgently needed to support the salaries for faculty positions, faculty development, instructional media material, and some of the operational expense of the school.

In selecting program options as a basis for eligibility for capitation programs, 25 percent of the schools indicated that they were conducting programs for recruitment of students from disadvantaged backgrounds; 27 percent were providing a significant portion of clinical experiences in geographically remote areas; and 44 percent were providing continuing education programs for nurses based on assessment of local and regional needs. Such important programs can be continued with capitation funds.

In order to assure a steady supply of qualified nurses, student support in the form of scholarships, loans, and traineeships are required. Data from the AACN study indicate that an additional 1,980 master and 165 doctoral students could pursue full-time versus part-time study, if additional student support were available. An adequate base of student financial assistance would allow us to respond more quickly to the critical need for nurses prepared at the graduate level. Rising tuition levels in both the public and private sectors have resulted in a reduced number of students being supported by traineeships.

The advanced nurse training funds are the only source of basic support to graduate programs. The need for more nurses with advanced preparation to work as practitioners, clinical specialists, educators, and administrators is critical. It is not expected that the need can be met for many years to come.

The AACN study indicates that during the 1977-78 academic year there were 381 budgeted, unfilled faculty positions requiring minimal preparation at the master's level, and another 513 budgeted, unfilled positions for faculty prepared at the doctoral level in our group of respondents.

Projection of additional needs for the year 1980 triples for master's prepared nurses and more than doubles for doctorally prepared nurses in educational settings alone. It is estimated that the need for nurses with advanced degrees in service settings is just as critical.

Special projects support has been of tremendous assistance to schools of nursing by fostering creativity and innovation in education, including basic, advanced, and continuing education. Support for special projects is necessary in order to continue the emphasis on newer approaches in nursing education which help establish community demonstration projects, interdisciplinary programs, and promote more effective utilization of resources.

In summary, the AACN supports H.R. 11434, the extension of the Nurse Training Act, as it does continue a sound program enabling schools of nursing to prepare the kinds of practitioner needed to meet national health needs. Through this program, the profes-

sion's capacity to respond to health care demands, especially the demand for primary care can be increased; and it will assure the supply of nurses for health care delivery and with advanced scholarly training for practice, teaching, and research.

Mr. PREYER. Thank you.

STATEMENT OF VALERIE LEWIS

Ms. LEWIS. Mr. Chairman and members of the committee, I am Valerie Lewis, a nursing student at Boston College and national chairperson of Breakthrough to Nursing, the National Student Nurses Association's minority recruit project.

This statement is presented on behalf of the National Student Nurses Association, an organization with a membership of approximately 33,000 students of undergraduate schools, diploma schools, and associate degree programs.

We strongly support an extension of the current Nurse Training Act. This legislation provides vital assistance to enable undergraduate nursing students to complete their education, and the Nurse Training Act of 1975 is due to expire later this year.

Three areas in the Nurse Training Act are of specific concern to NSA and to nursing students. These are nurse training loans, nurse training scholarships, and loan repayment. We strongly urge their continued inclusion in an extension of the Nurse Training Act.

Nursing education has continually increased in quality and sophistication over the years, which has made it a more expensive endeavor for both schools and students. In addition to tuition costs, books, and supplies, nursing students face an added financial burden for uniforms and transportation to and from the clinical experiences. Nursing students have less opportunities to earn the needed funds, since they have less time to work.

Clinical experiences often average 20 hours a week in addition to classroom instruction and study time.

The National Student Nurses Association is in the process of doing a survey of financial needs of nursing students. Although final results are not yet available, the preliminary returns indicate that a majority of the respondents work to meet the costs of their education. Approximately one-half of the respondents indicate that they receive Federal financial assistance within nursing education.

Approximately one-half of the respondents to date come from families with incomes below \$15,000 per year.

NURSE TRAINING SCHOLARSHIPS

The Nurse Training Act of 1975 provided for scholarships to be awarded to those of exceptional financial need who need such financial assistance to pursue some course of study at the school for such year.

Scholarships are of particular importance to nursing students from disadvantaged backgrounds. Many times Federal scholarship moneys are the only thing which make it possible for these students to complete their nursing education.

NURSE TRAINING LOANS

The Nurse Training Act of 1975 authorized the program of low-cost loans for full- or part-time students. The nursing student loan program has been quite successful and has given many students the chance to complete their nursing education.

The default rate for paying back nursing student loans has been quite low. A 1973 study of 20 percent of the nursing schools involved in the nursing student loan program conducted by the Office of Student Assistance showed that only approximately 2 percent of the principal loans were in default, a much lower rate than other health professions.

Loans are a principal source of financial aid for many nursing students. Many have begun, or continued their education, with the understanding that loan money will be available.

NSNA strongly believes that the nursing student loan program is necessary and should be continued.

LOAN REPAYMENT

Many areas in the United States suffer from a severe shortage of health care providers. Incentive for practice in underserved areas for newly graduating health professionals are suggested to help remedy the situation.

One such incentive is the loan repayment program, which provides for repayment funds for educational loans for nurse training costs for: One, up to 85 percent of all outstanding loans plus interest to the graduates who enter into an agreement with the Secretary to practice as a nurse for at least 2 years in a shortage area; and, two, all or part of any loans to exceptionally needy or low-income students who fail to complete their studies and cannot reasonably be expected to resume nursing studies within 2 years.

Nursing students, however, have not been able to utilize the loan repayment program to its fullest extent. Information on the designated shortage areas for nursing, a necessary component for the program, was not available until an interim listing of nursing shortage areas was released in 1973. The final listing was not released until 1976!

We believe that the lack of information about this program has had a serious impact on the number of students able to take advantage of it.

The National Student Nurses Association survey that is now being compiled, approximately one-half of the responses to date indicated that they are willing to serve in an underserved area as an option to repay a Federal loan. The loan repayment program is one way to increase the number of qualified health professionals practicing in a shortage area. We urge its continuation.

The importance of nursing in American health care delivery system has long been recognized by Congress. Nursing can help to offer many solutions to the health care delivery problems in the United States. We urge you to approve an extension of the Nursing Training Act.

We would like to thank the committee for giving us this opportunity to share our concerns with you.

Mr. PREYER. Thank you, Ms. Lewis, for a very helpful statement, and good luck to you with your breakthrough to nursing program. Thank you.

Dr. Novello?

STATEMENT OF DOROTHY JEAN NOVELLO, R.N., PH. D.

Dr. NOVELLO. Mr. Chairman, let's hope the last is best.

I am testifying on behalf of the National League for Nursing, a coalition of nurses, other health professionals, consumers, and health agencies—17,000 individual members and 1,900 agencies, dedicated to developing and improving the standards of quality nursing education, nursing services, and health care delivery in the United States—all of whom work together to help meet community nursing needs and to assure high quality nursing education.

Among its functions, the league is officially recognized as the national accrediting agency for all nursing education programs by the council on postsecondary accreditation and the U.S. Office of Education.

Mr. Chairman, since the 1960's, the role of the Federal Government has been, in addition to expanding financing for the aged and poor, to expand the resources devoted to health. The effort can only be regarded as a success. The growth in the number of registered nurses, aided by Federal expansion of nursing schools as well as nurses' roles, has been dramatic.

Yet, many problems remain. The need for qualified nurses in leadership positions is greater than ever, and the shortage of qualified faculty is particularly great. A discontinuation of funds at this time would be very disruptive to a great many schools who rely on these funds for major budget items.

The National League for Nursing has just analyzed the results of a special study of capitation provisions of the Nurse Training Act of 1975, jointly conducted by the American Nurses' Association, American Association of Colleges of Nursing, and the National League for Nursing.

The study surveyed public and private schools of nursing to determine how the funds were used and what effects cessation of the funds would have among the schools surveyed.

More than half of the schools stated that a reduction or discontinuation of these moneys would have a severe impact on their programs. Seventy-one percent of the baccalaureate programs stated that continuation of the funds was crucial to their survival.

Moneys were also heavily depended upon, according to the survey, for continuing education programs and for curriculum expansion. In many cases, new programs being supported by these funds could not sustain the loss of Federal support.

In all three types of programs, baccalaureate, associate degree, diploma, faculty salaries were reported to be the highest item of expenditure for use of capitation funds. In many cases, a withdrawal of these funds would mean losing at least two or three faculty members. Now that schools have increased their enrollments so that they

could be eligible for these funds, it would, therefore, be most unfair to students enrolled in these programs to abruptly discontinue the funds. In addition, many nurse practitioner programs offered through continuing education departments, as well as through curriculums initiated with Federal dollars, would be affected. A cessation of funds at this time without a thorough evaluation of the need to continue these programs would have damaging effects to the entire health care system and to the students of these programs as well.

Mr. Chairman, at the very least, perhaps a gradual phaseout of these moneys could be accomplished once the overall requirements for nurse manpower have been accurately assessed. Selective funding according to regional need might also prevent a viable alternative.

Another consideration is that faculty shortages have long been a problem in the nursing profession. The National League for Nursing's 1976 nurse-faculty census reports 776 budgeted vacancies.

We can see where the notion of faculty shortage might seem rather innocuous to someone who is unacquainted with nursing curriculum. Perhaps to a cost-conscious administration, faculty shortages might bring to mind overcrowded lecture halls. But in a school of nursing the problem does not end there. It has a ripple effect of very serious magnitude.

Clinical portions of nursing curriculum demand small student-faculty ratios. Teaching many procedures and special patient care settings require on-the-spot supervision of students. Without adequate ratios these program must simply cease to exist; it is an impossible situation to have students in these programs without adequate supervision.

Mr. Chairman, we appreciate what the Federal Government has done for advanced nurse training. But to infuse a windfall of dollars into nursing curriculums, to the extent that the entire scope of practice of the profession and the nature of preparation for that profession is dramatically changed, and then suddenly withdraw the funds because of a rise in head counts, is at best palliative; and at worst is placing students' careers and ultimately people's lives in jeopardy.

Mr. Chairman, this might sound a bit dramatic, but I suggest that now is the time to think about quality assurance. Nursing students at all levels need Federal support now so that they will be adequately prepared and possess the skills and professional judgment they need to practice safely and effectively—be it by a bedside or as a director of nursing.

Planning for quality assurance needs to begin at the educational level. I suggest that what we call failures in health care may be the result of putting new programs in place, funding them inadequately, and then not giving them enough time and support to flourish. Then they are deemed failures, and we start all over again and put a new Federal program into place.

In a very noble effort, I think, to meet the rapidly changing demands of a health care system, nurse educators have accepted expanded roles, rushed new curriculum into place that they were ill prepared to administer and to teach. Oftentimes, faculties do not possess the new skills that they, themselves, are expected to teach.

Mr. Chairman, to be sure, some progress has been made through Federal assistance to schools of nursing. Yet, a very recent feasibility study, "Leadership in Complex Organizations," conducted by Western Interstate Commission on Higher Education, to determine the need for the development of regional centers to give advanced leadership preparation to nurses, reported that all of the schools surveyed had unfilled faculty or administrative spots. The reason most frequently cited for this was the lack of appropriate educational credentials. Deficits included a lack of doctorates, clinical expertise, and research skills.

Currently the study goes on to report there are many deanships in nursing programs and directors of nursing service positions that are vacant. Shortages exist in both functional areas: teaching and administration.

In the area of administration, fewer than 15 percent of nurse administrators hold a master's degree or a doctorate. Members of search committees, who were interviewed by the nurse researcher, reported months of frustration as they struggled to fill administrative and faculty positions alike. The shortage of nurses with adequate educational preparation is particularly apparent in small rural hospitals and nursing homes.

According to "Some Statistics on Baccalaureate and Higher Degree Programs," published by NLN, this trend seems destined to continue unless incentives are provided. While the number of students enrolled in graduate study is increasing, the percentage of graduate students enrolled in nursing administration is decreasing. In 1968, there were 303 full-time master's students enrolled in administration programs; and in 1976, there were 258 students enrolled.

Graduate student enrollment in teaching programs has also declined. In 1968, there were 1,344 full-time students enrolled, and, in 1976, 1,323 were enrolled.

The feasibility study also showed that some States had no master's or doctoral programs at all. This could be very indicative considering that NLN's data service on newly licensed nurses shows that they are most likely to be employed in the States where they attended school. One could hypothesize perhaps, that those States without master's programs might have the greatest shortages of specialized nurse supply.

Mr. Chairman, there is a leadership crisis in nursing that is inextricably related to the crisis in the entire health care system. The severe shortage of nurses who are academically prepared for leadership positions will undoubtedly have increasingly negative effects as nurses assume their new roles and greater responsibilities. The dearth of adequately prepared faculty is the most essential concern, for it is they who are needed to prepare leaders for the future. We hope that you and your committee give special consideration to this area, as you have done in the past.

Thank you for this opportunity to testify. And I will be glad to answer any questions that you might have.

[Testimony resumes on p. 80.]

[Ms. Novello's prepared statement and attachment follows:]

STATEMENT OF DOROTHY JEAN NOVELLO, RN, Ph. D., ON BEHALF OF
NATIONAL LEAGUE FOR NURSING

We are the National League for Nursing, a coalition of nurses, other health professionals, consumers and health agencies--17,000 individual members and 1,900 agencies, dedicated to developing and improving the standards of quality nursing education, nursing services, and health care delivery in the United States--all of whom work together to help meet community nursing needs and to assure high quality nursing education. Among its functions, the League is officially recognized as the national accrediting agency for all nursing education programs by the Council on Postsecondary Accreditation (COPA) and the U.S. Office of Education.

Since the 1960's, the role of the Federal government in health care has been, in addition to expanding financing for the aged and poor, to expand the resources devoted to health. The effort can only be regarded as a success. The growth in the number of registered nurses, aided by Federal expansion of nursing schools as well as nurses' roles, has been dramatic.

But now, the Administration's perceptions and priorities are shifting. There is a concern that the health sector is growing too fast and that includes the supply of nurses.

Ten years ago, an increased supply of nurses and doctors, health planning, prospective reimbursements, PSRO's, were all regarded as solutions to the problem. But there is still the very stark reality that there is unequal access to the health care system, both to financing and to care itself.

The irony of the situation lies in the fact that just as nursing seems to be showing signs of success in terms of providing solutions to unequal access and rising costs, a new skepticism has surfaced on the part of the Administration. It would be a mistake to allow this skepticism to obscure the need for continued financial assistance to those portions of the health care system that are most promising with regard to cutting costs and increasing access. It will be to the benefit of us all if the Congress decides to make this short-term extension of Federal Funds in the interest of long-run reruns.

A discontinuation of funds at the time would be very disruptive to a great many schools who rely on these funds for major budget items.

The National League for Nursing has recently analyzed the results of a Special Study of Capitation Provisions of the Nurse Training Act of 1975, conducted by the American Nurses' Association, American Association of Colleges of Nursing and the National League for Nursing. The study surveyed public and private schools of nursing to determine primarily how the funds were used and what effects cessation of funding would have.

Among the schools surveyed the greatest percentage of funds was used for faculty salaries. In all three types of programs, faculty salaries was reported to be the highest item of expenditure with use of capitation funds. For example, out of \$67,000 (average dollar amount received per Baccalaureate program), \$45,900 (in average dollar amount per Baccalaureate program) was expended on faculty salaries. In many cases, discontinuing these funds would mean losing at least two or three faculty members. Now that schools have increased their enrollments so that they could be eligible for these funds, it would therefore be most unfair to students enrolled in these programs to abruptly discontinue the funds.

More than half of the schools stated that a reduction or discontinuation of these funds would have a severe impact on their programs. 71% of the Baccalaureate programs stated that they felt it would be crucial to continue these funds. Schools plan curricula years in advance, and often times these funds are an essential part of these plans.

Monies were also heavily depended upon, according to the survey, for continuing education and curriculum expansion. New programs are being supported by these funds, and in many cases, are not capable of sustaining the loss of federal support. In addition, many nurse practitioner programs, offered through continuing education departments, as well as through curricula initiated with federal dollars, would be affected. A cessation of funds at this time without a thorough evaluation of the need to continue

these programs would have damaging effects to the entire health care system, and to the students in these programs as well.

At the very least, perhaps a gradual phasing out of these monies could be accomplished once the overall requirements for nurse manpower have been accurately assessed. Select funding according to regions might also present a viable alternative.

The role of nurses in health encompasses not only professional practice and technical skills, but is inextricably related to the complexities of the entire health care system. In recent years our role has changed dramatically to meet the needs of a health care system undergoing widespread transformation. We wish to continue to address the problems in health care.

As a profession, we are committed to attaining a rational use of expensive resources as well as equitable quality of care. We have, in fact, made many inroads to the problems in maldistribution, primary care, and health education, to name a few.

In order to further direct our efforts toward providing remedies for the current health care crisis, we will need continued Federal support, and therefore, we strongly support the proposed two-year extension of the Nurse Training Act.

Representing the largest segment of providers, nurses are becoming involved in many new modes of health care delivery such as out-patient clinics, industries, schools, and primary care settings, as well as in the traditional hospital and community health settings. We are providing a wide range of new services including psychotherapy, counseling to families on death and dying, home health, physical assessment and health education.

