Compensation as a Function of Retention of Nurses

Retention Subcommittee Working Paper

October 2002

Prepared for
Maryland Statewide Commission on the Crisis in Nursing

By
Center for Health Program Development and Management
University of Maryland, Baltimore County

Table of Contents

Executive Summary ..... **ii**

I. Introduction and Purpose of This Paper **1**

II. Problem Statement **3**

III. Review of the Literature **6**

History of Nursing and Compensation 6

Role of Compensation 7

Components of Compensation 7

Salary Trends 11

Benefits 12

IV. Legal Aspects of Compensation **16**

V. Factors That Influence Compensation **18**

Nursing as a Female-Dominated Profession 18

Generational Issues 18

Market Forces and the Nursing Shortage 21

Unions and Collective Bargaining 21

VI. What Can Be Done **23**

Appendices

Appendix 1: A Statement on Patient Safety and the Quality of Patient Care 25

Appendix 2: A Description of Nursing and Compensation in 1895 30

Appendix 3: Unions Representing Nurses in the United States and Canada 31

References **32**

Executive Summary

The need for nurses is increasing due to the overall aging of the population as people live longer and the incidence of chronic disease associated with aging increases. In addition to this, more nurses are leaving the field of nursing (through retirement and changing careers) than are entering. These factors make up the foundation of the current nursing shortage, but the shortage is more than a matter of simple math.

Turnover and vacancy in nursing positions, nationally, are at all-time high levels. Nurses, as the single most numerous human resource in healthcare, and adequate quantities of well-trained, competent nursing professionals are key to the delivery of high quality, safe care. Research into the reasons for fewer new entrants into nursing and for the exodus of nurses from the profession before retirement has uncovered a number of factors that contribute to these phenomena.

Compensation is among the factors that are felt to be contributors to the nursing shortage. A review of nursing history provides insight into current approaches to nursing compensation. Historically, nursing was a non-professional, service-based, female-dominated occupation. Nurses' compensation included room, board, laundry, and transportation. Nursing continues to be a female-dominated profession, and as such, is impacted by gender-based wage issues. However, nursing has evolved into a profession requiring daily management of life and death scenarios in a highly technologically complex environment. It is a profession that is ably undertaken by caring women and men who are rigorously educated and trained, and who respond to the challenge of providing critical services often under trying circumstances.

Compensation, though not considered a satisfier that can function unilaterally to retain employees, is known to be a potential dissatisfier. Compensation must be considered a comprehensive concept that includes not only money, but also other tangible and intangible assets that are often included in the work contract. Non-monetary compensation includes benefits such as time off, insurance to protect income (health disability, social security, etc.), incentives, and others.

A number of opportunities exist to remedy the possible negative impact of compensation and the recruitment and retention of nurses. These actions can be taken by the current Commission (Maryland Statewide Commission on the Crisis in Nursing, or MSCCN), employers, and nurses themselves.

The Commission can:

- Educate nurses and encourage advocacy through participation of nurses in such organizations as the National Committee on Pay Equity, state nurses associations, and the American Nurses Association (ANA)
- Educate the public about the valuable role of nurses
- Support legislation and research to uncover and address wage discrimination or other legally-based compensation issues, such as restraint of practice (e.g., the inclusion of nurse practitioners by some third party payers)

Employers can:

- Communicate with nurses about compensation – and the development of an organization's compensation plan needs to be inclusive
- Offer flexible benefit structures so that nurses in different life stages can select benefits that are most important to them
- Pre-pay for education rather than reimburse to allow more nurses to take advantage of this opportunity, as well as pay for prior student loans
- Ensure internal equity to avoid gender or other biases and market adjustments to ensure external equity

Nurses can:

- Be knowledgeable about and use laws that provide compensation protection, such as the Equal Pay for Equal Work Act
- Understand the total value of their compensation packages, beyond their salaries, in order to represent themselves most effectively in employment negotiations – annual benefit statements might be a way to accomplish this

I. Introduction and Purpose of This Paper

In 2000, the Maryland Assembly created a commission to study and develop approaches to stem the current shortage of nursing personnel in the state. Maryland, like other states, is experiencing changing demographics among nurses and the population requiring care, which will lead to a critical shortage of nurses. In June of 2000, a summit was held at the University of Maryland School of Nursing, where nurses came to express their concerns about the current state of nursing. Critical topics were identified that the Commission felt were focal to its charge. As a result, four subcommittees were established: Workplace Issues, Education, Recruitment, and Retention.

Each subcommittee has a goal to elucidate the issues that lead to the decreasing numbers of young people entering nursing and the "premature" (early and elective) exodus of experienced nurses from direct patient care in pursuit of other health careers or to leave healthcare altogether. Among the many issues identified by the Retention Subcommittee that contribute to a nurse staying within her/his current work environment was compensation. Nurses have a narrow vision of compensation (primarily hourly pay rate and health insurance benefits). Understanding and addressing nurses' concerns about compensation is critical. If compensation issues were disregarded or acknowledgement of them were delayed, much of the Commission's work would be in jeopardy. The Retention Subcommittee first reviewed the literature to gain a holistic view of the issues, and then identified a number of pressing concerns regarding the role of compensation in attracting people to the profession and decreasing attrition from places of employment and the profession.

This document serves as a working paper to broaden the understanding of compensation as a fundamental component of the employer-employee relationship and an important issue in the retention of nurses. It is a multi-faceted process that reaches beyond the simple exchange of labor for hire. As social needs increase due to an aging population, which is being served by a dwindling number of nurses, we cannot afford to lose such valued resources.

Modification of compensation may entail some cost. Though many of the suggestions raised in the literature do not increase cost dollar-for-dollar (i.e., some have value beyond their actual costs), addressing the issue of nursing compensation will add to the overall expanding costs of healthcare, or perhaps a redistribution of the healthcare dollar. As such, this paper will have an impact on many groups:

- *Patients* are of primary importance in this issue as they rely on the life-saving presence of well-educated, qualified nurses to provide care at critical points in their lives. Patients may have to shoulder some cost as third party payers and employers pass additional cost to them through increased insurance premiums.
- These issues are important to professional *nurses* who, in function and in numbers, are pivotal members of the healthcare delivery team. Over the decades nurses have adapted to an expanding role that requires "specialized knowledge,

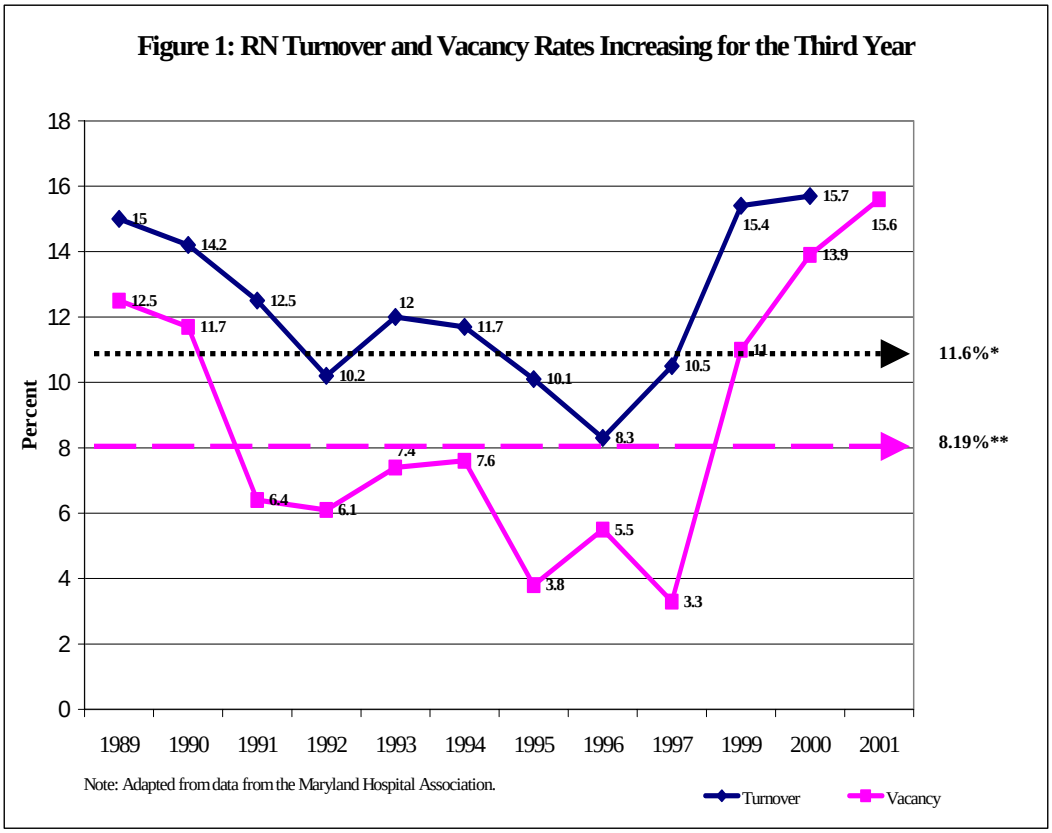
judgement and skill based on biological or sociological sciences as the basis for assessment …" (COMAR 10.27).

