

Pennsylvania School of Nursing, was funded by the Agency for Health Care Research and Quality. Researchers examined logbooks kept by 393 registered nurses around the country who worked full-time in hospitals. Data collected on 5,317 work shifts revealed that in nearly 40 percent of the cases, nurses worked at least 12.5 consecutive hours. More than 25 percent of the participants in the study reported working mandatory overtime at least once during a one-month period.

According to a 2001 ANA health and safety survey, 67 percent of respondents reported working some form of mandatory or unplanned overtime every month. The ANA has long warned that mandatory overtime is dangerous for patients and nurses, and that the practice has been driving nurses away from the profession, thus exacerbating an emerging nursing shortage that is expected to worsen dramatically over the next 10 years.

"Poor working conditions are a major contributor to the nursing shortage," said Blakeney. "As this study shows, nurses are consistently working long and unpredictable hours, often caring for a large number of critically ill patients. To improve the quality of care and patient safety, we must value nurses' contributions more and make a greater investment in nursing," she said.

To counter staffing insufficiencies that are already occurring, many health care facilities across the nation have increasingly imposed mandatory overtime as a common practice.

Typically, an employer may insist that a nurse work an extra shift (or more) or face dismissal for insubordination, as well as being reported to the state board of nursing for patient abandonment, a charge that could lead to a loss of license for the nurse. At the same time, ethical nursing practice prohibits nurses from engaging in behavior that they know could harm patients, thus leading to a dilemma for many nurses.

The Safe Nursing and Patient Care Act would prohibit health care facilities from forcing exhausted nurses to work extra shifts, an unsafe practice that puts both patients and nurses at risk.

The Safe Nursing and Patient Care Act would:

- Prohibit health care facilities that receive Medicare funding from requiring a registered nurse (RN) or licensed practical nurse (LPN) to work beyond an agreed-to, predetermined, regularly scheduled shift.

In no instance could a nurse be required to work more than 12 hours in a 24-hour period or for more than 80 hours in a two-week period - a provision that would prevent an institution from altering shift schedules in a way that would undermine the law.

- Include nondiscrimination protections for nurses who refuse overtime and for nurses who provide information and/or cooperate with investigations about the use of overtime.
- Include an exception in the case of a declared national, state or local emergency. Such an emergency would be in response to an unpredictable disaster, not in response to a staffing deficiency resulting from management practices.
- Provide for a study by the Department of Health and Human Services on the maximum number of hours that may be worked by a nurse without compromising patient safety.

###

The American Nurses Association is the only full-service professional organization representing the nation's 2.7 million registered nurses (RNs) through its 54 constituent member associations. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

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TIME AFTER TIME

Mandatory overtime in the U.S. economy

by Lonnie Golden and Helene Jorgensen

Over the last two decades, American workers have been clocking more and more hours on the job, and they now work more hours than workers in any other industrialized country. Annual work hours are 4% higher than they were in 1980, amounting to an extra 1 hour and 30 minutes at work per week, on average (ILO 1999). The cumulative rise in time on the job is even higher, of course, for families. In 1998 the typical middle-income, married-couple family worked six more weeks a year than did a similar family in 1989 (Mishel et al. 2001). Workers are also clocking more overtime hours. Almost one-third of the workforce regularly works more than the standard 40-hour week; one-fifth work more than 50 hours. Hourly manufacturing workers, the only group tracked by government statisticians, are putting in 25% more overtime than they were a decade ago.¹ In virtually every industry within the bellweather manufacturing sector, overtime had reached a record by the end of the 1990s.

The growth in overtime work, while helping to drive the healthy growth in output in the U.S., has unhealthy social costs. It is taking its toll not only on workers, but on their families, communities, and, ultimately in many cases, patients, customers, and employers. Families burdened by longer work hours are more likely to find it difficult to balance the conflicting demands of work and family. More hours spent at work mean less time with the family, less time to help a child with homework, less time for play, less time for housework, and less time for sleep. These sacrifices can translate into increased risk for accidents and injuries; greater chronic fatigue, stress, and related diseases; reduced parenting and family time; and diminished quality of goods and services – a serious public concern particularly in the health care sector. The social costs associated with the growth in work hours and persistent overtime are particularly worrisome when the long hours are involuntary.

The tenuous balance between work, family, and other non-work activities is thrown off most when overtime is mandatory (also referred to as "compulsory" or "forced"). Mandatory overtime hours are those above the standard work week (usually 40) that the employer makes compulsory with the threat of job loss or the threat of other reprisals such as demotion or assignment to unattractive tasks or work shifts. Given that overtime can have detrimental effects on workers and their families, mandatory overtime is a serious public policy concern, yet current law does not address it. The Fair Labor Standards Act of 1938 (FLSA), which regulates overtime, currently imposes no limits on overtime hours, nor does it prohibit dismissal or any other sanction for declining overtime work. Rather, the FLSA merely requires that payroll employees (who are not "exempt" from the overtime requirements of the FLSA) be paid an overtime premium of at least one-half of regular rate of pay for each hour worked over 40 during a work week.

With the rise in household work hours and overtime, there is a growing need for limits on involuntary overtime. Labor laws such as the FLSA need to be amended to protect workers against excessive work hours and mandatory overtime and to protect the public from the dangers of an overburdened, stressed workforce. Employees should have the legal right to refuse overtime after having worked a certain number of hours – without fear of job loss or other sanctions. Furthermore, an employee should be asked to work beyond some legislated upper limit only during exceptional circumstances such as a temporary health or public safety emergency. Amendment of the FLSA can preserve the right of workers to work long hours if they choose to do so, but ensure workers the right to refuse mandatory overtime.

The need for limits on mandatory overtime

In the United States, unlike in most European countries, employment is "at will," meaning that the employer can dismiss an employee for any reason or for no reason – except gender, race, age, or disability. Thus, employees who refuse to work overtime can lose their jobs or face other reprisals such as demotion or assignment to unattractive work or to less desirable shift times such as nights or weekends. Faced with the legal threat of these kinds of sanctions, many employees often work more hours than they would like and, in some cases, work an extreme number of hours well beyond the standard 40 a week.

The only disincentive to the unbridled use of overtime by employers is the FLSA requirement that payroll employees covered by the act be paid time-and-a-half for hours worked above 40 in a week. The Department of Labor estimates that about 74 million workers were covered under the FLSA overtime provision in 2000.² There is evidence that the required overtime pay premium for these "non-exempt" workers is effective – about 44% of "exempt" workers (i.e., most executives and supervisors, certain administrative and professional employees, and outside salespeople) work longer than 40 hours per week, compared to only about 20% of non-exempt workers. However, the share of the workforce exempted from the FLSA has been growing slightly (Hamermesh 2000) over time, despite recent court decisions reaffirming FLSA coverage over occupations such as journalists, paralegals, some computer technicians

(those positions that are not highly paid or highly skilled), and most on-call positions. Moreover, business interests continue to push Congress to broaden the exemptions to include "inside sales employees" and licensed funeral directors and embalmers. They also are lobbying to create a new classification of "knowledge workers," such as computer and network systems analysts and degreed clerical personnel, who would be exempt from the overtime regulations (see U.S. GAO 1999; Labor Policy Association 2000).

Long hours and risks to worker and public safety and health

Long hours can detrimentally affect workers, their co-workers, their families, consumers, and the public. Indeed, there is evidence that, despite the short-term benefits that make overtime attractive to employers (Easton and Rossin 1997), it may in the longer term create offsetting harm to an organization by decreasing quality, increasing mistakes (Babbar and Aspelin 1998; Hirschman 2000), and reducing productivity (Shepard and Clifton 2000). A study on the effects of overtime work on autoworkers found that overtime resulted in impaired performance in attention and executive functions. Workers also reported feeling more fatigued and depressed after working more than eight hours a day (Proctor et al. 1996). It is not surprising, then, that accident rates increase during overtime hours (Kogi 1991). For example, researchers have identified overtime as a factor contributing to safety incidents at nuclear power plants (Baker et al. 1994), confirming what researchers had previously found at manufacturing plants (Schuster 1985) and among anesthetists (Gander et al. 2000). Workers who work overtime face a greater risk of injury and illness (Aakerstedt 1994; Duchon et al. 1994; Kosa 1995; Smith 1996). For a typical example, a German study found that, after nine hours at work, the accident rate begins to rise; in the 12th hour the accident rate was twice as high as the rate for the first nine hours (Hanecke et al. 1998). Long work hours also multiply repetitive motions and exposure to harmful chemicals.

Further, frequent overtime and compressed work schedules that produce long workdays can be a major cause of the stress and chronic fatigue reported by many workers, as well as the ensuing occupational burnout or serious health conditions (Sparks et al. 1997; Spurgeon et al. 1997; Martens et al. 1999; Barnett et al. 1999; Shields 1999; Fenwick and Tausig 2001). Stress can result in increased blood pressure and cardiovascular diseases, which in some cases can have fatal consequences. The Japanese, known for long work hours, even have a word – *karoshi* – to describe death from overwork (Hayashi et al. 1996; and Sokejima and Kagamimori 1998).

In the U.S., job stress is estimated to cost industry \$150 billion per year in absenteeism, health insurance premiums, diminished productivity, compensation claims, and direct medical costs (Donatelle and Hawkins 1989). Longer work hours can only contribute further to this drain. A study by Northwestern National Life (1991), which investigated employee burnout, found that seven out of 10 employees experiencing job stress said they frequently suffered health ailments. Frequent mandatory overtime was one of the leading five factors that caused increased stress. Employees who worked overtime on a regular basis were twice as likely (62% vs. 34%) to report that they found their jobs to be highly stressful.

Overtime work and the crowding-out of non-work-time activities

While hours spent at work have increased, work responsibilities at home have not decreased much.

Therefore, working families more and more find themselves squeezed for time. Overtime, and in particular forced overtime without advanced notice, is a challenge to working families. Being told at the end of the workday to stay and finish a work assignment or work a second shift can leave working parents – especially single parents – scrambling to make arrangements for child care at the last minute. Some parents can rely on other family members to care for their children at these times, but of course not all parents have this option, and therefore must depend on child care centers or babysitters to watch their children, a costly option, or perhaps even have to leave children unattended or unsupervised. Further, overtime work can interfere with after-work classes in which workers have enrolled and with community volunteering and social activities that require advance planning.

Overtime often comes at the expense of sleep: three in four people say they suffer fatigue during the day (Atkinson 1999). A poll by the National Sleep Foundation found rampant sleep deprivation, with one-third of respondents reporting less than seven hours of sleep per night and 63% getting less than the eight hours recommended for superior health, performance, and safety. In the last five years, adults who spend more time at work than sleeping has just about caught up to those who spend the reverse. Those who work sleep significantly less than those who do not, particularly those who work over 40 hours (and 38% in this poll reported working 50 hours or more per week), and they report more sleepiness during awake time and insomnia. Job-related work ranked as the activity least likely to be given up among adults who reported a lack of time (National Sleep Foundation 2001).

When workers cut back on sleep, their work performance suffers. The National Commission on Sleep Disorders estimates that companies lose up to \$150 billion per year due to employee fatigue. A study conducted by the American Journal of Public Health in 1992 found that nurses in Massachusetts who work variable schedules (including mandated overtime shifts) were twice as likely to report an accident or error and two-and-one-half times as likely to report near-miss accidents (MassNurse News 2000). It concluded that these conditions were associated with “frequent lapses of attention and increased reaction time, leading to increased error rates on performance of tasks.” An Australian study found that sleep deprivation has the same effects as being drunk. As the number of hours increased without sleep, the study’s testers took a longer time completing a task, made more mistakes, and had problems with concentration and memorizing information. After 17-19 hours without sleep, the testers’ performance and alertness suffered notably, and “performance levels were low enough to be accepted in many countries as incompatible with safe driving” (Williamson and Feyer 2000, 653-4). Sleep deprivation poses a serious safety risk for workers not only at work, but also when driving home after a long day at work. And for workers who work late into the evening, commuting by car may be the only option, since carpools and public transportation are geared to workers on daytime schedules.

Since overtime can have detrimental effects on workers and their families, no worker should be forced to work overtime. Indeed, the public health considerations associated with long work hours suggest that excessive overtime hours should be legally capped.

Levels of overtime and trends

An analysis of the number of hours usually worked by wage and salary employees shows that overtime work is widespread in most industries.³ In the industries of agriculture, mining, manufacturing, transportation, communication, and some professional services, more than 25% of all employees reported that they worked more than 40 hours per week on a regular basis, and often considerably more. In fact, workers who clocked extra hours (both exempt and non-exempt workers) on average worked nearly 12 hours more than the standard work week of 40 hours in 2000 (see **Table 1**).

There has been a slight, gradual, yet detectable upward trend in this percentage over the last decade. According to data from establishments by the Bureau of Labor Statistics (2000), average overtime in manufacturing escalated over the 1990s, from 3.3 hours to a peak of 4.9. More than half of the 20 industries within manufacturing had increases of at least 1 hour over the 1991-98 period (Hetrick 2000). In fact, many of these industries had set records for their overtime series by early 1997. The National Study of the Changing Workforce (NSCW) survey, in its sample of almost 3,000 individuals, found that the employed put in six hours more than they are scheduled to work (Galinsky and Bond 1998).⁴

Moreover, there is evidence of substantial non-compliance with the existing FLSA rules and regulations regarding overtime hours and pay or exemptions. By misclassifying workers or evading overtime pay rules, employers presumably have employees work longer hours than if the employer followed overtime rules regarding computation of hours and exemptions. Violations are higher in certain major industries (see **Table 2**). Non-compliance appears to be highest in the construction industry, where non-exempts dominate the workforce. While the rate of compliance in services is high, there has been a dramatic decline in two of the industry's components – nursing homes and residential living facilities – in the proportion of firms that are in compliance with the FLSA.⁵ The level of compliance in nursing homes dropped from 70% to 40% of surveyed firms, and is 57% in residential living facilities. The vast majority of violations (84% and 92%, respectively) were non-compliance with the industry's overtime pay rules. The most common violations in the nursing care and residential living industries are the failure of employers to pay for all the hours that an employee works and the misclassification of workers as exempt.⁶

Estimates of mandatory overtime

The last attempt to directly measure the extent of mandatory overtime with specific survey questions in a nationally representative sample was the 1977 Quality of Employment Survey (QES) of the University of Michigan. These estimates can form a baseline to estimate the current degree of mandatory overtime. The QES asked workers who worked overtime hours whether overtime was "mostly up to the worker" or "mostly up to the employer" and, separately, if they could refuse overtime without some kind of penalty. About 45% responded that overtime work was "mostly up to their employer" (vs. 44% who that said it was up to them; the rest said "both"). About 19% reported they would suffer a penalty. About one in six workers, 16%, said their overtime was both up to their employer and they would suffer a penalty if they refused it (Ehrenberg and Schumann 1984); this portion represents the most conservative estimate of the extent of mandatory overtime. In the entire QES sample, from the "merged" 1974-77 panels, 21% of men were subject to such mandatory overtime work, and 35% worked overtime voluntarily. Workers in blue-

TABLE 1
Hours worked, part-time and overtime, by industry, 2000 (employed individuals at their main jobs)

Industry	Number of workers	Average weekly hours	Percentage working part-time (less than 35 hours)	Percentage working more than 40 hrs/week	Percentage of workers with variable weekly hours*	Average hours worked if working more than 40	Average no. of overtime hours if working more than 40
Agriculture	1,862,667	40.3	15.0%	25.2%	15.0%	54.5	14.5
Mining	495,340	48.0	2.0	40.0	9.7	59.0	19.0
Construction	7,238,868	41.2	5.7	18.9	9.0	51.8	11.8
Manufacturing - durable	11,733,130	42.2	3.0	26.0	4.4	50.4	10.4
Manufacturing - non-durable	7,508,890	41.2	5.7	22.5	5.5	50.5	10.5
Transportation	5,729,608	41.6	10.6	25.1	10.3	53.6	13.6
Communications	1,978,388	41.9	4.7	25.3	4.0	50.8	10.8
Utilities and sanitation	1,430,693	41.3	3.1	17.3	4.1	50.8	10.8
Wholesale trade	4,838,551	42.2	6.9	30.1	5.6	51.4	11.4
Retail trade	20,595,385	35.3	30.7	15.4	8.9	51.4	11.4
Finance, Insurance, and Real Estate	7,685,257	40.4	9.6	20.8	5.1	51.1	11.1
Private households	922,179	29.7	42.7	8.7	18.3	56.7	16.7
Business and repair services	7,898,715	40.3	11.4	22.2	6.9	51.3	11.3
Personal services	2,799,577	37.3	22.2	13.2	8.7	53.6	13.6
Entertainment and recreation services	2,269,862	34.2	31.3	13.1	9.4	52.4	12.4
Hospitals	5,021,226	38.7	15.8	12.2	5.9	54.3	14.3
Medical services	5,961,670	37.0	22.5	11.5	6.2	52.0	12.0
Educational services	10,971,126	37.3	21.5	18.0	5.8	51.9	11.9
Social services	2,979,796	35.7	25.4	9.6	4.8	52.0	12.0
Other Service professions	5,334,002	40.0	15.4	27.4	6.7	52.4	12.4
Forestry and fisheries	98,284	42.6	8.4	17.6	12.0	61.8	21.8
Public administration	6,024,910	40.3	6.0	14.4	4.0	51.1	11.1
All workers							
Weighted averages across all industries	121,378,123	39.1	15.4%	19.4%	6.9%	51.8	11.8
Standard deviation among industries		3.7	11.0	7.6	3.7	2.9	2.9

* Workers with "variable hours" are those whose work week is so variable week to week that they cannot specify its usual length. A significant portion of these workers may, on average, actually work longer than a 40-hour week.