To date, NLN's 1976 survey on newly-licensed registered nurses reports that 86.2% are still employed by hospitals with 3.9% by nursing homes and 9.9% falling into an "other" category. It seems reasonable to expect, however, that this trend may change. The growing trend toward non-institutional care will require nurses that are prepared in expanded roles. It will require nurses with a knowledge of economics, reimbursement procedures and above all sound decision-making abilities. As the data in this testimony will show, many nurses presently hold positions for which they are unqualified.

Thus, despite recent efforts and improvements, many gaps and omissions are apparent with regard to the nursing profession as well as to the entire health care system.

STUDIES UNDERWAY

We are currently engaged in efforts to identify these gaps and omissions for that is the first step toward solutions.

Section 951 of the Nurse Training Act of 1975, specifically requests information to be collected on a continuing basis regarding the current and future supply and distribution of nursing personnel, nationwide. In addition, it requests specific data including the supply and distribution of specialties, educational preparations, salaries, and activity statuses.

To meet these requirements a variety of studies funded by HEW are underway that will provide the data needed for sound decisions in all of these stipulated areas. However, these studies will necessitate additional time for completion due to the enormity of the task of integrating existing data as well as developing measures that will accurately reflect future trends in changing economic and social contexts.

The information that is presently available is fragmented, out-dated, and undifferentiated as to levels or types of practice. Another difficulty lies in the fact that as consensus has never been reached about how health status should be defined or how changes in health status should be measured. One means of determining nurse manpower requirements is to look at the need to improve, maintain, or restore the health status of the population. However, a lack of consensus as to a definition of health status has mitigated this approach. Steps to determine a measure of this concept are currently underway.

Models have been developed and are now being utilized in studies funded by HEW that will furnish the required data. (See attachment)*

* Among these is a national model that has been developed with the active involvement of a task force including representatives of nursing service, nursing education, comprehensive health planning, the Division of Nursing in DHEW, and Western Interstate Commission on Higher Education's nursing program staff.

The model is based on a set of techniques referred to as System Dynamics. A System Dynamics model describes a set of casual relationships responsible for changes in variables of interest to policy makers such as those variables characterizing the supply of, demand for and distribution of nursing personnel and services at the national level.

The data that are presented in this testimony are based on data collected up until and including 1972, from a variety of sources (American Nurses' Association, National League for Nursing, the American Hospital Association and HEW), to fulfill the requirements of the Nurse Training Act of 1975. Projections from 1975 to 1990 have been made as to supply, distribution and requirements by means of a special statistical formula called the "net attrition rate," whereby existing data on the total numbers of nurses and the number of graduates each year are interpreted on the basis of assumptions about the behavior of the derived net attrition rate. The graduation projections represent the net inputs into the nurse supply while the net attrition rate accounts for activity status (part-time, full-time, etc.), and foreign nurses inputs.

PROJECTIONS OF SUPPLY

HEW projects that by 1990 the number of those RN's available for employment would range between 1,467,000 and 1,541,000. About 62% of these would have as their highest educational preparation associate degrees or diplomas; 33% baccalaureate; and 5% masters or doctoral degrees.

In 1976, it was estimated that there were 961,000 RN's in the supply; 16% baccalaureate nurses and 3.4% masters or doctoral degrees.

A comparison of the estimates from 1976 and 1990 respectively, forecasts an increase of baccalaureate nurses from 16% to 33% of the nurse supply. A decline of 81% to 62% was projected for AD and diploma graduates. Masters and doctoral components would increase from 3.4% to 5.1% and 2% respectively.

When a state by state projection of supply in 1980 was considered, the overall picture revealed additional implications. The proportion of state's supply having only nurses whose highest education would be an associate degree or diploma predicted a decline by 1980 in all but five states. Nevertheless, this group will still represent a very sizable proportion of the total nurse supply. At least three-quarters of the

total nurse supply in half of the states will be composed of AD and diploma nurses by 1980. Therefore, given the increasing supply of nurses in each state, despite the decrease in the numbers of AD and diploma nurses, the number of nurses with these educational levels will still increase.

The proportionate supply of baccalaureate nurses will increase in all the states but four--Florida, Arkansas and the Dakotas. However, only in one-fifth of the states will the baccalaureate component equal at least 25% of the state's total supply in 1980.

While the master's and doctoral levels generally showed higher proportions by 1980, in most states they were still a very small proportion of the total supply.

PROJECTIONS OF DISTRIBUTION

State to state distributions, analyzed according to nurse per population ratio, have shown consistent increases over the years and future projections indicate a continuation of the trend.

The variation among states is very great, however; the difference between lowest and highest states being about three times as many RN's/100,000. The lowest ratios of RN's/100,000 population were projected in Alabama and Louisiana; the highest in Vermont and Washington, DC, ranging in the vicinity of 1,000 RN's/population.

While data of this nature is useful in determining trends, it is virtually meaningless unless related to the specific area requirements of each state including different specialties and levels of educational preparation. How the area's population receives its services also needs to be taken into consideration. These additional factors are currently being studied.

ASSESSMENT OF REQUIREMENTS

Preliminary assessments of requirements according to levels of educational preparation shed interpretive light on the overall picture.

The Western Interstate Commission for Higher Education, as part of its work on the project, "Analysis and Planning for Improved Distribution," has predicted what the appropriate mix of educational requirements should be, given current utilization patterns. Projections were made according to criteria established by the Surgeon General's Consultant Group on Nursing for appropriate educational attainment level for nurses serving in various capacities. One should keep in mind, however, that since the establishment of the criteria in 1962, nurses roles have become much more differentiated, and responsibilities have changed accordingly. Thus, these criteria are presently considered minimal educational criteria.

The number of employed registered nurses holding master's or doctoral degrees has been strikingly low. In 1972, 24,200 or 3% of employed registered nurses actually held masters or doctoral degrees and 107,200 or 13.7% had earned baccalaureate degrees. If employed RN's had the educational preparation that their positions warranted, 17% would have been employed at the masters or doctoral levels and 31% at the baccalaureate levels. Therefore, there should have been five times as many nurses with masters or doctoral degrees as there actually were in 1972; and twice the number of registered nurses with baccalaureates as their actually were.

In addition, when the educational preparation of employed nurses was considered on a statewide basis, (1972) none of the states had the number of baccalaureate, masters or doctorally prepared nurses that they should have (again, according to the Surgeons General Group criteria.) In fact, nine states needed ten times the number of nurses at that educational level than were in supply.

RECENT EVIDENCE

The need for advanced leadership preparation for nurses has been addressed by many experts as well as being documented in the literature.

A feasibility study conducted by Western Interstate Commission on Higher Education in 1976 to determine the need for the development of regional centers to give

advanced leadership preparation to nurses provides further evidence of this situation. The study surveyed schools and conducted on-site visits.

All of the schools surveyed indicated that they had unfilled faculty or administrative positions. The reason most frequently cited for this was a lack of appropriate educational credentials. Deficits included a lack of doctorates, clinical expertise and research skills.

Currently, there are many deanships in nursing programs and directors of nursing service positions that are vacant. Shortages exist in both functional areas: teaching and administration.

Faculty shortages have long been a problem in the nursing profession.

The National League for Nursing's 1976 Nurse-Faculty Census reports 776 budgeted vacancies. Regional variations were also evident in the League study. The vacancy rate is twice as high in the Midwest (295) as in either the North Atlantic (150) or West (62).

In the area of Administration, fewer than 15% of nurse administrators hold a masters degree or a doctorate. Members of search committees reported facing months of frustration as they struggled to fill Administrative as well as faculty spots. The shortage of nurses with appropriate Administrative education is particularly apparent in small rural hospitals and nursing homes.

According to Some Statistics on Baccalaureate and Higher Degree Programs, recently published by NLN, this trend seems destined to continue unless incentives are provided. While the number of students enrolled in graduate study is increasing, the percentage of graduate students enrolled in Nursing Administration is consistently decreasing. In 1968 there were 303 full-time masters students enrolled in Administration programs; and in 1976, there were 258 students enrolled. The percentage dropped to 3.8% in that year.

The number of graduate students enrolled in teaching programs has also declined. In 1968 there were 1,290 full-time students enrolled in teaching programs and in 1976 there were 1,323 enrolled.

The feasibility study also showed that some states had no masters or doctoral programs at all. This is quite indicative considering that NLN's Data Service on Newly-Licensed Nurses shows that they are most likely to be employed in the states where they attended school. One could easily hypothesize, then, that those states without masters programs might have the greatest shortages of specialized nurse supply.

To be sure, some progress has been made with Federal assistance through advanced nurse training funds. The overall number of doctoral programs as well as that of students has increased for the third academic year in a row. In addition, the proportion of full-time doctoral students increased for the first time since 1971-1972. Yet, despite additional programs, higher enrollments and greater proportions studying full time, doctoral graduations declined from 74 to 62.

A thorough assessment of the overall picture merits a note of caution: Planning cannot be done adequately and effectively on the basis of sheer numbers. The administration's appraisal that the nurse supply is adequate seems short sighted in light of these data projections. Leadership is imperative if nurses are to make a difference in the health of the people of this nation. It is imperative as practitioners, as educators and as decision-makers with the opportunity to participate in political processes, that we have more qualified nurses leaders.

NURSE PRACTITIONER

The nurse practitioner has been instrumental in addressing some of the deficiencies of health care in the United States. The utilization and acceptance of this new form of health manpower, in addition to enhancing the contribution of nursing in the planning and provision of health care, is expected to result in the improved quality of health care services.

Since nurse practitioners are such a new phenomena to the health care system, more time is needed to assess their total impact.

However, A Longitudinal Study of Nurse Practitioners, conducted and funded by HEW, has shown some pertinent findings.

The study identified 131 certificate-awarding programs and another 84 programs granting masters degrees. The major areas of specialization included Family Nurse Practitioners, Pediatric Nurse Practitioners and Adult Nurse Practitioners. Other major areas were women's health, community and mental health specialties.

The study demonstrated that many nurse practitioners practice in rural areas and that most are family practitioners, with more than 90% being certificate nurse practitioner graduates. These new professionals could very conceivably provide solutions to our problems with maldistribution and primary care. Thus far there is no national data of value to describe the impact of these practitioners on maldistribution of health care services. However, selected studies have demonstrated their cost effectiveness. For example, a study cited in the February '78 New England Journal of Medicine reported that average costs - including nurse practitioner time, charges for laboratory tests and medications, were 20 percent less.

These programs still require Federal support; many difficulties still need to be resolved before these programs can function without Federal dollars.

Many times the nurse practitioner encounters a situation that was not included in the Nurse Practitioner Curriculum, or she/he may be expected to practice seven days a week, with little relief. These situations must be rectified by providing more Federal incentives to practice in shortage areas. The additional monies proposed for Special Projects will be very helpful in this regard.

Up until now the market for these practitioners has been rather slow in terms of acceptance and demand for them. Now that nurse practitioners are eligible for reimbursement for service under the Social Security amendments, the volume and types of services provided will undoubtedly be greatly expanded.

If the nurse practitioner's function is to become more than a peripheral additive of fringe for the present system, and rather is to become part of an overall strategy for improving the quality and quantity of primary care services available, an extension

of Federal monies is essential. Three fourths of nurse practitioner programs in the Longitudinal Study offer some financial assistance through stipends or traineeships (77%); and, in many cases, availability of these monies is dependent upon federal dollars.

RESEARCH

All practitioners have ways of evaluating unknowns and various aspects of change.

Research in nursing approaches these areas in a manner which is very different from the medical disease model. Nursing research is concerned with a "holistic" model of man; that is, a model that does not treat mind and body as two separate entities. Nursing research is concerned with health promoting patterns in relation to the total behavior of the individual.

In this age of increasing complexity, many nurse researchers believe that a cause and effect, disease-oriented model is no longer adequate. Many disease processes such as cancer, for example, are beginning to be studied with regard to stressful events in the life of the individual.

Despite its short history, nursing research has already made valuable contributions to health care. However, Federal funding priorities have been oriented toward the cure of disease, rather than prevention, improvement in quality patient care, or basic research with other models.

In nursing, our concern is experimental; and there is no separateness of mind and body, psychosocial and biophysical. The nurse regards signs and symptoms of disease as manifestation of man's wholeness, for the patient is experiencing one event.

Nurse researchers have made major breakthroughs in basic as well as applied research. The nursing profession has a significant contribution to be made; however, there are very few nurses adequately prepared to do research. Out of approximately 1,500 nurses in the United States who have earned doctorates, only 30% are engaged in research.

A ratio of graduate and undergraduate students per biomedical and behavioral Ph.D. scientists employed in academic settings ranged from approximately 20:1 to 40:1 between 1960 and 1972. On the other hand, a 1974 ratio of full-time graduate students for each full-time nurse faculty member holding a doctorate was 158:1.

In view of the current national concerns in health care, it is necessary that federal support of health related research include nursing studies. The problem of quality assurance, health maintenance and prevention of disease need to be addressed through the support of research in nursing. The lack of clinical research, the area which investigates patient phenomena encountered by nurses and for which nurses are expected to initiate appropriate intervention, is a very real deterrent to positive change and progress. To achieve progress, nursing must be given the opportunity to explore a changing concept of health through basic, as well as applied, research. More of the same is clearly not the answer. We need the financial assistance to explore new solutions to old problems.

THE FUTURE

We are indeed witnessing the limits of modern medicine. While tremendous strides have been made, there have been very serious negative repercussions. The toll that medical technology and specialization have taken on costs is profound. The drastic rise in costs have also occurred as a result of the highly trained specialists required to use this equipment for diagnostic and curative purposes.

Medical care decisions have increasingly been made without the slightest regard for costs vs benefits. Key examples can be seen in the areas of kidney dialysis and increased use of intensive care units.

The consumer movement, the self-care movement, and the increasing involvement of the Federal government in health care all herald new trends.

In the midst of these changes, the concept of the expanded role of the nurse has been introduced in response to the growing needs of the health care system. With changes in the priorities of their duties and a willingness to accept new responsibilities, nurse manpower has presented some very viable alternatives to many problems that the health care delivery system faces. Nurses provide care at the lowest level of technology, meet the emotional requirements of patients for counseling and support in an age of ennui and depersonalization, provide health education (as they have always done), in whatever role she/he functions.

The enactment of many new legislative proposals is on the horizon for health care. Health planning legislation, the HMO amendments, national health insurance and the coming of age of home health care will evoke new needs and requirements for nurse manpower. Nurses must be prepared for these plans now. Needs for nurse manpower supply must be viewed in the context of the projected political and financial settings. As different trends take shape, objectives and assumptions must change to meet different needs.

Whatever future trends may be projected, registered nurses presently form by far the largest group of health professionals. Their increasingly differentiated roles has led to greater responsibilities and independence in practice. These new roles warrant more leadership preparation, an element which is currently a scarce commodity in the nursing profession, as we trust was communicated by the data in this testimony.

Mr. Chairman, thank you for the opportunity to testify and we hope that you will continue, as you have done in the past, to assist nursing to maximize its contribution to health care.

Sources of information: all statistics in this testimony were documented by the HEW Division of Nursing, the NLN Division of Research and the Western Interstate Commission on Higher Education.

ATTACHMENT I

To fulfill the need for requirement projections prior to the enactment of Public Law 95-63, the Division of Nursing launched four studies concerned with the projection of nursing resources and requirements. Since requirements can be approached from several points of view (i.e., demands, needs, or wants) it was important to examine a variety of approaches.

The different models and a brief summary of the methods and purposes utilized in each of the studies follows:

1. A Model of National Supply and Requirements for Nursing Personnel.

(Pugh-Roberts Associates, Inc.)

This effort is directed from a national perspective toward the analysis of factors affecting nursing requirements and resources from the present through the year 1990. The technique used for the development of this model, known as System Dynamics, describes a set of causal relationships responsible for changes in pertinent variables. As part of this approach, a series of issues or particular relevance to the questions surrounding supply and requirements is being developed. These will be used in the overall analysis of impacts on supply and requirements, particularly from a long-range viewpoint.

2. An Analysis of the Impact of Nurse Manpower Requirements of Changes in the National Health Care System. (Vector Research, Inc.)

This work was directed toward the assessment of the impact of three anticipated changes in the health care system on the requirements for nurses: (1) the introduction of National Health Insurance; (2) the increased enrollment in Health Maintenance Organizations;

and (3) the reformulation of nursing roles. The model predicts requirements for nurses under various alternative assumptions surrounding these subjects with one developed as "most probably." Projections are based on a 10-year time frame. The first analysis level is on a national basis with subsequent application of the approach to the State level.

3. Analysis and Planning for Improved Distribution of Nursing Personnel and Services: State Model. (Western Interstate Commission for Higher Education)

This effort is being directed toward the systematic use of data available on a national basis, but capable of being disaggregated to State and county levels, to determine nursing resources and requirements. The approach being designed is one that would allow for practical application at the State level. Projections will be made for a 5-year period since that time frame is best suited to a trend approach. Since this activity is most specifically directed to the State level, it will form the basis of the first-level analysis on the numbers of nurses available and the numbers required in each State. The impact of these individual State data nationally will be examined through the application of uniform criteria in each State. Since the areas that are being addressed in this activity are particularly relevant to overall health planning as well as to nurse requirements, this will be incorporated into the overall analysis to provide additional insight into the effects of the delivery system on nurse requirements.