- *Third-party payers* (profit and not-for-profit) are affected as they seek to provide affordable healthcare to their clients
- *Healthcare organizations and their administrators* are involved as the major employer of nurses, and as they struggle to remain fiscally solvent

II. Problem Statement

Nurses work in many venues, but primarily in healthcare organizations that deliver direct care to patients. Nurses, like other wage earners or salaried professionals, must negotiate with employers for compensation. Based on the role played in the organization (function, level of responsibility, etc.), the individual nurse reaches an agreement with the prospective employer as to the work conditions and employer expectations. Nurses are affected by the state of the economy and the prevailing market forces, as are other workers, in regard to compensation. There is a national shortage of nurses in terms of vacant positions and the extended time it takes employers to fill these positions. In Maryland, the vacancy rate increased for the third year in a row, to 15.6 percent in 2001 ("Nursing shortage," 2002). Among staff nurses, the vacancy rate as of June 30, 2001, was as high as 23.1 percent in Maryland long-term care facilities (American Health Care Association, 2002). A reasonable benchmark for turnover and vacancy might be the extent of these occurrences among Magnet hospitals. The ANA Magnet Nursing Services Recognition Program designates hospitals as exhibiting sustained excellence in nursing care. Among Magnet hospitals, the average turnover is 11.6 percent (36 percent better than Maryland in 2000), and the average vacancy rate is 8.19 percent (41 percent better than Maryland in 2000) (American Nurses Credentialing Center, 2002). From 1997 to 2000, nursing turnover rates in Maryland increased 50 percent. See Figure 1.

Figure 1: RN Turnover and Vacancy Rates Increasing for the Third Year



Source: American Nurses Credentialing Center. (2002). The Magnet Nursing Services Recognition Program: Making a difference – highlights from 2001. Credentialing News, 5(1).
*Average Magnet Hospital Turnover (year not reported) **Average Magnet Hospital Vacancy (year not reported)

Lowering staffing levels and filling positions with less experienced persons impacts the quality of patient care (i.e., the amount of time a professional nurse spends with a patient, assessing patient needs, planning interventions, implementing those interventions, and evaluating their effect). Patient safety can be compromised as well. The Maryland Statewide Commission on the Crisis in Nursing (MSCCN) has developed a statement about the impact of the nursing shortage and its related issues entitled, "A Statement on Patient Safety and the Quality of Patient Care" (Appendix 1).

The retention of qualified individuals is a core activity of all businesses. While wages are not considered "satisfiers" and cannot unilaterally resolve retention issues, it can be a dissatisfier, and is the foundation of the employment contract. A 2001 survey found that only 18 percent of the nurses who considered leaving nursing for reasons other than retirement cited pay as the reason. Thus, pay is not a primary cause of the loss of nurses (Heinrich, 2001). In a study of nurses' job satisfaction/dissatisfaction, McNeese-Smith found only brief mention of salary and benefits, with no specific themes (1999). However, if pay is not considered "fair," then correcting other workplace issues for nurses may be futile. Vacancies that occur as a result of turnover hurt businesses. Vacancies filled with less experienced nurses also result in short-term losses in productivity and profit. Dissatisfaction due to increased overtime and inadequate staffing (often-cited concerns) can be problematic for retaining valuable nurses and recruiting new ones.

There are currently not enough practicing nurses in healthcare. This shortage is going to be exacerbated by:

- An aging nursing workforce, with many nurses retiring in the next ten years
- Fewer nursing graduates because fewer are choosing nursing due to many other careers to select
- Experienced nurses leaving the nursing profession for more lucrative and less stressful positions outside of hospitals/long-term care/home health, or even outside of healthcare
- An aging population requiring more and more nursing care in a variety of settings

Nationally, the average age of nurses is 46 years. A recent survey of Maryland nurses shows that 70 percent are over age 45, and 32 percent are over age 55 (Maryland Statewide Commission, 2002).

It is postulated that fewer young adults are choosing nursing as a career because they have more and better opportunities than did earlier generations, particularly women. Many jobs have higher entry-level salaries, accelerated career paths, and do not require a 24/7 commitment with life and death responsibilities that are physically demanding.

The aging of the nursing workforce and opportunities outside of nursing and/or healthcare prompt nurses to exit from positions requiring 24/7. At the same time, there is an increased demand for nurses in work settings such as home health; nurse-managed health centers; nurse health advisers; health promotion; home infusion therapy; and nurse

administrative positions such as health risk management, disability management, case management, and expert legal witnesses. Although important to patient care, these positions take nurses away from the bedside.

In a recent presentation on the state's hospitals, the president of the Maryland Hospital Association, Cal Pierson, cited many of these factors as contributing to the pressure on Maryland hospitals (2001). While there are other issues facing American healthcare, it is clear that compensation (both current earning power and career trajectory earnings) is a major factor for the selection and continuation of a career choice. Among other actions, Mr. Pierson cites "retention/compensation initiatives" as approaches needed to correct the current and ongoing shortage of nurses.

III. Review of the Literature

History of Nursing and Compensation

"Those who ignore history are doomed to repeat it" is an often-cited phrase. With this in mind, it is important to understand nursing's history and compensation. Nursing was initially a voluntary, often religion-based effort, to which individuals were drawn due to feelings of compassion, duty, and altruism. Until the 1500s, nursing care consisted primarily of custodial functions of either servants or kindly persons who visited the poor. If there was any compensation, it was on a case-by-case basis, presumably with whatever resources the individual needing care could offer. In the 1500s, the Sisters of Charity began "systematic education" of nurses, which was later reformed and expanded in the 1800s by efforts such as Florence Nightingale in London and events such as the American Civil War (Wolfe, 1997).

An excerpt from an 1895 treatise on nursing, "Ambulance Work and Nursing – A Handbook of First Aid to the Injured With a Section on Nursing, Etc." provides a telling description of the financial arrangements of nursing compensation (Emergency Nursing World) (Appendix 2). Mentioned in this writing are the arrangements for training, compensation following graduation, and the benefits that one could look forward to, including salary, vacation, and pension. The excerpt even describes nursing agencies and how nurses preferred such arrangements because these agencies were known for their competent nurses, fair dealings, and improved compensation of nurses. Hours were long, with little opportunity for personal time. There is a description of the special relationship that nurses had with patients, expressed by the patients' appreciation of the care provided. Historically, the nurse, not an ancillary service, was primarily responsible for the patient's wellbeing. With just a few changes, the description in this excerpt is not too unlike what nurses experience today. In the early1900s, nurses worked shifts around the clock as they still do today (Texas Nurses Association, 1996).

Through the establishment of the Army Nurse Corps and, shortly thereafter, the Navy Nurse Corps during the early 1900s, the professional status of nursing began to gain credibility. Through the 1930s and 1940s, nursing, as well as other labor groups, was affected by legislative mandates to improve the conditions of American workers. However, later actions were taken that excluded nurses, and others, from some of the protections that were provided (Wolfe, 1997).

Nurses received fewer benefits and worked longer hours than many workers whose skills were similar to or less than the skills of nurses. Despite nurses' notable professional responsibilities and rigorous education requirements, a 1955 study showed that nurses' salaries were below those of accountants, draftsmen, teachers, social welfare and recreation workers, and librarians (Wolfe, 1997).

Throughout the 1960s, nurses' salary increases lagged behind those for other professions. In 1960, nurses earned $25-30 per week less than office, clerical and maintenance personnel in the 15 cities surveyed by Bureau of Labor Statistics (Wolfe, 1997). Though

salaries improved in the late 60s and early 70s, they continued to lag behind. More recent salary trends are discussed later in this section.

Role of Compensation

Compensation is a primary element of the employment contract. The employer contracts with the employee to perform certain functions that the business requires in order to produce an output, in exchange for money, which the employee uses to purchase goods and services that are needed or wanted (Figure 2).

Figure 2: The Relationship Between Business Goals and Employee Needs As a Basis for Compensation

2002: Center for Health Program and Development and Management

Businesses whose primary output is service (e.g., healthcare organizations) are heavily vested in human resources as their primary input and throughput (means to produce services). The provision of healthcare is a service-oriented process, especially in acute hospitals, long-term care, and home health/hospice. Nurses are the single largest human resource component in healthcare, and in order to protect the integrity of this valuable resource, serious efforts must be made to maintain it.

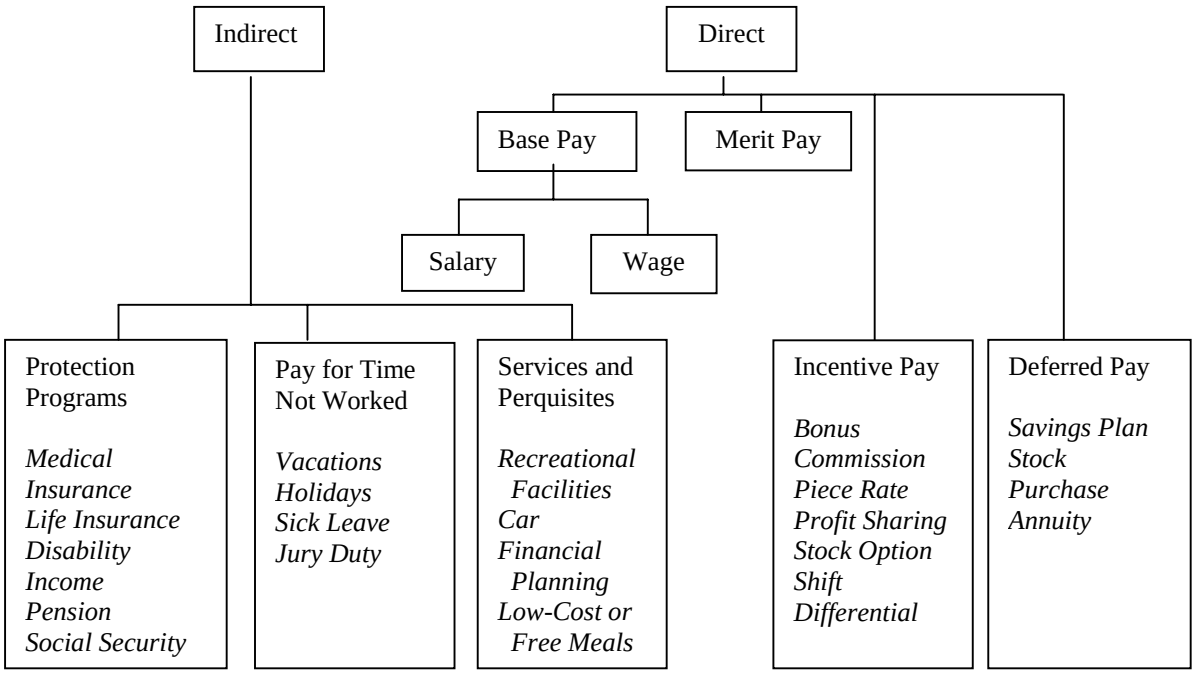
Components of Compensation

Compensation is a system of exchange. Individuals are rewarded with either money or other valuable assets (optional and mandatory benefits), or both in exchange for performing certain functions. This discussion of compensation is confined to the basic exchange of money for time and other benefits, some of which are common and others that are not so common.