Source: Authors' analysis of the monthly Current Population Survey of households, 2000.

TABLE 2
FLSA coverage and overtime compensation by industry, FY 1996

Industry	Employees under executive, administrative, professional	Non-exempt employees	Estimated percent exempt from overtime	Rate of employer compliance with FLSA overtime regulations
All	31,729	74,044	39.5	90%
Private	25,495	61,899	39.9	88
Agriculture	252	12	99.4	90
Mining	95	3	17.2	92
Contract construction	736	4,584	15.1	73
Manufacturing	3,230	166	19.2	91
Transportation and public utilities	1,413	2,777	55.6	83
Wholesale trade	1,580	4,069	37.2	96
Retail trade	3,049	15,445	28.6	91
Finance, insurance, and real estate	2,706	3,493	49.4	86
Services	12,434	6,154	54.4	93
<i>(not including private households)</i>				
Private households	0	459	50.6	96
Public sector	6,234	12,144	37.5	
Federal government	1,233	1,472	46.6	
State and local government	5,002	10,672	36.1	100
Nonclassified				
<i>Correlation coefficient: percent exempt with percent compliance</i>				0.133

Source: U.S. Department of Labor, Wage and Hour Division, 1998.

collar positions had a greater likelihood of facing mandatory overtime, as did workers who had medical or pension plans, while unionized workers had a lower likelihood (Idson and Robbins 1991).

More recent attempts to infer the extent of mandatory overtime are far from satisfactory. Given the long-term rise in average weekly overtime hours (at least in manufacturing), however, one might suspect that the incidence of *mandatory* overtime has risen more or less commensurately (Smith 1996). A particularly informative study by Cornell University's Institute for Workplace Studies (1999) surveyed 4,278 unionized hourly workers, concentrated mainly in the Northeast and consisting of six industries, primarily construction (craft workers), manufacturing (auto workers), and services (emergency medical technicians; mail handlers; and workers in utilities, transportation, nursing homes, and retail). In this sample, 60% worked some overtime in the previous month, with about a third of these workers putting in 11 or more hours of overtime per week. About a third of the overtime workers reported being compelled by their employer to work overtime (a proportion the authors concluded was surprisingly low). Workers employed in the transportation and emergency health services faced more employer pressure than workers in other industries.

Almost one in five workers, 18%, reported working more overtime hours than they preferred. This amounted to half the proportion satisfied with their number of overtime hours and even less than half of

the proportion actually wanting more overtime. Thus, there appears to be a maldistribution; if hours could be redistributed within all industries away from those who work overtime involuntarily and toward those who wanted more overtime (presumably to build their incomes) this would reduce the latter group by up to 40% of its current size.

Involuntarily scheduled overtime work may further worsen the negative well-being, safety, and health outcomes of overtime per se. The Institute for Workplace Studies (1999) survey found that the proportion of workers who reported high levels of work/family conflict jumped dramatically for those who put in more than 50 hours a week. In addition, respondents who faced supervisory pressure to work overtime reported negative effects. For example, 19% of all workers reported feeling depressed more than "once in a while," but among the 8% of workers who reported high levels of supervisory pressure to work overtime, the percentage jumped up to 23%. Similarly, as supervisory pressure to work overtime increased, workers reported significantly higher levels of somatic stress, higher levels of job-escape drinking, and higher absenteeism due to illness. Supervisory pressure to work overtime was also significantly associated with injuries at work. Among the 66% of workers who reported no supervisory pressure to work overtime, 9% experienced multiple injuries at work during the prior year; among workers reporting low, moderate, or some levels of supervisory pressure, the share was 14%; for workers reporting high levels of supervisory pressure to work overtime, the share was 16%. Yet, financial demands and feelings of job insecurity were cited more frequently than employer pressure as the ultimate motivator of extra work time.

It is important to keep in mind that employees who are not subject to mandatory overtime may still end up working more overtime hours than they would prefer. Many workers have overtime scheduled by their employer, and "choose" overtime because their base wage or salary is insufficient to support their family; some may feel that their chances for a promotion or pay increase improve if they put in extra hours.

Sources of mandatory overtime

The need for mandatory overtime is in part an outcome of the prolonged economic expansion of the 1990s. Low unemployment rates led to labor shortages in certain industries such as health care and telecommunications and in occupations such as nursing. Rather than raising wages to attract new employees, employers opted to have their current workforce work more hours – even if it meant paying an overtime premium. In addition, adjusting hours to the seasonality of demand may be more common, tending to intensify the use of mandatory overtime. Half of all surveyed accounting firms, particularly the larger ones, used mandatory staff overtime for this purpose (Pfau, Quint, and Huttlinger 1997). Further, employers appear to be less willing to invest in training of new employees, and instead prefer to have their current workforce put in more hours; this has been the case in the high tech industry. Overtime continues to be appealing, despite its apparent longer-term harms and risks, because employers can enjoy non-wage cost savings (Cutler and Madrian 1998), while employees gain greater access to higher wage rates (Bell 2000; Hecker 1998) and more flexible daily work schedules (Golden 2000, 2001).

Mandatory overtime in health care: accident risks and compromising of quality

Overtime work is widespread among nurses, medical residents, and doctors, and this pattern of work can lead to situations that jeopardize the health of patients. Understaffing of nurses at hospitals means that nurses sometimes are forced to work a second shift after their first shift ends. High patient load and fatigue from long hours can result in inadequate compliance with procedures and less monitoring of patients. As a result, overtime can compromise patients' health or safety. Medical residents cited fatigue as a cause for their serious mistakes in four out of 10 cases (Boodman 2001), and two studies linked infection outbreaks at hospitals to overtime work (Arnow et al. 1982; and Russell et al. 1983). Indeed, the California Nurses Association reports that more nurses are refusing to work in hospitals with unsafe conditions, in which they include being forced to work unplanned overtime. The American Nurses Association (ANA), in a national survey of 7,300 of its members, found, disturbingly, that 56% of nurses believe that the time they have available for care for each patient has decreased, and 75% feel that the quality of patient care at their own facility has decreased in the last two years. The cited inadequate staffing as the chief reason.

Mandatory overtime in health professions generally is likely high, although no reliable data regarding its extent are available. In the Institute for Workplace Studies (1999) report, health sector workers averaged a little over three hours of overtime per week – not particularly high. In a survey on mandatory overtime, the journal *Nursing2000* reported that 36% said they never worked mandatory overtime. One quarter of the respondents worked mandatory overtime once or twice a month, while another quarter worked it once or twice a week. However, about 14% worked additional mandatory hours every day (*Nursing2000*). Respondents to a poll (2,125 total) administered by the American Association of Critical Care Nurses in May-June 2000 found that 43% of their members' hospitals have a mandatory overtime policy. The same poll found that responding members attributed mandatory overtime mainly (three-quarters of the reasons designated) to both routine short-staffing policies and a nursing shortage. Perhaps it is no coincidence that nurse's aides were second only to truck drivers in the total number of cases of disabling injuries and illness. And not surprisingly, the ANA delegates voted almost unanimously to declare that refusing overtime does not constitute patient abandonment, from which nurses are legally prohibited.

Mandatory overtime provisions in collective bargaining agreements

Generally, union workers are better protected from mandatory overtime than are nonunion workers, since union contracts can specify upper limits on overtime, establish a scheme to make overtime more orderly or voluntary, or establish a system of compensatory leave. In 1977, over one in five union members had collective bargaining agreements that restricted mandatory overtime, according to the QES. But as many unions have lost membership, in particular those in manufacturing and communication industries, workers' bargaining power to obtain such contract provisions may have diminished.⁷ Unions may find it increasingly difficult to both oppose mandatory overtime measures in workplaces and negotiate better premiums for overtime work. In addition, unions whose members have experienced declining wage rates are under pressure to preserve overtime work as a way to allow members to prop up their earnings.

In recent years, several unions have successfully negotiated contract language that places limits on mandatory overtime or requires steps to make such arrangements more voluntary in nature.⁸ For example, in the health services sector, Tenet Health Care and St. Vincent's Hospital in Worcester, Mass., signed an agreement with 600 nurses that allowed the hospital to mandate overtime but for no more than for a four-hour period twice every three months. (The hospital has the right to assign up to two hours of mandatory overtime, and the nurse can work an additional two hours if she felt capable of doing so safely.) Tenet management had initially demanded that the nurses agree to work mandatory 16-hour shifts with one hour's advance notice.⁹ Limits to forced overtime have been implemented in telecommunications and other industries as well. The Communications Workers of America (CWA) strike at Verizon in 2000 resulted in reduced mandatory overtime limits, in some instances cutting them in half, from 15 to 7.5 hours a week; the company is also now required to give at least 2.5 hours notice if overtime work is required, and it must give consideration to those employees requesting to be excused from overtime.¹⁰ Northwest Airlines permits employees to refuse overtime if they provide reasons such as child care responsibilities that cannot be altered on short notice. The American Postal Workers Union and the National Association of Letter Carriers agreed with the U.S. Postal Service to restrict excessive mandatory overtime. The agreement protects those members who sign up on a list of "overtime desired" but want to work only limited overtime, plus those members who are not on the overtime list at all.¹¹ In the manufacturing sector, the United Steelworkers of America negotiated a cap on mandatory overtime at FMC, a Baltimore, Md. pesticide plant. Newspaper Guild Local 35 (covering Washington-Baltimore) and the Bureau of National Affairs negotiated a voluntary overtime arrangement in which members can be excused from working compulsory overtime unless no other appropriate employee is available.

Policy solutions: legislated mandatory overtime limits, bans, and other remedies

Legislative initiatives at both the federal and state levels would regulate mandatory overtime. Bills have been introduced in the 107th U.S. Congress that would limit the amount of forced overtime that nurses and other licensed health care providers could work. The Safe Nursing and Patient Care Act of 2001 was introduced in the Senate (S-1686) and House (HR 3238). It aims to amend the Social Security Act by limiting the number of mandatory overtime hours a nurse may be required to work among providers of services to which payments are made under the Medicare program Under the Registered Nurses and Patients Protection Act (H.R. 1289, also referred to as the Lantos-McGovern Bill, and a very similar bill with different sponsors, H.R. 1902), licensed health care professionals could not be required to work more than eight hours in a day or 80 hours within a two-week period, unless a written agreement between the employer and the employee specifies otherwise. Nurses associations across the country have endorsed such bills, arguing that it would reduce overtime and improve both patient safety and quality of care. While the latter bill refers only to registered nurses, it would cover all other licensed health care workers in the country (except medical doctors). To date, House leaders have taken no action on it.

These federal proposals as well as a number of similar state initiatives have been important first

State Public Health Employee Worker Shortage Report: A Civil Service Recruitment and Retention Crisis



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Table of Contents

Section I	
Executive Summary	2
Section II	
Introduction	3
Section III	
Public Health Workforce Shortages	4
Trends Impacting the Public Health Workforce	4
Public Health Shortage Profiles by Profession	7
Section IV	
Keys to Success: State Plans to Address Public Health Workforce Issues	10
Section V	
Conclusion	13
Section VI	
References	14

Table of Charts

Figure 1	
Agencies Affected By Worker Shortage	3
Figure 2	
Average Age of Public Health Workers	4
Figure 3	
Annual Growth Rate of the U.S. Labor Force	5
Figure 4	
Percent of State Public Health Employees Eligible for Retirement	7
Figure 5	
Position Vacancy Rates in the State Public Health Agencies	6
Figure 6	
Turnover Rates for State Public Health Personnel	6
Figure 7	
Composition of Total Public Health Workforce	7
Figure 8	
State Public Health Occupational Classes Most Affected	8
Figure 9	
State Public Health Personnel Recruitment and Retention Plans	11
Figure 10	
Keys To Solving Public Health Workforce Challenges	12

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State Public Health Employee Worker Shortage Report: A Civil Service Recruitment and Retention Crisis



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ASTHO extends a sincere thanks to the 37 state health agencies that completed the National Survey on State Public Health Employee Worker Shortage for their time and contribution.

In addition, ASTHO extends special thanks to Kathy Vincent, LCSW and Rose Conner, RN, MEd for their vision, support, guidance and passion for workforce development.

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The Association of State and Territorial Health Officials is the national non-profit organization representing the state and territorial public health agencies of the United States, the U.S. territories, and the District of Columbia. ASTHO's members, the chief health officials in these jurisdictions, are dedicated to formulating and influencing sound public health policy, and assuring excellence in state-based public health practice.

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Table of Contents

Section I	
Executive Summary	2
Section II	
Introduction	3
Section III	
Public Health Workforce Shortages	4
Trends Impacting the Public Health Workforce	4
Public Health Shortage Profiles by Profession	7
Section IV	
Keys to Success: State Plans to Address Public Health Workforce Issues	10
Section V	
Conclusion	13
Section VI	
References	14

Table of Charts

Figure 1	
Agencies Affected By Worker Shortage	3
Figure 2	
Average Age of Public Health Workers	4
Figure 3	
Annual Growth Rate of the U.S. Labor Force	5
Figure 4	
Percent of State Public Health Employees Eligible for Retirement	5
Figure 5	
Position Vacancy Rates in the State Public Health Agencies	6
Figure 6	
Turnover Rates for State Public Health Personnel	6
Figure 7	
Composition of Total Public Health Workforce	7
Figure 8	
State Public Health Occupational Classes Most Affected	8
Figure 9	
State Public Health Personnel Recruitment and Retention Plans	11
Figure 10	
Keys To Solving Public Health Workforce Challenges	12

Executive Summary

The most difficult challenge state and local public health agencies face in developing the capacity to respond to terrorist events, emerging infectious diseases, and other public health threats and emergencies is assuring a qualified workforce is available to carry out these functions. If current workforce demographic trends are left unchecked, they will have an adverse affect on the capacity of state health agencies to carry out their mission; including responsibilities that have continued to expand since the events of September 11, 2001, and the ensuing anthrax attacks.

In October 2002 the Council of State Governments (CSG) and the National Association of State Personnel Executives (NASPE) conducted a workforce survey of all state agencies. The resulting report, "State Employee Worker Shortages: The Impending Crisis," noted that state governments could lose more than 30 percent of their workforce to retirement, private-sector employers, and alternative careers by 2006, and that health agencies would be the hardest hit.

The findings from the CSG/NASPE workforce survey appeared to confirm the anecdotal evidence and other information that was emerging about the pending crisis in the state public health workforce. The combination of that evidence and the CSG/NASPE findings were so compelling that ASTHO concluded a broader inquiry and analysis of state public health workforce trends were warranted. Consequently, in November and December of 2003, ASTHO surveyed its members, the senior health officials of the 57 states and territories (and the District of Columbia), on a wide spectrum of workforce trends and indicators. ASTHO received responses from 37 states. This report contains the results of the survey.

The following are key findings from the ASTHO/CSG survey:

- A rapidly aging workforce whose average age is 46.6 years
- Public health retirement rates as high as 45 percent over the next five years
- Current vacancy rates of up to 20 percent in some states
- Public health employment turnover rates of 14 percent in some parts of the country

These findings illustrate a growing public health employee shortage in a majority of the states that has been further exacerbated by severe state budget cuts during 2002 and 2003—the deepest cuts in 60 years⁽¹⁾—which have had profound effects on the ability of public health agencies to fill vacant positions.

More than 50 percent of the states cite the lack of qualified personnel or individuals willing to relocate as major barriers to preparedness.⁽²⁾ Approximately 42 percent of the current epidemiologists in state health agencies lack formal academic training in epidemiology.⁽³⁾ Only public health nurses, an occupational group that averages more than 30 years of service,⁽⁴⁾ are more affected by workforce shortages than epidemiologists.

State health agencies are supporting and, in some cases, implementing a variety of strategies to head off the workforce crisis. States reported that increased access to advanced education, competitive pay and benefits, and flexible work schedules and telecommuting opportunities are the three most important incentives in attracting and retaining an adequate public health workforce.