4. Micro-Model for Nursing Manpower Needs. (CSF, Ltd.)

The model is intended to incorporate demand and supply factors into a framework for determining nursing manpower requirements on a sub-State level. It will have a capability for annual requirement projections over a 10-year period. The model incorporates three submodels: health services utilization, nursing manpower demand, and nursing manpower supply. It will take into account registered nurses, licensed practical nurses, and nursing aides/attendants/orderlies. The supply model will be on a county level and requirements will be developed on an institutional and county level.

These modeling efforts will not only serve the important purpose of furthering the analytical capability for this series of reports, but will have wider application. In the development of approaches and in the consideration of outcomes, particular attention has been paid to the need for effective tools at other levels. Thus, it is anticipated that, in addition to the actual generation of requirements estimates from a Federal viewpoint, the processes will be developed in a way that could provide material appropriate for consideration by States and the newly developing Health Systems Agencies in their planning.

Mr. PREYER. Thank you very much.

We should note also the presence with the panel of Constance Holleran, with whom the committee has long had a fine working relationship.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

Dean Lewis, is there a tendency for nursing students to seek less expensive training and not work for a baccalaureate degree?

Ms. LEWIS. To my knowledge, many of the students who are juniors and seniors at Boston College are intending to go to school for a master's or a doctoral degree later on, but this is on the premise that they can have at least 5 to 3 years of clinical experience to earn that money to allow them to attend a master's program.

Mr. CARTER. Would a lack of Federal support make a baccalaureate degree more expensive?

Ms. VALERIE LEWIS. Most definitely.

Mr. CARTER. Could you describe the minority recruitment efforts that have occurred under the Nurse Training Act?

Dr. BLAKENEY. The schools have largely taken that as an individual responsibility, Mr. Carter. There is no program sponsored by the American Nursing Association which relates to that. We believe that not only recruitment is important, but retention is equally important, and that seems to be our greater problem.

Our students in the minority group tend to come from the disadvantaged educationally handicapped backgrounds. They need support. They need remediation and capitation money has made a very significant impact on that. I would say, then, that the Nurse Training Act has contributed to our ability to both attract minority students and other students whose educational background is limited.

Dr. NOVELLO. May I respond to that, then I think Val would like to respond.

Tied in with capitation funds, one had the alternative to increase enrollment or select for another project, which one might do, one of those projects was to put into place a specific program designed to preclude and assist minority students in the program. Many of us who opted for the projects have put those programs in place, and I think you will find that they have been successful and much effort has been expended. Such a program in a small liberal arts college where I came from would have been impossible without Federal funds to support that kind of program, but the colleges do not have the money to do it.

Val?

Ms. VALERIE LEWIS. Back in 1974, the HEW nursing division allowed moneys to help in the recruitment of ethnic students. When this money was available, and it was easier and a lot more beneficial to the National Student Nursing Association to helping those students who would like to have gone to nursing schools, but otherwise would not have been able to do without assistance, such as tutorial problems and finding out which type of nursing program in relation to a diploma, associate or baccalaureate divisions would be better suitable for them.

This amount of money allotted through the grants stopped in June 1977. Since then, this past year when I served as the national breakthrough chairperson has shown me that this has brought also a breakdown in the recruitment we can do due to the financial burden being so strong and being able to reach all parts of the country on a small allotment.

Also, again, in recruiting students, one of the premises we go on in recruiting ethnic students when it comes to financial areas is that the Nurse Training Act had, in the past, allowed for a certain amount of student loans and scholarships and grants.

I, myself, went to school due to the Nurse Training Act student loan, and if it were taken away, many minority students would not be able to attend schools of nursing.

Mr. CARTER. Thank you for that answer.

It is quite apparent that these things are needed. As you know our bill transfers the \$5 million which has been authorized, but not funded, for financial distress, to the special project grant authorization.

What projects do you feel should be given priority under that authority?

Dr. ELOISE LEWIS. One of the project areas that would be helpful to continue to do is the projects to enable us to offer a different kind of program in continuing education for the practicing nurse. This is a category that has been used and it certainly makes a difference.

The types of innovative programs that would enable us to do things with the students, like Valerie was mentioning, would have a top priority listing for these special projects. We have seen a move to innovative programs that would enable us to have a variety of kinds of students and to offer opportunities for a different level of programs that we did not have until we had the Nurse Training Act.

Mr. CARTER. What has been the impact of the enactment of the rural health clinics legislation on the Nurse Practice Acts in various States throughout the country?

Dr. NOVELLO. I feel very confident to speak of the Commonwealth of Pennsylvania. I am not sure how confident I am to speak to all the States.

In our particular state, we are fortunate to have several things in place. We do have a practice act, 151, that does have within its definition professional nursing. That definition we allude to as an expanded role. It does provide the nurse with the responsibility for contributing to the health care of the Commonwealth's citizens.

In addition to that, we have the authority in both the Nurse Act and the Medical Act to jointly promulgate—with the Medical Board—rules and regulations for certified registered nurse practitioners. Those rules and regulations were put in place last summer. They had been legally promulgated and they had been screened and had been certified.

It is our understanding at this point in time, none of which is in writing, that the Department of Health will be the agency in Pennsylvania that will satisfy the rural and inner city clinics as

to their eligibility for reimbursement and Blue Cross-Blue Shield is our fiscal intermediary and all of our nurses that we have certified by State law as registered nurse practitioners will be eligible as far as the reimbursement mechanisms are concerned.

Mr. CARTER. Thank you.

What considerations are important to a nurse practitioner in deciding whether to practice in an underserved area?

Dr. ELOISE LEWIS. The type of peer support that Dorothy alluded to is possible in some of our work between the medical boards and nursing boards to help. Peer support, salaries that attract do have a significance, of course, and then plans to make it possible for continuing education opportunities for the practitioner is important so he or she can keep up her skills.

One of the things that we have found to be very helpful in stimulating this group of practitioners is the mechanism for feedback and constant contact that we have with our medical centers so if there is a need for instant back-up this is available for the person.

For that kind of a support, it enables the person unfamiliar with the rural setting that might have concern about working there, where will I get the immediate back-up that I need. Our networks work very well and our success rate in keeping people in the rural areas is good.

Mr. CARTER. What are you referring to?

Dr. ELOISE LEWIS. When I said "we," I meant, in North Carolina, our system, has been developed as communications through our rural health clinics and through our educational institutions, medical school centers, but we have had a very positive impact.

Mr. CARTER. I certainly support that system. I think we should have going out from each State, from every school of nursing and medical school.

Dr. BLAKENEY. If I may say something in relation to the outreach program, at the University of Maryland we have two such programs and they have two points of emphasis. Essentially it is an educational program. The faculty is the same, that is, qualified to the same degree as faculty on campus. Then members from the faculty go out where, being a woman's profession, largely, many women have difficulty leaving home to go to school, and so the university has made the effort to take to the Cumberland area of our State the baccalaureate degree program, essentially the same as the one we operate on campus in Baltimore.

We also have one at the Eastern Shore. That tends to raise the level of both nursing care and the level of education, the requirements that they set in those areas for their practitioners we think is enhanced by such efforts, and the Nurse Training Act has contributed a great deal to our ability to do that.

In addition, our students in the undergraduate program may have what we call the mini-semester, the month of January, go to those outlining areas.

I believe that we are quite successful in making that attractive to students, but the intermittent and uncertain level of funding often causes us to take these initiatives and then have to withdraw, losing

the faculty that would be interested in implementing that. I think we have to be a bit wasteful when we cannot persist in following that kind of initiative.

Mr. CARTER. Do you expect the tri-partite system of education to continue?

Dr. BLAKENEX. I am very pleased to report that at a recent national invitational conference, it was a meeting to consider the concerns of nursing education relative to entry into practice and while this particular conference did not have the ability to say that this is the way that nursing would go, every group reporting did report acceptance of the two-level system of both education for nursing and for practice.

That means that we are looking towards the preparation of the baccalaureate nurse to be the professional nurse to give the leadership in education and patient care. That is the beginning of her preparation, and that we would have another group of nurses prepared at the associate level who would function at the bedside and under supervision of a professional nurse working, therefore, in a supportive role.

We believe that, perhaps, given the level of our medical technology at this point in time, given the nature of nursing as we see it, that less than those levels of preparation would be unsafe to our clients.

We are proud of the contribution that has been made by diploma education. We believe that the time for appropriate education in nursing is now; that we should find education placed in educational institutions.

Mr. CARTER. Thank you very much for that answer.

Ms. VALERIE LEWIS. Although the National Student Nursing Association would not be the ones who would legislate the baccalaureate move into nursing, we have passed a resolution to have all nurses come into the profession at the baccalaureate level, to have cohesiveness in our ranks as in other professions.

Mr. CARTER. Nurses are capable, comfortable, take good care of their patients. Actually, you really learn from doing.

Dr. NOVELLO. You see before you a group of diploma nurse graduates. We concur that we are among the greatest.

Mr. CARTER. I think you are. I cannot forget that person who came up the practical way.

Thank you, Mr. Chairman.

Mr. PREYER. Thank you, Dr. Carter.

Mr. Walgren?

Mr. WALGREN. Do any of you on the panel have any reaction to where the money is going, in as much as it is being taken away from the nursing side for something else is being said that is more important, can you give us some brief reaction to that?

Dr. NOVELLO. I think, Mr. Walgren, I do not remember whether it was you or Dr. Carter, certainly Mr. Preyer called attention to the fact that apparently the money is going into beefing up some specific types of delivery systems, if what I heard over here was correct, and the question ultimately would be, if you are going to beef up those delivery systems, where is the manpower for the delivery system. Because to do one without the other is absolutely faulty thinking.

We, of course, have feelings about that because we believe that a good delivery system is built on manpower and to build a system and correlating it without increasing your manpower is a faulty way of approaching the problem.

Dr. ELOISE LEWIS. As an expansion of that, the preparation of those needed for leadership positions who indeed would be able to move forward with providing the care that was mentioned, therein lies one of our greatest needs in the advanced training phase.

Mr. WALGREN. Do we know—for example, there is a substantial increase in community mental health centers, \$54 million or thereabouts. What kinds of things would that be going for, if not manpower? Would that be in the establishment—perhaps you are the wrong people to be asking the question.

Dr. NOVELLO. I really would not know what HEW intends to use that money for.

Mr. HOLLERAN. We do strongly support the increases in the health services programs and are pleased to see those increases in the program to move it ahead in order to have the health centers nationwide. It has not moved as quickly as we had hoped.

The services for the mentally ill or people with less serious emotional problems close to home is a great improvement. I think the problem HEW faces is the very low ceiling that has been placed on them by OMB and when they have to make some cuts, frequently nursing is the one that they do cut.

Mr. WALGREN. Did HEW place a lower ceiling then they did last year?

Ms. HOLLERAN. There has been some growth in the overall health area.

Mr. WALGREN. Is there any area at all that you, without being put in the position that some program is not worthwhile, from the nurse training standpoint, what would you rather see less of in order to allow more in the nurse training area?

Ms. HOLLERAN. That is a very difficult question to answer. It is the growth of the uncontrollables in the HEW budget that has made it so difficult for the operational programs to be continued at the level that people would like to see them. The continuing control of costs, I think, and the efforts to promote utilization review to keep down some of the costs of medicare and medicaid are the areas that we would be supportive of.

Mr. WALGREN. I see in this budget figure that what seems to be a totally new figure of \$377 million for research and training in maternal and child health. Is that a brand new expenditure? It is up from \$29 million on this sheet that I happen to have to \$377 million.

Ms. HOLLERAN. I think that relates to the State grants for maternal and child health. That the \$377 million includes all of the grants to States for that purpose.

Out of that money, a percentage is normally earmarked for research and training in maternal and child health. The two figures are not comparable.

The amount of money this year that has gone to training and research and material and child health is probably the \$29 million. The percentage for the next year out of that \$377 million would be closer to \$37 million. It is a percentage of the total.

Mr. WALGREN. Thank you. Thank you very much.

Mr. PREYER. We certainly do appreciate all of you being here today. It is good to hear that the loan default rate is relatively low and that our success rate is relatively good on keeping the nurse practitioners in the underserved areas. I think we are all sensitive to the point that many of you raised that once we start funding Federal programs we turn around and start cutting them off. It is like pulling up the potato plant to see whether it is growing properly.

We do appreciate your testimony and thank you for being with us today.

We have two more witnesses. I expect we are going to have a quorum call any moment, although we may not. I hope that our next two groups of witnesses will be able to return at 2 p.m.

At this time, we will recess until 2 p.m. this afternoon.

[Thereupon, at 12:10 p.m., subcommittee recessed, to reconvene at 2 p.m. this same day.]

AFTER RECESS

[The subcommittee reconvened at 2 p.m., Hon. Doug Walgren, presiding.]

Mr. WALGREN. The hearing will resume.

I want to apologize for the others that may come in the middle of the afternoon, but they have some other commitments right now that prevent them from being here.

To complete the hearings, there are, I gather, two further witnesses and we want to thank you both for holding over from the morning to the start of the afternoon.

The first is Michael Booth, a member of the faculty of Nazareth Hospital, School of Nurse Anesthesia, Philadelphia, Pa., accompanied by Nancy Fevold and Kenneth Williamson.

We want to welcome you to the committee and you may proceed as you see fit.

STATEMENT OF MICHAEL BOOTH, C.R.N.A., CHAIRMAN, EDUCATION COMMITTEE, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, ACCOMPANIED BY NANCY FEVOLD, DEPUTY EXECUTIVE DIRECTOR; AND KENNETH WILLIAMSON, CONSULTANT

Mr. BOOTH. Mr. Chairman, members of the committee, my name is Michael Booth, CRNA, I am a faculty member, School of Nurse Anesthesia, Nazareth Hospital, Philadelphia, Pa., and chairman, AANA Education committee. With me today are Nancy Fevold, CRNA, AANA deputy executive director and Kenneth Williamson, our Washington consultant. We are here representing the American Association of Nurse Anesthetists to testify on H.R. 11434, the Nurse Training Amendments of 1978.

We support the purpose of the legislation, which we understand is to provide for continued education and training of nurses. We believe that, over the years, this legislation has served the public well, and a continuation is not only logical but necessary.

We also believe that the broad intent of the Congress can be greatly enhanced by amending the legislation to include provisions

to make available Federal assistance for professional nurse anesthetists. Our testimony today will be directed to such an amendment.

I would like to mention we are very pleased that the American Nurse Association is supportive of our appearance here today, and their recognition of the lack of assistance under present Federal laws for students in nurse anesthesia programs. We appreciate greatly their support.

The American Association of Nurse Anesthetists, ANAA, is a professional organization whose membership is comprised of Certified Registered Nurse Anesthetists (CRNA's) who are engaged in anesthesia practice. The Association's two major goals are: (1) To assure the continued existence of high quality schools of nurse anesthesia, and (2) to enhance and further develop the professional skills of individual nurse anesthetists.

Certified Registered Nurse Anesthetists are acknowledged by the Federation of Specialty Nursing Organizations and the American Nurses' Association, the American Society of Anesthesiologists, the American Hospital Association, the American College of Surgeons, and by the Joint Commission on the Accreditation of Hospitals, which has established specific standards related to the field of anesthesia. The AANA Council on Accreditation is recognized by the U.S. Office of Education as the accrediting agency for educational programs in nurse anesthesia.

The performance of CRNA's and the quality of the services they render is attested to by their widespread use in university medical centers, community hospitals, Veterans Administration Hospitals and the U.S. Military.

Nurse anesthetists are a major group in delivering anesthesia services. There are currently 13,522 actively practicing Certified Registered Nurse Anesthetists and there are approximately 11,800 anesthesiologists positions. The largest percentage of anesthetics given to patients in the United States is provided by nurse anesthetists. Dr. Paul Feldstein, a nationally recognized health economist at the University of Michigan in his recent study of the subject, indicated that there were approximately 16,500,000 surgical procedures performed in the year 1974. The largest percentage of anesthetics administered, 48.5 percent, was rendered by Certified Registered Nurse Anesthetists; 38.3 percent by anesthesiologists, including both board-certified and nonboard certified; 9.7 percent by physicians other than anesthesiologists; and 3.5 percent by registered nurses who are not CRNA's.

We believe you will be interested in the table below showing the percentage of anesthetics administered by the size of hospital and category of personnel.

HOSPITAL BEDS

[In percent]

Personnel category	0 to 49	50 to 99	100 to 249	Over 200
CRNA's.....	67.0	65.0	50.4	42.5
Anesthesiologists.....	11.0	16.6	35.0	47.5
Medical doctors.....	16.0	14.0	11.0	7.3
Registered nurses.....	5.0	4.0	3.0	2.0
Others.....	9.57	.5	.6	.7

Mr. WALGREN. At this point in the record we will include that table so people reading it will be able to refer to it in context.

