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A SOCIAL MANDATE FOR NURSING:
PRESCRIPTION FOR THE FUTURE

Sister Rosemary Donley*

This essay will discuss nursing as a profession in the year 2000. The selection of the year 2000 as the future to be anticipated reflects a fascination with round numbers, a belief that long-range planning is a substitute for science fiction, and a conviction that we shape our future. We are creating the year 2000 and most of us will live to see our work.

Many of the elements which will shape the year 2000 are present in today's society. Social theorists such as Alvin Toffler comment that we are on the edge of an informational society, an "R2D2" world where machines will communicate with and direct each other.¹ More popular authors such as John Naisbitt characterize our developing society as highly technological.²

These reflections do not startle health professionals. Physicians and nurses have witnessed revolutionary changes in their practices with the development of high technology medicine. Today computerized axial tomography and third generation monitoring devices, once restricted to academic health centers, are ordinary equipment in community hospitals. Research in genetics and molecular biology has deepened our understanding of health and illness and enabled us to observe the very beginnings of life. Public perceptions about the health care establishment have exceeded the prophecy of Ivan Illich when he foresaw that people would give "medical gods" the power of life and death.³ It is not necessary, however, to quote a social philosopher to offer evidence that Americans have invested in their health. The Medicare and Medicaid programs provide remarkable testimony of public endorsement of the importance of treatment.

It is generally accepted that professions develop in response to societal need. Professionals then shape and are formed by the society that called them into being. It is interesting to examine the emergence of the nursing profession within the context of a social mandate for high technology

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¹ A. TOFFLER, THE THIRD WAVE (1980).
² J. NAISSBITT, MEGATRENDS (1982).
³ I. ILlich, MEDICAL NEMESIS (1976).
medicine. This paper, which spans twenty-five years (1960-1985), is especially provocative because the public is re-evaluating the cost of its commitment to high technology care. The data to be examined are public documents: The Report of the Surgeon General (1963) which established a nursing shortage and laid the groundwork for federal investment in nursing education under the rubric of the Nurse Training Act; the Position Paper of the American Nurses' Association on the education of professional nurses; the eighteenth and nineteenth amendments to the Social Security Act which made the federal government the major financier of health care services and brought the health care industry to the market place, turning around the payment mechanisms for hospitals and stimulating alternate systems for the delivery of health services. The thesis of this essay is that socially mandated public policy shaped the profession of nursing in the mid-twentieth century. The question to be then answered is, "will nurses offer leadership in future health care systems?"

The Commission which drafted the Surgeon General's Report portrayed a society in need of nursing services. Before 1960, the education of nurses was under the aegis of hospitals. There was, however, sentiment that nursing education should take place in universities and colleges and that the costs of nursing education should be more equitably distributed. For some, new community colleges were ideal sites for nursing programs because they satisfied both criteria. The manpower legislation which developed in response to the Surgeon General's Report did not address the locus of nursing education. It is fair to observe, however, that while hospitals blossomed in the sixties and seventies, diploma schools closed. In 1962 there were eight hundred and sixty-six hospital-based schools of nursing. In 1981 there were three hundred and three. In the same period, associate degree programs grew from eighty-four to seven hundred and fifteen. Meanwhile, the federal government through its nursing training acts invested heavily in the education of nurses in diploma, associate, baccalaureate, and graduate degree

9. See generally supra note 1.
10. Id.
Most nurses (65.7 per cent) staffed the nation’s hospitals. Nurses who entered the field with graduate degrees in this period found new roles in transformed tertiary hospitals. Federal initiatives against such diseases as heart disease, cancer, and stroke attracted specialists as well as patients. Nurses who practiced in new clinical fields built networks with physician and nurse colleagues, founded over twenty-seven specialty nursing organizations, and launched twenty-five journals. Given this historical perspective one wonders why the American Nurses’ Association (ANA) Position Paper was controversial. The statement merely described the gradual transition of nursing education into colleges and universities. However, this single-page document foreshadowed the development of nursing science, professional autonomy, expanded practices, and nurses’ roles in the woman’s movement. Today, it is still seen as a divisive document.

Data indicate that successive nurse training acts improved the number and level of education of practicing nurses. That these initiatives were a public response to a shortage highlighted the fact that the education of professional nurses was a necessary part of federal health policy. Federal intervention into the expansion and financing of health care, however, had more effects on professional practice than the components of the Nurse Training Act (e.g., student loans, traineeships, curriculum revisions, and forgiveness clauses). Medicare and, to a lesser degree, Medicaid revolutionized the health field. Health care became accessible to the poor, the retired, the old, and the chronically ill. It also became a big business. While entitlement legislation increased the volume of patients, federal reimbursement policies encouraged hospitals to build and equip specialty care units, purchase more equipment, and diagnose and treat patients without major preoccupation with cost. Intensive training in specialty-care nursing, the employment of ancillary workers, the advent of disposable equipment, and increasing availability of monitoring devices and high technology medicine, in general, gave new graduates sites for professional practice. Nurses responded enthusiastically to therapeutic imperatives. Standards for practice were developed, specialists managed acutely ill patients and prescribed their nursing care, and

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15. Personal Communication with Nell Watts, executive director of Sigma Theta Tau (February 1985).
nurses assumed evolving positions as clinical specialists, utilization review coordinators, patient-educators, home care consultants, and clinical researchers. In contrast to these high technology practices, other new professionals, "nurse practitioners" and physician's assistants, joined health maintenance organizations and helped define primary care.