Compensation can be sorted into direct and indirect categories. Direct compensation is actual money given to a worker and consists of base pay, merit pay, incentive pay, and deferred pay. Indirect compensation does not involve actual money, but is usually associated with monetary value, (i.e., items that would otherwise have to be purchased by the worker her/himself). Indirect compensation includes protection

programs such as health and other insurance, pay for time not worked, and other services. See Figure 3.

Figure 3: Components of the Compensation System



Adapted from: Fisher, C., Schoenfeldt, L., & Shaw, J. (1996). Human resource management. Houghton Mifflin Company, p. 506.

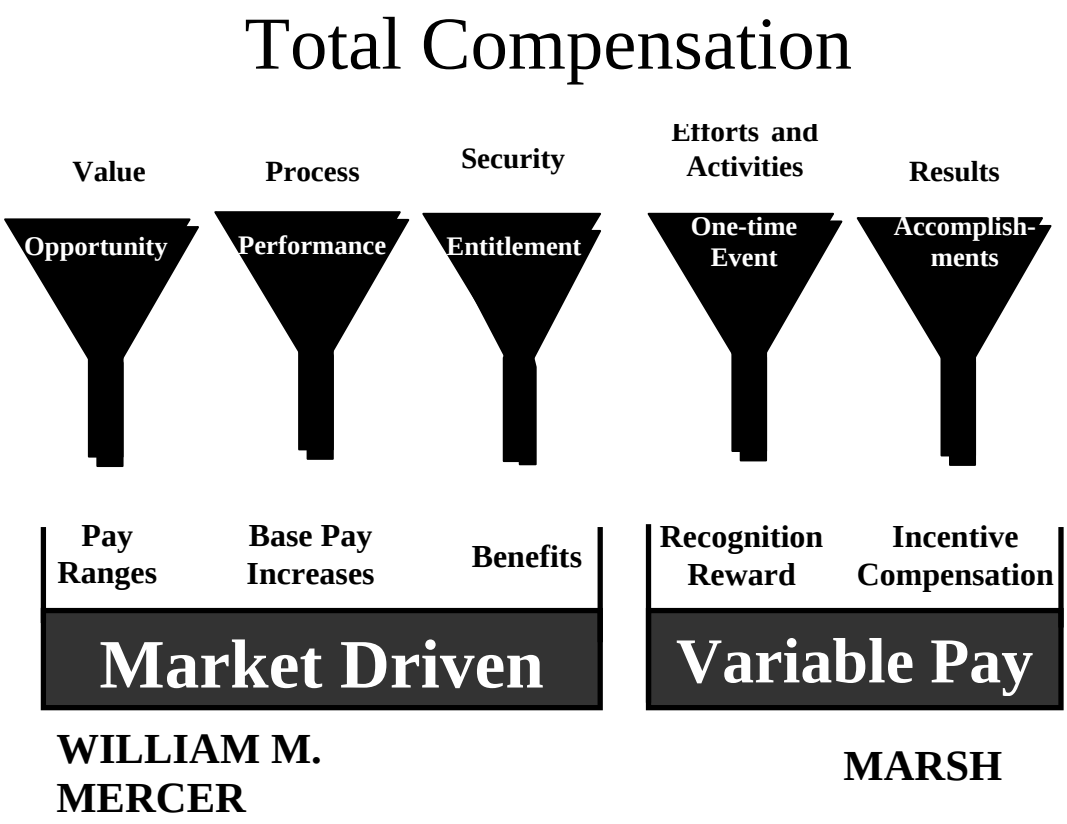
The Retention Subcommittee has conceptualized "total compensation" as the following combination of elements: value, process, security, efforts and activities, and results (Figure 4).

Total Compensation = Value + Process + Security + Efforts & Activities + Results

- *Value* is the pay received for time worked, either hourly or salary. Pay should be market-based, competitive, and be determined partly by education and experience.
- *Process* is the action of modifying base pay, generally through raises to the base pay for cost of living increases, merit pay for performance, etc.
- *Security* consists of items that provide protection, as in Figure 3, and provide workers with relief for costs that they would incur to improve the quality of their lives, such as paid time off, education assistance, dependent care, and parking

- *Results* consist of incentives for high performance, improved productivity, and other behaviors beneficial to the company
- *Efforts and Activities* are recognition offered by the company that acknowledges and appreciates the contributions of workers

Figure 4: Mercer Total Compensation Model



The Retention Subcommittee prioritized particular "security" and "results" variables as being available in current benefit packages, available but needing improvement, or desirable additions to standard benefits (Table 1). Some benefits may only lend themselves to being offered in for-profit organizations (such as stock options and 401K plans), while others are more suited to not-for-profit sector organizations (403B plans).

Table 1: Retention Subcommittee Categorization of Current Benefits, Benefits Needing Improvement, and Desired Benefit Additions

	Available in Most Current Benefit Packages	Available in Most Current Benefit Packages/Need Improvement	Desirable Additions to Standard Benefits
Security	– Dental/vision/ – hearing care – Health insurance – Dependent care – Flexible spending	– Life insurance – Disability insurance – Retirement - 401K/403B match – PTO (paid time off) vacation/sick time – Education (internal continuing education, tuition)	– Child/eldercare (well and sick) – Alternative medicine – Longevity benefits/incentives (certification, precepting students and mentoring new staff) – Debt relief – Free parking/commuting assistance – Reimbursement for certification – Rent/mortgage subsidy
Results			– Retention Bonus – Gain sharing

Compensation administration requires the expertise of an experienced human resources professional who has access to critical and timely data, such as profession- and position-specific market analysis and preference/satisfaction surveys of employees. William H. Mercer is conducting a survey of healthcare agencies to understand compensation issues among Maryland healthcare workers, especially nurses. It is also essential that staff at the point of care be involved in the design and periodic reviews of the compensation system. Compensation is not a satisfier, but every effort must be made so that it does not become a dissatisfier. Knowledge of current salary surveys; market analysis of prevailing wages; and equity within the work setting (internal equity) and outside of the work setting (equal pay for equal work and comparable worth issues) are all factors that must be understood by all parties involved in the compensation continuum.

Equity is the perceived balance between an individual's rewards or outcomes relative to the individual's contribution, compared to the rewards of others relative to others' contributions, either in the same job/industry, or even in another job/industry. Internal equity exists when "fairness" is perceived among the compensation levels of jobs within an organization. External equity compares similar jobs from different companies. Individual equity refers to balance among persons in the same job within the same organization. "There is no single basis for compensation decisions that will always be seen as fair. Justice seems most likely to be attained when the parties agree on the most appropriate basis for reward distribution, but such agreement cannot be assumed to occur without discussion" (Fisher, Schoenfeldt, & Shaw, 1996, p. 511).

The employee's response to perceived inequity may involve quitting and seeking employment in another location (or possibly field) where the perceived inequity does not exist. In regard to compensation as a factor, turnover might be due to institutional failure to remain competitive. These occurrences of turnover and vacancy must be reduced. In a survey conducted by MSCCN in 2001of registered nurses (RNs) and licensed practical

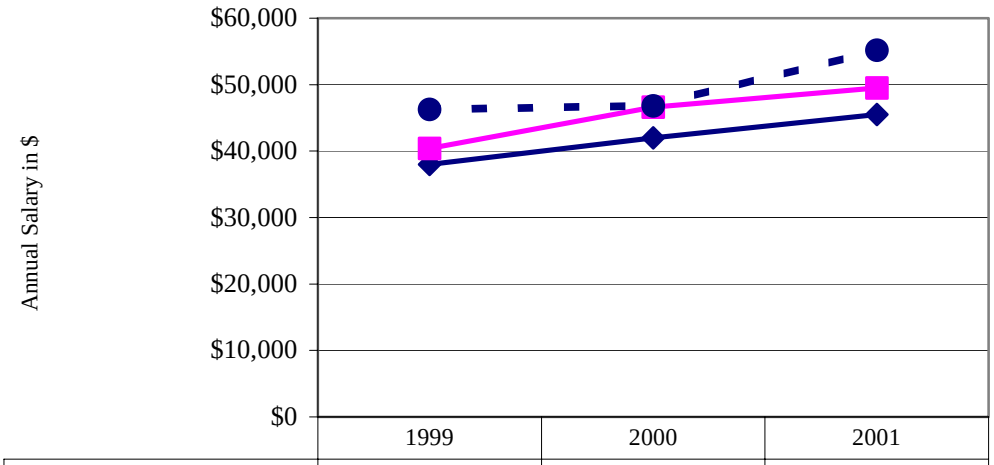
nurses (LPNs) at the point of care, 35 percent reported that there is internal equity in compensation at their place of employment. Twenty-nine percent reported that there was no equity, and 35 percent said that they were not sure, a testament to the "secrecy" surrounding salary prevalent in many businesses. An open system without such secrecy assures that all are being compensated fairly (Fisher et al., 1996).