Mr. BOOTH. Thank you.

As you can see, the professionals providing anesthesia services are related to the location and size of the hospital, and, as Dr. Feldstein points out in his study:

Anesthesiologists are more often located in urban areas, in larger hospitals, and in university settings. CRNAs function in all types of settings with or without the supervision of anesthesiologists. They provide proportionately more of the anesthesia in small hospitals and in rural areas.

We know, however, that the percentage of anesthetics performed by nurse anesthetists in hospitals over 250 beds is substantially higher than the above figures indicate. The basis for this statement comes from nurse anesthetists who practice in the larger hospitals and tell us that, while the anesthesiologist may sign the patient's chart, in many instances, it is the nurse anesthetist who administers and manages the anesthetic throughout the operation.

As we have previously stated, CRNA's provide anesthesia services in university medical centers, community hospitals, Veterans Administration Hospitals and the U.S. Military Services. Many statements attesting to the high quality performance of nurse anesthetists have been made by members of the surgical staffs of the uniformed services where CRNA's are used extensively.

In 40 percent of the hospitals in the United States there are no anesthesiologists available. Thus, in these and other situations, the nurse anesthetist provides the anesthesia services needed and works as a member of the operating team in performing a highly essential service to hospital patients.

We would like to address the financial needs of students in nurse anesthesia. One hundred seventy-two accredited educational programs for nurse anesthetists were surveyed in September, 1977 to determine the financial needs of the students in those programs. We have attached this listing of recognized programs to our testimony [see p. 92]. Eighty-five schools responded, a 50 percent response. Of those 85 programs, 17 stated that all of the students needed financial assistance, 24 schools reported that most of the students needed aid, 22 schools had some students who required aid, and 16 schools did not have any students who required financial assistance.

Six schools did not address the issue in their survey response. Of the 16 schools in which none of the student nurse anesthetists needed financial assistance, seven are military or public health institutions, which pay students full salaries and, in some cases, provide amenities such as room, board and text books.

It seems clear from this brief background that there is a definite need for students to be made eligible for loans and scholarships under provisions of Title -III of the Public Health Services Act. Nurse anesthesia students throughout the country are experiencing difficulties in meeting their financial responsibilities while in anesthesia school. Many of these students are ineligible for State and Federal assistance due to restrictive residency rules or previously earned salaries. Many have received loans from banks and other financial institutions to help them through school. Many others are indebted

to their families for support. Almost without exception, students in nurse anesthesia pursue their education in the face of great financial hardship.

Fifty-six of the schools which responded to the survey stated that they pay their nurse anesthesia students stipends. Five schools reported that they do not pay stipends and the 24 remaining schools did not mention stipends. Several schools noted that even small stipends are becoming difficult for the schools to maintain.

Low stipends have resulted in financial problems for students in nurse anesthesia programs. For example, in one Florida school, the seven students receive a \$125 monthly stipend and incur approximately \$400 in expenses. As a result, five of the students have borrowed heavily to finance their nurse anesthesia education and all would welcome financial aid.

At another school in Florida, "Most of the students are in dire economic circumstances." Elsewhere in the country, a school in Maine, for example, stated that: "They [the students] do receive a meager stipend, but with expenses climbing every day, we are finding it less and less feasible to maintain stipends."

A school director in Maryland remarked, "The stipend does not cover the costs at present and will be cut by one-half during the first year of the program beginning in September, 1978."

Even the stipends which the students do receive are inadequate to cover the students' basic expenses. The average monthly stipend paid to nurse anesthesia students is \$259. The average monthly expense incurred by these students is \$409. This leaves an average monthly deficit of \$150 or an average yearly deficit of \$1,800 per student.

Nurse anesthesia students have few opportunities to make up the difference between stipends received and actual expenses. These students are deterred from holding part-time jobs due to the structure of the nurse anesthesia program. Unlike a traditional college program with 9 months of classes and 3 months of vacation, a nurse anesthesia program extends for 24 consecutive months. Student nurse anesthetists also find it difficult to hold part-time jobs on evenings or weekends during the school year due to rotating clinical schedules.

Several schools, such as one in West Virginia, "... do not encourage the student to work during their 2 years in anesthesia school." Some schools have specific policies against students working while in school, such as in Tennessee, where students are affected by, "Loss of income during the time that they are in school since they cannot hold a job and attend school. Their normal living expenses go on just the same." on Ohio:

Nurse anesthetist students here * * * are not allowed to be employed during their education period and only receive a stipend of \$300 monthly. Therefore, our students are suffering financially during the 24-month program.

Even in schools where students are allowed to work, such as in Pennsylvania, "The major problem is finding parttime positions for the students as the school policies limit their working to a maximum of two shifts/week." A school director in North Carolina reports that most of the students, "* * *" have to work during school and this

deprives them of studytime." Further, "If we did not furnish meals to the second year students they would be hard put to stay in school working the two shifts that we allow them to work."

Nurse anesthesia students in Virginia are suffering financially as well. At one school, the "Majority of students must supplement their incomes by part-time positions in other nursing areas. By working evenings and weekends they are unable to devote otherwise sufficient time to study. Consequently, grades may falter or they may suffer physically with working so many hours per week, that is, little rest, improper meals, et cetera."

At another school in Virginia:

Five of our students receive G.I. benefits and seven are dependent upon their parents and savings. Many of our students have taken loans to pursue their education and work part-time to support themselves. The demands of our program limit off-duty employment and only in their second year can they be employed to supplement their stipend which totals \$3600 over a two-year period (\$150 a month).

As a result of this policy:

The degree of suffering is directly proportionate to his/her [the student's] income. Within our student body there are instances of nutritional, physical, cultural, and mental deprivation.

A similar situation exists in New Jersey, where:

The low stipend, \$200 per month, and rental allowance, \$100 per month (has not been increased in the past 8 years) plus meal tickets, supplied by the hospital, present a difficult situation for students during their 2-year curriculum.

Further:

All students would welcome financial assistance. Rental allowance seems to be the main problem, plus the low stipend. \$300 per month does not go far in the present day economy.

It is safe to say that the majority of students currently enrolled in nurse anesthesia programs are receiving supplemental financial aid. These students rely on hospital loans, bank loans, credit union aid, and family assistance, as well as governmental loans, when the students are eligible. In Ohio:

* * * 50 percent of the students suffer financially. The remaining 50 percent live on a close budget. It necessitates obtaining loans from finance companies, anesthesia corporations, credit unions, banks, Veterans Administration Education Aid, and parents. A few live in substandard housing areas * * * Several students were forced to drop their medical insurance because of lack of funds.

The situation is similar in Wisconsin, where:

Students have a difficult time financially. Many borrow heavily. All students seek financial aid and only those who have spouses with full-time jobs and low expenses have a minimum of financial difficulties. About five out of six students have serious financial needs.

Similarly, in New York, "The few—students—who have no family help lead a life of deprivation in the second year and cut in the only two areas possible—housing and food." The treat number of comments in this vein indicate that the aid which is presently available is inadequate, at best.

In fact, the only two nurse anesthesia students who seem to be financially comfortable are those who are receiving veterans benefits and those who are attending programs conducted by the military services:

Students enrolled in the military program receive pay and allowances commensurate with rank and years of service. No tuition is required, all texts and supplies are provided. Duplicating and secretarial services are available and qualifying examination fees are reimbursed (Department of the Army).

In addition, "Financial assistance, medical, and dental care and other benefits normally afforded the military person is provided to each active duty officer student." The Air Force, Navy and Public Health Hospital nurse anesthesia programs report similar perquisites. Students who receive veterans benefits also have few financial difficulties. In South Carolina, "Out of 26 students, 11 students said they did not need financial help. Their reasons were: (1) husband or wife with good jobs; (2) GI bill assistance." In New York, "Those on the GI bill are luckier than those who are not." A school in Vermont recognizes that, "Our veteran students, of course, have the benefits of military aid."

Even students who have been granted Federal loans prior to entering a nurse anesthesia program meet discrimination once they start the program. As a school in Minnesota reports:

*** Anesthesia School is not considered by the Federal Government to be a continued nursing education, and loans negotiated during their nursing education are not forgiven. Example: A student who has a loan while attending nursing school and continues his/her education to receive a BSN will have the initial loan "forgiven." A student who had a loan while attending nursing school and goes into a nurse anesthesia school will have the repayment of the loan delayed, but not forgiven.

It is widely reported that hospitals conducting educational programs may well have to seriously curtail or eliminate the payment of stipends to students as hospitals are faced with the possibility of cost containment. It is our belief, therefore, that the economic situation facing students in nurse anesthesia will become markedly worse in the months ahead.

Our primary reason for requesting that nurse-anesthetist students be accorded Federal assistance is to insure that the best candidates are permitted to achieve the highest level of education, regardless of their financial ability. This is in keeping with the historic role of the Federal Government in education. We are also aware that increased use of nurse anesthetists will have the overall net effect of reducing the cost of anesthesia, which is estimated to be in excess of \$2 billion annually.

It is for all of these reasons that we urge this committee to amend title VIII of the Public Health Service Act so that nurse-anesthesia students will be eligible for financial assistance under the act.

THE AMOUNT NEEDED FOR ASSISTANCE

We are not proposing Federal assistance for capital funding for construction of educational facilities, nor are we requesting capital funds for schools of nurse anesthesia. We are requesting Fed-

eral funds in such form as to assist students directly. We would hope that funds would be available for a 2-year period.

We anticipate a growth in the number of students enrolled in nurse-anesthesia programs because there is an increasing demand for their services as evidenced by the fact that all nurse anesthetists are employed immediately upon graduation. Further, students are increasingly receiving employment commitments as much as 1 year prior to graduation. One example of such need for nurse anesthetists is the fact that about 20 percent of the 3,040,000 deliveries in 1975 were not attended by anesthesia personnel. In other words, 60,800 babies were born without anesthesia personnel available.

We have determined that the average nurse anesthesia student requires \$5,000 a year for tuition and other costs. There are 3,000 students currently enrolled in nurse anesthesia programs. If funds were provided for one-third, or 1,000 of these students, \$5 million would be needed that year.

Further, if funds were provided for 2,000 students, \$10 million would be needed; if funds were provided for 3,000 students, \$15 million would be required.

We recommend that a new section be added to the act to provide assistance to students in nurse-anesthesia training. We believe that the form of such assistance should be similar to the traineeships now provided in subpart I of Part B, "Assistance to Nursing Students."

It is our belief that this approach would make grants available to those recognized educational programs in nurse anesthesia approved by the AANA Council on Accreditation. This would provide the most effective and efficient means for distributing the funds. The varying tuition and other costs for the training, as well as the needs of individual students, are best understood by the school at the local level.

We appreciate this opportunity to testify and we ask that our full statement be included in the hearing record. We will be pleased to answer any questions you may have.

[Testimony resumes on p. 105.]

[The attachment to Mr. Booth's prepared statement follows:]

American Association of Nurse Anesthetists Council on Accreditation List of Recognized Educational Programs For Nurse Anesthetists December, 1977

This list of recognized nurse anesthesia schools throughout the United States includes such information as the length of the course offered, the starting dates of the programs, whether or not cash stipends are given, and whether or not room and board are provided. The list is further broken down into schools that offer BS degree programs, MS degree programs, and those that accept applicants only from the U.S. Air Force, Army, Navy, or Public Health Service.

In addition, new schools—both those that have been granted provisional approval and those that have been granted Initial Accreditation—are listed. The date of last review and the date of next review by the Council are stated.

ALABAMA

Birmingham-Baptist Medical Center, 35211; L24; SD Oct.; CS; DLR 8/77; DAR 8/81; Joseph H. Harrell, CRNA; ASR 4 yrs.

Birmingham-School of Community and Allied Health Resources, Nurse Anesthesia Program, University of Alabama, 35294; L24; SD Sept.; CS; DLR 3/75; DAR 3/77; Zolika Heath, CRNA

Dothan-Manley L. Cummins School of Anesthesia, Southeast Alabama General Hospital, 36301; L24; SD Sept.; CS; DAR 3/77; B. Joyce Williams, CRNA

Mobile-University of South Alabama Medical Center Hospital and Clinics, 36617; L24; CS; DLR 8/77; DAR 8/78; Julia H. Box, MD; ASR 1 yr.

ARKANSAS

Little Rock-St. Vincent Infirmary, 72201; L24; SD Apr., Oct.; CS; Nolan F. Beverly, MD; Public Probation

CALIFORNIA

***Loma Linda-School of Allied Health Professions, Loma Linda University, 92354; L24; SD Sept.; CS; DLR 8/76; DAR 8/80; Floyd Brauer, MD; ASR 4 yrs.**

Los Angeles-Kaiser Permanente Hospital, 4867 Sunset Blvd., 90027; L24; SD Sept. 15; CS; DAR 12/76; Joyce W. Kelly, CRNA

CODE: L—length of course. All schools are 18 months unless otherwise indicated; for example, L24. SD—starting dates—months as indicated. If no date given, write to the school. CS—cash stipends where known to be given; specific amounts may be obtained by writing directly to the school. M—all or part of room, board and laundry is provided. PA—Pre-Accreditation status: New program that has been approved by the Council and is eligible to admit students. IA—Initial Accreditation: New program that is operational and has students enrolled. DLR—Date of last review by the Council on Accreditation. DAR—Date of next accreditation review by the Council on Accreditation. ASR—Accreditation status received at last review. *—indicates Baccalaureate degree program offered. **—indicates Masters degree program is offered. ***—applicants accepted only from the respective branches of the government services and paid government salary. Individual names refer to the person to whom mail is to be directed; otherwise, address mail to the Director, School of Nurse Anesthesia.

Los Angeles-Martin Luther King, Jr. General Hospital, 90059; *L24; CS; M; DLR 3/77; DAR 3/79*; Jerome P. Wykoff, CRNA; ASR 2 yrs.

Los Angeles-U.C.L.A. Hospital & Clinic, 90024; *L24; SD; Sept.; CS; DLR 11/75; DAR 12/79*; Leah E. Katz, CRNA

*****San Diego**-U.S. Navy School of Anesthesia, Naval Regional Medical Center, Clinical Phase V NAVERGMEDECEN, 92134; *L24; SD June; CS; M; Affiliates with George Washington University; DLR 8/76; DAR 8/80*; Lt. Henry Mitchell, Jr., CRNA; ASR 4 yrs.

*****San Francisco**-ANC Anesthesiology Nursing Course, Phase II, Letterman Army Medical Center, 94129; *L24; DLR 11/75; DAR 12/79*; Maj. Judith M. Cusick, CRNA

COLORADO

*****Denver**-ANC Anesthesiology Nursing Course Phase II, Fitzsimons Army Medical Center, 80240; *L24; DLR 11/75; DAR 12/79*; MAJ. George P. Haag, CRNA

CONNECTICUT

Bridgeport-Bridgeport Hospital, 06602; *L24; CS; DLR 3/77; DAR 3/81*; John A. Moses, MD; ASR 4 yrs.

New Haven-Hospital of St. Raphael School of Nursing Anesthesia, 1423 Chapel St., 06511; *L24; SD Jan., July, Sept.; CS; DLR 12/76; DAR 12/78*; Philip J. Noto, MD; ASR 2 yrs.

DELAWARE

Dover-F. B. Lane Haines, M.D. School of Anesthesia Kent General Hospital, 19901; *CS; DLR 8/75; DAR 8/79*; Robert E. Heckman, MD

Wilmington-Wilmington Medical Center, Delaware Division, 19899; *SD Apr. 1, Oct. 1; CS; DLR 8/76; DAR 8/79*; Gerald J. Savage, MD; ASR 3 yrs.

DISTRICT OF COLUMBIA

*****Washington**-ANC Anesthesiology Nursing Course, Phase II, Walter Reed Army Medical Center, 20012; *L24; DLR 12/76; DAR 12/80*; Maj. Joseph Massimino, CRNA; ASR 4 yrs.

***Washington**-Greater Southeast Community Hospital, 20032; *L24; SD July; Affiliates with George Washington University; CS; M; DLR 11/75; DAR 12/77, PA*; Solomon N. Albert, MD

FLORIDA

Gainesville-Shands Teaching Hospital and Clinics, 32601; *L24; SD Mar.; CS; DAR 3/78*; H. M. Perkins, MD

CODE: L—length of course. All schools are 18 months unless otherwise indicated; for example, L24. SD—starting dates—months as indicated. If no date given, write to the school. CS—cash stipends where known to be given; specific amounts may be obtained by writing directly to the school. M—all or part of room, board and laundry is provided. PA—Pre-Accreditation status: New program that has been approved by the Council and is eligible to admit students. IA—Initial Accreditation: New program that is operational and has students enrolled. DLR—Date of last review by the Council on Accreditation. DAR—Date of next accreditation review by the Council on Accreditation. ASR—Accreditation status received at last review. *—indicates Baccalaureate degree program offered. **—indicates Masters degree program is offered. ***—applicants accepted only from the respective branches of the government services and paid government salary. Individual names refer to the person to whom mail is to be directed; otherwise, address mail to the Director, School of Nurse Anesthesia.