Introduction

The Council of State Governments (CSG) and the National Association of State Personnel Executives (NASPE) conducted a survey in October 2002 that predicted state public health departments would be the state agencies most likely to experience the government workforce shortage. The survey data captured in the report, "State Employee Worker Shortages: The Impending Crisis", indicated that 85 percent of the state agencies responding named the health field as the most affected by personnel shortages.⁽⁵⁾

The Association of State and Territorial Health Officials (ASTHO), in conjunction with CSG and NASPE, conducted the National Survey on State Public Health Employee Worker Shortage in December 2003. This report reflects the survey findings provided by the State Health Officials and serves as a companion to the NASPE/CSG report. The new survey findings provide a better understanding of current public health workforce challenges and state health agencies' strategies for addressing the workforce crisis.

The last major review of the national public health workforce was conducted in 2000 by the Bureau of Health Professions in the Department of Health and Human Services Health Resources and Services Administration.⁽⁶⁾ The Bureau's report, "Public Health Work Force Enumeration 2000," illustrated the differences in responsibilities among state public health agencies, the variation in ways agencies enumerate their employees, the large variety of professional disciplines employed, and the complexity of making cross-agency comparisons. This report stated that the ratio of state public health workers to population had dropped from 219 per 100,000 in 1980 to 158 per 100,000 in 2000. This landmark report did not examine the issues of recruitment and retention.

In the five years since the enumeration study state public health has entered a new era with new responsibilities. Public health has been subject to significant new pressures and challenges. The events of 9/11 and the anthrax attacks brought the role and responsibility of the public health workforce in emergency response efforts to the fore in public understanding and to the attention of colleagues in emergency management and other first response agencies. This was followed by severe state budget cuts during 2002 and 2003—the deepest in 60 years. Public health agencies did not escape the cuts.

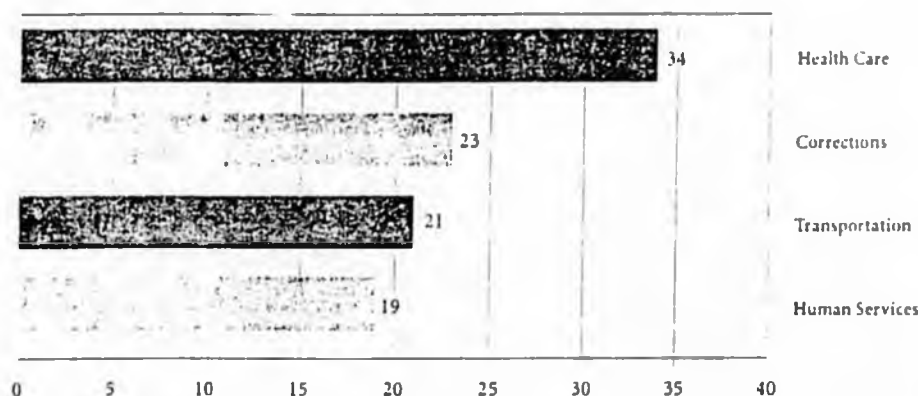


Figure 1

Agencies Affected by Worker Shortage

Chart represents the number of states that listed each agency as one "most likely to be most affected by a worker shortage."

Source: CSG/NASPE Survey.

Public Health Workforce Shortages

Trends Impacting the Public Health Workforce

Four trends emerged from the survey of ASTHO members which confirm the findings in the earlier report, "State Employee Worker Shortages: The Impending Crisis":

- 1 A rapidly aging public health workforce and shrinking labor pool
- 2 A high percentage of the public health workforce is eligible for retirement eligibility.
- 3 Chronic shortages in professional areas such as public health nursing, epidemiology, laboratory science and environmental health.
- 4 High turnover rates in states.

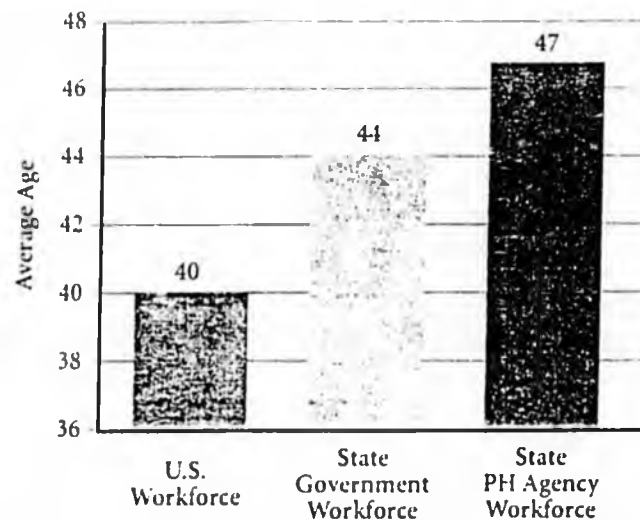
One: A Rapidly Aging Workforce

The average age of state public health employees is 46.6, according to the ASTHO/CSG survey. Since the largest portion of the U.S. working population is starting to move into retirement age, this trend toward an aging workforce creates new challenges for filling vacant positions in public health. By comparison, the "State Employee Worker Shortages: The Impending Crisis" report revealed the average age of all state agency employees to be 44 years, the center of the baby boom generation's age range and the age of the U.S. workforce.⁽⁷⁾ According to the Social Security Administration, the average age of the American workforce is 40, or 15 percent younger than the state public health workforce.⁽⁸⁾

Figure 2

Average Age of Public Health Workers, by Region

Source: ASTHO/CSG Survey, CSG/NASPE Survey, Social Security Administration



The population of the United States is undergoing significant change. The nation is experiencing a significant bulge in the eligibility for retirement. The older population (65 and over) numbered 35.6 million in 2002, an increase of 3.3 million or 10.2 percent since 1992. However, the number of Americans aged 45-64, increased by 38 percent during this period.⁽⁹⁾ Figure 3 shows the falling growth rate of the U.S. workforce. The baby boomer generation is aging and the succeeding generation of workers is significantly smaller.⁽¹⁰⁾

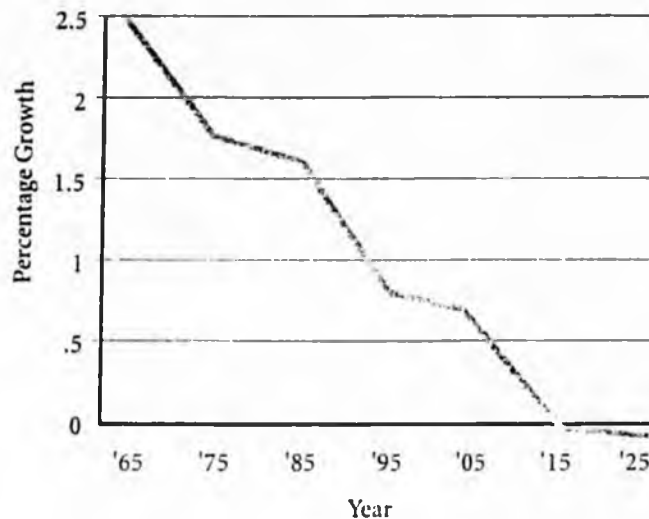


Figure 3

Annual Growth Rate of the U.S. Labor Force

Source: Social Security Administration

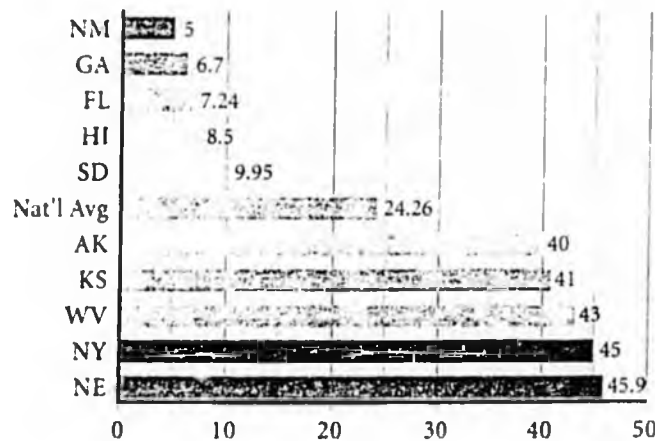


Figure 4

Percent of State Public Health Employees Eligible for Retirement

Source: ASTHO/CSG Survey

Note: The five states with the highest and lowest percentages each are shown.

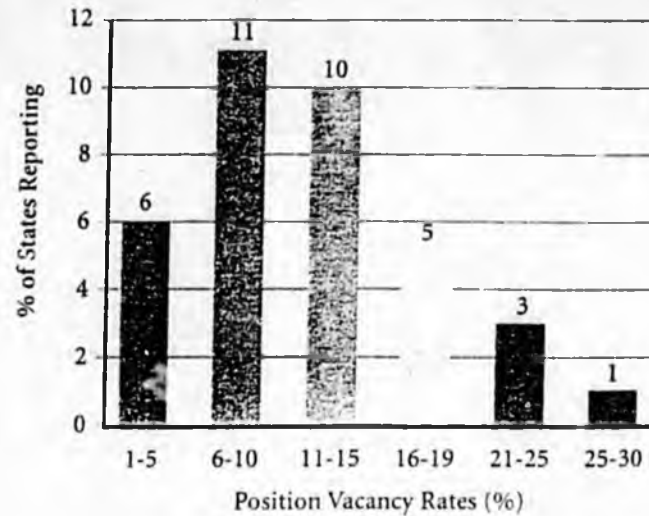
Two: High Percentage of Workers Eligible for Retirement

The "State Employee Worker Shortages: The Impending Crisis" reported that state governments could lose more than 30 percent of their workforce to retirement, private-sector employers, and alternative careers by 2006. The rates for state public health agencies according to the ASTHO/CSG survey are as high as 45 percent (Figure 4). On average, about 24 percent of the public health workforce is eligible for retirement compared to 21 percent reported for all state employees in October 2002.⁽¹¹⁾

Figure 5

Position Vacancy Rates in the State Public Health Agencies

Source: ASTHO/CSG Survey



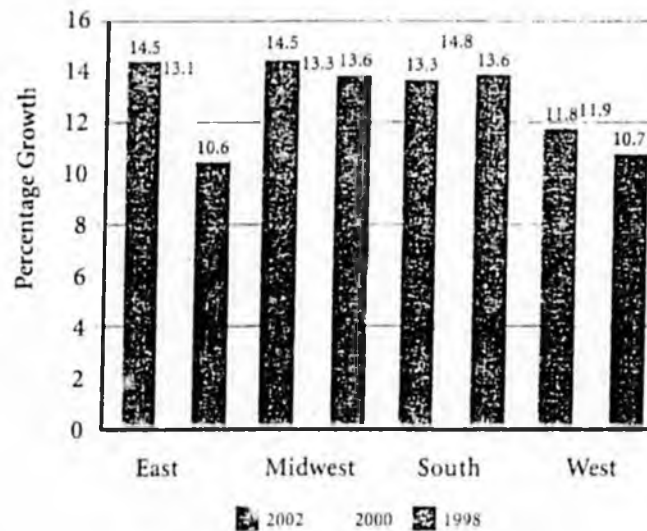
Three: Chronic Shortages in Professional Areas

Four states from the survey show vacancy rates for public health positions of 20 percent or higher. Seventeen out of 35 states reported vacancy rates in the 11-20 percent range. Fourteen states reported that the percentage of state health agency vacancies did not change or had declined in the last five years. The ASTHO/CSG report shows that around 11 percent of state jobs across all state agencies are vacant.⁽¹²⁾

Figure 6

Turnover Rates for State Public Health Personnel, by Region and Year

Source: ASTHO/CSG Survey



Four: High Turnover Rates

In addition, states must contend with an annual employee turnover rate that averaged 14 percent for the 28 states responding to this question. The high turnover represents a potentially huge loss of institutional knowledge, leadership, and experience for state health agencies. Although in most states the turnover rate for public health is comparable to the turnover rate for all state government agency employees, hiring freezes and shortages will make it hard for state public health agencies to fill vacant positions.⁽¹³⁾ The earlier CSG survey documented that 27 states had enforced some type of mandatory hiring freeze.⁽¹⁴⁾

Public Health Shortage Profiles by Profession

As highlighted in Figure 7, public health professionals such as nurses, laboratory scientists, environmental workers, physicians, nutritionists, educators, and social workers comprise 45 percent of the current public health workforce. The rest of the workforce consists of health officials and administrators (3.5 percent), technicians (9.4 percent), administrative support personnel (12 percent), paraprofessionals (3.5 percent), and other technical and administrative categories.⁽¹⁵⁾

State and local health agencies are reporting the most significant worker shortages in the areas of nursing, environmental health, epidemiology, and laboratory science.⁽¹⁶⁾ Figure 8 of the ASTHO/CSG survey reflects that the state health agency workforce shortage issue is most noticeable among public health nurses. Thirty out of 37 reporting states identified public health nursing as the field that is and will continue to be the most affected by the personnel shortage. Furthermore, the survey documented considerable shortages for three other public health disciplines including epidemiologists (15 states), laboratory workers (11 states) and environmental health specialists (11 states).

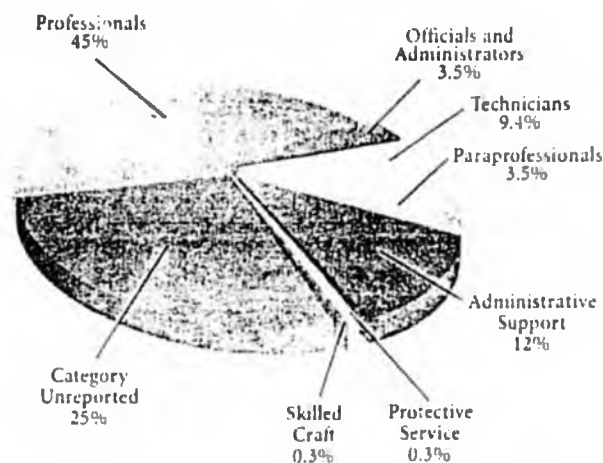


Figure 7

Composition of Total Public Health Workforce

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce Information and Analysis, *The Public Health Work Force: Enumeration 2000*, Dec. 2000.

Public Health Nursing

Thirty out of 37 reporting states indicated that nursing is the occupational class most affected by the workforce shortage, shortages are twice that of the next leading class, epidemiologists (Figure 8).

The leaders of state public health nursing average more than 30 years service and are very close to retirement. In one state nearly 40 percent of the public health nursing workforce is eligible for retirement today.⁽¹⁷⁾

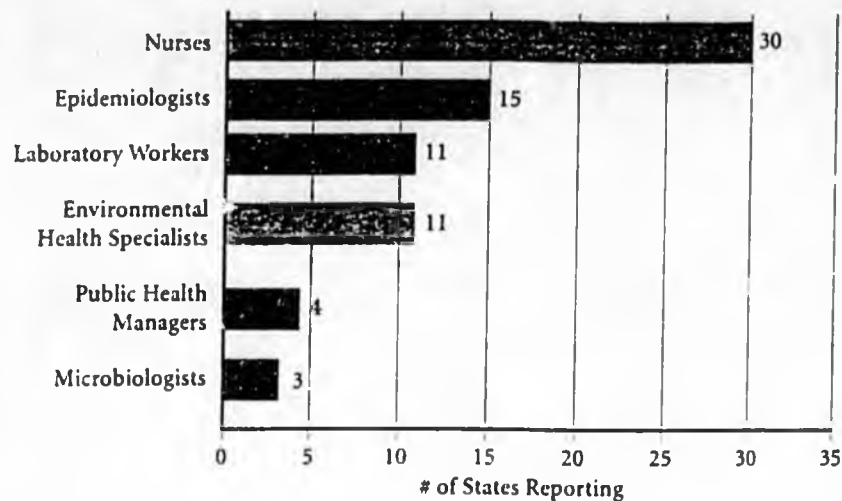
Public health nurses comprise 11 percent of the total public health workforce and 25 percent of all public health professionals⁽¹⁸⁾ The ASTHO/CSG survey shows the 37 reporting states have a total of 14,733 nurses working for public health agencies. The number of public health nurses varies by state; one state reported six nurses on staff, while another reported having 2,591.

The roles and responsibilities of the public health nurse can also vary by state. They might include, for example, instructing individuals on preventive care, nutrition, and childcare and arranging for immunizations, blood pressure screening, and/or working with community leaders to promote health education.⁽¹⁹⁾

Figure 8

State Public Health Occupational Classes Most Affected by Worker Shortage

Source: ASTHO/CSG Survey



Health providers across the nation, public and private, are reporting serious deficiencies in the supply of nurses in all health care settings. According to national projections, by the year 2010 there will be a need for one million additional registered nurses in all health fields.⁽²⁰⁾ The nursing shortage in the private sector adds to the challenge for the public health sector, which must compete for a limited pool of applicants.