In the same survey, respondents reported that their institution's inadequate approach to compensation for attained education (19 percent) and experience (20 percent) would cause them to want to leave their job (MSCCN, 2001). Increasing wages for new employees because of external competition may create internal inequities, as newer staff wages begin to approach the wage levels of employees with longevity/seniority. Salary compression occurs when the wages of entry-level persons increase at a faster rate than those already employed, leading to smaller differences in the salaries of new versus longer-standing employees (Fisher et al., 1996). The experience factor is critical to the nursing profession since nurses change jobs and therefore may not build seniority at a particular place of employment. Nurses often reach the upper limits of their salary range early in their careers. As a comparison, lawyers can expect a 226 percent progression over their careers; nurses can expect 69 percent. A relatively small amount of money (sometimes $8/hr, or $16,640/yr.) separates new graduates from those with decades of experience (Fitzpatrick, 2000).

Salary Trends

Salary surveys may be the most frequently performed surveys of nurses. There are a number of annual, biannual, and mixed surveys from employers, government agencies, unions, professional organizations, and professional journals that continuously track the changes in nursing salaries/wages and benefits. One recent survey conducted by Nursing 2002 shows that the average nursing salary has risen in the past two years for both certified and uncertified nurses (Figure 5). Certified nurses (nurses who have demonstrated expertise in a particular area of nursing practice through examination and by the American Nurses Credentialing Center) have slightly higher salaries on average, though the rate of increase for certified nurses slowed dramatically from 2000 to 2001 (15.3 percent to 6 percent). The rate of increase of uncertified nurses fell less dramatically from 10.5 percent to 8.3 percent. Maryland nursing salaries average slightly higher and experienced an 18 percent increase from 2000 to 2001. The average starting base rate rose from $15.45 per hour in 1999 to $17.33 per hour in 2001, a 12.2 percent increase. In 2000, 38 percent of new hires received sign-on bonuses, while only 32 percent reported such bonuses in 2001.

Figure 5: Average Salaries for RNs 1999-2001



	1999	2000	2001
Average Annual Income Regardless of Certification	$38,000	$42,000	$45,500
Average Annual Income if Certified	$40,400	$46,600	$49,500
Maryland Overall Average (no work level)	$46,280	$46,821	$55,162

Adapted from Robinson, E. S. (2002). Nursing 2002 salary. Nursing 2002, 32(4) at www.springnet.com., and from Bureau of Labor Statistics online data compilation at http://data.bls.gov.

Although nurses' "actual" salaries have, on average, increased 169 percent since 1980, the "real" average increase (based on the Consumer Price Index and adjusting for the purchasing power of the dollar) is only 34 percent (Spratley, Johnson, Sochalski, Fritz, & Spencer, 2000).

Factors affecting compensation levels include: higher salaries in Veterans Administration and military hospitals than in community hospitals (though community hospitals are still above average for all nurses at $46,700); higher salaries in hospitals with more beds; and geographical differences. The gap between hospitals and other settings is decreasing.

Benefits

A 2001 MetLife study of employee benefits trends shows that 78 percent of employers viewed retention and 73 percent viewed controlling costs of health/welfare benefits as their most critical benefits objective. Employers also view work/life balance as one of their most important benefit strategies. These include personal leave; flex time; information and counseling services; convenience or concierge services; and an array of

voluntary offerings, as well as providing employees with access to a wide range of financial and group insurance products ("Metlife review," 2001). A nationwide William Mercer survey (Carey, 2001b) reported that all employees want four basic benefits:

- 401K/403B
- Medical care
- Pension
- A clear sense of organizational purpose

A schema for a full array of benefits is presented in Figure 3. Many of these are reviewed below.

Among the optional benefits, and in the protective category, are health/medical benefits. Healthcare costs have risen dramatically and employers are beginning to shift more share of the costs to employees with co-payments, deductibles, coordinated coverage, and coinsurance payments to lower employer premiums. The goal of cost sharing is to "make the employee more aware of costs" and to reduce "unnecessary" use of healthcare. For example, IBM decreased admission by 36 percent and saved $100 million by requiring employees to pay 40 percent of the first day of hospital costs. However, cost shifting presents barriers to needed healthcare in some instances.

Retirement benefits are an important consideration for an aging society, and a large number of nurses are approaching retirement. Retirement and pension plans and health benefits for retirees are major concerns for nurses and healthcare organization administrators because such benefits can have a great impact on profits. Formerly thought of as "doing nice things for retirees," retirement benefits are expensive and can cost up to 10 percent of payroll (Fisher et al., 1996). The size of the retirement benefit often depends on the length of service with the employer. Frequent moving of nurses diminishes the likelihood that they will have enough equity in a single place of employment to reap significant benefits. Choosing more portable options such as tax-deferred retirement plans (e.g., 401K and 403B in the not-for-profit sector) might be advantageous. Typically, pension income is 20 to 30 percent of pre-retirement income (supplemented by Social Security and Medicare).

Pension benefits can be one of three types:

1. Defined Benefit - payments based on length of service and salary during last years of employment
2. Defined Contribution - a fixed contribution, by the employer, to an employee account, and payments are based on accumulated contributions and gains (losses) on investment; includes profit sharing and employee stock ownership plans
3. Capital Accumulation - deferred tax contribution by employee, such as 401K

Optional benefits that could assist in retention are those that provide opportunity to ease workers' lives in ways that enrich their work experience and their family/leisure time. Wellness programs (e.g., health club memberships or subsidies) or direct payment for healthy behaviors (e.g., smoking cessation classes or lowering cholesterol) can not only improve employee health and reduce absenteeism, but may also improve morale, productivity, and workplace relations.

Educational assistance in the form of tuition reimbursement and payment for books and/or fees is often provided. Employers should consider prospective payment rather than reimbursement, since cash-poor employees may not be able to take advantage of education benefits if an initial cash outlay is required. Johns Hopkins Hospital not only has tuition assistance for its employees, but also offers tuition benefits for dependents of some employees.

For many employees, especially women, child care assistance is critical. For some the issue extends to care needs of older adult relatives for whom they have assumed responsibility. A proportion of employees will be in what has been termed the sandwich generation, which has responsibility for both children and older adult relatives. Dependent care can be offered onsite, or it may take the form of financial assistance or information and referral. Because situations cover diverse needs, referral and/or cash assistance may be the best approach. Dependent Care Spending Accounts can provide savings for employees by providing pre-tax opportunities to pay for dependent care for children or elders. Tax-deferred earnings up to $5,000 a year can be set aside to pay for these expenses. The downside to tax-deferred spending accounts is that one loses what is not spent; however, there is no cost to the employer except administratively.

Flexible benefits or cafeteria-style benefit plans allow employees to choose what they want/need and can address issues of different ages, life situations, etc. Though the administration of flexible benefits is more complex and expensive, the benefits outweigh the cost in terms of organizational reputation and employee satisfaction. This can impact retention. The generational issues discussed in the nursing workforce make it imperative that more creative and flexible approaches be implemented.

Benefit programs need to have goals to improve work and family balance. Logically, work conflict will lead to family conflict, which in turn will impact the quality of work. There is a movement among employers to implement "Work/Life Programs" and to employ specialists to oversee them. There may be an on-site full-time coordinator, and/or employees can access these services by phone or the Internet 24 hours a day. Because these programs provide "benefits" that are an option for the employee and are of little or no cost to the employer, they are usually less than 1 percent of the benefits package (Costello, 1991).

Examples of work/life benefits include permanent life insurance, long- or short-term disability, cancer/critical illness plans, long-term care insurance and group-purchase of legal services, and vision and dental coverage. Some of the less usual work/life benefits include concierge services – pick-up and return laundry, deliver flowers and other gifts,

change oil, wash car, fix watch or shoes, etc. Benefits can also be onsite – fitness centers, dry cleaning, bank, nontraditional health services such as massages and lactation rooms for nursing mothers, and adoption assistance services. Work/life programs focus on making life more livable and giving something back to employees (Wojcik, 2002).

IV. Legal Aspects of Compensation

Complex statutes govern the actions of employers and employees, even in the private sector. Beginning with the Fair Labor Standards Act of 1938 (FLSA), which created the minimum wage, wage for overtime, and other protections, laws have been established periodically to guide labor and business in ways to ensure the ongoing production of goods and services to the American public. Despite the 64-year history of FLSA, which clearly defines the classifications and functions of employees who are exempt (not covered by the law) and non-exempt (covered by the law), nurses continue to fall between the two, often managed as non-exempt workers but compensated like exempt professionals.