Miami-Pan American Hospital, 33126; *L24; SD July; CS; M; DLR 3/76; DAR 3/77*;
Richard F. Tejera, MD; Closing 9/1/78
Panama City-Bay Memorial Medical Center, 32401; *L24; CS; M; DAR 9/78*;
Laura M. Johnson, CRNA

GEORGIA

Atlanta-Georgia Baptist Hospital, 30312; *L24; SD Sept.; CS; M; DLR 8/77; DAR 8/81*; Gloria Turner, CRNA; ASR 4 yrs.

Columbus-The Medical Center Nurse Anesthesia Program, 31902; *L24; SD Sept.; CS; PA; DLR 12/76; DAR 12/77*; Matthew Y. Faier, CRNA

HAWAII

Honolulu-The Queen's Medical Center, P.O. Box 861, 96808; *L24; SD Oct.; CS; M; DLR 12/76; DAR 12/80*; Alexis Carreiro, CRNA

ILLINOIS

Chicago-Ravenswood Hospital, 60640; *L24; SD Sept.; CS; DLR 12/76; DAR 12/79*;
Eleanor Nuellen, CRNA; ASR 3 yrs.

Chicago-Rush-Presbyterian-St. Luke's Hospital, 60612; *L24; SD Jan., May, Sept.*;
CS; M; DLR 8/75; DAR 8/79; Carole E. Thomason, CRNA

Decatur-Decatur Memorial Hospital, 62526; *L24; SD Sept.; CS; DLR 8/75; DAR 8/79*;
Paul H. DeBruine, MD

Springfield-St. John's Hospital, 62702; *L24; SD Aug.; CS; M; DLR 8/76; DAR 8/80*;
Sister Marie Neier, CRNA; ASR 4 yrs.

KANSAS

Garden City-St. Catherine Hospital, 67846; *L24; SD Oct.; CS; IA; DLR 3/77*;
DAR 3/78; Theodore J. Bittner, CRNA

Kansas City-University of Kansas Medical Center, 66103; *L24; SD Jan., Aug.*;
DLR 3/75; DAR 3/79; Carole G. Elliott, CRNA

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Wichita-St. Francis Hospital, 67214; *L24; SD Apr., Oct.; CS; DLR 3/77; DAR 3/79;*
Robert Marullo, CRNA; ASR 2 yrs.

Wichita-Wesley Medical Center, 67214; *SD Apr., Oct.; CS; DAR 12/77;* Gary
Townsend, CRNA

Wichita-Wichita Clinic School, 67208; *L24; CS; DLR 3/77; DAR 3/79;* Arcola J. Allen,
CRNA; ASR 2 yrs.

Wichita-Wichita Physician's School, 303 S. Hillside, 67211; *L24; SD Mar., Sept.;*
CS; DLR 12/76; DAR 12/78; Pere A. Owen, MD; ASR 2 yrs.

KENTUCKY

Harlan-Harlan Appalachian Regional Hospital, 40831; *SD Jan., July; CS; DLR 3/75;*
DAR 3/79; Paul M. Hodel, MD

LOUISIANA

New Orleans-Charity Hospital, 70140; *SD q. 4 mo.; CS; M; DLR 3/75; DAR 3/79;*
Patricia Lally, CRNA

MAINE

Bangor-Eastern Maine Medical Center, 04401; *SD Apr., Oct.; CS;* Pauline Barbin,
CRNA; Public Probation

Lewiston-St. Mary's General Hospital, 04240; *L24; SD Mar. 1; M; DLR 12/76;*
DAR 12/77; Yasuo Kanda, MD; ASR 1 yr.

Portland-Mercy Hospital, 04101; *L24; SD Oct.; CS; M; DLR 8/76; DAR 3/78;* Georgia
A. Greeley, CRNA; ASR 1 yr.

Waterville-Mid-Maine Medical Center, 04901; *SD Mar.; Sept.; CS; M; IA;*
DLR 8/77; DAR 8/78; Martha Jean Ponitz, CRNA

MARYLAND

Baltimore-Johns Hopkins Hospital, 21205; *L24; SD Sept.; CS; DLR 8/76; DAR 8/80;*
Suzanne F. Stoltzner, CRNA; ASR 4 yrs.

*** * * Bethesda-U.S. Navy School of Anesthesia, Didactic Phase HSETC**, 20014; *L24;*
SD Sept.; CS; M; Affiliates with George Washington University; DLR 8/76;
DAR 8/80; CDR Donna L. Barbarick, CRNA; ASR 4 yrs.

Cheverly-Prince Georges General Hospital, 20785; *L24; SD Sept.; CS; Affiliates with*
George Washington University; DLR 8/76; DAR 8/80; Fern Healey, CRNA;
ASR 4 yrs.

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where known to be given; specific amounts may be obtained by writing directly to the school. M—all
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gram that is operational and has students enrolled. DLR—Date of last review by the Council on Ac-
creditation. DAR—Date of next accreditation review by the Council on Accreditation. ASR—Accred-
itation status received at last review. *—indicates Baccalaureate degree program offered. **—indi-
cates Masters degree program is offered. ***—applicants accepted only from the respective branches
of the government services and paid government salary. Individual names refer to the person to
whom mail is to be directed; otherwise, address mail to the Director, School of Nurse Anesthesia.

MASSACHUSETTS

Boston-Carney Hospital, 02124; *L24; SD Oct.; CS; DLR 12/76; DAR 12/80;* Virginia A. Gaffey, CRNA; ASR 4 yrs.

Boston-New England Medical Center Hospitals, 02111; *L24; SD Variable; CS; DLR 3/77; DAR 3/81;* Bonney Knick, CRNA; ASR 4 yrs.

Pittsfield-Berkshire Medical Center, 01201; *L24; SD Sept.; CS; DLR 12/76; DAR 12/78;* Philip N. Daoust, CRNA; ASR 2 yrs.

Quincy-Quincy City Hospital, 02169; *L24; SD Oct.; CS; DLR 3/77; DAR 3/80;* Joseph Goldman, MD; ASR 3 yrs.

Worcester-St. Vincent Hospital, 01610; *L24; SD Apr.; CS; DLR 12/76; DAR 12/80;* Richard W. Parker, CRNA; ASR 4 yrs.

MICHIGAN

Ann Arbor-University of Michigan Hospital, 48109; *L24; SD Sept. 30; CS; M; DLR 3/77; DAR 3/81;* Neil G. Morse, CRNA; ASR 4 yrs.

Detroit-Grace Hospital, 48201; *L24; SD Mar., Sept.; CS; DLR 3/77; DAR 3/81;* A. Michael Prus, MD; ASR 4 yrs.

Detroit-Mt. Carmel Mercy Hospital, 48235; *L24; SD Jan., May, Sept., Bi-annually; CS; DLR 3/77; DAR 3/81;* Bernice L. Szymanski, CRNA; ASR 4 yrs.

***Detroit**-Wayne State University College of Pharmacy and Allied Health Professions, Department of Anesthesia, 48202; *SD Sept.; CS; DLR 8/77; DAR 8/81;* John F. Garde, CRNA

Flint-Hurley Hospital, 48502; *SD Oct.; CS; M; DLR 3/77; DAR 3/79;* Howard Stickney, CRNA; ASR 2 yrs.

Wyandotte-Wyandotte General Hospital, 48192; *L24; CS; M; DLR 3/77; DAR 3/78;* Anna I. Allen, CRNA; ASR 1 yr.; Closing 1/12/79

MINNESOTA

Hibbing-Hibbing General Hospital, 55746; *L24; SD Fall and Spring; CS; M; DLR 3/75; DAR 3/79;* William C. Lee, MD

Minneapolis-Minneapolis School of Anesthesia, Inc., 916 E. 15th St., 55404; *L24; SD Sept.; CS; DAR 12/78;* Sandra J. Kilde, CRNA

Minneapolis-Minneapolis Veterans Administration Hospital, 55417; *L24; SD Oct.; DLR 3/77; DAR 3/80;* Patricia L. Sterner, CRNA; ASR 3 yrs.

Minneapolis-Northwestern Hospital, 55407; *SD Jan.; CS; DAR 9/78;* Jim McCormick, CRNA

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Minneapolis-St. Mary's Hospital, 55406; *SD Sept.*; *CS*; *DAR 9/78*; Mary A. Crandall, CRNA

Rochester-Nurse Anesthesia Program Mayo School of Health-Related Sciences, Mayo Foundation, 55901; *L24*; *SD Jan., Apr., July, Oct.*; *CS*; *DAR 8/78*; Donald R. Krabill, MD

Rochester-Rochester State Hospital, 55901; *L24*; *CS*; *DAR 6/78*; Hannaliene Kralemann, MD;

St. Paul-St. Paul-Ramsey Hospital & Medical Center, 55101; *L24*; *SD Sept.*; *CS*; *DLR 3/75*; *DAR 3/79*; Wilbur L. Wheeler, CRNA

MISSISSIPPI

***Jackson**-School of Health Related Professions, Department of Nurse Anesthesiology, University of Mississippi Medical Center, 39216; *L24*; *SD June*; *CS*; *DLR 8/76*; *DAR 8/80*; Georgie Coleman, CRNA; ASR 4 yrs.

MISSOURI

Kansas City-Kansas City Medical Center, 64108; *L24*; *SD Jan., Sept.*; *CS*; *M*; *DLR 3/75*; *DAR 3/79*; Nina Beatty, MD

St. Louis-Barnes Hospital, 63110; *L24*; *SD Apr., Oct.*; *CS*; *M*; *DAR 8/78*; Helen A. Ogle, CRNA

Springfield-Southwest Missouri School of Anesthesia, c/o St. John's Hospital, 65802; *L24*; *SD Variable*; *CS*; *DLR 3/75*; *DAR 3/79*; Gordon F. Wise, MD;

NEBRASKA

Lincoln-Bryan Memorial Hospital, 68506; *SD Apr., Oct.*; *CS*; *DLR 3/75*; *DAR 3/79*; Darleen Herman, CRNA

Omaha-St. Joseph's Hospital, 68131; *SD Apr., Oct.*; *CS*; *DLR 3/75*; *DAR 4/79*; Jean R. Behrens, CRNA

****Omaha**-University of Nebraska Medical Center, 68105; *L24*; *SD Oct.*; *DAR 3/79*; Kennetha Scheer, CRNA

NEW HAMPSHIRE

Concord-Concord Hospital, 03301; *L24*; *SD Apr., Oct.*; *CS*; *DLR 8/76*; *DAR 8/80*; John E. Christie, MD; ASR 4 yrs.

Hanover-Dartmouth-Hitchcock Medical Center, 03755; *L24*; *SD Jan.*; *CS*; *DLR 8/76*; *DAR 8/78*; Donald Hooper, MD; ASR 2 yrs.

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NEW JERSEY

Atlantic City-Atlantic City Hospital, 08401; *SD Jan.*; *CS; M; DLR 3/76; DAR 4/78;* William Roadarmel, CRNA

Neptune-Jersey Shore Medical Center, 07753; *L24; SD q. 3 mo.*; *CS; M; DLR 8/76; DAR 12/77;* Michael L. LaPorta, MD; ASR 1 yr.

Newark-United Hospitals Medical Center, 07107; *L24; SD Feb., Sept.*; *CS; DLR 11/75; DAR 12/79;* Gene L. D'Alessandro, MD

NEW YORK

Albany-Albany Medical Center Hospital, 12208; *L24; SD Sept.*; *DLR 12/76; DAR 12/78;* Kathleen Vainosky, CRNA; ASR 2 yrs.

Albany-Veterans Administration Hospital, 12208; *L24; SD July;* *CS; DLR 8/76; DAR 8/78;* Ramona E. Doran, CRNA; ASR 2 yrs.

Buffalo-Edward J. Meyer Memorial Hospital, 14215; *L24; CS; DLR 12/76; DAR 12/78;* Robert Bryndle, CRNA; ASR 2 yrs.

Buffalo-Roswell Park Memorial Hospital, 14203; *L24; SD Jan.*; *CS; DLR 8/77; DAR 8/81;* Raymond J. Trudowski, MD; ASR 4 yrs.

New York-Harlem Hospital, 10037; *L24; SD Apr., Oct.*; *CS; M; DLR 12/76; DAR 12/78;* Goldie D. Brangman, CRNA; ASR 2 yrs.

New York-N. Y. Medical College-Metropolitan Hospital Center, 10029; *L24; SD July; CS; M; DLR 12/76; DAR 12/80;* William M. Bethea, CRNA; ASR 4 yrs.

New York-Roosevelt Hospital, 10019; *L24; SD Oct.*; *CS; M; DLR 8/76; DAR 8/80;* Elsie Svozil, CRNA; ASR 4 yrs.

Staten Island-U.S.P.H.S. Hospital, 10304; *L24; SD q. 8 mo.*; *CS; DLR 12/76; DAR 12/80;* *Recommended by the University of the State of New York for 57 semester credit hours;* Leonard B. Krich, MD; ASR 4 yrs.

NORTH CAROLINA

Asheville-Memorial Mission Hospital, 28778; *SD Mar., Sept.*; *CS; M; DLR 3/76; DAR 4/78;* Charles W. Durrant, CRNA; ASR 2 yrs.

Charlotte-Charlotte Memorial Hospital, P.O. Box 2554, 28254; *SD Mar., Sept.*; *CS; M; L24; DLR 8/76; DAR 7/78;* John M. Snyder, MD; ASR 2 yrs.

Durham-Duke University Medical Center, 27710; *L24; SD Sept.*; *CS; DLR 3/76; DAR 4/80;* Larry Stump, CRNA; ASR 4 yrs.

Durham-Durham County General Hospital, 27704; *SD Jan.*; *CS; DLR 3/76; DAR 4/80;* Vivian S. Roberts, CRNA;

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***Winston-Salem**-North Carolina Baptist Hospital (*optional) 27103; *L24; SD Sept.; CS; DLR 3/76; DAR 4/80; Shirley S. Crump, CRNA; ASR 4 yrs.*

NORTH DAKOTA

Bismarck-Central North Dakota School, c/o St. Alexius Hospital, 58501; *L24; SD July; CS; M; DLR 8/75; DAR 8/79; Riffat Morgan, MD*

Fargo-St. Luke's Hospital, 58102; *L24; SD Sept.; CS; M; DLR 12/76; DAR 12/78; Nora K. Anderson, CRNA; ASR 2 yrs.*

Grand Forks-Grand Forks School of Anesthesia, c/o Deaconess Hospital, 58201; *SD Feb., May, Aug., Nov.; CS; DLR 3/76; DAR 4/80; Mary Templin, CRNA*

Minot-Trinity Hospital 58701; *SD Jan., Sept.; CS; DLR 8/75; DAR 8/79; Ellen S. Aitken, CRNA*

OHIO

Canton-Aultman Hospital, 44710; *L24; SD Oct. q. 2 yrs.; DLR 8/77; DAR 8/78; Rita T. Nesbitt, CRNA; ASR 1 yr.*

Cincinnati-Cincinnati General Hospital, 45229; *L24; SD Apr., Oct.; CS; M; DAR 12/77; M. Evelyn Harris, CRNA*

Cleveland-Cleveland Clinic Hospital, 44106; *L24; SD Jan.; CS; DAR 9/78; Jack R. Kless, CRNA*

Columbus-School of Allied Medical Professions, Division of Nurse Anesthesia, 1583 Perry Street, 43210; *SD Each University quarter; CS; M; DAR 12/78; Jaeson L. Stafford, CRNA*

Steubenville-Ohio Valley Hospital, 43952; *SD Sept.; CS; DLR 3/77; DAR 3/79; B. Barry Greenhouse, MD; ASR 2 yrs.*

Toledo-St. Vincent Hospital & Medical Center, 43608; *SD q. 9 mo.; CS; DLR 8/77; DAR 8/78; Nancy Bowers, CRNA; ASR 1 yr.*

Warren-Trumbull Memorial Hospital, 44482; *L24; SD Sept. q. 2 yrs.; CS; DAR 12/76; William E. Masters, MD; Closing 9/1/78*

Youngstown-St. Elizabeth Hospital, 44505; *SD Apr.; CS; DLR 8/77; DAR 8/81; R.S. Richards, MD; ASR 4 yrs.*

PENNSYLVANIA

Altoona-Mercy Hospital, 16603; *SD Sept.; CS; DLR 8/77; DAR 8/81; Sister Michele Collins, CRNA*

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Danville-Geisinger Medical Center, 17821; L24; SD Sept.; CS; DAR 9/78;
William J. Kirk, CRNA

Elkins Park-Rolling Hill Hospital & Diagnostic Center, 19117; SD Feb., Sept.; CS;
DLR 8/75; DAR 8/79; M. L. Kanis, MD

***Erie-Hamot Medical Center**, 16512; L24; SD Feb., Sept.; CS; DLR 3/76; DAR 4/80;
Kenneth S. Anderson, CRNA; ASR 4 yrs.

Greensburg-Westmoreland & Latrobe Hospitals, 15601; L24; SD Jan.; CS;
DLR 8/77; DAR 8/81; Bernadette Miller, CRNA; ASR 4 yrs.