Part of the public health nurse recruitment challenge is that young people are increasingly reluctant to enter public health nursing, primarily because of low salaries in the field.⁽²¹⁾ Unfortunately, fiscal conditions in many states do not permit the salary increases necessary to allow state health agencies to effectively compete for limited talent.

Women in the past have traditionally filled the vast amount of nursing positions due to limited career paths. However, today's women have greatly expanded career opportunities to choose from when selecting a career leaving behind significant recruiting gaps.

Epidemiology

Epidemiology provides the fundamental public health functions of monitoring health status, diagnosing and investigating health hazards and events, and evaluating the effectiveness of health services.

According to the ASTHO/CSG survey, at least 15 of the 37 reporting states have a shortage of epidemiologists (Figure 8). The U.S. General Accounting Office reports that barriers to recruiting and retaining epidemiologists in the public health field include noncompetitive salaries and a general shortage of professionals.⁽²²⁾ Approximately 42 percent of the current epidemiology workforce in state health departments lacks formal academic training in epidemiology.

The shortage of epidemiologists may be partly explained by the high level of education required for this profession in relation to public salaries: 28.6 percent of epidemiologists have doctoral level training, 40 percent have master's level training, 18.4 percent have bachelor level training and 13 percent have various other types of educational qualifications.⁽²³⁾

Laboratory Scientists and Technicians

Public health laboratories are often the first line of defense in protecting the American people against diseases and other health threats. Public health laboratories provide diagnostic testing, disease surveillance, applied research, and training. The laboratory workers in state public health constitute 3.1 percent of the total public health workforce.⁽²⁴⁾

While several states participating in the ASTHO/CSG survey noted the shortage of laboratory workers, other surveys have also found shortages of laboratory personnel. A report by the Association of Public Health Laboratories that includes data as of December 2002, reveals a severe shortage of qualified laboratory personnel in the states.⁽²⁵⁾ Thirteen states reported no doctoral-level molecular scientist on staff, and 23 states reported only one. Most states agreed that at least two doctoral-level molecular scientists were needed on staff to ensure emergency readiness.

A shortage of information technology specialists can seriously imperil the ability of states to meet the national goal of timely and effective communication of laboratory results during an emergency.⁽²⁶⁾ Sixteen states reported no dedicated, full-time information technology specialist to manage laboratory information systems and 18 states reported only one person serving in this capacity.

The primary barrier to hiring adequate laboratory staff is the lack of trained personnel willing to serve in the public sector. In recognition of this, Congress took steps in 2003 to help meet the need of more public health laboratory staff by appropriating \$146 million to improve laboratory capacities. However, even though the supplemental funding provides for hiring of a skilled laboratory workforce, the needed workforce simply does not exist. Of 22 states that have not met the August 2003 deadline for preparedness benchmarks from the grant money, 17 cited the difficulty in recruiting new staff as a major problem.⁽²⁷⁾

The Association of Public Health Laboratories cautions that policy-makers might erroneously assume that because all of the funds have not been spent, states don't need the money. In fact, intractable vacancy rates and the physical unavailability of professionals willing to work in the public sector are the core of the problem.⁽²⁸⁾

Environmental Health Professionals

The term environmental health professional covers a broad array of services in the public health field. For the past 150 years environmental health services have focused on food, water and sanitation. The emergence of new threats – such as cryptosporidium, hantavirus, West Nile virus, SARS, and bio/agro-terrorism – shows the need for a strong environmental public health system and workforce.

Eleven of the 37 reporting states in the ASTHO/CSG survey identified a shortage of environmental health professions. There are slightly more than 20,000 environmental health professionals and technicians in the United States.⁽²⁹⁾ They comprise about 4.5 percent of the total public health workforce.⁽³⁰⁾

Current challenges for recruiting and retaining existing environmental health workers include low pay scales at the state level, minimal advancement opportunities, and competition with the private sector. State environmental programs often serve as a training ground for people to learn needed skills and then move into the private sector at higher salaries.

Keys to Success: State Plans to Address Public Health Workforce Issues

Measuring the extent of the current workforce deficit, projecting future staffing needs, and developing effective strategies to meet these needs present new challenges to State Health Officials. Given current budget constraints at the state level, states are experimenting with new approaches in recruitment and retention. Some of these strategies have been implemented, while others are still in the planning stage.

Workforce Recruitment and Retention

States are considering various strategies to ensure adequate staffing of public health agencies, including:

- Increasing pay and benefits
- Offering flexible work schedules and telecommuting opportunities
- Providing professional training
- Training future public health leaders
- Marketing public health careers at high schools and on college campuses
- Partnering with educational institutions
- Using information technology and the Internet for recruitment

The ASTHO/CSG survey identified six trends that are developing in the approaches to workforce recruitment and retention among the states. These are shown in Figure 9. The CSG/NASPE Survey reported that 34 states are establishing new recruitment and retention strategies and 75 percent of states have developed long-term plans to address the personnel crisis.

Outreach Campaigns

Seven of the 37 reporting states are implementing recruiting strategies that promote public health careers at high schools and higher education institutions. For example, outreach campaigns aimed at universities and colleges, schools of public health and health services, and historically minority colleges. State health agencies are also redefining public service by developing public health career promotion campaigns that showcase state public health agency positions as interesting careers where giving back to the community, detecting new and emerging threats, and keeping America healthy are just part of the job.

All 37 states that participated in the survey have proposed various approaches to alleviating public health worker shortages. For example, some states are developing mid-life career change programs to attract professionals leaving other career paths. Other states are developing reports on the current conditions affecting the workforce to aid policymakers in determining future planning.

Information Technology

Five states reported using information technology and the Internet to expand their outreach and optimize their outreach campaigns. Some states are using the Internet to advertise public health vacancies, taking advantage of commercial partnerships offered by web-based job search engines for augmenting recruitment capabilities and shortening the hiring process. States are also developing clearinghouses for current in-depth information on health careers.

Professional Training

Recognizing the value of institutional knowledge, state health agencies are devising innovative strategies to retain current employees. Fourteen of the 37 reporting states are considering incentives designed to advance the competencies of their public workforce, such as scholarship and loan repayment programs, work-study arrangements, professional training, and distance learning opportunities. Emphasis on the value and attainment of proper qualifications through higher education and continuing education is essential if the public health workforce is to keep up with the escalating demands of new scientific technologies and methodologies.⁽³¹⁾

Eleven of the 37 reporting state public health agencies are considering partnering with various professional educational institutions to design public health programs and curricula. By educating all health professionals about public health skills, states can develop basic public health curriculum units that can be adopted into any baccalaureate or graduate health professional program. This increases the pool of partners for public health organizations that reach out for collaboration in future retention, training, and mentorship.

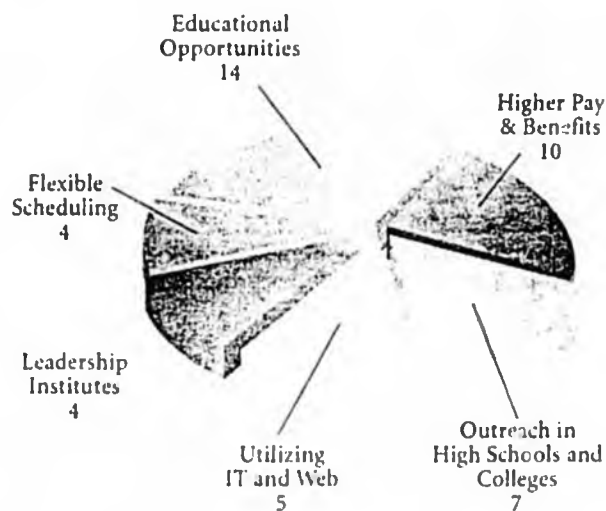


Figure 9

**State Public Health
Personnel Recruitment
and Retention Plans**

Source: ASTHO/CSG Survey

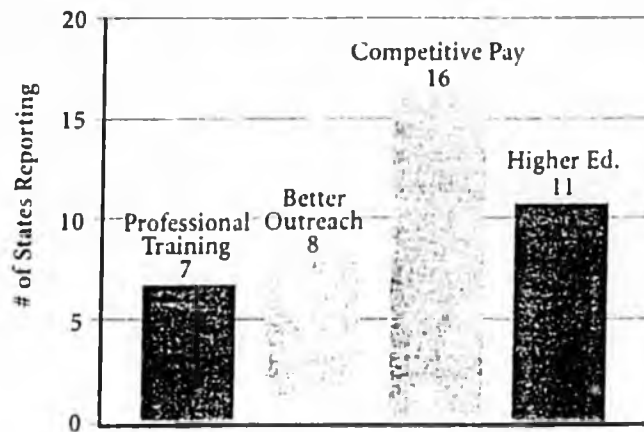
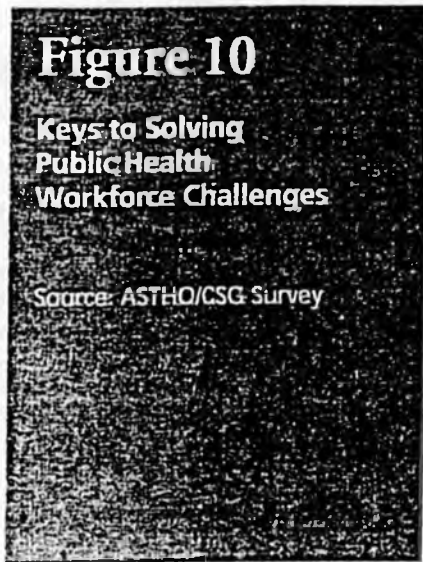
Higher Pay and Benefits and Flexibility

States are concerned that considerably lower salaries in governmental public health positions make it difficult to compete with the private sector for employees. Sixteen states are considering offering pay and benefits that are in line with the private sector as a potential solution to public health worker shortages (Figure 10). The ASTHO/CSG report documents that 45 states have faced serious budget difficulties during the past two years that will make it difficult for them to address the state workforce shortage.⁽³²⁾ Despite funding cuts, the ASTHO/CSG survey demonstrates some states are finding vehicles to increase pay to retain employees when the market shrinks for particular high-need occupational categories.

Four of the 37 reporting states are offering telecommuting and other flexible scheduling opportunities to their public health employees. States found flexible schedules improve organizational resilience, promote skills retention for those who might want to move out of state but continue to work on a full-time or part-time basis, lower absenteeism, and reduce the desire to "job hop".

One way to retain the expertise and experience of the aging workforce is to rehire retired employees. Of 36 states that responded to this question in the survey, all but four states reported that they actively seek to rehire retired employees. Of the 33 states responding that are permitted to rehire, 16 provide retirement benefits to the rehired employees. Some states are offering part-time employment to attract public health system retirees.

Tapping the retired worker talent pool offers a significant opportunity to avoid the loss of institutional knowledge and retain highly-skilled employee. It also allows more time for succession planning activities. Currently, Americans age 50 and older make up 28 percent of the population, with 50.6 million people between ages 50 and 70. As the baby-boomers mature, it's predicted that there will be as many Americans of retirement age as there are 20-25 year olds.⁽³³⁾



Enhancing Leadership Capacity

Four of the 37 reporting states are focused on enhancing the leadership capacity of their public health managers through leadership training institutes. Public health agencies partner with state educational institutions to help future health leaders acquire and develop necessary leadership skills.



Conclusion

An adequate supply of competent public health professionals is a vital component of the governmental public health infrastructure. A number of factors are having an adverse affect on the ability of state public health to ensure that there are sufficient numbers of these individuals to fill current and rapidly growing vacancies. Chief among these are that the current workforce is rapidly aging and nearing retirement while there are few students and young professionals who are interested in careers at public health agencies. The combination has resulted in a critical narrowing of the public health workforce pipeline in a majority of the states. If left unchecked, time will exacerbate the crisis.

The ASTHO/CSG survey shows that the greatest worker shortages are in the areas of public health nursing, epidemiology, laboratory science, and environmental health, all of which require advanced specialized training and education. These professionals detect emerging diseases; educate the public about actions to take to prevent exposure, protect the food supply, and help develop public health policy to prevent the spread of disease. A long-term aggressive plan must be implemented to educate, recruit, and retain competent public health professionals.

States are implementing various strategies to improve worker recruitment and retention, such as reaching out to school-aged children to spark interest in the public health profession, using information technology to recruit new public health workers, providing incentives to improve skills, increasing the pay and benefits of the existing public health workforce, and rehiring retired public health employees. The underlying current of tight state budgets, however, affects all of these efforts.

Aside from offering competitive salaries, long-term solutions will require innovative programs for on-the-job training and expensive advanced degree education. Many states said outreach campaigns to new partners, institutes of higher learning, school aged children, and legislatures are critical to building the public health workforce pool. Many states also indicated that scholarship and loan repayment programs could help public health to recruit the best and the brightest America has to offer.

There are a variety of reasons for the public health workforce shortage. The survey provides examples of the practices states are implementing to alleviate the shortages and how the entire public health system must plan for long-term solutions. Both the problems and the solutions are multi-dimensional and will require a well-coordinated effort on the part of the public health agencies, legislatures, institutes of higher learning, and the federal government to help improve the outlook for the future workforce and guarantee the security and health of the American people.

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Alaska Employment Projections in Healthcare

Occupation	Employment		Percent Change	Comments
	Year 2002	Projected 2012		
Licensed Practical & Licensed Vocational Nurses	521	609	16.9	Employment of LPNs is expected to grow about as fast as the average for all occupations through 2012 in response to the long-term care needs of an increasing elderly population and the general growth of healthcare. Replacement needs will be a major source of job openings, as many workers leave the occupation permanently.
Registered Nurses (registered nurse, hospital nurse, office nurse, nursing care facility nurse, home healthcare nurse, public healthcare nurse, occupational health nurse, head nurse, nurse supervisor, clinical nurse, nurse anesthetists, and nurse mid-wives)	5,004	6,670	33	Job opportunities for RNs are expected to be very good. Employment of registered nurses is expected to grow faster than the average for all occupations through 2012, and because the occupation is very large, many new jobs will result. In fact, more new jobs are expected to be created for RNs than for any other occupation. Thousands of job openings also will result from the need to replace experienced nurses who leave the occupation, especially as the median age of the registered nurse population continues to rise.
Nursing Aides, Orderlies & Attendants	1704	2148	26	Excellent job opportunities are expected for this occupation, as rapid employment growth and high replacement needs produce a large number of job openings. Employment of personal and home care aides is projected to grow much faster than the average for all occupations through the year 2012. The number of elderly people, an age group characterized by mounting health problems and requiring some assistance, is projected to rise substantially. In addition to the elderly, however, patients in other age groups will increasingly rely on home care, a trend that reflects several developments, including efforts to contain costs by moving patients out of hospitals and nursing care facilities as quickly as possible, the realization that treatment can be more effective in familiar rather than clinical surroundings, and the development and improvement of medical technologies for in-home treatment.
Dental Hygienist	438	619	41.3	Employment of dental hygienists is expected to grow much faster than the average for all occupations through 2012, in response to increasing demand for dental care and the greater utilization of hygienists to perform services previously performed by dentists. Job prospects are expected to remain excellent. In fact, dental hygienists is expected to be one of the fastest growing occupations through the year 2012. Population growth and greater retention of natural teeth will stimulate demand for dental hygienists. Older dentists, who have been less likely to employ dental hygienists, are leaving the occupation and will be replaced by recent graduates, who are more likely to employ one or even two hygienists. In addition, as dentists' workloads increase, they are expected to hire more hygienists to perform preventive dental care, such as cleaning, so that they may devote their own time to more profitable procedures.
Dental Assistant	703	980	39.4	Job prospects for dental assistants should be excellent. Employment is expected to grow much faster than the average for all occupations through the year 2012. In fact, dental assistants is expected to be one of the fastest growing occupations through the year 2012. In addition to job openings due to employment growth, numerous job openings will arise out of the need to replace assistants who transfer to other occupations, retire, or leave the labor force for other reasons. Many opportunities are for entry-level positions offering on-the-job training.