While American labor was reformed by the FLSA, the Wagner Act of 1935, and the Taft-Hartley Act of 1947, it was the changing climate of the post World War II economic boom that encouraged employers to add many of the benefits that are now sometimes considered "entitlements." There are, in fact, just a few benefits required by law, which have been administered in most states since the 1920s with no federal involvement (Fisher et al., 1996). These mandatory benefits are:

- Social security
- Unemployment compensation insurance
- Workers' compensation

Though the quantity varies a great deal from employer to employer, compensation for time not worked (paid and unpaid) is a common, though still optional, benefit. These include:

- Holidays
- Vacation
- Sick leave
- Personal days
- Other days (bereavement; pregnancy; adoption; family medical leave; and civic jury, election, and military duty)

Nurses "qualify" for FLSA exempt status (salaried position) by virtue of salary level, professional status, level of responsibility (judgment and discretion), and the intellectual and varied nature of their work. Being classified as salaried versus hourly, however, is a matter of how one is worked, and not solely the nature of the work (Texas Nurses Association, 1996). If an employee is salaried, pay should not be reduced for absence of less than a full day, and the employee must receive a full week's pay for any portion of a week worked. However, nurses are scheduled "shifts" and work in an hourly fashion. For example, overtime requires a minimum compensation of 1½ times the usual rate of pay for hours worked in excess of 40 hours per week. However, nurses are often scheduled like hourly workers (shifts of 8½ hours) but are not compensated for hours worked beyond their shift or given overtime pay. Few nurses can say that they are paid for an entire week if they come in late or leave early, as provided for by FLSA. In the 2001

MSCCN Workplace Issues Survey, 60 percent of the respondents reported not receiving compensation when staying beyond their work hours to complete documentation. It is essential for nurses to know that FLSA impacts their work life and for them to take action when the law is violated.

The Equal Pay for Equal Work Act of 1963 (EPEW) prohibits different pay to opposite sexes when work performed requires equal skill, effort, and responsibility under similar conditions. Legal interpretation of EPEW has required that jobs be almost identical and that at least one man is getting higher pay than the others in that job. Since the field of nursing is approximately 97 percent female and is different than "men's work," the enforcement of this legislation has had variable outcomes and has not provided opportunity to show how nursing is comparable to work traditionally done by men and thus associated with higher wages.

Title VII of the Civil Rights Acts of 1964 has been used as a basis to address discriminatory compensation based on gender. In 1981, a Supreme Court decision in Gunther v. County of Washington ruled that Title VII of the Civil Rights Act of 1964 applies to sex-based wage discrimination (ANA, 1986). Use of this approach could be important, as nursing is a female-dominated profession.

The Family Medical Leave Act of 1993 (FMLA) was established with the intent to provide job security to workers who need to attend to the "serious" health needs of family. FMLA requires that employers grant up to 12 weeks of unpaid leave with the assurance that the employees can return to their job. There are concerns that FMLA is not working well or as intended. For many workers, unpaid leave is not an option, as their financial needs do not allow the loss of income. Other problems include administrative issues, such as additional responsibilities for co-workers if employers do not temporarily replace the absent worker. The implementation of this law could be a valuable protection in the work life of nurses of all ages; the controversy should be monitored closely to ensure that nursing organizations and advocates are being proactive and that legislators are aware of how decisions will impact their nurse constituents.

V. Factors That Influence Compensation

Nursing as a Female-Dominated Profession

Nursing is a female-dominated profession in an industry that is driven by decision-makers who are usually male (physicians and organizational leaderships – hospital CEOs, etc.). Compensation for women, even in highly educated professions, lags behind that for men. In hospital and medical services, women's earnings average 85 percent of what men earn (up from 80 percent in 1995) (Gutner, 2002). Nursing is one of the most underpaid occupations when compared to male-dominated occupations.

Nursing's relatively low compensation levels may be partly due to image: "portable skills…frequent job changes and many [working] part-time…like seasonal workers" (Wolfe) may cause some to not take nursing seriously as a profession of importance or worth. Because nurses perform many clerical and custodial tasks, they may be perceived as not highly specialized or knowledgeable. Another factor that contributes to the "invisibility" of nursing is that its "costs" to the organization are often bundled with operational costs rather than being shown as a revenue generating item, even though nursing care is often the reason for admission (Wolfe, 1997).

Pay equity must be sought systematically throughout the workforce. Pay equity is the "eliminati[on of] sex-based wage discrimination and providing equal pay not just for equal work, but for work of comparable value … to assure that all disadvantaged groups … are compensated on the basis of the inherent value or worth of the work they perform…[and not] on the basis of historically depressed pay levels or other discriminatory factors" (ANA, 1986). EPEW does not always correct institutionalized variances in men's and women's salaries since its enforcement requires finding an exact match where a man is being paid more than a woman. In a profession that is primarily female, this is difficult.

Equal pay for jobs that are different in content, but entail comparable demands in regard to traditional job evaluation factors (such as skill; education; experience; knowledge; physical demand; mental demand; responsibility for product, others' safety, or others' work; working conditions; and hazards), requires invoking the doctrine of Comparable Worth. This doctrine defines pay based on the fact that the job has the same relative value to the employer and to society (Fisher et al., 1996). As much as 90 percent of the gap in men's and women's salaries may be explained by the fact that women's employment is concentrated in a low percentage of all possible job classifications, and those tend to be lower paying jobs (Robinson, 2002).

Generational Issues

The Retention Subcommittee discussed the impact of the multi-generational nature of the nursing workforce on the nursing shortage. The current nursing workforce is aging, and the recruitment of young nurses is needed. The average age of new nurses has increased to 31 years, as many adults choose nursing as later-life careers and second careers. It is

important to recognize that nursing is a multi-generational profession that requires multiple approaches and solutions when considering recruitment of the Generation Xers, Millennials (~1981-1999), and future generations yet to be named or understood. The Boomers (and the few Silents remaining) need to stay in the workforce to avoid its collapse.

These generations, explained in detail below, approach their work life and careers, and integrate work life into the broader context of their existence, in different ways. What is important to them depends on their current stage of life. Workers expect jobs to offer perks that suit the needs of whatever life stage they are in. The social constructs, historical contexts, and paradigm shifts that create the diversity of perspectives among the generations must be dealt with when framing a retention strategy, including compensation (especially benefits). Of course, there is overlap among the generations, and everyone assigned to a particular group does not bear all, or possibly any, of the identified characteristics of the group. For instance, people born near the ends or beginnings of generations will likely show characteristics of both. Still, as broad strokes, an understanding of the life forces that let us recognize these groups as being different can aid the development of employment approaches that are appealing to them. Respondents to the MSCCN Workplace Survey include approximately 32 percent Silents, 50 percent Boomers, and 18 percent Generation Xers, which is consistent with national indicators. There are many analyses of these age cohorts, and years may vary depending on the source. Following are the descriptions offered by Kathleen Dunn-Cane (1999), along with values of the generations identified by the Retention Subcommittee, and work place motivators, demotivators, and ideals for each generation.888

Silents. The Silent Generation are those born between 1925 and 1945. Nurses of this generation have retired or are soon to retire. They lived through the Great Depression and WWII, and from that experience, learned to pull together and overcome obstacles. They are mediators and mentors, though they tend to be overly cautious, conservative, inflexible, and follow the rules by the book. Silents are likely to adjust slowly to massive new information and technology.

Boomers. The large number of births that swelled the nurseries of America by 18.6 percent from 1946 to 1964 are much discussed and anticipated as they have moved through the stages of their lives (Codrington, 2002). Their childhood, adolescence, and young adulthood created a new America. They witnessed America's ascendancy as a superpower and rode the tide of "technological feats of wonder, followed by breakdowns of mammoth scale … produced a sense of failure and despair in the system" (Codrington, 2002, p. 6). These years were a time of unprecedented economic growth, and as 40 percent of the population as children, the Boomers comprised the largest workforce ever. Major features of their maturing years were the sixties – rock and roll; Viet Nam; increased crime and suburbanization; and new beliefs about family and marriage, civil rights, and the status of women. Though now comprising about 30 percent of the population, the Boomers will drop below 25 percent at retirement. However, they will have more money in pension funds than any previous generation. To a large extent, the aging of the Boomers is contributing to the impending shortage of nurses. That is, many

nurse are Boomers, and it is this large contingent of aging Americans that will create the need for even more nursing care as they age.

Generation (Gen) Xers. More permissive than the Silents, the Boomers – with Dr. Spock-based child rearing practices, sexual freedom and the birth control pill, and "space, the final frontier" – parented the Gen Xers. Also know as "Baby Busters," the Gen Xers were born from 1965 to 1975, a time of a volatile economy with trade deficits and limited real growth. With high rates of divorce and commuter marriages, Gen Xers are accustomed to great diversity in family situations, ethnicity, sexual orientation, gender roles, religion, and political affiliation. At work, they expect direct answers, challenging projects, and immediate feedback. They feel no innate loyalty to institutions and do not expect it in return. Gen Xers need to feel that they are making a valuable contribution but believe in dividing time appropriately among work, family, and play.

The Retention Subcommittee identified the following characteristics as being indicative of employees in the three generations that currently make up the majority of the nursing workforce (Table 2). The characteristics of each generation give clues as to the approach that might work best in terms of management, supervision, and human resource administration (compensation and benefit plans).

Table 2: Generational Values, Motivators, Demotivators, and Ideals

Generation	Silents (57+ years)	Boomers (38-56 years)	Generation Xers (27-37 years)
Core Values	– Loyalty – Sacrifice – Adherence to rules – Honor	– Personal gratification – Youth – Contribution – Involvement	– Balance – Self reliance – Diversity – Global thinking
Work Values	– Respect authority – Hard work – Loyalty	– Challenge/distrust authority – Quality of life – Work fulfilling – Personal needs & having meaning	– Ignore authority – Balance in personal & professional life – Future opportunity
Motivators		– Adventure – Independence & risk – General goals – Creativity – Moderate stimulation	– Recognition and praise – Opportunities to learn new things – Individual time with managers – High stimulation – Time with family and friends
Demotivators		– Aging – Evaluations – Hitting the glass ceiling	– Disparaging comments about their generation – Long work assignments – Feeling disrespected
Workplace Ideals		– Control – Compensation – Competence	– Capitalize on skills – Adequate funds for training – Short training events – See companies as "place to grow, not grow old" – Control – Compensation – Competence

Market Forces and the Nursing Shortage

One view of compensation design allows the market to determine the value of the work performed by a particular job category. Using prevailing market forces and assuming a competitive marketplace, supply and demand for a given function or activity will determine its worth. However, this concept holds only in a purely competitive market, and nursing is not purely competitive. Rather, the market for nursing is monopsonistic (Wolfe, 1997). In a monopsony, a few firms hire the majority of a particular type of employee (e.g., hospitals hiring nurses), and those few firms can then freely set wage levels due to lowered competition. Even in major metropolitan areas where nurses may have other choices for employment, hospitals are their major employers. In many cases, there may be only one hospital in a geographic area, which severely limits the employment opportunities for nurses and the competition for their services.