Harrisburg-Harrisburg Hospital, 17101; L24; SD Oct.; CS; M; DLR 12/76; DAR 12/78;
Jeanne L. Wilders, CRNA; ASR 2 yrs.

Johnstown-Lee Hospital, 15901; L24; SD Sept.; CS; DLR 12/76; DAR 12/80;
John R. Quinn, MD; ASR 4 yrs.

Lancaster-St. Joseph's Hospital, 17604; L24; SD Sept.; CS; DLR 11/75; DAR 12/79;
Charles D. Rickerhauser, CRNA

McKeesport-McKeesport Hospital, 15132; SD Sept.; CS; M; DLR 8/76; DAR 8/80;
Doris Stoll, CRNA; ASR 4 yrs.

Norristown-Montgomery Hospital, 19401; SD Sept.; CS; DLR 3/76; DAR 4/80;
Frank J. Tornetta, MD

Philadelphia-Episcopal Hospital, 19125; SD Mar., Oct.; CS; M; DLR 8/75; DAR 8/79;
Jeannette Buhr, CRNA

Philadelphia-Frankford Hospital, Red Lion & Knight's Rd., 19114; SD Sept.; CS;
M; DLR 3/77; DAR 3/79; Stephen J. Foldes, MD; ASR 2 yrs.

Philadelphia-Graduate Hospital, 19146; SD Jan., Mar., Sept.; CS; M; DLR 8/76;
DAR 3/78; Hrant H. Stone, MD; ASR 1 yr.

Philadelphia-Jefferson Medical College Hospital, 19107; L24; SD Mar., Sept.; CS;
DAR 6/78; Jay Jacoby, MD

Philadelphia-Lankenau Hospital, 19151; L24; CS; DLR 3/75; DAR 3/79;
Elizabeth A. McCormick, CRNA

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Philadelphia-Medical College of Pennsylvania, 19129; L24; SD Apr., Sept.; CS; DLR 11/75; DAR 3/78; Athole G. McNeil Jacobi, MD

Philadelphia-Nazareth Hospital, 19152; SD Mar., Sept.; CS; M; DAR 9/78; Sister M. Lucian, CRNA

Philadelphia-Pennsylvania Hospital, 19107; SD Sept.; CS; M; DLR 8/76; DAR 8/80; Mario V. Troncelliti, MD; ASR 4 yrs.

Pittsburgh-Mercy Hospital, 15219; L24; SD Sept.; CS; M; DLR 3/77; DAR 3/81; Constance E. Neary, CRNA; ASR 4 yrs.

Pittsburgh-St. Francis General Hospital, 15201; SD Mar., Sept.; CS; DLR 3/77; DAR 3/79; E. Jean Duwall, CRNA; ASR 2 yrs.

Pittsburgh-Shadyside Hospital, 15232; L24; SD Jan.; CS; DLR 3/77; DAR 3/81; Wynne Waugaman, CRNA; ASR 4 yrs.

Pittsburgh-University Health Center of Pittsburgh, School of Anesthesia for Nurses, 15213; L24; SD Sept.; CS; DLR 12/76; DAR 12/80; Mary DePaolis, CRNA; ASR 4 yrs.

Pittsburgh-Western Pennsylvania Hospital, 15224; L24; SD Sept.; CS; DLR 12/76; DAR 12/80; Nancy J. Gaskey, CRNA; ASR 4 yrs.

Pottsville-Good Samaritan Hospital, 17901; SD May, Nov.; CS; M; DLR 3/76; DAR 4/78; Roy C. Green, MD

Reading-Reading Hospital and Medical Center, 19603; SD Sept.; CS; M; DLR 3/75; DAR 3/79; Edgar Lloyd, MD

Scranton-Mercy Hospital, 18510; SD May, Oct.; CS; M; DLR 3/76; DAR 4/80; Virginia J. Jama, CRNA

Washington-Washington Hospital, 15301; L24; SD Jan.; CS; M; DLR 8/77; DAR 8/79; Gilbert B. McMaster, MD; ASR 2 yrs.

Wilkes-Barre-Wilkes-Barre General Hospital, 18702; L24; SD Apr.; CS; M; DLR 8/76; DAR 8/78; C. Wilmer Brobyn, MD; ASR 2 yrs.

PUERTO RICO

Ponce-Hospital de Damas, 00731; SD July; M; DLR 3/76; DAR 4/78; Carmen C. DeRubio, CRNA

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Santurce-Puerto Rican School for Nurse Anesthetists, Ashford Medical Center, Suite 806, 00907; *SD July, Jan.*; *CS; M; DLR 3/76; DAR 4/78*; Brunilda Malave, CRNA

RHODE ISLAND

N. Providence-St. Joseph's Hospital-Our Lady of Fatima, 02904; *L24; SD Feb., Sept.*; *CS; DLR 3/77; DAR 3/81*; Julius C. Migliori, MD; ASR 4 yrs.

Pawtucket-Memorial Hospital, 02860; *L24; SD Sept.*; *CS; DLR 3/77; DAR 3/80*; Charles Cox, MD; ASR 3 yrs.

SOUTH CAROLINA

Charleston-Medical University of South Carolina, 29401; *L24; SD Sept.*; *CS; DLR 3/76; DAR 4/80*; Everard R. Hicks, CRNA

Columbia-Richland Memorial Hospital, 29203; *L24; SD Sept.*; *CS; M; DLR 3/76; DAR 4/80*; Ruby P. Johnson, CRNA

Lancaster-Elliott White Springs Memorial, 29720; *L24; DLR 3/76; DAR 4/78*; Lily Grubb, CRNA

SOUTH DAKOTA

***Sioux Falls**-McKenna Hospital, 57101; *SD Fall Semester*; *CS; DAR 12/77*; Craig Stevens, CRNA

***Yankton**-Mount Marty College, 57078; *L24; SD Feb., June, Sept.*; *DAR 12/77*; Sr. M. Arthur Schramm, CRNA

TENNESSEE

Chattanooga-Baroness Erlanger Hospital, 37403; *L24; SD Aug.*; *CS; DLR 8/75; DAR 8/79*; Neal W. Collins, CRNA

Kingsport-Holston Valley Community Hospital, 37662; *L24; SD Mar.*; *CS; DLR 8/76; DAR 3/78*; Jack Testa, CRNA; ASR 1 yr.

Knoxville-University of Tennessee Memorial Research Center & Hospital, 37920; *L24; SD Jan., Sept.*; *CS; M; DLR 3/76; DAR 4/80*; W. Forrest Powell, MD;

Madison-Madison Hospital, 37115; *L24; SD Jan., Oct.*; *CS; DLR 3/76; DAR 4/80*; Bernard V. Bowen, CRNA

TEXAS

Dallas-Baylor University Medical Center, 75246; *L24; SD Mar., Sept.*; *CS; DLR 8/75; DAR 8/79*; Lucille P. Stampley, CRNA

*****El Paso**-ANC Anesthesiology Nursing Course, Phase I-Phase II, Academy of Health Sciences, 79920; *DLR 8/75; DAR 8/79*; LTC Joseph T. Rando, CRNA-Phase I; LTC Sanford A. Clayton-Phase II

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Fort Worth-Harris Hospital, 76104; L24; SD Mar., Sept.; CS; M; DLR 11/75; DAR 12/79; David Ely, CRNA

Fort Worth-St. Joseph Hospital, 76104; L24; SD Jan.; CS; DLR 11/75; DAR 12/79; Joyce K. Wood, CRNA

Houston-Harris County Hospital District, 77030; L24; SD Jan.; CS; DLR 8/75; DAR 8/79; Rodney Lester, CRNA

Houston-The University of Texas Health Science Center, School of Allied Health Sciences, Program in Nurse Anesthesia Education, P.O. Box 20036, 77025; L24; SD Sept.; PA; DLR 8/76; DAR 3/78; Hershah Bradshaw, CRNA Sr., MD

*** **San Antonio-Wilford Hall USAF Medical Center**, 78236; L24; SD Jan., July; DLR 3/76; DAR 4/80; Col. Betty L. Johnson, CRNA

Wichita Falls-Wichita General Hospital, 76307; L24; SD Jan., July; CS; DLR 3/76; DAR 4/80; J. R. McKinney, MD

VERMONT

Bennington-Henry W. Putnam Memorial Hospital, 05201; L24; SD Sept.; CS; DLR 3/77; DAR 3/78; Kenneth J. Cestone, MD; William Ryan, CRNA; ASR 1 yr.

VIRGINIA

Clifton Forge-Emmett Memorial Hospital, 24422; L24; IA; DLR 12/77; Edith Raab-Chucker, CRNA

Danville-Danville Memorial Hospital, 24541; L24; SD Mar.; CS; M; DLR 8/76; DAR 8/79; Ruperto E. Perez, Jr., MD; ASR 3 yrs.

* **Falls Church-Fairfax Hospital**, 22046; L24; SD Sept.; CS; Affiliates with George Washington University; DLR 8/76; DAR 8/80; Janice M. Willson, CRNA; ASR 4 yrs.

Norfolk-DePaul Hospital, 23505; SD Apr., Oct.; CS; DLR 3/76; DAR 4/80; M. Ann Greenwell, CRNA

Norfolk-Norfolk Community Hospital, 23504; L24; SD Sept.; CS; DAR 9/78; Srirama Prasad Chalasani, MD

* **Norfolk-Medical Center Hospitals-Norfolk General Division**, 23507; L24; SD July; CS; DLR 8/75; DAR 8/79; Russell R. Wickizer, CRNA

*** **Portsmouth-U.S. Navy School of Anesthesia, Clinical Phase, NAVERGMEDCEN**, 23708; L24; SD June; CS; M; Affiliates with George Washington University; DLR 8/76; DAR 8/80; LCDR Charles Reese, CRNA; ASR 4 yrs.

* **Woodbridge-Potomac Hospital**, 22191; L24; SD Sept.; CS; Affiliates with George Washington University; IA; DLR 3/77; DAR 3/78; Ann M. LePoer, CRNA

Richmond-Dept. of Nurse Anesthesia, School of Allied Health Professions, Medical College of Virginia, Virginia Commonwealth University, 23219; L21; SD Aug.; CS; DLR 8/76; DAR 8/80; Herbert T. Watson, CRNA; ASR 4 yrs.

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WASHINGTON

Seattle-Group Health Hospital, 98102; *L24; SD Sept.; CS; M; DLR 3/76; DAR 4/80;*
Don Stromberg, MD

Spokane-Sacred Heart Hospital, 99204; *SD Apr., Oct.; CS; M; DLR 8/76; DAR 8/79;*
Dale R. Bartline, CRNA; ASR 3 yrs.

Tacoma-ANC Anesthesiology Nursing Course, Phase II, Madigan Army Medical Center,
98431; *DLR 8/76; DAR 8/80;* Francis L. Sargeant, CRNA; ASR 4 yrs.

WEST VIRGINIA

Bluefield-Bluefield Sanitarium, 24701; *SD q. 6 mos.; CS;* David H. Gatherum, MD;
Public Probation

Charleston-Charleston Area Medical Center, Inc., McMillan Division, 25326; *SD Sept.;*
CS; DLR 12/76; DAR 12/80; Nancy Carvey, CRNA; ASR 4 yrs.

Parkersburg-St. Joseph's Hospital, 26101; *SD Mar., Sept.; CS; DLR 8/77;*
DAR 8/79; Logan W. Hovis, MD, ASR 2 yrs.

Wheeling-Wheeling Hospital, 26003; *L24; SD Oct.; CS; DLR 12/76; DAR 12/78;*
R. S. Robbins, MD; ASR 2 yrs.

WISCONSIN

LaCrosse-St. Francis Hospital, 54601; *SD Mar., Sept.; CS; M; DAR 12/77;*
Sister M. Yvonne, CRNA

Milwaukee-Milwaukee County Hospital, 53226; *SD Spring, Fall; CS; M; DLR 8/76;*
DAR 8/80; Yvonne M. Porth, CRNA; ASR 4 yrs.

Oshkosh-Mercy Medical Center, 54901; *SD Mar., Sept.; CS; DLR 8/76; DAR 8/80;*
Anthony J. Gospodarek, CRNA; ASR 4 yrs.

Wausau-Wausau Hospital-North, 54401; *L24; SD q. 8 mos.; CS; DAR 3/78*
W. G. Lochner, MD



**American Association of Nurse Anesthetists
Council on Accreditation**
Suite 929
111 East Wacker Drive
Chicago, Illinois 60601

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Mr. WALGREN. Thank you very much for your statement.

I wanted to just explore very briefly, and towards the end of your statement, you may have covered it. Are enrollments in this type of program increasing?

Mr. BOOTH. Yes, they are.

Mr. WALGREN. By what degrees? How quickly are they increasing?

Mr. BOOTH. I do not have the exact figures. Maybe Ms. Fevold might be able to address that.

Ms. FEVOLD. I would be happy to forward a survey. The increased enrollment has been about 150 students per year. That is an average figure that I could give you at this point.

Mr. WALGREN. How many people each year are in this kind of training?

Mr. BOOTH. Usually 1,000 students come in every year.

Mr. WALGREN. The reason that they do not qualify for other kinds of advanced nursing training is that the type of setting that the training is given is not an accredited school, as such?

Mr. BOOTH. No, it is not that. I think in the past in the Nurse Practice Act, because we do not operate within a school of nursing or a college of nursing setting, we have been sectioned out of any funding that has occurred. It has nothing to do with accreditation, but the fact that schools of nurse anesthesia do not operate within a school of nursing.

There was a comment this morning about that, and I would just like to address it at this time. It has been very difficult to try to get our programs into schools of nursing. We have tried in the past with 100 percent denial.

In the last year, two programs of nurse anesthesia, are in the initial stages of moving into schools of nursing. There is one in the Medical College of Virginia and one in the Chicago area.

Mr. WALGREN. There is a vote on the floor of the House that I will have to answer. Dr. Carter may be back very shortly, in which case he should feel free to continue the exploration, but if you would suspend until I return, I would appreciate that.

I apologize for the interruptions and the delays, but that seems to be necessary to create a record.

[Brief recess.]

Mr. CARTER. Up until the present time, how have the nurse anesthetists funded their education?

Mr. BOOTH. They have been funded through the hospitals, funded through the general fund of the hospital and, of course, students very often paid administrative fees, some of them paid a small tuition, but generally it has been a hospital-funded endeavor.

Mr. CARTER. Usually from \$100 to \$200 a month, something like that?

Mr. BOOTH. In terms of stipend?

Mr. CARTER. Yes, sir.

Mr. BOOTH. The stipends run from \$100 to \$300 a month, where stipends are paid.

Mr. CARTER. How much is needed to pay their tuition and pay for their books and so on?

Mr. BOOTH. Most students pay—

Mr. CARTER. What does it cost them for 1 year of schooling?

Mr. BOOTH. We have figured somewhere about \$5,000, I believe.

Mr. CARTER. \$5,000?

Mr. BOOTH. That is the projected figure we have, \$5,000.

Mr. CARTER. How are nurse anesthetists generally reimbursed?

Mr. BOOTH. As practitioners?

Mr. CARTER. Yes.

Mr. BOOTH. I think the vast majority of them are paid by the hospital, as a hospital employee.

Mr. CARTER. By the hospital?

Mr. BOOTH. Yes.

Mr. CARTER. On a salary, or are they paid on a case by case basis?

Mr. BOOTH. The vast majority are paid on a salary basis. Some of them work free-lance, but the vast majority are hospital employed.

Mr. CARTER. Do nurse anesthetists tend to stay in a rural area once they go there, or is there a significant turnover?

Mr. BOOTH. I think from the information we have, nurse anesthetists in substantial numbers work in the rural areas. Sixty-seven percent of nurse anesthetists work in rural areas as opposed to 42 percent working in urban areas, in hospitals.

Mr. CARTER. Those in rural areas do not usually stay in one position, but instead, they go from one hospital to another.

Mr. BOOTH. Very often that is the case.

Mr. CARTER. Have you discussed your proposal for Federal training support with the American Nurses Association?

Mr. BOOTH. I have not myself, no.

Ms. FEVOLD. We have.

Mr. CARTER. What is their position?

Mr. BOOTH. I think they support us.

Mr. WILLIAMSON. They support the need. They have a very legitimate concern. They see themselves as being under enough pressure to get funds for nursing they need and did not want us to cut into those moneys. I believe, too, that they feel that having a separate or a new category for nurse anesthetists would be desirable.

With those two provisos, as they indicated this morning, they were quite supportive of the needs of the nurse anesthetists.

Mr. CARTER. What is the usual annual salary of a nurse anesthetist?

Ms. FEVOLD. The average in 1976 was \$19,700.

Mr. CARTER. \$19,000?

Ms. FEVOLD. Correct.

Mr. CARTER. Of course, the hospital carries the insurance?

Ms. FEVOLD. In the great majority of the cases, no. In the majority of the cases, they do not. We carry our own.

Mr. CARTER. What does it cost per year?

Ms. FEVOLD. \$1,100 per year.