Alaska Employment Projections in Healthcare

Occupation	Employment		Percent Change	Comments
	Year 2002	Projected 2012		
Medical Records and Health Information Technician	357	549	53.8	Job prospects should be very good. Employment of medical records and health information technicians is expected to grow much faster than the average for all occupations through 2012, due to rapid growth in the number of medical tests, treatments, and procedures that will be increasingly scrutinized by third-party payers, regulators, courts, and consumers. Although employment growth in hospitals will not keep pace with growth in other healthcare industries, many new jobs will nevertheless be created. The fastest employment growth and a majority of the new jobs are expected in offices of physicians, due to increasing demand for detailed records, especially in large group practices. Rapid growth also is expected in nursing care facilities, home healthcare services, and outpatient care centers. Additional job openings will result from the need to replace technicians who retire or leave the occupation permanently.
Physical Therapist Assistant	51	72	41.2	Employment of physical therapist assistants and aides is expected to grow much faster than the average through the year 2012. The impact of proposed Federal legislation imposing limits on reimbursement for therapy services may adversely affect the short-term job outlook for physical therapist assistants and aides. However, over the long run, demand for physical therapist assistants and aides will continue to rise, in accordance with growth in the number of individuals with disabilities or limited function. The growing elderly population is particularly vulnerable to chronic and debilitating conditions that require therapeutic services. These patients often need additional assistance in their treatment, making the roles of assistants and aides vital. The large baby-boom generation is entering the prime age for heart attacks and strokes, further increasing the demand for cardiac and physical rehabilitation. In addition, future medical developments should permit an increased percentage of trauma victims to survive, creating added demand for therapy services.
Pharmacy Technicians	359	571	59.1	Good job opportunities are expected for full-time and part-time work, especially for technicians with formal training or previous experience. Job openings for pharmacy technicians will result from the expansion of retail pharmacies and other employment settings, and from the need to replace workers who transfer to other occupations or leave the labor force. Employment of pharmacy technicians is expected to grow faster than the average for all occupations through 2012 due to the increased pharmaceutical needs of a larger and older population, and to the greater use of medication. The increased number of middle-aged and elderly people—who, on average, use more prescription drugs than do younger people—will spur demand for technicians in all practice settings. With advances in science, more medications are becoming available to treat more conditions.

Alaska Employment Projections in Healthcare

Occupation	Employment		Percent Change	Comments
	Year 2002	Projected 2012		
Physician Assistant	185	251	35.7	Employment of PAs is expected to grow much faster than the average for all occupations through the year 2012, due to anticipated expansion of the health services industry and an emphasis on cost containment, resulting in increasing utilization of PAs by physicians and healthcare institutions. Physicians and institutions are expected to employ more PAs to provide primary care and to assist with medical and surgical procedures because PAs are cost-effective and productive members of the healthcare team. Physician assistants can relieve physicians of routine duties and procedures. Telemedicine—using technology to facilitate interactive consultations between physicians and physician assistants—also will expand the use of physician assistants. Job opportunities for PAs should be good, particularly in rural and inner city clinics, because those settings have difficulty attracting physicians.
Speech-Language Pathologists and Audiologist	190	199	4.7	Employment of speech-language pathologists and audiologists is expected to grow faster than the average for all occupations through the year 2012. Members of the baby boom generation are now entering middle age, when the possibility of neurological disorders and associated speech, language, swallowing, and hearing impairments increases. Medical advances are also improving the survival rate of premature infants and trauma and stroke victims, who then need assessment and possible treatment. Many States now require that all newborns be screened for hearing loss and receive appropriate early intervention services. Many States now require that all newborns be screened for hearing loss and receive appropriate early intervention services.

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER

OCT 05 2005
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JUNEAU, ALASKA 99811-0200
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September 30, 2005

Saul
Feldman

The Honorable Peggy Wilson
Alaska House of Representatives
PO Box 109
Wrangell, AK 99929

Dear Representative Wilson:

You have asked me to advise your committee regarding the collective bargaining implications of proposed legislation concerning mandatory overtime for nurses and other health care employees. First, Registered Nurses must be distinguished from other unlicensed or lesser-licensed employees. Registered Nurses are classified as professionals for purposes of the federal Fair Labor Standards Act (FLSA), to which the State, other public employers, and private sector employers are subject. Under the FLSA, Registered Nurses and other professionals are exempt from overtime so long as they are paid a salary. In those instances where Registered Nurses are compensated for overtime, it is a creature of a labor agreement or employer policy. The State pays overtime to some levels of the Registered Nurse classification by agreement with the general government and supervisory bargaining units. Lower levels of health care employees, e.g., Certified Nurses Aides and Psychiatric Nursing Assistants, are overtime eligible under the FLSA.

The Alaska Public Employment Relations Act (AS 23.40.070 – 260, PERA) requires public employers to bargain over “wages, hours, and terms and conditions of employment” (AS 23.40.250(1)). Clearly, overtime eligibility criteria and thresholds are matters concerning hours of work and thus are mandatory subjects of bargaining. A mandatory subject is a matter about which the parties must bargain if either party makes a proposal and over which either party may persist to impasse. Nurses and other health care employees are Class One employees within the meaning of AS 23.40.200 *et seq.* and may not strike. If the parties reach impasse on a subject such as overtime, the dispute is submitted to arbitration under AS 23.40.200 (a)(1). The arbitrator’s award is subject to legislative approval under AS 23.40.215 and 250(4). If approved by the Legislature, the State is bound by the arbitrator’s decision.

It is not uncommon for state employee unions to propose contractual restrictions on or prohibitions of mandatory overtime. Similarly, it is not uncommon for the State of Alaska to fight to retain the ability to assign an employee to lawful work. It remains our department’s position that recruitment and retention of nurses should be addressed in a more comprehensive



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The Honorable Peggy Wilson

2

September 30, 2005

and longer term solution as detailed in our recent testimony before the House Health, Education, and Social Services Committee.

If you have any questions regarding this correspondence, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Tibbles". The signature is fluid and cursive, with the first name "Michael" being more prominent than the last name "Tibbles".

Michael Tibbles
Deputy Commissioner

cc: The Honorable Paul Seaton
Alaska House of Representatives

Katie Shows

From: michael.tibbles [michael_tibbles@admin.state.wk.us]
Sent: Tuesday, September 27, 2005 11:23 AM
To: Katie Shows
Subject: Re: question from HESS meeting

Katie,

I have talked to several of our directors here at DOA and staff at H&SS. I have only been able to come up with one example where a department has actually fined another. This would be in the case of OSHA (DOL - Division of Labor Standards and Safety) violations. However, in the context you have requested, it does not make a lot of sense. The Department of Labor could find the Department of Health and Social Services. The Department of Health and Social Services would not have budgeted money to pay the fine and therefore would request funds from the Legislature only to deposit the money back into the General Fund.

I also wanted to pass along to you that we are preparing a short letter to address one of the questions Rep. Seaton raised at the hearing. We will outline what items are subject to bargaining under state law and as interpreted by the court system. Please let me know if you have any additional questions.

Mike Tibbles

Katie Shows said the following on 9/23/2005 9:59 AM:

Mr. Tibbles,

Rep. Seaton had a question for you after this morning's HESS committee meeting.

On page 3, lines 23-28 of the CSIB 27J (version 24-I.S083/Y) it outlines the provisions of the fine and that the Commissioner of Labor assess on the health care facilities, which are under the authority of the Department of Health and Social Services. Is it common practice for one commissioner to assess a variable fine against a facility controlled by a different department?

Thanks,

Katie Shows
Legislative Aide
Rep. Paul Seaton
1.907.233.2921

*For to Peggy Wilson
from Paul Seaton*

Testimony to House HESS Committee on CSHB 271(HES), Draft "Y"
Limitations on Overtime for Registered Nurses in Health Care Facilities
BY: Rod Betit, President/CEO Alaska Hospital & Nursing Home Association
January 24, 2006

Madame Chair, members of the Committee I appreciate the opportunity to speak to CSHB 271 on behalf of my membership.

This bill as drafted would apply to the following ASHNHA members:

HOSPITALS

- | | |
|------------------------------------|----------------|
| • Alaska Regional Hospital | Anchorage |
| • Bartlett Regional Hospital | Juneau |
| • Central Peninsula Hospital | Soldotna |
| • Fairbanks Memorial Hospital | Fairbanks |
| • Ketchikan General Hospital | Ketchikan |
| • Mat-Su Regional Medical Center | Palmer/Wasilla |
| • Providence Alaska Medical Center | Anchorage |
| • South Peninsula Hospital | Homer |
| • Alaska Psychiatric Institute | Anchorage |
| • North Star Behavioral Health | Anchorage |

NURSING HOMES

- | | |
|-----------------------------------|---|
| • Denali Center | Fairbanks |
| • Heritage Place | Soldotna |
| • Ketchikan General | Ketchikan |
| • Mary Conrad Center | Anchorage |
| • Providence Extended Care Center | Anchorage |
| • South Peninsula | Homer |
| • Wildflower Court | Juneau |
| • Alaska Pioneer Homes | Anchorage, Fairbanks, Juneau, Sitka,
Ketchikan, Palmer |

My membership has deep respect for the sponsor's commitment for improving health care delivery in the State, and for her concern about the fair treatment of health care professionals in these institutions.

We support the sponsor's goal to avoid excessive use of mandatory overtime as this can lead to reduced quality of patient care if exhausted health care workers have worked too many hours without a break.

ASHNHA
Alaska State Hospital and Nursing Home Association

Testimony to House HESS Committee on CSHB 271(HES), Draft "Y"
Limitations on Overtime for Registered Nurses in Health Care Facilities
BY: Rod Betit, President/CEO Alaska Hospital & Nursing Home Association
January 24, 2006

ASHNHA members try to limit the use of mandatory overtime to situations that are unforeseen and would leave patients with inadequate supervision, inadequate assistance with personal care needs, or inadequate medical management. When these unexpected staffing situations arise facility management may have to keep nursing staff into the next shift. Facility management has to balance the impact on nursing staff against the patients' needs. Failure to meet the patients' needs expose the facility to serious licensing action if they do not insure that all patients' needs are adequately met.

The problem being addressed by CSHB 271 is when nursing staff are frequently required to work into the next shift, particularly during certain periods of the year. This obviously raises some concerns about quality of patient care and fairness to nursing staff.

In testimony given on this bill last year, and during the interim, there was general agreement that non-State facilities have used mandatory overtime infrequently and that this bill is not aimed at correcting problems in those facilities. I have not come by one complaint against a non-State facility for excessive use of overtime, mandatory or otherwise.

It is my understanding that this bill is attempting to address on-going mandatory overtime problems in state facilities, most frequently cited is API. API's use of mandatory overtime varies throughout the year. The heaviest periods of use are during the winter months when patient census predictably increases.

It is important to look at the reasons for use of mandatory overtime by API when determining whether CSHB 271 provides a reasonable remedy that would fix the underlying problems. We understand the reasons to be:

1. Inadequate number of filled nursing positions to provide patient care due to hiring difficulties caused by non-competitive salaries and the stress of the job leading to higher turnover than in general acute care facilities.
2. A State and community expectation for API to take all patients who need hospitalization regardless of staffing available at the time. The business of caring for patients who are a "risk to themselves or others" is not something that can be turned away or passed to other providers as this is a very intense, complex population that API is best able to serve.
3. Inadequate provision in state employee contracts to allow API to request a market survey to validate salary disparities with the private health care market, and permission to increase salaries to be competitive throughout the year without legislative review.

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4. Inadequate funding in API's operating budget to actually pay higher salaries to hire staff as soon as they deem a problem developing without budget authority from the Legislature which generally cannot come in time to head off a serious problem.

During the interim the sponsor worked diligently to craft an alternative solution to this problem in hopes that CSHB 271 would become unnecessary. We participated earnestly in trying to help find that solution but it proved elusive. We believe that the sponsor has brought CSHB 271 back up in hopes of keeping the discussion alive and fleshing out a better answer.

We understand the sponsor's decision to do that but have real problems with this bill. In my membership's view CSHB 271 does not address the underlying reasons listed above for the State facility problems. CSHN 271 provides punishment for excessive use of mandatory overtime but does not put any measures in place to break the cycle at State facilities.

In addition, CSHB 271 throws a net around the entire health care system with a system of reporting and monitoring that is not supported by my membership given the lack of evidence of any problem with use of mandatory nurse overtime in non-State facilities.

So, we would like to offer an alternative set of recommendations to consider that we believe would address the underlying problems. We believe the following actions would place API and other State facility management in a position to more effectively staff their facilities according to changing patient census throughout the year, and reduce the dependence on mandatory overtime.

1. Immediately authorize State managers to offer higher salary levels as validated by market surveys so they can hire additional nurses soon. We understand the Legislature and the Administration will need to figure out how to handle the budget impact, but we believe this step is necessary to make the State hiring system responsive to the market conditions it is facing.
2. Consider providing API funding for an ongoing nurse preceptor program that will help newly hired nurses gain advanced skills to provide care in an inpatient psychiatric setting. A preceptor program is an excellent way to close the gap between hiring nurses with little or no experience and moving them to a proficient level. Through the efforts of the University of Alaska, ASHNHA members, the Alaska Nurses Association and others the University of Alaska nursing program is now graduating 200 new nurses a year rather than 100. With competitive pay, mentorship, preceptor training and

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periodic respite from intense nursing demands in an inpatient psychiatric setting, API will have more success attracting and keeping the nursing staff they need.

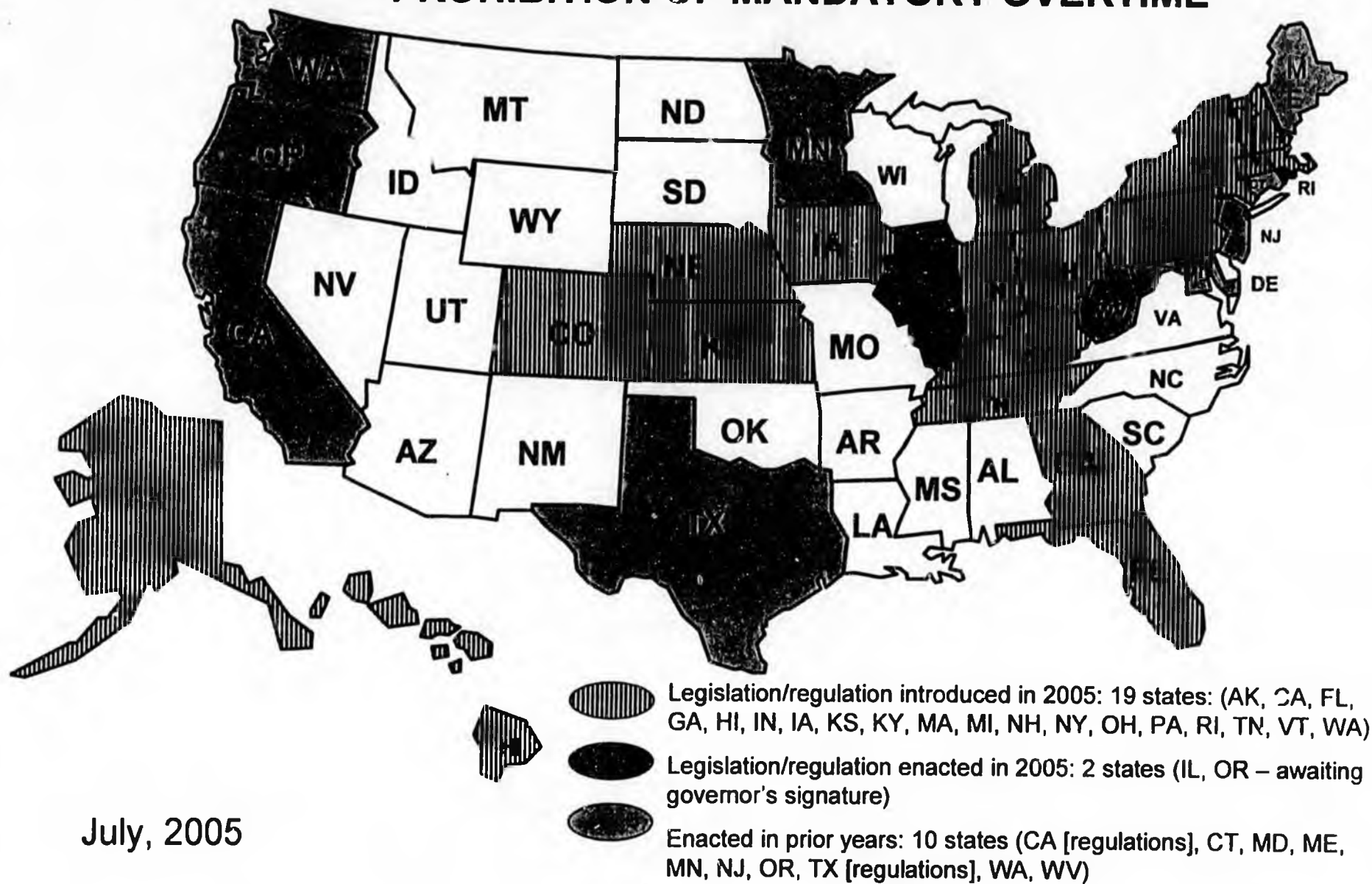
3. Help API solve the problem of coming up with a pool of temporary nurses that can be hired during staffing crises to fill gaps. This is a specialized area of nursing that most temporary staffing agencies do not address. Even under the best of circumstances there will be need for temporary staffing to cover changes in census and unexpected loss of staff.
4. Consider establishing a separate bargaining unit for essential health care related staff separate from other employees to allow special procedures to be developed that will address these problems in the future. Ongoing market survey of nursing salaries should be a routine part of this program.
5. Create a work group to find other solutions to this problem.