In addition to monopsony, the historical pattern of gender-based job discrimination compromises the efficiency of market-driven wage processes when the artificially low customary rates of compensation are the basis for determining "market" value. Supply and demand may force wages up or down despite the relative value of a particular job category, but these gains, depending on how they are administered, may only be short-term. Changes to nursing compensation during periods of shortage are often one-time hiring, retention bonuses, or other perquisites that are of short duration; changes are not necessarily durable as would be increases to base pay.

Unions and Collective Bargaining

Unions are formal organizations of employees with the purpose of improving work conditions, including pay (Fisher et al., 1996). In 1935, the National Labor Act (known as the Wagner Act) established the right for labor to bargain collectively. In 1946, ANA endorsed state nurses associations as the agent for nurses' collective bargaining and advocated for the 40-hour workweek for nurses. Medicine and hospitals controlled nursing and prevented education and experience needed for professional and personal growth. The Taft-Hartley Act exempted not-for-profit hospitals from having to bargain collectively, thereby excluding many nurses from being able to choose this option (Wolfe, 1997). Though many nurses are in unions today, unionization is still a foreign concept to the majority.

Among Magnet hospitals, 19 percent are organized for collective bargaining. According to ANA, unionized women earn 30 percent more than non-unionized women in the United States. Others have also found that unionized nurses are more likely to receive most benefits (Bauer, 2001). Collective bargaining can assist wages and benefits to become more competitive (Wolfe, 1997). Nurses in unions make about $2.80 per hour more with collective bargaining. The 1997 and 2001 RN Salary Survey found that 14 percent of full-time nurses are in unions (the same as for the preceding six years).

Twenty-five state nurses' associations participated as inaugural members/associates of ANA's labor entity (American Nurses Association, 1999). The Maryland Nurses Association does not participate. American Federation of Teachers Healthcare represents over 63,000 nurses and other health professionals. The Service Employees International Union (SEIU) is an affiliate of the AFL-CIO (American Federation of Labor-Congress of Industrial Organizations), and includes the SEIU Nurse Alliance. A list of 22 unions that represent nurses is included in Appendix 3.

VI. What Can Be Done

The Retention Subcommittee strongly urges the Commission and the nursing community to advocate for remedies to the compensation issues of Maryland nurses. The work of the Commission can be undermined if nursing compensation is not acceptable to potential candidates for nursing education and experienced nurses. Compensation alone cannot address the complex issue of the nursing shortage. An economic principle has shown that there is a point of diminishing returns at which higher salaries can actually have the adverse effect of reducing an individual's incentive to work. There is a point at which leisure time is worth more to the worker than the wage, and will actually induce a decrease in work. Also, it is apparent that the healthcare system is straining under the pressure of increased costs, which presents the additional paradox that as employers struggle to find affordable ways to provide health benefits for their employees, appropriate salary increases for nurses would create an even greater strain, further driving healthcare costs up.

Win-win scenarios for nurses, employers, and purchasers of healthcare must be sought and found. A few shorter-term actions that can be taken are:

- Nurses becoming aware of the total value of their compensation packages; benefits are usually 20 to 30 percent of the salary [provided in addition to salary] (Carey, 2001a)
- Nurses becoming aware of organizational grievance procedures and utilizing them when they have concerns about compensation or other practices in the workplace
- Suggested by ANA, female nurses taking legal remedies such as filing complaints under EPEW if they are being paid less for the same or nearly identical job, or filing administrative and court complaints using other federal and state laws (if the nurse is eligible, she may be able to invoke possible civil service protections as a local, state, or federal employee)

In order to achieve the desired outcomes, the Retention Subcommittee understands that nurses must be knowledgeable about compensation to effectively negotiate compensation packages. Also, there is a need for nurses to further research this topic.

The Subcommittee recommends the following Compensation Guiding Principles:

- Salary review every six months/reduce compression
- Flexible benefits structure
- Individual annual benefits statements

Additional Subcommittee recommendations are:

- Benefits need to be tailored to the age of the individual nurse. Benefit plans need to be designed to be flexible as in so-called cafeteria structures.
- Help to pay for education (prior loans and offer prepayment or educational subsidies rather than reimbursement). Many nurses may not have the ability to front the costs for a reimbursement approach and would not benefit.
- Assure internal equity so that there is comparable pay for comparable work between settings within the same institution and between genders.
- Market adjustments for entry level staff must be reflected in adjustments for tenured staff with attention to salary compression created by increasing lower end of salary ranges without adjusting upper limits.

Areas of recommendations from ANA are:

Education of nurses and the public

Nurses need to:

- Be aware of specific nursing studies of pay inequities
- Remain informed of their state nurses association and ANA activities in this area
- Be aware of activities of National Committee on Pay Equity, which works to achieve equal pay for work of comparable value

Legislation

- Advocate for legislation based on research and data collection (urge state legislators to address wage discrimination in female-dominated professions such as nursing)
- Understand what is happening in other states, public hearings, task forces, and commissions
- Understand current status of legislative activity in Maryland and Maryland Nurses Association's lobbying efforts (a good example in Maryland was the successful defeat of legislation to allow nurse practitioners – predominantly female – to receive third party reimbursement)

Appendix 2: A Description of Nursing and Compensation in 1895*

The nurse's wages vary somewhat in different institutions, but in all they are small…at King's College Hospital the wages are none the first year, £15 the second year, £20 the third year, £30 the fourth year, £33 the fifth year, and £36 the sixth year…In some of the regulations we note that the nurses "pay their own laundry." …As a rule the indoor uniform, or material for making up the uniform, is provided after the end of the trial month……the hours of duty for nurses vary somewhat in different hospitals. In the regulations of one hospital we find the following note:---"Hours on duty, twelve; two and a half hours off duty every alternate day, and half a day once a month." At another hospital the hours on duty are given as twelve. At a third the day nurses rise at 6 a.m. and retire to rest at 10 p.m., but they are allowed an hour and a half for exercise in the middle of the day. At Guy's Hospital the holidays are two weeks at the end of the first year, three weeks at the end of the second, and afterwards four weeks. Staff nurses get five weeks, and sisters the same, and also every alternate Sunday to Monday. … it is still true that [holidays] are drawn up too much in the interest of the training school… One advantage which nurses now enjoy is that conferred upon them by the Royal National Pension Fund for Nurses. In many hospitals all the nurses who join this excellent Fund have half the premium paid for them by the institution…the charge made for a nurse varies somewhat in different town and districts. For many years there was a uniform fee of a guinea a week, but of late the price has risen, and it is no uncommon thing to be asked two or even three guineas. The institutions charge extra for surgical cases, for fever cases, for mental cases, for cases of influenza, and in fact for almost any disease that a patient is likely to suffer from. No one objects to pay an extra fee in cases of fever, for the nurse runs an extra risk, and has to go into quarantine for a time, but why an additional charge should be made because the patient is attended by a surgeon, and has to undergo some trifling operation, is not very clear. It will be remembered that the fee is not the only expense, for the nurse must be fed, and will expect an allowance for washing as well as for cab fares and travelling expenses. If the money actually went into the pocket of the nurse it would not be grudged, but as the nurse, as a rule, receives a salary of £25 or £30a year, or less, there seems to be no particular reason for giving her three guineas a week. There are in some towns co-operative nurses' associations, which pay over to the nurse the whole of the fee minus seven and a half per cent. for working expenses. These associations are popular with nurses and attract the skilled hands. It is usually perfectly safe to deal with them, for it is to their interest to send out only competent people. Patients at the conclusion of a long illness often ask the doctor if they are expected to make the nurse a present. The answer is decidedly in the negative, the patient pays the full fee for her services, and if she is underpaid by the institution from which she is obtained, he can hardly be expected to make up the deficiency. It may happen, however, that the nurse has been exceptionally kind and attentive, and that the patient is really desirous of giving her some little memento, something that will convey to her in a tangible form his appreciation of her services. There can, of course be no possible objection to this. It may be contrary to the rules of the institution, but the patient is not bound by them. He had better take care that the present to the nurse assumes a form that will be personally useful to her, and he must give her to understand that it is for her use and hers alone, and that it is not to be handed over to the nursing home.

* The entire text of this excerpt can be found at: Emergency Nursing World. An 1895 Look at Nursing, <http://enw.org/1895_Nursing.htm>. The original source is: Ambulance work and nursing – A handbook of first aid to the injured with a section on nursing, etc.