Mr. CARTER. There are a lot of hazards to what you are doing. What type of anesthesia do you give?

Mr. BOOTH. We give all types. The only limiting factors would be the local mores. There are many nurse anesthetists that are using regional anesthesia that is not generally accepted as general anesthesia as a tool for nurse anesthetists.

There are many who do give regional anesthesia in the armed services. They are very much into regional anesthesia.

Mr. CARTER. Thank you very kindly.

Mr. WALGREN. I just want to explore very briefly the limit on employment during the program. Why is that absolute?

Mr. BOOTH. Students in an anesthesia program must commit themselves, we figure, to somewhere in the area of 64 hours a week. We figure the clinical experience, together with the work that they must take home and prepare for courses, and with their preparations for pre-operative visitations with the patient, they are committed to 64 hours a week in many instances, and we feel that that is enough work for anybody for one week.

They may be allowed to work providing their patient care, their general health and their ability in the classroom does not suffer. We feel that we have to curtail them for the patient's safety, so we say if you are going to be committed to the program for the length of time that you are committed to nurse anesthesia, we would very definitely hope that you do not have to work.

For a student to go out to work 11 p.m. to 7 a.m. and come back to the anesthesia environment at 7:30 in the morning is an unhealthy situation for patient care. That is just one rule that we feel that we have to encourage, that students come to us fully rested and prepared, academically and clinically, to do the job.

Mr. WALGREN. When they are in the school, are they conferring a benefit on the hospital in any sense?

Mr. BOOTH. I think some students do, yes. There is a rationale for allowing students to deal in a service within a program and within a department providing they are not exploited.

Mr. WALGREN. How long would it take to recoup the extra expense that a student would incur at hopefully a higher salary with her degree? How many years?

Mr. BOOTH. I do not know what the average salary, for example, for a baccalaureate nurse is at this point. Nancy?

Ms. FEVOLD. I am sorry. I really do not—it would be, a salary for a nurse, for 2 years—I am sorry; I do not have those figures.

Mr. CARTER. We have people here that could answer that question.

Ms. HOLLERAN. Depending on the geographic area, between \$9,000 and \$12,000 a year.

Mr. BOOTH. When you look at a nurse anesthetist's salary you are not looking at a 40-hour week, you are looking at a much longer schedule because they are taking calls very often.

When you look at the mean salary of a nurse anesthetist, you must take into consideration that they provide 24-hour coverage in many hospitals. They are giving 50 hours a week where a nurse is working a 40-hour week.

Mr. WALGREN. The average salary for a nurse anesthetist is what?

Mr. BOOTH. \$19,000.

Mr. WALGREN. On behalf of the other members of the committee who are not here, thank you for your presentation. It is very helpful and thank you for making our record complete.

The final witness for today is Dr. Leo Gehrig, senior vice president of the American Hospital Association, accompanied by Patrick Logue, regional legislative assistant with the same organization.

Any written remarks you have will be incorporated into the record. You may proceed as you desire. Welcome to the committee.

**STATEMENT OF LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT,
AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY PATRICK
LOGUE, REGIONAL LEGISLATIVE ASSISTANT**

Dr. GEHRIG. Thank you, Mr. Chairman. I am Dr. Leo J. Gehrig, senior vice president of the American Hospital Association. As you indicated, Mr. Pat Logue, a regional legislative assistant of our Washington office, is with me.

We certainly welcome this opportunity to testify before the committee on the nurse training amendments of 1978. I will not read our entire statement, but in the interests of the committee's time, I would like to highlight just a few areas.

H.R. 11434, which proposes a 2-year extension of the Nurse Training Act at the present levels of authorization, is legislation which the AHA wholeheartedly supports. We would like to offer a few observations.

The American Hospital Association is concerned with the educational preparation of nurses because of the role that many hospitals play in the training of these professionals. Among our some 6,400-member institutions, 390 of them operate diploma schools with some 50,000 students in these programs.

A second very important reason for our interest is that the American Hospital Association looks not only at the educational preparation of these nurses but also their capability for practice, since our member institutions are the largest employer of this very important segment of health manpower.

Thus, it is an overriding concern of hospitals that nursing students receive high quality and appropriate training.

Their educational preparation should enable them to function effectively in their profession upon graduation, and it also should put them in a position so they might pursue advanced training, should this be their desire.

It is because of these concerns and what is addressed in the Nurse Training Act that we strongly support this legislation.

We have consistently supported, for example, capitation grants, not just for diploma schools but for basic nursing education in diploma, baccalaureate and associate degree programs. We believe these grants are a fundamental part of the support to these institutions and, as was indicated earlier this morning, the withdrawal of such support abruptly and at this time, can have a very serious impact on these programs.

We believe that it certainly should continue. We do recognize and appreciate that the extension legislation in connection with capitation grants continues the alternative of either increasing class size or moving in the direction of other projects, any two of which might include nurse practitioner training, remote site training, continuing education, or the recruitment of students from disadvantaged backgrounds.

We think this is important. We advocated it in 1975 and we are delighted that your committee bill at this time continues it because,

in fact, increasing the size of student enrollments groups became a very real difficulty for some institutions which had a very well-qualified program but, because of limitations of facility, faculty or even clinical resource, could not honestly continue the expansion.

Special project grants in the past have been funded to encourage mergers and cooperative arrangements between institutions of higher learning and hospital schools of nursing. Such grants have also been used to develop new curricula initiatives and to increase educational opportunities for individuals from disadvantaged backgrounds. We support the provisions which continue this assistance in your present bill.

I would add at this point with regard to the variety of institutions participating in the training of this important group of manpower, diploma schools are, in fact, important because, as you look now at the need for continued Federal assistance, you will find that of the totality of some 1,400 programs, about one quarter are diploma, one quarter are baccalaureate and about half are associate degree programs.

It has been our position all along that all of the effectively developed training programs, regardless of type of basic training, should be encouraged and assisted.

Truthfully, as one looks at programs—and now I refer to the diploma programs—we feel not only a pride in what these individuals learn in this surrounding, but you will find also that the potential for training in many areas is uniquely available to an institution like a hospital, and it cannot always be supplanted by that of educational institutions, be it at the baccalaureate or associate degree level.

I would like to be very sure, because of the discussion earlier today, to represent that this is not a competitive position. Hospitals in fact, if you look at the data over recent years, have very significantly decreased the number of diploma schools, have worked constructively for the merger of their programs with institutions of higher education, and I am sure will continue to do so, although transition in this area is not clear in terms of its totality, and I think it is important that all such schools be both involved and continued.

As we look at some of the elements within the need for continued nursing school assistance, I think the question that was asked on the recent National League for Nursing questionnaire on the impact of its withdrawal I have already pointed to, will show that withdrawal of capitation assistance to these schools will have a serious impact or a very significant number of them.

Similarly, if we look to the shortage problem, I think this is one that frustrates, I am sure the Members of Congress, the Department, and I think everybody else who deals with it, because in the past where one could make more sweeping statements with regard to national shortages, I think this is becoming less evident on a national basis as a result of some recent studies.

On the other hand, there are serious areas which anecdotally can be pointed to. The comments that were made this morning about the State of Texas are really significant. That State has been recruiting foreign-trained nurses for some years to meet their needs.

The city of Chicago has some 2,000 unfilled nursing positions in its locale and I think a couple of other things that frustrate us, that where hospitals have been forced to compromise staffing patterns because of the unavailability of registered nurses in some areas, it is a little difficult to make a count.

Finally, even in areas where the number of available nurses seem adequate, I can only testify to the frustration of hospital administrators who find it very difficult to cover certain shifts in certain areas. You recognize that our nurses do not work only 8 to 4 or that variety, but in shifts around the clock. Really, the difficulty in filling the shifts of some of these difficult hours, even in well-staffed areas, if you will, or at least areas in which we recognize an availability of nurses, is difficult.

It goes beyond that, even in terms of the neighborhood. A city center oftentimes is a problem because of security and because of ingress and egress at peculiar hours.

So I would only suggest that there are many factors in this staffing relationship that come to play that make it exceedingly difficult.

Student assistance, we think, is also a terribly important part of your bill. Certainly in the area of nurses seeking advanced education, a great deal has been made today—and we certainly are supportive of it—of the need for training of more individuals at advanced levels for clinical, for administrative, and for nursing education activities.

I would only indicate one thing, that in the HEW study that was recently accomplished, it is my understanding that they found that of the nurse faculty of training programs, only some 56 percent hold degrees beyond the baccalaureate level. As I think you can readily recognize in this day and age when we are dealing with the complex and complicated parts of technology in the hospital and other settings that the faculty need, generally speaking, a much higher level of training than they presently have.

Finally, if you go to just the regular student, and it was so eloquently stated this morning, when you had your first panel on with regard to the opportunity for the disadvantaged student, past studies have indicated that a very high percentage of nursing students come from families in the United States whose total income is very limited.

It was only a few years ago that we would say \$10,000. Today, I believe the figure is something like over half of these students come from families in which the total income is in the vicinity of \$15,000 or less, so I think immediately it brings into bold relief the import of not just institutional assistance, but also student assistance.

Finally, Mr. Chairman, while my full statement had some other points, there is one other area that I would like to briefly touch upon and that is the National Advisory Council on Nurse Training. We believe this Advisory Council fulfills a very important function of bringing the thought and, really, the contribution of the nongovernmental field into play in the conduct of the Nurse Training Act.

We think it is a good Council; we think it is a needed Council, and we would hope that this committee would attempt to insure

that it would continue in existence, in contrast to some of the efforts that have been made in the Department up to now.

With that, Mr. Chairman, I appreciate the time you have given me, and if we can answer any questions, we would be delighted to.

[Testimony resumes on p. 119.]

[Dr. Gehrig's prepared statement follows:]


AMERICAN HOSPITAL ASSOCIATION

 444 NORTH CAPITOL STREET, N.W., SUITE 500, WASHINGTON, D.C. 20001 TELEPHONE 202-638-1100
 WASHINGTON OFFICE

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
 ON PROPOSED NURSE TRAINING EXTENSION LEGISLATION
 BEFORE THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
 SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

March 20, 1978

Mr. Chairman, I am Leo J. Gehrig, M.D., Senior Vice President of the American Hospital Association. With me is Patrick Logue, a Regional Legislative Assistant in our Washington Office. Our Association represents more than 6,400 member institutions, including most of the hospitals in the country and over 2,300 nursing service administrators who are personal members of the Association. As of October 1976, AHA-member hospitals operated approximately 390 diploma schools of nursing with an enrollment of 56,000 students. We welcome the opportunity to testify before this subcommittee on the proposed "Nurse Training Amendments of 1978," introduced by you, Mr. Chairman, as H.R.11434.

The bill proposes a two-year extension of the Nurse Training Act at present levels of authorization, with one exception. This would be a deletion of the present authority for financial distress grants to nursing schools and a transfer of the \$5 million authorized for this program to the authorization for special project grants for each of the next two fiscal years. The AHA wholeheartedly supports enactment of this legislation and wishes to offer the following observations and recommendations concerning it.

The American Hospital Association's concern with the educational preparation of nurses stems both from the role of many hospitals in training professional nurses and from the fact that its member institutions are the nation's largest employers of practicing

CABLE ADDRESS: AMERHOSP

registered nurses. It is therefore an overriding concern of hospitals that nursing students receive high-quality, appropriate training. Their educational preparation should enable them to function effectively in their profession upon graduation, and also should prepare them to pursue further education to develop their professional skills if they desire.

Past Support

The American Hospital Association has long supported federal assistance for nurse training. During the legislative development of the current Nurse Training Act, P.L.94-63, we presented testimony before the Congress on three occasions: May 1974, June 1974, and again in February 1975. In our statements, the Association urged federal support for construction assistance for new or renovated nurse training facilities, capitation grants for nursing schools, traineeships, and loans and scholarships for nursing students, as well as special project and financial distress grants to schools of nursing. When the bill including these programs, S.66, was vetoed in July 1975, the American Hospital Association joined in a collective effort that led to the successful override of the veto and enactment of the Nurse Training Act of 1975. Since enactment of the law, the Association has repeatedly supported its adequate funding by testifying in favor of restoring appropriations for nursing education which former Administrations proposed be cut in their budget requests.

The Association also has supported the Act's authorities for development of nurse practitioner training programs and the use of nurse practitioners in rural and urban medically underserved areas. We continue, Mr. Chairman, to monitor the development of nurse practitioners in institutional and other settings and expect that their use will be greatly expanded through the recent passage of the Rural Health Clinic Services bill you introduced and which is now P.L.95-210.

Capitation Grants

The American Hospital Association has consistently supported capitation grants for all three types of basic nursing education programs: diploma, baccalaureate degree and associate degree. The AHA did, however, recommend, in its 1975 testimony, elimination of the enrollment increase requirement as a condition of eligibility for these grants. Since a continuing shortage of available faculty and physical limitations on space or the size of clinical facilities often preclude expansion of student enrollment for many schools of nursing, we were pleased to see the law allow schools the option of either increasing enrollments or carrying out at least two programs in either nurse practitioner training, remote site training, continuing education or recruitment of students from disadvantaged backgrounds. Such an approach has removed a barrier to participation in the capitation program for many schools.

Special Projects

Special project grants have been funded in the past to encourage mergers and cooperative arrangements between institutions of higher learning and hospital schools of nursing. Such grants also have been used to fund the development of new curricular initiatives and to increase educational opportunities for individuals from disadvantaged backgrounds. One such grant to an Illinois diploma school of nursing funded the development and implementation of a model curriculum designed to teach the nurse to identify those aspects of stress which have the greatest impact upon the hospitalized patient. One anticipated result is the development of new nursing measures which support the patient and his family in adapting to his illness.

Another grant has supported development of changes in nursing school curricula which emphasize community outreach in nursing. A program of follow-up telephone consultations with mothers of newborns has facilitated earlier hospital discharges for these women.

The knowledge of the availability of such telephone consultations has apparently relieved many of the anxieties these women associate with caring for their new infants. Special project grants continue to provide the stimulus for much of the innovation in nursing education today.

The Need for Continued Federal Assistance in Nursing Education

There are currently a total of 1,373 programs which prepare student nurses for practice. Approximately 50 percent of these are associate degree programs, 25 percent are baccalaureate programs, and 25 percent are diploma programs. Of the 77,633 graduates in 1976, 35,094 received associate degrees, 22,678 received baccalaureate degrees, and 19,861 received diplomas. The American Hospital Association supports all three types of education for beginning practice and recommends continued capitation support for each type of program. A national survey of the deans and directors of nursing education programs was conducted in December 1977 by the National League for Nursing. Of those responding, over 90 percent indicated that a substantial reduction in capitation funds would create financial difficulty for their programs and in about 50 percent of these instances the impact will be severe. When asked to detail the use of federal capitation funds in nursing programs, nursing school administrators in both public and private institutions ranked faculty salaries as the highest priority. Other important uses of capitation funds included purchase of instructional equipment, development of expanded curricula, payment for clinical training facilities, development of continuing education programs, and support for research activities.

Although some studies tend to show there no longer is a nursing shortage throughout the country, certain areas continue to suffer from chronic shortages of registered nurses. Hospitals in Texas, for example, are forced to recruit foreign nurse graduates in order to fill posted positions. Chicago hospitals presently have over 2,000 positions unfilled.

The shortage of nurses to fill available positions is particularly acute in the inner cities and rural areas. The quantification of nursing shortages, furthermore, is often difficult to document where hospitals have been forced to compromise staffing patterns because of the unavailability of registered nurses in their areas.

There also continues to be a severe shortage of nurses educated at advanced levels to fill positions in administration, education, and the clinical specialist fields. According to HEW's February 1977 Report to Congress on the Supply and Distribution of Nurses, "Only 2,900 of the nursing service administrators and assistants and 1,260 of the supervisors in the more than 7,000 hospitals, and only 2,400 nurses in the administrative positions in the more than 11,000 community health agencies, are prepared at the graduate level, i.e., hold master's and doctoral degrees. Only 44 percent of the faculty in all schools of nursing are so prepared."

Student assistance programs also merit continuation, particularly for nurses seeking advanced education. Many nurses return to the academic setting after several years of nursing practice; however, it is often a considerable hardship for such individuals to abandon their salaries in order to seek advanced degrees. The federal traineeship has been of vitally-needed assistance to many of these graduate students in offsetting tuition, fees, and living expenses.

Special consideration also is needed for students in basic nursing education programs. Without a continuation of federal nursing student loans and scholarships in this bill, many deserving applicants would not be able to prepare for a career in nursing. We believe the loan and scholarship program as it now exists should continue to be administered by the Bureau of Health Manpower, HEW, to ensure the coordination and continuity of the federal government's nursing education policy.

Continued assistance will be necessary to provide the student in nursing with more individualized and diversified learning experiences. The development of the "university without walls" and other external degree programs provides academic credit for practical experience. Career mobility, particularly for the nursing student seeking a baccalaureate degree, requires carefully developed programs that give sufficient attention to the needs of individual students. A self-directed autotutorial laboratory is an example of a method which can be developed by an institution to meet the needs of these students. Such instructional programs are expensive, however, and often cannot be developed without funding, such as provided by Nurse Training Act special project grants.