While nursing salaries reflected the growth in the health care industry, the figures which are usually quoted to support the explosion in health care are displayed in the following graph and table. These charts form the natural backdrop for explaining the passage of the Prospective Payment Act of 1983.

Aggregate and *per capita* National Health Expenditures by Source of Funds and Percent of Gross National Product Selected Calendar Years, 1929-1982

<table>
<thead>
<tr>
<th>Year</th>
<th>National Health Expenditures (billions)</th>
<th>As a Percentage of the GNP</th>
</tr>
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<tbody>
<tr>
<td>1982</td>
<td>$322.4</td>
<td>$286.6</td>
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<td></td>
<td>10.5</td>
<td>9.8</td>
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<table>
<thead>
<tr>
<th>Year</th>
<th>National Health Expenditures (billions)</th>
<th>As a Percentage of the GNP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>$74.7</td>
<td>$65.5</td>
</tr>
<tr>
<td></td>
<td>7.5</td>
<td>7.0</td>
</tr>
</tbody>
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18. See *supra* note 7.
FIGURE 1
National Health Expenditures and Gross National Product:
Growth and Relative Sizes, 1966-1982

Calendar Year
Source: Bureau of Data Management and Strategy, Health Care Financing Administration.
While the acronym "DRG" (Diagnostic Related Groupings) captures public and professional fancy, prospective payment promises to revise and restructure health care systems. Today vertically and horizontally integrated corporations (profit as well as non-profit) crowd out single purpose health institutions much the way chain supermarkets closed "mom and pop" grocery stores. New payment arrangements will extend the site, scope, and responsibility of multidisciplined providers under the rubric of HMO's (Health Maintenance Organizations) and PPO's (Preferred Provider Organizations). Primary care practitioners rather than specialists are now gatekeepers, controlling entry into and use of the tertiary care facilities. The acute care hospital system, smaller as a result of flat payments and prospective reimbursement, will not continue to be the bastion of health care services because patients will be treated in less costly "surgi" and "urgi" centers (surgical and emergency care centers in shopping malls), ambulatory clinics, and at home.

As significant as the restructuring of the health care system is the recasting of values. Popular and professional literature challenges accepted diagnostic and therapeutic rationales. Some of the questions sound crass. Do we intend to spend three of every ten health care dollars to care for Americans whose abilities to work, keep house, or perform other activities of daily living are limited by chronic disease? Other observers suggest that we may be entering a period where criteria, such as age, may be used to ration available, costly treatments.19 In contemporary literature there is an examination of the ethics of tertiary care, emphasis on the escalating costs of treatment, and a concern that cost analysis may overshadow therapeutic and ethical examinations of benefit and burden.20 This author believes that highly technological, tertiary care is a fact of life. Secondary level community hospitals will be absent in the health system, circa 2000. Clinics close to home and office, and homes themselves will become centers of diagnosis, treatment, and care.

The central question, however, is not which center of treatment will be favored by new reimbursement formulae. The important dialogue is about the health of the American people. How will people seek care in decentralized systems? Will some advanced informational unit or new provider shepherd patients from ambulatory centers to their homes? Will shopping centers rival hospitals as sites for urgi and surgi care? Can families, who also seem to be scarce human resources, be mobilized to help their relatives?

Will the pendulum swing toward prevention, continuity of care, and encouraging healthy life styles?

Public policy has directed the provider community to diagnose and treat illness. These values must be scrutinized as carefully as the federal expenditures for health. It seems unlikely that any real savings will accrue until the preservation and promotion of health receive the attention and support reserved for such dramatic therapies as transplantation. Phrased another way, the savings which result from early discharge, delayed treatment, or substitution of homes and families for professional care will be marginal unless an emphasis on health life styles replaces our preoccupation with treatment of disease.

Even in the best of worlds, this social transformation requires advocacy, clinical decision making, management of information, and coordination of care. Where is the professional nurse? Social forces have placed women in the market place. Statistics reveal that not only are women mothers and homemakers, they are often the sole support of their families. After years of affirmative action, the nursing population remains overwhelmingly female. Will the energy which transformed the women’s movement enable nurses to assume appropriate leadership in the evolution of a new health care system?

Twenty years ago Medicare shaped the health milieu and made hospitals the center of the therapeutic hub. The education and social restriction of nurses in the fifties put them in disadvantageous positions when the health system was reformed. While nurses debated the structure of their profession and the role of hospitals in education, reimbursement policies of Medicare established physicians and hospitals as providers of care. In essence, the last time a health care system was created, nurses did not emerge as significant forces.

This paper began with a question about the future role of nurses as professional care givers. Social and educational constraints, the rationales of the fifties, cannot excuse modern nurses from recasting their traditional presence in health affairs. Because they have been categorically eliminated from fee-for-service reimbursement models, flat rate reimbursement does not threaten them. Nursing education has emphasized preventive health care more than tending to the ill. Nurses have addressed the needs of the aged.

History will record whether idealism and advocacy will enable nurses to

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carve out new roles as coordinators and providers of care in a changed health care system. Self-image more than self interest may well determine how nurses position themselves in the evolving health care constellation.