Appendix 3: Unions Representing Nurses in the United States and Canada*

Union	Description	Website
AFSME (American Federation of State, County and Municipal Employees, AFL-CIO)	Associated with United Nurses of America, represents 45,000 RNs and LPNs	www.afscme.org/
American Federation of Teachers	Represents more than 63,000 nurses and other health professionals throughout the United States	www.aft.org/healthcare/
Federation of Nurses/UFT	An autonomous arm of United Federation of Teachers	www.uft.org/?fid=68&tf=479
MNU (Manitoba Nurse's Union)	Represents 11,000 nurses who work in a variety of healthcare settings across Manitoba	www.nursesunion.mb.ca/
NLNU (Newfoundland and Labrador Nurses' Union)	Represents over 5,000 RNs	www.nlnu.nf.ca/
NSNU (Nova Scotia Nurses' Union)	Represents LPNs and RNs in hospitals, LTC facilities, adult residential centers, VON branches, and Canadian blood services	www.nsnu.ns.ca/main/
NYPNU (New York Professional Nurses Union)	"A union of nurses, by nurses, and for nurses"	www.nypnu.org/flash.html
ONA (Ontario Nurses' Association)	Represents 50,000 nurses	www.ona.org/
OPEIU (Office and Professional Employees International Union)	Represents a diverse membership, including nurses	www.opeiu.org/index.htm
QNU (Queensland Nurses' Union)	In association with the Australian Nursing Federation	www.qnu.org.au/
SEIU (Service Employees International Union)	Represents 1.5 million working people	www.seiu.org/
SEIU Nurse Alliance	Represents more than 110,000 nurses from every healthcare setting	www.seiu.org/health/nurses/
Teamsters International Union	Represents 60,000 nurses in all areas	www.teamster.org/divisions/public/represent.htm
UAN, AFL-CIO (United American Nurses)	Represents RNs	www.nursingworld.org/uan/
UAW (United Automobile, Aerospace and Agricultural Implement Workers of America)	Represents RNs and other healthcare professionals	www.uaw.org/
UFCW (United Food and Commercial Workers Union)	Represents more than 40,000 nurses & other healthcare workers	www.ufcw.org/
UFCW 141 Nurses	Represents nurses in Washington State	www.ufcw141nurses.org/
UNA (United Nurses of Alberta)	Represents 18,000 RNs, RPNs, student nurses, and mental health workers	www.una.ab.ca/
UNAP (United Nurses & Allied Professionals)	Represents over 4,000 healthcare workers	www.unap.org/

* Found at Brownson's Nursing Notes, <http://diannebrownson.tripod.com/nursehome.html>

References

American Health Care Association/Health Services Research and Evaluations. (2002, February 7). Results of the 2001 AHCA Nursing Position Vacancy and Turnover Survey.

American Nurses Association. (1986). Pay equity: What it means and how it affects nurses.

American Nurses Association. (1999, November 5). United American Nurses announces founding members (Press Release). <www.nursingworld.org/pressrel/1999/pr1105.htm>.

American Nurses Credentialing Center. (2002, Spring). The Magnet Nursing Services Recognition Program: Making a difference – highlights from 2001. Credentialing News, 5(1), 2.

The Association of Maryland Hospitals & Health Systems. (2000, Summer). Summit kicks off work of Commission on Crisis in Nursing. Maryland Health Care, 1.

Bacchus, C. (2001, August 6). Benefits more compelling than salary. Las Vegas Business Press.

Bauer, J. (2001, November). The 2001 Earnings Survey: The other half of the picture. RN, 64(11), 38.

Brownson's Nursing Notes. Nurses and unions. <http://diannebrownson.tripod.com/nursehome.html>.

Carey, T. (2001a, January 24). Statement made at the MSCCN Compensation Committee meeting.

Carey, T. (2001b, November 11). Statement made at the MSCCN Compensation Committee meeting.

Codrington, G. (2002). The boomer generation: Detailed description. <http://tomorrowtoday.biz/generations/indexgens.htm>.

Costello, M. A. (1991, December 17). Hospitals using voluntary benefits to recruit. AHA News, 37(49), 5.

Depp, M. (2000, December 11). Incentives for nurses grow as their numbers dwindle. New Orleans City Business.

Dunn-Cane, K. M., Gonzalez, J., & Stewart, H. (1999, May). Managing the new generation. AORN Online, 69(5). <www.aorn.org/journal/1999/may.htm>.

Emergency Nursing World. An 1895 look at nursing. <http://enw.org/1895_Nursing.htm>.

Fisher, C., Schoenfeldt, L., & Shaw, J. (1996). Human resource management. Houghton Mifflin Company.

Fitzpatrick, M., Mee, C. L., & Steltzer, T. M. (2000, July). Salary Survey 2000. Nursing Management, 31-35.

Gutner, T. (2002, June 24). How to shrink the pay gap. Business Week, 3788, 151.

Health care and nursing workforce issues in the United States. (1998, March). Nursing trends and issues – analysis and commentary on topics affecting nurses, the profession and healthcare, 4(1). <www.nursingworld.org/readroom/nti/mar99.htm>.

Health Occupations Article, §§8-205, 8-206, and 8-301—8-315, Annotated Code of Maryland, Title 10, Subtitle 27, Board of Nursing. COMAR 10.27.

Heinrich, J. (2001, August 1). Health workforce: Ensuring adequate supply and distribution remains challenging. Testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives.

Jordan, C. B. Job satisfaction affects nursing supply. Texas Nurses Association/Foundation (Press Release). <www.texasnurses.org/foundation/dataproject/press/vol2release.html>.

Kramer, N. (1995, April). Employee benefits for older workers. Monthly Labor Review, 118(4), 21-27.

Maryland Statewide Commission on the Crisis in Nursing. (2002, Spring). Workplace Survey 2001. <www.mbon.org>.

McNeese-Smith, D. K. (1999). A content analysis of staff nurse descriptions of job satisfaction and dissatisfaction. Journal of Advanced Nursing, 29(6).

Metlife review of employers reveals retention as most important benefits-related priority. (2001, November 17). Insurance Advocate, 112(44), 38.

Nursing shortage in Maryland hospitals continues. (2002, May 13). <www.marylandhealthcareers.org/docs/Nursing.shortage.in.md.continues.05.2002.pdf>.

Pierson, C. (2001, January). State of the state's hospitals: Performing under pressure (Presentation). <www.mdhospitals.org/MHA/2001_state_of_the_state.pdf>.

Quyen-Nguyen, B. (2001, August). Workplace rights. The Fair Labor Standards Act: Nurses should be familiar with how the law applies to them. The American Journal of Nursing, 101(8).

Radcliffe Public Policy Center. (2000). Life's work: Generational attitudes toward work and life integration – A national survey. <www.radcliffe.edu/pubpol/Life'sWork.pdf>.

Robinson, E. S. (2002, April). Salary survey. Nursing 2002, 32(4), 46.

Ruth, J-P. S. (2001, May 15). New workers want tailor-made benefits. Business News, 22.

Schumacher, E. J. (2001, October). The earnings and employment of nurses in an era of cost containment. Industrial and Labor Relations Review, 55(1), 116.

Sebrant, U. (1999). Being female in health care hierarchy: On the social construction of gender and leader identity in a work organization having a predominance of women. Scandinavian University Press, ISSN 0283-9318.

Smith, S. S. (2001). Mobilizing social resources: Race, ethnic and gender differences in social capital and persisting wage inequalities. The Sociological Quarterly, 41(4), 509.

Spratley, E., Johnson, A., Sochalski, J., Fritz, M., & Spencer, W. (2002, March). The registered nurse population: Findings from the National Sample Survey of Registered Nurses.

Texas Nurses Association Council on Workplace Issues. (1996, May). RN alert. Wages: Hourly vs. salary. Texas Nursing, 70(5), 1, 13.

Tompkins, D. (2001, June 4). Expanding benefits good for bottom line. Business Insurance, 35(23), 10.

Ventura, M. J. (1997, October). The 1997 Earnings Survey: Slow gains, high earnings. RN, 60(10), 40-47.

Ventura, M. J. (2000, January). Office nursing: Does it pay? ON, 2-8.

Wojcik, J. (2002, April 1). Work/life benefits propagating. Business Insurance, 36(13), 1-2.

Wolfe, M. N. (1997, Spring). Nursing compensation: A historical review. Hospital Topics, 75(2), 27.

Appendix 1:

A STATEMENT ON PATIENT SAFETY AND THE QUALITY OF PATIENT CARE

Prepared by the Maryland Statewide Commission on the Crisis in Nursing

September 2001

Nursing is quintessentially a patient-centered profession. The definition of nursing, as written in the 2001 Maryland Nurse Practice Act, focuses the broad range of nursing activities on outcomes of care for the patient. The Act defines nursing as:

> "the performance of acts requiring substantial specialized knowledge, judgment and skill based on the biological, physiological, behavioral or sociological sciences as the basis for assessment, nursing, diagnosis, planning, implementation and evaluation of the practice of nursing in order to: ***maintain health; prevent illness; or care for or rehabilitate the ill, injured, or infirm***" (1).

This definition can be expanded to include the family and community, and special types of interventions and knowledge, but the common thread to all definitions of nursing is the care of the patient. The Maryland Statewide Commission on the Crisis in Nursing holds this patient-centered outlook as the central tenet of its information gathering, problem-solving, and decision-making. Under the legislative mandate of the Maryland Assembly to "develop recommendations on and facilitate implementation of strategies to reverse the growing shortage of qualified nursing personnel, *to improve quality of care and meet the needs of patients*" (2), the Commission endeavors to fashion a plan that will ensure adequate nursing resources to care for Marylanders in the years to come.

Nurses and nursing have been at the forefront of state and national initiatives and research efforts to ensure quality patient care and safety. The American Nurses Association (ANA) participated in drafting the Patient Safety Act of 2001, which was introduced in Congress in 1997 (3). The Act underscored the need of adequate nursing resources by citing the "growing body of data suggesting a linkage between the number and mix of nursing staff and positive patient care outcomes, including the avoidance of patient death and injury" (4). In its original writing, the Act also included protection for nurses to report unsafe patient conditions, though in 2001 this is covered by a separate legislative initiative (HR 2340).