Accordingly, we support your proposal, Mr. Chairman, in H.R. 11434, to eliminate the present financial distress grant authority in the Act and transfer the \$5 million authorized under that program to the special project grant authority, where such an increase in appropriation authority is needed.

Data Collection and Nursing Personnel

Section 951 of the Nurse Training Act of 1975 mandates the Secretary of HEW to determine the supply, distribution, and requirements for nursing personnel both on a national and a state-by-state basis. These data are to be collected on a continuing basis and included in annual reports to the Congress. The first such report was released February 1, 1977. It catalogs existing data sources on the supply and distribution of nurses, makes several projections of future supply and demand, and identifies deficiencies in the present system of data collection along with strategies for more complete and accurate data collection in the future. The Association supports extension of these data collection provisions of the Act to aid in planning appropriate future needs for nursing personnel across the nation.

In conclusion, Mr. Chairman, we wish to reiterate our strong support for H.R.11434 to provide for a two-year extension of the Nurse Training Act. We also wish to offer our assistance to the committee during this period in developing long-term provisions for the present law which would meet future national needs for appropriate numbers and types of professional nursing personnel.

Thank you for the opportunity to appear before the subcommittee. I will be pleased to answer any questions you may have.

Mr. WALGREN. Thank you very much.

Mr. Logue, do you have anything that you would like to add?

Mr. LOGUE. No, sir.

Mr. WALGREN. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

As Pontius Pilate said at the trial of Jesus: "I find no fault."

Have nurse anesthetists helped to meet the needs of rural hospitals?

Dr. GEHRIG. Mr. Carter, at the moment, there is a great deal about nurse anesthesiology that I cannot profess to know, but I think from your and my practical experience, I do believe that, in both rural and in urban areas, they have been a very important part of our entire medical pattern.

Mr. CARTER. How would hospitals be affected if the programs were to be gradually phased out?

Dr. GEHRIG. This varies a good deal and it was a point that I was trying to make, and I am delighted that you focus on it. There are certain hospitals who have already moved to phase out the diploma program in areas where this has been an important resource for the recruitment of nurses. They have worked with educational institutions in having them take this role.

Where it has been possible to transfer, many times they have.

There are areas, however, where I think hospitals would be very, very loathe to step back from it because there is not a feasible alternative, and because the program provides for given areas, not a totality of its product for local use, but a very significant number who remain.

So, I think in those institutions—and we have some very excellent diploma schools of nursing—I would suspect that many of those would continue for quite some time in the future.

Mr. CARTER. I would agree with you. I think many of them are tremendous and they learn by doing and seeing things done. A profession like this is a profession that cannot be taken away from you. I think professions such as that will always be.

What do you see as the main cause for the thousand-odd unfilled nursing slots that were referred to this morning?

Dr. GEHRIG. Well, there are a variety of reasons. If I could digress for a moment, though. First, Dr. Carter, with regard to your other question, I think, in terms of diploma schools, as you are well aware, hospitals do operate their own diploma programs, some 390. To show the importance of the hospital in training, there is no—not to my knowledge—adequate nursing program that does not utilize the hospital. As you well know, the baccalaureate programs use their university hospitals as a part of their affiliation.

I just want to be sure that I do not put this in the wrong perspective. Hospitals are involved in nurse training wherever it occurs. In fact, they operate programs themselves.

If you look to the vacancies in Chicago, as we referred to in my statement, one basis, obviously, is the unavailability of qualified personnel. The other very significant factor—I am not referring now to that specific figure, but to other areas where there are vacancies—

obviously includes cutbacks for other purposes, so I cannot lay every nursing vacancy on the lack of a qualified nurse. But very significantly in some areas of vacancies it is because funding is unavailable, it is needed, and there are not qualified persons available.

I think that we should focus on that. As you look across the country, we cannot make a blanket statement. It is most frequent in the urban area, depressed area, as in the rural area.

Mr. WALGREN. If you will yield, does that conflict with HEW's testimony this morning about how there is no increased need at this point?

Mr. CARTER. It certainly does conflict with what they said.

Dr. GEHRIG. I wish I had had the opportunity to read their testimony more carefully. I am not sure what they said. I think that if they said that there are no nursing shortages existing, then we are in direct conflict.

I think the statement I am making, as honestly as I know how, that you cannot talk about nursing shortage nationally. You have got to look at the significant pockets.

When we refer to a State like Texas, I know that the Texas Hospital Association has been aggressively recruiting for nurses trained overseas because of shortages.

What I am really saying is, as you look at it—and I guess it is not unfair to suggest—that this represents a very significant problem in maldistribution. Whatever it is, there are significant areas of our country that do not have adequate nurse manpower. If you go the other step—that is, nursing manpower obviously is a broad rubric—you begin to look at the advanced training necessary for the technical skills in, for example, the nurse who is going to be a practitioner versus the nurse who staffs an intensive care unit, or the nurse who is doing a relatively independent job in public health.

This sort of thing here, you have a dimension in nursing because, in these situations, different levels of nursing are involved. In other words, your needs will be rather specific and particularly in the advanced training as another area of real need.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. WALGREN. Thank you, Dr. Carter.

I just wonder, it seems that the administration's proposal is really to reduce the funding in various nurse training areas to zero and it seems that that is a difficult thing to do when you have been given certainly a substantial effort in that area; and it seems to me that if you have brought something into being, that at least you want to continue or maintain it on the level that it is presently if it takes a little bit of an effort, and not a zero effort.

Is that your feeling also?

Dr. GEHRIG. It really is. If you just look at the bottom line of the administration's appropriation requests this year, where it ostensibly—and I do not have the exact figures in mind—it went from about \$120-odd million to \$20 million which was split between two areas, the dramatic position of pulling the rug is thus pictured.

The administration has congressional authority under the last act to provide studies of a continuing nature with regard to nursing manpower needs and we think this needs to continue. And I think

that there are changes that occur for which we can move into alterations in where we put our money.

You put your finger, I noticed in your earlier questioning today, on what is such an often-seen problem in Federal funding because a great initiative is started, many people in good faith run rapidly to get there and all of a sudden the Federal Government is gone from the scene and the alternatives are not really identified and sometimes the pulling of the rug does not relate to a study.

I think this morning we heard Dr. Foley of HRA state something that the retrenchment was not necessarily specifically related to planning with regard to certain elements of the Nurse Training Act, but rather represented a trade-off with the OMB because of other health initiatives. We understand that sort of thing, but the very thing that you have carefully looked at is so important because we are not here, I do not believe, at least it is not our intention to be here screaming wolf, but I think it is an extremely important time where plan changes in an educational program for this need to occur.

We could have had a discussion as to what the needs would be under revised national insurance, what the impact of the rural health clinic bill is going to be.

Again, we need to be looking ahead in order to look at those, but there are so many unknowns there. We would hope that this would begin to be a planned approach, whatever it might be, to an alteration, because what is suggested in the administration package is unrealistic at this point in time.

Mr. WALGREN. Thank you very much. We appreciate your effort and the work that goes into these presentations. We appreciate them because we will have a complete record to try to evaluate the different competing considerations.

That concludes the hearing.

[The following statement and letters were received for the record:]

Statement of the
Honorable Charles Thone
before the
Subcommittee on Health and the Environment

Mr. Chairman, the President's budget request for nursing is distressing and is not compatible with realistic planning for improved health care for rural and urban Americans. In this regard, I have introduced legislation to extend the Nurse Training Act for two years for the same total authorization. The five million authorized for financial distress, which has not been funded, would be transferred to the Special Project Grants Section, where it can be utilized in the most effective way.

There can be no doubt that Federal support for nursing has been instrumental in relieving what was a serious shortage of registered nurses. While there has been an increase in the numbers of nurses with advanced preparation for positions in nursing education, administration and supervision of nursing services and an increase from 13 percent to 20 percent of nurses holding a baccalaureate or higher degree, there still exists a tremendous need for nurses with advanced training. We have made giant steps forward in Nebraska, but providing improved health care to our rural population is impossible without even more registered nurses.

If we are to avoid disruption of funding for some 1,400 nursing programs with a quarter of a million nursing students, extension of the Nurse Training Act is essential at this time. The two year

extension of this Act will allow time for ongoing studies on credentialing, manpower needs, entry into practice, etc., to be completed. After careful review of these studies, of how these programs are helping to meet the public's need for health care, and of various sources of funding, new legislation can be developed.

We are very proud in Nebraska that Nebraska's graduating Registered Nurses achieved the highest average mean score of any state or jurisdiction on the national standardized licensing examination in July 1977. We want to maintain this high level of achievement. Therefore, it is of utmost importance to assure continuity in the nurse training programs in our state and others. If changes need to be made in funding, it is only reasonable that we allow sufficient lead time so that students and schools can prepare to meet the changes.



American Health Care Association 1200 15th Street, Washington, DC 20005 (202) 833-2050
March 16, 1978

Honorable Paul Rogers, Chairman
Subcommittee on Health and Environment
Committee on Interstate and Foreign Commerce
U. S. House of Representatives

Dear Congressman Rogers:

On behalf of the 7500 member long-term care facilities of AHCA, I wish to seek your support and the support of the Subcommittee members for a modification in Section 823 of the Nurse Training Act relating to cancellation of student loans. (42 U.S.C. 297b)

Under this section, up to 85% of a Nursing Student Loan may be cancelled if the recipient is employed as a professional nurse. This provision, however, is only applicable if the employing institution or agency is public or non-profit. Therefore, it is in the best interest of loan recipients to seek employment in such agencies or institutions. Conversely, it is not in the best interest of loan recipients to seek employment in private proprietary institutions. This discrimination compounds the difficulties faced by long-term care facilities in attracting qualified professional nurses.

Approximately three out of four nursing homes and other licensed long-term care facilities are operated on a proprietary basis. These facilities have great need for qualified professional nurses. The Senate Subcommittee on Long-Term Care of the Special Committee on Aging has explored the critical shortage of professional nurses in nursing homes. The subcommittee's report, Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper Number 4: Nurses in Nursing Homes: The Heavy Burden (The Reliance on Untrained and Unlicensed Personnel, stated "(o)ne government survey says that 80% of care in long-term institutions is provided by aides and orderlies. Nurses were said to perform only 17 per cent of all tasks, and there is reason to believe that even this overstates the case". In view of growing need for long-term care in the United States and the continued growing need for qualified nurses to provide care in these facilities, it seems inappropriate to place barriers to new nursing graduates who might be interested in pursuing careers in long-term care.

The Nurse Training Act of 1975 included several provisions that encouraged quality gerontological nursing. The Special Project Assistance provision specified geriatric nursing as an appropriate area for funds to be awarded in planning and developing new nurse training programs or programs of research in nursing education. This section also encouraged short-term or in-service training programs for LPNs, nurses aides, and orderlies working in nursing homes. Emphasis was also placed on the problems of geriatric and nursing home patients in developing Nurse Practitioner Programs. We believe the renewal of the Act should continue this progress by expanding the employment incentives for Student Loan recipients in the gerontological nursing field.

During the 1976-1977 academic year, approximately 28,100 student nurses received Nurse Training Act funds through the Nursing Student Loan Program. This figure is anticipated to increase over the next two years. We believe that it is important to quality care in nursing homes that recipients of these Nursing Student loans be encouraged to seek careers in long-term care rather than discouraged from seeking such employment.

Accordingly, Mr. Chairman, we urge the Subcommittee to adopt a suitable amendment to achieve this suggested modification. I would appreciate your inclusion of this correspondence in the record of the Subcommittee's hearings on legislation extending the Nurse Training Act.

Respectfully,

Bruce D. Thevenot
 Bruce D. Thevenot
 Administrator
 Government Services Division

BDT/rmc

Attachment

Amendment of Nurse Training Act

Subsection 297b(b)(3) of Title 42 of the U.S. Code is amended by striking the words "public or non-profit private."



Federation of American Hospitals

Michael D. Bromberg, Esquire, Director

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March 20, 1978

Honorable Paul G. Rogers, Chairman
Subcommittee on Health and the
Environment
Committee on Interstate and
Foreign Commerce
U. S. House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

On behalf of the members of the Federation of American Hospitals, I wish to submit the following comments on H. R. 10468, the Nurse Training Amendments of 1978.

The Federation of American Hospitals strongly supports H. R. 10468, the Nurse Training Amendments of 1978, which extends for two fiscal years the program of assistance for nurse training. Such a program is necessary to assist in the education of professional nurses and to assist and encourage graduates to pursue a career in professional nursing.

Though we support such an extension of the authorities and authorizations in the nurse training programs, we wish to comment on certain discriminatory provisions of Section 836 of the Public Health Service Act relating to loan cancellation. Under the present law Section 836(b)(3) stipulates that up to 85% of a loan obtained from the federal nursing student loan program may be cancelled for full time employment as a professional nurse (including teaching, administration, supervision or consultation) in any public or non-profit private agency, institution or organization. Section 836(h), however, stipulates that up to 85% of any loans (not restricted to loans received under this title) could be cancelled by the Federal Government in cases where the professional nurse signs a contract to serve in any facility that is in a designated nursing shortage area. We support the broad cancellation provisions in Section 836(h), but object to the prejudicial, limiting phrase "public or non-profit private" in Section 836(b)(3).

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The present provision of Section 836(b)(3) discriminates against recipients of Federal nursing loans seeking employment with proprietary facilities, discriminates against the facilities themselves, and discriminates against the patients served by such institutions. Such facilities, and the patients, will not benefit from the most recent advances in nursing education and techniques. The purpose of the loan cancellation program should be to give financial help to new graduates and to encourage the employment of nurses in all facilities. The criteria for such loan cancellations should be what is in the best interests of the public. To encourage the employment of nurses in any facility, regardless of ownership, is in the best interest of the public.

Further, there is a problem of maldistribution of health care professionals in the country (professional nurses and others). The health status of rural Americans is poor, particularly when contrasted to the health status of urban citizens. Approximately 49 million people live in medically underserved areas, and 27.4 or 56 percent live in rural areas. Yet rural areas have greater difficulty in attracting and keeping professional health personnel. Over 83 percent of areas lacking adequate health personnel are rural. Many proprietary facilities are located in and serve rural areas, and in many rural communities these facilities are the sole community providers. In many cases, these facilities are in need of professional nurses, but are not in designated nursing shortage areas, thus, the recipients of Federal loans would not qualify for cancellation. Such facilities have difficulty in attracting professional nurses and the limiting provisions of Section 836(b)(3) make it particularly difficult to recruit qualified professional staff.

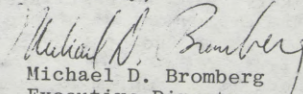
It should be noted that little or no added funds would be required by broadening Section 836(b)(3) to cover all facilities and not limit loan cancellations only to those working in public or nonprofit private institutions.

Under the present requirement, it is not in the best interests of the student to seek employment in proprietary facilities. By deleting the restrictive "public or nonprofit private" clause, the number or amounts of loan cancellations would not increase, but the recipients of such loans would be able to choose freely where they wish to work. Any such change in the present law would not result in a proprietary facility receiving any funds. The change would only benefit the recipients of the loans and those they serve, the patients.

We urge that H. R. 10468 be amended by designating paragraphs (b) and (c) of Section 9 as paragraphs (c) and (d), respectively, and by adding a new Section 9(b): Sub-section (b)(3) of Section 836 (relating to loan provisions) is amended by striking out "public or nonprofit private."

Please include these remarks in the formal record of the Subcommittee's hearings on the extension of the Nurse Training Act.

Sincerely,


Michael D. Bromberg
Executive Director

MDB:rt

cc: Honorable Tim Lee Carter



JAMES H. SAMMONS, M.D.
Executive Vice President
(751-6200)

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 751-6000 • TWX 910-221-0300

March 31, 1978

The Honorable Paul G. Rogers
Chairman
Subcommittee on Health and Environment
Committee on Interstate and Foreign Commerce
United States House of Representatives
Washington, D. C. 20515

Dear Congressman Rogers:

The American Medical Association submits the following comments on H.R. 11434, the Nurse Training Amendments of 1978. This bill would extend for two years the program of federal assistance for nursing education.

The AMA recognizes the important role of nurses in the delivery of health services. An adequate supply of properly trained nursing personnel is essential to maintaining the continuity and effectiveness of patient care. We believe that the federal government has played an important role in the support of nursing training and we recommend that support be continued.

The primary need now is to insure that students obtain adequate financial support to take full advantage of existing facilities and that existing facilities receive needed assistance. In view of the limited budgetary funds available, as indicated by the Administration, such an approach is particularly desirable.

Therefore, we support a one-year extension of the authorization of appropriations for the following nurse training programs: capitation grants to schools of nursing, special project grants and contracts, advanced nurse training programs, traineeships for advanced training of professional nurses, student loans, and scholarship grants.

We request that this letter be made part of the Subcommittee's official hearings record on H.R. 11434.

Sincerely,

James H. Sammons, M. D.

[Whereupon, at 3:10 p.m., the hearing was adjourned.]