ASHNHA believes there are solutions to the problems that State facilities are facing. We appreciate the work the sponsor has done to bring attention to this problem and to look for solutions. We think the solutions outlined above have merit but more importantly recommend a work group be convened to support the sponsor's efforts to figure out how to place State facilities on a more solid footing so they do not have to resort to excessive mandatory overtime for lack of other options.

Thank you for the opportunity to comment on this bill and I would be happy to respond to any questions the committee might have.

The American Nurses Association's Nationwide State Legislative Agenda

PROHIBITION OF MANDATORY OVERTIME



Background: Mandatory Overtime

Mandatory overtime is a difficult problem for RNs and health care facilities. Because of inadequate RN staffing, employers have used mandatory overtime to staff facilities often as a cost savings factor. Nurses are concerned about the health effects of long term overtime and the quality of care being provided. Research indicates that risks of making an error were significantly increased when work shifts were longer than 12 hours, when nurses worked overtime, or when they worked more than 40 hours per week.¹

As part of the American Nurses Association's (ANA) Nationwide State Legislative Agenda on the nurse staffing crisis, State Nurses Associations support the enactment of mandatory overtime legislation in state legislatures and regulatory agencies. ANA is also pursuing the enactment of federal legislation to prohibit mandatory overtime. The Safe Nursing and Patient Care Act of 2005 (HR 791/S 351) www.anapoliticalpower.org has been introduced in the House and Senate and would prohibit the requirement that a nurse work more than 12 hours in a 24 hour period and 80 hours in a consecutive 14 day period, except under certain circumstances.

In 2005, legislation to prohibit mandatory overtime was introduced in the following 19 states: **AK, CA, FL, GA, HI, IN, IA, KS, KY, MA, MI, NH, NY, OH, PA, RI, TN, VT and WA.** The Illinois Nurses Association was instrumental in the passage of legislation in **IL** that allows hospitals to mandate a nurse to work overtime only in unforeseen emergent circumstances. Even if they must do so, no nurse may work more than 4 hours beyond her/his regularly scheduled work shift. A nurse may not be punished for refusing to work overtime, and if a nurse works 12 hours there must be an 8 hour rest period before working again. This bill awaits the governor's signature. The Oregon Nurses Association was successful in amending **OR** mandatory overtime law (enacted in 2001) by prohibiting a hospital from requiring a nurse to work more than 48 hours in a week or more than 12 consecutive hours in a 24-hour period. There are a few specific exceptions to the limits on mandatory overtime. Nothing in the bill prevents voluntary overtime. This bill also awaits the governor's signature.

In 2004, **WV** enacted legislation prohibiting a hospital from mandating a nurse to accept an assignment of overtime. The commissioner of labor is charged with the enforcement of the law and shall administer a penalty for any violations. **CT** enacted legislation prohibits a hospital from requiring a nurse to work in excess of a predetermined scheduled work shift except in certain circumstances such as participating in a surgical procedure until the procedure is completed, public health emergency etc. Legislation was also introduced in **FL, GA, HI, IA, IL, MA, MI, MO, NY, OH, PA, RI, TN, VT, and WA.**

In 2003, three states, **LA, NV and WV,** enacted legislation requiring the establishment of study committees to further explore the issue. 22 other states introduced prohibition of mandatory overtime legislation/regulation designed to set maximum hours of work per day/week with protected right of refusal for work time requested in excess of predetermined maximums.

In 2002, the following states enacted prohibition of mandatory overtime legislation: **MD** law states that an employer may not require a nurse to work more than the regularly scheduled hours according the predetermined work schedule. There are some exceptions including an emergency

¹ Rogers A, et al. The working hours of hospital staff nurses and patient safety. *Health Affairs* 2004;23(4):202-12.

situation that could not be reasonably anticipated and if a nurse has critical skills and expertise that are required for the work. **MN** law prohibits action against a nurse who refuses mandatory overtime because it would jeopardize patient safety. **NJ** enacted legislation prevents a health care facility from requiring an employee to work in excess of an agreed to, predetermined and regularly scheduled daily work shift, not to exceed 40 hours per week. **TX** regulations require hospitals to develop policy and procedures for mandatory overtime. **WA**'s new language states that acceptance of mandatory overtime by a nurse is strictly voluntary and refusal is not grounds for adverse actions against the nurse.

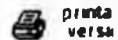
Legislation enacted in 2001 in **ME** would prevent a nurse from being disciplined for refusing to work more than 12 consecutive hours except in certain circumstances and must be given 10 consecutive hours off following overtime. **OR** enacted legislation prevents a nurse from being required to work more than 2 hours beyond a regularly scheduled shift or 16 hours in a 24 hour time period. Regulations adopted in **CA** prior to 2001 prevent an employee scheduled to work a 12 hour shift from working more than 12 hours in a 24 hour period except in a health care emergency.



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Nursing Matters

Nursing Matters fact sheets provide quick reference information and international perspectives from the nursing profession on current health & social issues.



Nurses and Overtime*

Nurses are increasingly working overtime. Nurses' overtime (mandatory** or voluntary) has been used as a measure to reduce the impact of the critical shortage of nurses and/or the downsizing of nursing departments in both private and public health care. However, the increasing amount of overtime threatens nurses' ability to provide individualised care for patients.

While in many countries federal regulations define the maximum hours that can be worked in sectors having a direct impact on public safety (e.g. aviation, transport), nurses and other health care workers are rarely protected. A few examples have been selected to provide an overview of existing situations.

* Overtime is time worked in addition to the normal or regular contracted hours.

** Mandatory overtime is obligatory, compulsory or imposed by the employer leaving no choice to the employee.

Examples

1. USA – mandatory overtime

Promoted by hospital management as a way to staff effectively during an emergency, mandatory overtime has become instead a means to cover routine personnel shortages.

In a large number of hospitals nurses report the existence of a documented policy that imposes mandatory overtime. Overtime may be from 4 to 16 hours (or more) and nurses are included in a duty roster to perform the overtime after their regular shift. Depending on the state where the nurses are employed, they may be paid extra money (not always) but do not get any time off.

In January 2001 the "Registered Nurse and Protection Act" was introduced in the US Congress. It aims to limit the number of hours that licensed health care workers, including registered nurses (RNs), would be obliged to work. The bill will amend the Fair Labour Standards Act to bar mandatory overtime beyond 8 hours in a workday or 80 hours in any 14-day work period. Exceptions are

accepted in cases of natural disasters or in the event of a state of emergency declared by the authorities. A licensed health care employee may however voluntarily work beyond 8 hours in any given workday.

2. *Australia*

Australian nurses report a significant increase in their workload over the past five years. A recent report shows an increasing amount of regularly worked overtime. On 23 June 2000, Australian Nursing Federation (ANF) ACT Branch members voted unanimously to outlaw the working of 16 and 18-hour shifts and ban recall shifts when individual nurses considered them to be unsafe.

3. *Europe*

Nurses within the EU are protected by law from being forced to do overtime but it is still common practice in almost all countries that nurses do work overtime. To date, the directive that exists has not been implemented in all European countries. According to the Working Time Regulations, work time must not average more than 48 hours per week over a standard averaging period of 17 weeks. It is possible however to extend this period to 26 weeks a year if agreement is reached by employers and employees. Daily and weekly rest entitlements are also specified in the regulations:

- ⇒ *Daily rest:* Employees are entitled to a rest period of not less than 11 consecutive hours in each period of 24 hours during which the employee works for the employer.
- ⇒ *Weekly rest period:* Employees are entitled to an uninterrupted rest period of not less than 24 hours in each 7-day period. This is in addition to the daily rest period.
- ⇒ *Breaks:* Employees are entitled to a rest break when daily working time exceeds 6 hours.

United Kingdom:

A national survey of registered nurses commissioned by the Royal College of Nursing (RCN) and carried out by the Institute for Employment Studies (IES) in 1999 showed that 59% of the respondents report that they work an average of 6.6 of excess hours per week. In 1998, the average was 5.8 hours/week. Twenty-eight percent of the nurses report undertaking paid work in addition to their main job. They work an average of 6.6 hours a week in these additional jobs. The increased income is the main reason given for taking on this secondary employment.

4. *Japan*

A 1997 survey by the Japanese Nursing Association showed that 4,636 nursing personnel reported working an average of 12 hours 36 minutes of overtime each month. More than 70% of hospital employees were required to work rotating night shifts (Japanese Nursing Association News, 1998).

It is common practice that individuals in certain positions (e.g. management) work overtime without specific compensation or benefits. Most often, however, this overtime is not mandatory and the risk to public safety is not present. Perceptions about the number of hours constituting long hours vary according to the type of work. However, some employees work 100 hours per week or more. British employees are reported to work some of the longest hours in Europe.

Rationale for working long hours:

The main reasons for working long hours are:

- Work pressure – arising from heavier workloads, increasing demand, few and tighter budgets.
- Work organisation – in some cases lack of prioritisation or individual inefficiency can increase the workload.
- Long hours culture – generated by the example of managers working long peer pressure, job insecurity, individuals feel their presence at work is critical to the realisation of the organisation's mission.
- A strong commitment amongst individuals towards their work, colleagues, customers or clients.
- A need to increase take-home pay.

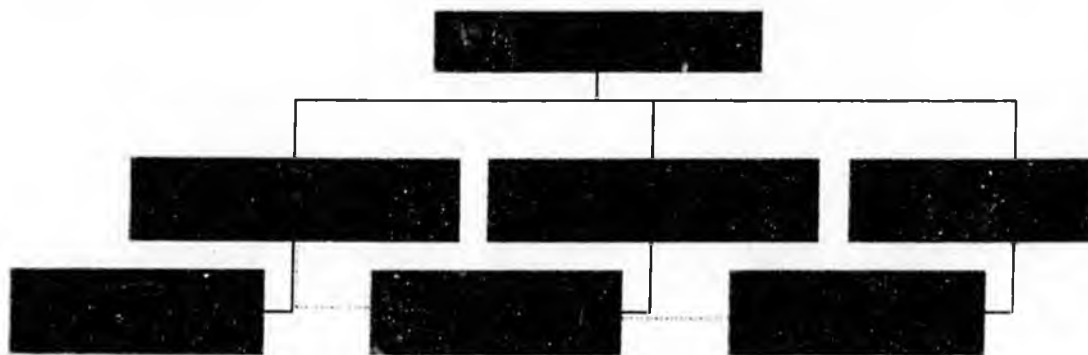
Some, if not all, of these reasons are relevant to nurses.

Effect on health

When no limits are set on overtime work and no guidelines exist for the rest period following extended hours of work, the burden of these physical and mental demands have a negative effect on patients as well as nurses. Extensive overtime (voluntary or mandatory) may put patients and nurses at risk.

Nurses

A limited number of studies demonstrate the relationship between extended shifts (more than eight hours) and fatigue as well as increased safety risks. The negative consequences are not limited to physical health, e.g. fatigue, headache, sleep deprivation. Disruptions and stressed dynamics within the social and family life are also reported.



Patients

Extensive overtime puts patients at risk, due to:

- Nurses being less alert to changes in patients' condition.
- Nurses having slower reactions.
- Medication errors – adverse drug events (ADEs).
- Errors in clinical judgement.
- Increase in nosocomial infections.
- Increase in decubiti.

All the above potential consequences are likely to lead to deterioration in the quality of care provided.

What Nurses can do

- A professional nurse is the best judge of her own capability. If she cannot provide safe care in a given situation, she must inform her supervisor.
- Research on the subject of extended overtime and related health issues and its influence on medical errors should be undertaken so that more comprehensive data is available.
- The public should be informed about the working conditions in health care – not to frighten them but to alert them about the actual situation and generate support for constructive change.
- National nurses' associations should work together with other health professional organisations to ensure appropriate regulation of overtime.
- National nurses' association should provide the ethical framework for nursing overtime practices, especially in cases where nurses reject an assignment due to physical exhaustion or mental stress.



For further information please contact
ICN at icn@icn.ch

Fact sheet/Nurses and Overtime

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"The work of bedside nursing has become increasingly demanding, from physical tasks such as securing and transporting patients in wheel chairs, to caring for sicker and more obese patients, and even enduring abusive behavior from patients, family members, and staff, including physicians. Marked reductions in hospital length of stays have also made it more difficult for nurses to get to know patient needs. These and other factors have decreased the average nurse retirement age to the mid-50's. Many initiatives to address the nursing shortage are focusing on making it safer and less stressful for nurses to stay at the bedside as they age."

An excerpt from *Charting Nursing's Future*, a publication of the Robert Wood Johnson Foundation, November 2005.

KIDS TOGETHER, Inc.

People First Language Examples to Use and to Share by Kathy Snow

Labels Not to Use...	People First Language...
the handicapped or the disabled	people <i>with</i> disabilities
the mentally retarded or he's retarded	people <i>with</i> mental retardation or he has a cognitive impairment
my son is autistic	my son <i>has</i> autism
she's a Down's; she's mongoloid	she <i>has</i> Down syndrome
birth defect	<i>has</i> a congenital disability
epileptic	a person <i>with</i> epilepsy
wheelchair bound or confined to a wheelchair	<i>uses</i> a wheelchair or a mobility chair or is a wheelchair user
she is developmentally delayed	she <i>has</i> a developmental delay
he's crippled; lame	he <i>has</i> a physical disability he has a mobility impairment
she's a dwarf (or midget)	she <i>of</i> short stature
is learning disabled or LD	<i>has</i> a learning disability
afflicted with, suffers from, victim of	person who <i>has</i> ...
she's emotionally disturbed; she's crazy	she <i>has</i> an emotional disability

normal and/or healthy kids	typical kids or kids without a disability
quadriplegic, paraplegic, etc.	he <i>has</i> quadriplegia, paraplegia, etc.
she's in Special Ed	she <i>receives</i> Special Ed services
handicapped parking, bathrooms, etc	<i>accessible</i> parking, bathrooms etc.
she has problem with...	she has a need for...

See Also:

Pennsylvania's Executive Order

"All Commonwealth agencies, boards or commissions under the Governor's jurisdiction shall use 'People First' language..."



[Return to previous page](#)

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Madam Chair and members of the committee,

My name is Cathy Feaster. I am a nurse practitioner and nursing supervisor in the Community Health Services Division of the Municipality of Anchorage Department of Health and Human Services. I'm here to testify on behalf of House Bill 271.

This bill recently came to our attention at the department, and although we support the spirit and intent of this bill, we have some concerns regarding possible unintended consequences.

It appears the bill will have no negative consequences in regards to the majority of our nurse driven programs and services. However, we have one program, the Sexual Assault Response Team clinic known as SART which by its nature creates special circumstances.

Team members SART is a team comprised of a police detective, a forensic nurse, and a STAR advocate ~~all of whom~~ are on call 24 hours a day, 7 days a week. Upon receiving a call the team joins as a unit to interview, medically examine and support the sexual assault client. The SART clinic has many challenges. We would hate to see legislation jeopardize this critical service.

We would like this bill to move forward in this committee and offer to work with the sponsor in looking closely at the implications and language to ensure there are no unintended consequences that might negatively impact the viability and important mission of the Sexual Assault Response Team.

Thank you Madam Chair and members of the committee.

Cathy Feaster, MSN, ANP

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ASHNHA Position on Draft Committee Substitute for CSHB 271 Version 'P'

Prepared by: Rod Betit, President/CEO

February 28, 2006

The Alaska State Hospital and Nursing Home Association (ASHNHA) wishes to express its appreciation for the sponsor's efforts to reach consensus on CSHB 271 Version 'P'. The meetings held in the intervening weeks have been very helpful and constructive. While the measure now contains a very useful reporting requirement that ASHNHA members support, there remains one major provision of this legislation which ASHNHA members cannot support.

First, I would like to draw your attention to a survey ASHNHA conducted of its membership regarding the use of "mandatory overtime" as defined locally between management and nursing. As the attached survey conducted by ASHNHA shows, facilities are not using mandatory overtime to fill the nursing gaps that exist around the State (see attached Survey results). Further, to ASHNHA's knowledge there has been no evidence presented to the contrary by other parties. Therefore, ASHNHA's membership cannot support measures that reduce management's ability to fairly and openly negotiate employment practices with their nursing staff.

Specifically, ASHNHA's concern is around Sec. 18.09.010 of the bill which provides that a nurse will be the sole determiner of whether overtime is appropriate. In effect the bill removes management from this decision process. This is simply not reasonable personnel policy to adopt by state law. Currently, overtime parameters are negotiated between management and representatives of nursing staff in each community. Different standards exist in different communities, acceptable to both management and nursing representatives, based on a host of factors. This language would interfere with the local ability to arrive at these employer/employee relationships.

On the other hand, ASHNHA supports the intent of Sec. 18.09.040 of the bill. We believe this is the heart of this legislation. This section would require periodic reporting of nurse overtime utilization, as well as use of temporary nursing services by each facility. We agree with the sponsor that there is a valid public health concern to monitor in the years ahead. By collecting this level of information from health facilities the Legislature will be able to determine whether steps being taken to address the nursing shortage are having any impact, and if not, what other measures should be implemented to address the problem.