The issue of patient safety remains a prominent component of ANA activity. The ANA was a charter member of the National Patient Safety Foundation (NPSF), as well as the National Patient Safety Partnership (NPSP), established in 1998. The NPSF mission is to ensure that patient safety is the central component of efforts to

provide quality health care and is achieved through prevention, utilizing scientifically sound information in a "culture of trust, honesty, integrity and open communications" (5). The ANA joined the NPSP in 1999 as a partner in its Preventable Adverse Drug Events Initiative. "The registered nurses of America, through representation by the American Nurses Association in the National Patient Safety Partnership, share a keen interest in advancing quality, safe practices for those receiving health care."

THE ANA STATEMENT ON PATIENT SAFETY: PATIENT SAFETY/ADVOCACY

By effecting positive change around issues that are so critical to nursing and its future, ANA will advance its ultimate goal, "quality patient care." In today's environment, that means ensuring that patient safety and quality are the priority, not profit-making (6).

The 2000 ANA House of Delegates crafted an eight-point platform delineating key actions it supports to ensure patient safety and positive outcomes for patients (7). The platform includes the ANA's voluntary hospital accreditation program and is focused on indicators that lead to good patient outcomes. The Magnet Recognition Program for Excellence in Nursing Services measures nursing indicators and patient outcomes, and recognizes the best of the best nursing services and quality patient care (8).

In her recent testimony to Congress (9), Kathryn Hall, the Executive Director of the Maryland Nurses' Association, cited the litany of nursing shortage issues that negatively impact quality of care and lead to poor patient outcomes:

- Fewer nurses taking care of larger numbers of more ill patients, who need more care, requiring nurses to work harder and longer hours.
- Health care industry cost-cutting measures such as layoffs of nurses to hire less expensive workers.
- Inadequate staffing (number and mix of nursing staff) to provide safe, quality care.

It is important to note that most authorities agree that patient safety issues track back to systemic deficits and not individual practitioners (10). Multiple initiatives analyzing the factors leading to poor quality health care point to system characteristics that leave healthcare workers vulnerable in their efforts to care for patients. In the Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (11), improvements are recommended in six dimensions to meet patients' needs. The six dimensions are: safety, effectiveness, patient-centered care, timeliness, efficiency, and equity. These areas are directly relevant to the role of the

nurse and thus affected by a shortage of nurses. Delayed surgeries, closed hospital beds, emergency room diversions due to "saturation" (lack of ability to take additional patients due to lack of hospital beds for admissions, which means patients stay in the ER longer), and patients in hospitals experiencing delayed nurse response times to address the needs of inpatients have been all been reported. Media sources have even suggested that patients ask questions about nursing turnover and staffing ratios, or even consider hiring private duty nurses to ensure the availability nursing care (12).

A recent study by Needleman and Buerhaus shows conclusively that nursing staffing makes a positive difference in decreasing what they call "Outcomes Potentially Sensitive to Nursing" (OPSNs) (13). The Needleman/Buerhaus study showed "strong and consistent relationships" between outcomes such as urinary tract infections, length of stay, upper gastro intestinal bleeding , shock, and death occurring as a result of complications with the ratio of nurses to patients. Higher ratios of nurses to patients were associated with improved outcomes. These factors are important, given that patients' care needs are increasing. During the 1990s, the average surgical inpatient was as sick as the average critical care patient in the 1980s, which means that higher levels of nursing care are needed (14). In addition, as the population ages and chronic illnesses become an ever more prominent feature of the health care needs of Americans, there is a greater need for community-based care (which takes nurses away from institutional settings) (15).

Appropriate numbers and appropriately trained staff and systems to support their function are needed (16, 17). Curtin and Simpson (2000) discuss the changes in the health care industry and the impact of these changes on the clinical professionals it depends upon for the delivery of services. According to Curtin and Simpson, much of the $333 billion dollar cost to retool the industry through such actions as mergers, managerial reductions, increased reliance on cross-trained multi-purpose workers, and service integration, came from personnel budgets (see also, IOM, 1996, p. 92). Nursing is usually the largest single component of hospital staffing and costs, and therefore often the target of cost-cutting measures (18, 19). The impact of these industry changes has created decreasing morale, uncertainty, vacant and difficult to fill positions, high turnover, and, some feel, low recruitment of new persons into the nursing profession. High turnover and prolonged vacancies mean fewer and newer (less experienced) staff, which, in turn, increases the workload of tenured staff. These issues and others, such as mandatory overtime, lead to nurse exhaustion and burnout (20). Studies have shown that there is increased likelihood of worker and patient injury when nurses are fatigued from extended shifts. Roger Rosa cites overtime required as a result of nursing understaffing as an example of extended work shifts that lead to fatigue.

Many nurses say that it is their concern for patients and their inability to do all that they feel needs to be done for patients that lead many to want to leave the

profession. In a recent ANA study:

- 55 percent [of nurses] respond that they have an increased patient care loads and less time to care for them.
- 75 percent say that quality of care has decreased, and 50 percent say that this is due to inadequate staffing.
- 42 percent would not recommend care at their pace of employment to someone close to them.

Nurses are a vital and essential component of the health care delivery system. System actions, such as cutbacks of nurses and other workplace issues, contribute to the nursing shortage - overworked and burned out nurses who are opting out of the profession, and lower recruitment into the profession - are prodromal to an eventual, and some say already, lessening of quality of care and safety for patients (23, 24). Adequate staffing is one key. It is difficult to anticipate the number and type of nurses needed at a particular time and place, and for a particular group of patients. There is no consensus and not yet enough empirical evidence to know whether levels of staffing should be based on minimum ratios of nurses to patients, nurses to beds, or various patient classification systems. It is clear, however, that we must ensure that an adequate supply of well-trained nurses continues to be available in the future to provide high quality and safe patient care (25).

References

(1) Nurse Practice Act, Maryland Board of Nursing, January 2001.

(2) Senate Bill 311 Entitled: Statewide Commission on the Crisis in Nursing. Http.mlis.state.md.us/2000rs/billfile/sb0311.htm.

(3) Press Release, ANA Applauds Introduction of Patient Safety Act of 1997, http:// www.nursingworld.org/pressrel/1997/hr1165.htm, March 26, 1997.

(4) HR 3355 104th CONGRESS 2d Session, http://www.nursingworld.org/gova/hr3355htm.

(5) National Patient Safety Foundation, http://www.npsf.org/html/about_npsf.htm.

(6) Statement of Beverly L. Malone, PhD, RN, FAAN President American Nurses Association on the launch of the National Patient Safety Partnership's Preventable Adverse Drug Events Initiative May 12, 1999, www.nursingworld.org/pressrel/1999st0512.htm.

(7) 2000 ANA House of Delegates: Build Safe Health Care Systems for Informed Patients Action Report), www.nursingworld.org/about/summary/sum00/safe.htm.

(8) Aiken, L., Haven, D. and Sloane, D., “The Magnet Nursing Services Recognition

Program," AJN, Vol 100, Number 3, March 2000.

(9) Testimony of the American Nurses Association on The Nursing Shortage and Its Impact on America's Health Care Delivery System before the Subcommittee on Aging, Commttee on Health, Educations, Labor and Pensions, February 13, 2001, www.nursingworld.org/gova/federal/legis/testimo/2001/shortage.htm.

(10) Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001, National Academy Press.

(11) Wakefield, M. K. and Maddox, P. J., Patient Quality and Safety Problems is the U.S. Health Care System: Challenges for Nursing, Nursing Economics, Mar/Apr 18 Issue 2, p. 58-63.

(12) Parker-Pope, T., "How to Lessen Impact of Nursing Shortage on Your Hospital Stay," Wall Street Journal, Friday, Mary 2, 2001.

(13) Needleman, J., and Buerhaus, P., Nurse Staffing and Patient Outcomes in Hospitals, Report for US Department of Health and Human Services, HRSA, February 2001.

(14) Curtin, L., and Simpson, R., Staffing and the Quality of Care, Health Management Technology, May 2000, Vol. 21, Issue 5, p. 42-3.

(15) News Release: NCSBN Responds to the Nursing Shortage, National Council of State Boards of Nursing, January 29, 2001.

(16) JCAHO, Revisions to Joint Commission Standards in Support of Patient Safety and Medical/Health Care Error Reduction, Effective July 1, 2001, www.jcaho.org/standard/fr_ptsafety.html.

(17) Patient Safety in Maryland, www.marylandpatientsafety.org.

(18) Seago, J., Nurse Staffing, Models of Care Delivery, and Interventions, http://www.ahcpr.gov/clinic/ptsafety/chap39.htm.

(19) Wunderlich, G., Sloane, F. and Davis, C., Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?, Institute of Medicine, 1996.

(20) Freudenheim, M. and Villarosa, L., Nursing Shortage is Raising worries on Patients' Care, New York Times, April 8, 2001.

(21) Rosa, R., Extended Workshifts and Excessive Fatigue, Journal of Sleep Research 4, Suppl. 2, 51-56, 1995.

(22) ANA, Analysis of American Nurses Association Staffing Survey, February 6, 2001.

(23) (Stapleton, S, "Where's the nurse? Staff streteched too thin," American Medical News, www.amaassn.org/sci-pubs/amnews/pick_01/hlsa0618.htm)

(24) Hospital Restructuring Affects Quality, Peoples Medical Society Newsletter, Jun95, Vol. 14 Issue 3.

(25) Quality Quarterly, http://www.dfmc.org/qqtext/html/body_ana_.htm.