Again ASHNHA's membership appreciates the sponsor's willingness to work on the provisions of this bill. Unfortunately, although a number of important amendments have been made, there still remains a major provision of this bill which ASHNHA members cannot support. Thank you for this opportunity to testify today.

ASHNHA Represents the Following Alaska Health Care Providers

Alaska Regional Hospital, Alaska Native Medical Center, Alaska Pioneer Home System, Bartlett Regional Hospital, Bassett Army Community Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kakanak General Hospital, Ketchikan General Hospital, Manillaq Health Center, Mary Conrad Center, Mat-Su Regional Hospital, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, U.S.F 3rd Medical Group- Elmendorf, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, Alaska Psychiatric Institute, North Star Behavioral Health System, Wildflower Court Nursing Home.

ASHNHA 2004 and 2005 NURSE OVERTIME SURVEY RESULTS - VERSION 'D' (February 13, 2006)

Facility		Nurses in Union?	Shortage Better or Worse?	Length of Shift (Hrs)	Nurse Vacancy Rates		Mandatory OT Usage- Total Hrs		On-call Policy		OT hrs	OT hrs	# of OT grievances filed
					2004	2005	2004	2005	Require	# times /month			
Alaska Regional Hospital	No	Yes	Worse	8,10,12	4 to 6%	4 to 6%	NONE	NONE	Certain Units	varies	3750 hrs	5000 hrs	NONE
Alaska Native Medical Center	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Alaska Pioneer Homes (All Six Facilities)	No	Yes	Worse	7.5	unknown	unknown	unknown	unknown	No	NONE	NONE	NONE	unknown
Alaska Psychiatric Institute	No	Yes	Worse	8,10,12	20%	30%	unknown	46 hrs.	No	NONE	NONE	NONE	unknown
Bartlett Regional Hospital	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Bassett Army Community Hospital	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Central Peninsula General Hospital	No	Yes	Worse	12	14%	11%	NONE	NONE	Certain Units	7-8 X	3764 hrs	3613 hrs	NONE
Cordova Community Medical Center	No	No	No Chg.	12	10%	20%	NONE	NONE	Certain Units	varies	1872 hrs	3744 hrs	NONE
Danah Center Nursing Home	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Fairbanks Memorial Hospital	No	No	No Chg.	8, 10, 12	7%	7%	NONE	NONE	Certain Units	varies	1144 hrs	12175 hrs	NONE
Heritage Place Nursing Home	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Kanakanak General Hospital	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Ketchikan General Hospital	No	Yes	Better	12	12%	8%	NONE	NONE	Certain Units	10 X	10000 hrs	10000 hrs	NONE
Manillaq Health Center	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Mary Conrad Center Nursing Home	No	No	Worse	8, 10, 12	15%	5.55%	NONE	NONE	No	NONE	NONE	NONE	NONE
Mat-Su Regional Medical Center	No	No	No Chg.	8 & 12	10%	12%	unknown	unknown	Certain Units	7 X	1400 hrs	1000 hrs	NONE
Mt. Edgecumbe SEARHC Hospital	No	No	Worse	8, 10, 12	15%	15%	NONE	NONE	Certain Units	8 X	4200 hrs	1800 hrs	NONE
North Star Behavioral Health System	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Norton Sound Regional Hospital	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Petersburg Medical Center	No	No	Worse	8 & 10	5%	5%	unknown	NONE	Yes	4 X	NONE	NONE	NONE
Providence Alaska Medical Center	No	Yes	Worse	8, 10, 12	4.36%	4.76%	NONE	NONE	Certain Units	NA	NONE	NONE	NONE
Providence Extended Care Center	No	No	Worse	8, 10, 12	20.83%	20.75%	NONE	NONE	No	NONE	NONE	NONE	NONE
Providence Kodiak Island Medical Center	No	Yes	No Chg.	12	10%	10%	NONE	NONE	Certain Units	NA	unknown	4000 hrs	NONE
Providence Seward Medical & Care Center	No	No	No Chg.	8 & 12	unknown	5%	NONE	NONE	Yes	3 X	NONE	NONE	NONE
Providence Valdez Medical Center	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Sitka Community Hospital	No	No	No Chg.	12	20%	20%	NONE	NONE	Certain Units	varies	5847 hrs	4738 hrs	NONE
South Peninsula Hospital	No	Yes	No Chg.	8,10,12	6%	3%	NONE	NONE	Certain Units	15 X	144 hrs	1058 hrs	NONE
USAF 3rd Medical Group-Elmendorf	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Wildflower Court Nursing Home	No	No	No Chg.	8 & 12	0%	0%	NONE	NONE	No	NONE	1040 hrs	80 hrs	NONE
Wrangell Medical Center	No	No	No Chg.	8 & 12	0%	0%	unknown	NONE	Yes	55 hrs	NONE	NONE	NONE
Yukon Kuskokwim Delta Regional Hospital	No	No	Better	8 & 10	40%	28%	NONE	NONE	Certain Units	NONE	34000 hrs	26208 hrs	NONE
TOTAL Temporary Nursing Hours Purchased by Non-exempt Facilities											104391 hrs	128817 hrs	\$24.17

HB

287

Alaska State Legislature

Chairman

Military & Veterans' Affairs Committee

Member

Labor and Commerce Committee

State Affairs Committee

Economic Development, Trade & Tourism
Committee

Education Committee

Joint Armed Services Committee

Finance Subcommittees

Labor & Workforce Development

Community & Economic Development

Military & Veterans' Affairs



A Communication From

REPRESENTATIVE BOB LYNN

District 31 Anchorage

Representative Bob Lynn | legis.state.ak.us

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SPONSOR STATEMENT HB 287

Medical Facilities Certificate of Need

By Representative Bob Lynn

Free enterprise motivates excellence, encourages competitive prices, and benefits consumers. The beneficial principles of free enterprise apply to businesses large or small: hot dog stands, automobile manufacturers, as well as health care facilities, and nursing homes.

HB287 removes the current requirement for a Certificate of Need for health care facilities and nursing homes in a borough with a population of more than 25,000. In other words, a Certificate of Need would not be required for a health care facility or nursing home in Anchorage, Fairbanks, Juneau, Matsu and Kenai. Smaller communities would still require, as a practical matter, the Certificate of Need.

Competition typically lowers prices. Passage of HB287 would help lower the escalating costs of Workers' Compensation, PERS/STRS, Medicaid, and the cost and availability for Alaskan companies and individuals.

The free marketplace should decide if a business is needed, not the government. A health care facility or nursing home should not have to beg for a government issued Certificate of Need to open a business, so as to protect similar businesses from healthy competition. Medical facilities and nursing homes keep patients healthy; competition keeps the economy healthy.

Medical costs in Alaska have reached crisis levels. It is past time to restore American competition and freedom of choice for the benefit of Alaska's medical consumers.

Your support of HB 287 is respectfully requested

24-LS0611\Y
Mischel
2/13/06

CS FOR HOUSE BILL NO. 287()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES LYNN, Coghill, Chenault, Kohring

A BILL
FOR AN ACT ENTITLED

1 "An Act amending the certificate of need requirements to apply only to health care
2 facilities that are nursing homes or residential psychiatric treatment centers or that are
3 located in a borough with a population of not more than 25,000, in the unorganized
4 borough, or in a community with a critical access hospital."

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

6 * Section 1. AS 18.07.031(a) is amended to read:

7 (a) Except as provided in (c), (d) and (g) [(c) AND (d)] of this section, a
8 person may not make an expenditure of \$1,000,000 or more for any of the following
9 in a borough with a population of not more than 25,000, in the unorganized
10 borough, or in a community in which a facility has been designated by the
11 department as a critical access hospital, unless authorized under the terms of a
12 certificate of need issued by the department:

- 13 (1) construction of a health care facility;
14 (2) alteration of the bed capacity of a health care facility; or

1 (3) addition of a category of health services provided by a health care
2 facility.

3 * **Sec. 2.** AS 18.07.031(b) is amended to read:

4 (b) Notwithstanding the expenditure threshold in (g) [(a)] of this section, a
5 person may not convert a building or part of a building to a nursing home that requires
6 licensure as a nursing facility under AS 47.32 unless authorized under the terms of a
7 certificate of need issued by the department.

8 * **Sec. 3.** AS 18.07.031 is amended by adding new subsections to read:

9 (f) In this section, reference to the department's designation of a facility as a
10 critical access hospital means action taken by regulatory authority exercised under
11 AS 18.05 or AS 18.20 by which a facility eligible for designation as a critical access
12 hospital has been so identified.

13 (g) Notwithstanding the limitations in (a) of this section, a person may not
14 make an expenditure of \$1,000,000 or more for any of the following unless authorized
15 under the terms of a certificate of need issued by the department:

16 (1) construction of a nursing home or residential psychiatric treatment
17 center;

18 (2) alteration of the bed capacity of a nursing home or residential
19 psychiatric treatment center; or

20 (3) addition of a category of health services provided by a nursing
21 home or residential psychiatric treatment center.

22 * **Sec. 4.** AS 18.07.111 is amended by adding a new paragraph to read:

23 (11) "nursing home" means a facility that is not used for acute care that
24 provides nursing care and related medical services 24 hours a day to individuals
25 admitted to the home because of illness, disease, or physical infirmity.

26 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to
27 read:

28 **APPLICABILITY.** Sections 1 - 3 of this Act apply to health care facilities, except for
29 nursing homes and residential psychiatric treatment centers, in existence or proposed on or
30 after the effective date of this Act. A decision of the Department of Health and Social
31 Services denying or granting a certificate of need that has been applied for or issued for a

1 health care facility, except for nursing homes and residential psychiatric treatment centers,
2 located in an area of the state other than in a borough with a population of not more than
3 25,000, the unorganized borough, or a community in which a facility has been designated as a
4 critical access hospital before the effective date of this Act shall be void and unnecessary. A
5 pending application for a certificate of need for a health care facility, except for nursing
6 homes and residential psychiatric treatment centers, located in an area of the state other than
7 in a borough with a population of not more than 25,000, the unorganized borough, or a
8 community in which a facility has been designated as a critical access hospital before the
9 effective date of this Act shall be returned to the applicant.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: HB287CS(HES)-DHSS-DBH-03-16-06

Revision Date/Time (Note if correction): _____

() Publish Date: _____

Title LIMIT CERTIFICATE OF NEED TO BOROUGHES WITH A POPULATION OF LESS THAN 25,000

Dept. Affected: Health & Social Services

RDU Behavioral Health

Component Behavioral Hlth Medicaid Svcs

Sponsor LYNN

Requester HOUSE (HES)

Component No. 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						26,724.4
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	26,724.4

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES (0)						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						13,362.2
1003 GF Match						13,362.2
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	26,724.4

Estimate of any current year (FY2006) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

CS HB287 amends the certificate of need (CON) by exempting certain health facilities in the most populated areas from the program. The current CON program applies to all areas of the state (AS 18.07). This bill would require CON only to health facilities (other than nursing homes and residential psychiatric treatment centers) in the less populated areas of the state: (a) boroughs with a population of less than 25,000, (b) the unorganized borough, and (c) communities with a critical access hospital.

Continued

Prepared by: Janet Clarke, Assistant Commissioner
Division Finance & Mgmt Services
Approved by: Karleen Jackson, Commissioner
Agency Department of Health and Social Services

Phone 465-1630
Date/Time 03/08/2006
Date 03/16/2006

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Alaska law requires that a person who plans to undertake certain activities related to a health care facility or to convert a facility to a nursing home must first demonstrate a need for the proposed service and obtain a certificate of need from the Department.

The CON program applies to these health care facilities: private, municipal, state or federal hospital, psychiatric hospital, skilled nursing facility, residential psychiatric treatment center, independent diagnostic testing facility, tuberculosis hospital, kidney disease treatment center, intermediate care facility, and ambulatory surgical facility. Excluded are the Alaska Pioneer Homes and Alaska Veterans Home and the offices of private physicians or dentists.

This bill would exempt facilities other than nursing homes and RPTCs in locations with population at or above 25,000 from the certificate of need requirement. It would eliminate the review of approximately 90%-95% of all certificates of need for the remaining health care facilities as almost all facilities are located in the exempt areas. Of the facilities currently subject to CON, 12 of the 25 hospitals/co-located nursing facilities, and all of the 9 ambulatory surgical centers, 3 independent diagnostic/testing facilities, 4 kidney dialysis centers, would be exempt under CS HB287. All of the 4 freestanding nursing facilities and 4 residential psychiatric treatment centers would still be subject to CON.

CS HB 287 would affect the 5 boroughs with population greater than 25,000: Municipality of Anchorage, Matanuska-Susitna Borough, Fairbanks North Star Borough, City and Borough of Juneau, and Kenai Peninsula Borough. Health care facilities and nursing home beds in these boroughs would not be subject to the CON process. Within the Kenai Borough, the community of Seward has a critical access hospital meaning that Seward is still covered by the CON program, but all other areas in the borough are not. Since the remainder of the state is either in a borough with a population less than 25,000 or is part of the unorganized borough the CON program would still be required in all other locations.

Based on interest expressed by health care providers and national trends the Department estimates that there are many projects in the exempt areas that would potentially start development immediately after the bill was passed. It is anticipated that construction on these facilities would peak within 3 years and that most, but not all, of the construction would be completed within 5 years.

In the Behavioral Health Medicaid component, the projects described below might be built if certain health facilities in the 5 largest boroughs are exempt from the CON program.

FISCAL NOTE
FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Note that Residential Psychiatric Treatment Centers are not exempt under CS HB 287.

The fiscal note is based on a list of potential projects. It is not possible to identify with any confidence which projects would or would not have been approved anyway, although we know that some would. The department's best estimate is that approximately 30% of the projects would have successfully completed the CON process. **The fiscal note represents the aggregate Medicaid costs for the 70% of potential projects affected by CS HB 287 that likely would not have received a CON.**

The uncertainty stems from several reasons: some projects are for new services that we do not have experience with yet; the standards for CON were recently changed and we do not have enough experience yet to speculate; some projects would not submit an application because the provider was aware that they were unlikely to receive the CON.

Alcohol and Drug Hospital: A couple of years ago a 30-bed facility in Anchorage was discussed with Department staff. The cost is based on similar types of facilities and would be about the same as an RPTC facility except without all of the educational and gym facilities. This specialty hospital would be licensed as a psychiatric hospital but serve alcohol and drug clients. *Estimated annual cost to Medicaid: \$16,607.5 starting in FY2012.*

Psych Hospital Beds: Valley Hospital has an empty 40-bed acute care facility that they are looking to sell or lease. They have contacted the Department on at least 3 occasions regarding the conversion of the facility to a psych hospital. If Fairbanks became a regional center and CON was not required, 40-60 beds would likely be built, primarily for adolescents and children. Last year North Star submitted a CON proposing development of 30 inpatient psychiatric hospital beds for children in Fairbanks. They would likely have planned for more if it were not for CON. In addition, Providence had plans up until recently to build a 60-bed psych facility in Anchorage. Although this facility will not be built, someone else might consider building a facility of that size. The costs per bed were estimated from recent CON applications. *Estimated annual cost to Medicaid: \$10,116.9 starting in FY2012 for a total of 90 beds.*

The GF match is based on the statutory SFY average FMAP for Title XIX for the appropriate year (2007-2008=57.58%; 2009=50.44%; 2010-2012=50.00%).

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB287CS(HES)-DHSS-DHCS-03-16-06

Revision Date/Time (Note if correction): _____

() Publish Date: _____
 Dept. Affected: Health & Social Services

Title LIMIT CERTIFICATE OF NEED TO BOROUGHES WITH A POPULATION OF LESS THAN 25,000

RDU Health Care Services
 Component Medicaid Services

Sponsor LYNN

Requester HOUSE (HES)

Component No. 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	2,373.5	4,747.0	7,142.4	14,546.6	16,195.1	18,942.7
Miscellaneous						
TOTAL OPERATING	2,373.5	4,747.0	7,142.4	14,546.6	16,195.1	18,942.7

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES (0)						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,366.7	2,733.3	3,602.6	7,273.3	8,097.6	9,471.4
1003 GF Match	1,006.8	2,013.7	3,539.8	7,273.3	8,097.5	9,471.3
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	2,373.5	4,747.0	7,142.4	14,546.6	16,195.1	18,942.7

Estimate of any current year (FY2006) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

CS HB287 amends the certificate of need (CON) by exempting certain health facilities in the most populated areas from the program. The current CON program applies to all areas of the state (AS 18.07). This bill would require CON only to health facilities (other than nursing homes and residential psychiatric treatment centers) in the less populated areas of the state: (a) boroughs with a population of less than 25,000, (b) the unorganized borough, and (c) communities with a critical access hospital.

Continued

Prepared by: Janet Clarke, Assistant Commissioner
 Division Finance & Management Services
 Approved by: Karleen Jackson, Commissioner
 Agency Department of Health and Social Services

Phone 465-1630
 Date/Time 03/10/2006
 Date 03/16/2006

FISCAL NOTE

FN ¹⁷

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Alaska law requires that a person who plans to undertake certain activities related to a health care facility or to convert a facility to a nursing home must first demonstrate a need for the proposed service and obtain a certificate of need from the Department.

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Based on interest expressed by health care providers and national trends the Department estimates that there are many projects in the exempt areas that would potentially start development immediately after the bill was passed. It is anticipated that construction on these facilities would peak within 3 years and that most, but not all, of the construction would be completed within 5 years.

In the Health Care Services Medicaid component, the projects described below might be built if certain health facilities in the 5 largest boroughs are exempt from the CON program.

FISCAL NOTE

FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

The fiscal note is based on a list of potential projects. It is not possible to identify with any confidence which projects would or would not have been approved anyway, although we know that some would. The department's best estimate is that approximately 30% of the projects would have successfully completed the CON process. **The fiscal note represents the aggregate Medicaid costs for the 70% of potential projects affected by CS HB 287 that likely would not have received a CON.** The cost estimates are conservative because, while all will have additional costs for Medicaid, for some of the facility types we were unable to quantify the cost.

The uncertainty stems from several reasons: some projects are for new services that we do not have experience with yet; the standards for CON were recently changed and we do not have enough experience yet to speculate; some projects would not submit an application because the provider was aware that they were unlikely to receive the CON.

Ambulatory Surgery Centers: Based on letters of intent, prior CONs that were denied or withdrawn, or request for information for surgery suites in a location. The cost is an average of recent surgery projects that submitted certificate of need applications. *Estimated annual cost to Medicaid: \$2,196.7 by 2009 with 12 beds added in FY2007 and another 14 beds in FY2008 and FY2009, for a total of 40 beds.*

Cardiac Hospital: Although the Department has not received any specific inquiries for this type of service it is growing around the country and interest in Alaska may not be too far off. The cost was estimated based on an average cost of acute hospital beds in recent CON applications. *Estimated annual cost to Medicaid: \$2,747.6 with 30 beds starting in FY2010.*

Cardiac Cath Labs: Four Labs are expected in the next 3 years. Fairbanks Memorial Hospital is considering one or two Labs now. It is expected that competition for labs in Anchorage and the Mat-Su Valley would develop and that Soldotna will want the service also. *Estimated annual cost to Medicaid is unknown.*

Independent Diagnostic and Testing Facilities: Additional competition would be expected in this area with 7 new facilities starting up in Juneau, Soldotna, Fairbanks, Mat-Su and Anchorage. Information received indicates Alaska Open Imaging has considered opening in Juneau and Providence Imaging in Wasilla. These projects would likely all be built in 1-2 years. *Estimated annual cost to Medicaid is unknown.*

FISCAL NOTE

FN #

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

General Acute Care Hospital: Providence has indicated a need for 50-100 beds and Valley Hospital has a partially completed space for 75 beds. Soldotna and Fairbanks would be expected to add beds as well. The costs were estimated based on recent certificate of need applications. *Estimated annual cost to Medicaid: \$8,242.8 by 2011 for 200 beds, with 40 new beds added in each of the next 5 years.*

Kidney Dialysis Centers: One new 16-station facility may be developed in Anchorage. We did have one contact requesting information on certificate of need for such a facility. *Estimated annual cost to Medicaid is unknown. Probably not started until FY2010.*

Long Term Acute Care Hospital Beds: This is a new service that was approved for Anchorage in 2005. There may be an interest in developing these same services in Fairbanks and the Mat-Su Valley. Long Term Acute Care hospitals are specialty hospitals, without emergency rooms or outpatient services, designed to provide extended medical and rehabilitative care for critically ill, medically complex patients who have multiple acute or chronic conditions. Most patients in these facilities are age 65 and over. Their length of stay is too long for acute care, but their medical condition is not right for long-term care, plus they have an opportunity for rehabilitation. These services will be paid for primarily through Medicare and Medicaid. *Estimated annual cost to Medicaid: \$3,008.0 for 90 total beds starting in FY2010.*

Radiotherapy: Three programs are expected. Inquiries have been made for this type of facility in Wasilla and Fairbanks and a letter of intent for expansion was received a couple of years ago for expansion of radiotherapy in Anchorage. *Estimated annual cost to Medicaid is unknown. Probably not started until FY2010*

PET/CT Scanner: Fairbanks has indicated a continuing interest in this service even though a project was denied recently. A new one might be added in Anchorage. *Estimated annual cost to Medicaid is unknown. Probably started in FY2007.*

Orthopedic Hospital: Although none exists in Alaska, these specialty hospitals are growing rapidly in the rest of the US. It is only a matter of time before they move to Alaska. Costs were estimated to be similar to Cardiac Hospitals. *Estimated annual cost to Medicaid: \$2,747.6 for 30 beds starting in FY2012.*

The GF match is based on the statutory SFY average FMAP for Title XIX for the appropriate year (2007-2008=57.58%; 2009=50.44%; 2010-2012=50.00%).

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

FRANK H. MURKOWSKI, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
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April 13, 2006

The Honorable Bob Lynn
Representative District 31
State Capitol, Room 415
Juneau, Alaska 99811

Dear Representative Lynn:

The following information is provided in response to your letter of March 23, 2006 requesting information related to HB 287 and the Certificate of Need (CON) program.

- ***Would HB 287 cause an increase in the number of eligible Medicaid recipients? If so, how?***

HB 287 does not change the eligibility criteria for Medicaid enrollment; therefore it would not cause an increase in the number of persons eligible for Medicaid.

- ***Would HB 287 cause additional services to be offered which are not currently available to Medicaid recipients in Alaska?***

HB 287 would not add new services to the Medicaid program which are not already covered under the Medicaid State Plan. Most standard services covered are by now offered in-state.

- ***It is my understanding that, if services are not available in Alaska, Medicaid recipients will be sent to outside facilities to receive treatment. If people don't have to be flown out for treatment, wouldn't the cost be lower?***

Most out-of-state services are less costly on a per-day charge. If people receive treatment in Alaska instead of out-of-state, the cost would be higher. Medicaid pays for transportation to the lower 48 in cases where specialized care is not available in Alaska. If services which are not currently available to Medicaid recipients in Alaska become available in-state there may be some savings in transportation costs. The department estimates that nearly 18% of transportation costs are associated with the types of facilities affected by HB287; however, virtually all of that is in-state travel. Less than one half of one percent of transportation costs is to these types of facilities out-of-state. The savings opportunity is further limited because recipients from rural Alaska will still need transportation to urban areas to access the services. We estimate that between \$38,000 and \$76,000 of general fund dollars for transportation could be avoided."

- ***Why would HB 287 cause services to be more expensive than what is charged by existing providers?***

HB 287 increases costs to Medicaid by increasing the rates paid for procedures. Medicaid payment rates for facilities are "...based on reasonable costs related to patient care..." (AS 47.07.070). This includes operations costs and capital costs. New facilities add additional capital and operating costs. If 25% of a facility's patient load is Medicaid, this statutory section requires Medicaid to pay rates that include 25% of the capital and operating costs. This share of new facility costs is a new cost to the Medicaid program.

As stated above, the number of eligible persons and services offered would not change under HB 287; and if we assume that the utilization rate of the services remains constant, then the number of procedures provided across all facilities would not change. With the same number of procedures divided between more facilities, a greater share of the capital and operating cost is distributed to fewer procedures, thereby increasing rates. One purpose of the CON program is to assure that there is sufficient demand for the services to minimize increased rates.

- ***According to the pricing worksheet you provided in your example of a fractured arm, both procedures were less expensive (more than 50% less) than the same procedure provided in a hospital setting. If these numbers are accurate, then would not HB 287 have a negative fiscal note indicating the savings to the State?***

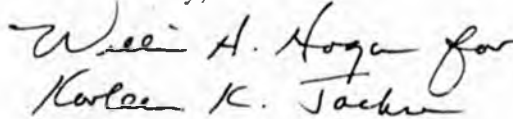
In the pricing worksheet we provided, the cost of treatment for a fractured arm was 53% lower in an ambulatory surgical center than in an outpatient hospital. The cost for an abdominal CAT scan example was 23% lower in an ambulatory surgical center than in an outpatient hospital. These examples were in response to a request for comparison of pricing methodologies. They are an accurate comparison of payments under current rates for a similar diagnosis treated in two different facility types for different patients, possibly with different circumstances and care needs. They are not a comparison of "before and after" HB287, therefore they do not indicate that HB287 should have a negative fiscal note.

- ***You claim that providing services in facilities that would qualify for the additional facility fees could cause Medicaid costs to go up, for example Medicaid subsidies such as the DISH payments to hospitals. But in your letter dated March 13, you indicated that the only facility you could imagine in this category would be a surgery center physically connected and adjunct to a hospital. So if none of the facilities would be paid more, how would this generate a higher fiscal note?***

It is possible that a new hospital or co-located facility could affect either total DSH payments made or DSH payments made to other hospitals if it has high uncovered uninsured care costs. If that happened, then the hospital's facility specific limit for DSH could increase, which could generate a higher fiscal note. An increase in facility specific limit does not automatically mean additional DSH payments. Hospitals participating in the DSH program must also meet eligibility requirements and agree to perform necessary health and social services through an approved project. DSH payments are subject to the availability of matching funds and the continued allotment of federal financial participation.

If you have questions concerning this information, please feel free to contact either Tony Lombardo at 465-3030 or Janet Clarke at 465-1630.

Sincerely,

Handwritten signature of Karleen K. Jackson in cursive script.

Karleen K. Jackson, Ph.D.
Commissioner

cc: Anthony Lombardo, Deputy Commissioner
Janet Clarke, Assistant Commissioner
Sherry Hill, Special Assistant
Elmer Lindstrom, Special Assistant
Laura Baker, Budget Chief
Jack Nielsen, Office of Rate Review
David Pierce, CON Program



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My Turn: State attacks bill with inflated cost estimates

Sponsor: Repealing Certificate of Need law encourages competition

Want to open a health care business in Alaska? Under current law, you'll have to go hat-in-hand to the governor and his minions to beg for a "Certificate of Need." That's why I've sponsored House Bill 287, and co-sponsored an initiative to repeal the Alaska Certificate of Need law. If someone wants to open a hot dog stand, shoe store, or a health care facility, it's none of the government's business.

A competitive marketplace is as American as apple pie, whether for medical care or anything else. Competition encourages lower prices, motivates excellence, and facilitates consumer choice. That's Economics 101. Current Certificate of Need requirements discriminate against small businesses by denying entry into the health care market. Limited choices inflate prices. Perhaps the Certificate of Need should be relabeled "Certificate of Monopoly."

When I get sick, I don't want the government limiting my choices. The more medical availability the better. When I shop for a new TV, things usually turn out better if I have a wide range of dealers and models to choose from. Good medical care is no different, and is infinitely more important.

Medical costs in Alaska are skyrocketing to crisis levels. Eliminating Certificate of Need requirements should help lower Alaska's health care costs, reduce Workers' Compensation costs, and help keep things more affordable for both families and businesses. We can't lower the price of gasoline by limiting oil production. Why would limiting the supply of medical facilities lower health care costs?

As expected, health care monopolies with vested interests have responded the only way they can - by attaching humongous fiscal notes to both my bill and the initiative. To paraphrase Ronald Reagan, "There they go again!"

The first cost scenario for the initiative eliminating the Certificate of Need was an amazing \$41 million. Fiscal notes by the Department of Health and Social Services estimated the bill would cost the state about \$45 million.

Recently a newspaper opinion piece by the administration pegged the fiscal impact at more than \$30 million. Trying to get realistic estimates from the administration has been like trying to pick up a bar of soap in the shower. News flash! Fiscal notes for any proposed legislation should be based on clearly substantiated and verifiable data. Anything else is disingenuous.

Experts believe the astronomical figures attached to the bill are grossly misleading and inaccurate.

- 1) Estimates are based on extremely unlikely expenditures, like the cost of a new cardiac hospital. That's as likely as Lockheed building an aircraft factory here.
- 2) The administration makes projections for new facilities without demonstrating interest or need (see cardiac hospital above).
- 3) Most expenditures cited in the administration estimates are paid for by the business owners, at no cost to the state (for example, ambulatory surgery centers, independent diagnostic facilities, etc.) - nonetheless they're lumped into the fiscal note.
- 4) Statistics aren't verifiable. No explanation accompanying the data - just numbers changing with each phase of the moon. The state admits the cost estimates are suspect by stating, "It is not possible to identify with any confidence which projects would or would not have been approved." So the state just includes all of them.
- 5) Fiscal notes don't even mention potential savings to the state if the Certificate of Need requirement is scrapped.

The goal of my bill and the related initiative is to eliminate obsolete and artificial Certificate of Need barriers, thereby allowing expanded medical choice and less expensive health care. My Bill and the initiative should be judged on verifiable fiscal information, potential cost savings and excellence for all concerned. That's only fair. Like everything else, medical care should be based on the principles of free enterprise - not political influence from large monopolistic hospitals.

• State Rep. Bob Lynn, R-Anchorage, is sponsor of House Bill 287.

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Nancy Manly

From: Jermey Hayes [jhayes@admin.apcak.net]
Sent: Thursday, March 30, 2006 2:30 PM
To: Nancy Manly; Rep. Bob Lynn; Rep. John Coghill; Rep. Vic Kohring; Rep. Mike Chenault
Subject: HESS- Requested Studies from HB 287 Hearing
Attachments: Conover & Sloan - Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending.pdf, Washington Policy Center . Publications.mht

Representatives—

Here are the studies that were requested from me at the HB 287 hearing Tuesday. I hope these prove useful. Thank you for your time, and have a great day!

Jeremy Hayes
Assistant Administrator
Advanced Medical Centers of Alaska

Pain Management - Sports Medicine & Rehab - Health Psychology

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Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?

Christopher J. Conover and Frank A. Sloan
Duke University

Abstract This study assesses the impact of certificate-of-need (CON) regulation for hospitals on various measures of health spending per capita, hospital supply, diffusion of technology, and hospital industry organization. Using a time series cross-sectional methodology, we estimate the net impact of CON policies on costs, supply, technology diffusion, and industry organization, controlling for area characteristics, the presence of other forms of regulation, such as hospital rate-setting, and competition. Mature CON programs are associated with a modest (5 percent) long-term reduction in acute care spending per capita, but not with a significant reduction in total per capita spending. There is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations. Mature CON programs also result in a slight (2 percent) reduction in bed supply but higher costs per day and per admission, along with higher hospital profits. CON regulations generally have no detectable effect on diffusion of various hospital-based technologies. It is doubtful that CON regulations have had much effect on quality of care, positive or negative. Such regulations may have improved access, but there is little empirical evidence to document this.

For more than two decades, health care cost containment has been at the forefront of the health policy agenda. However, the approaches used to achieve cost containment have changed. One of the first policies adopted by states (and that for a time was required by federal statute) was certificate-of-need laws (CON). Such laws, which focused on hospitals and nursing homes, were adopted to curb needless duplication of ser-

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vices and consequent excess capacity. At the time, retrospective reimbursement provided guaranteed reimbursement even if facilities operated at well below capacity. Also, given nearly complete insurance coverage for hospitals, competition for patients occurred on a nonprice basis (Robinson and Luft 1987; Dranove, Shanley, and Simon 1992). The hospitals that could offer the most sophisticated range of services and equipment were most attractive to patients and their physicians. The price of such care did not matter, or at least it mattered much less. Competition by service expansion and proliferation of new technology has been termed the "medical arms race." At least in principle, CON regulations could control the medical arms race by requiring that organizations demonstrate need for a facility, service, or equipment before investing in them. Also, in the 1980s, some states expanded CON regulations to control the proliferation of ambulatory care providers that was occurring (Finkler 1985). Other perhaps secondary objectives of CON regulations were to promote access and to promote quality. A less charitable view is that CON regulations sought to establish entry barriers to protect the income of existing providers, especially hospitals (Feldstein 1988; Wendling and Werner 1980).

Several developments have occurred since the late 1960s and early 1970s that have lessened the popularity of CON regulations, especially as they affect hospital care. First, other regulatory mechanisms thought to be more effective in cost containment have been adopted. Primary among these is Medicare's Prospective Payment System (PPS), but some states implemented various forms of regulation of hospital rates and revenue. Although PPS is still in effect, hospital rate-setting remains in only one state.¹ Second, there has been substantial growth in various forms of managed care, stimulated in part by legislation, such as selective contracting laws. Although specific incentives differ, managed care provides incentives for hospitals to be concerned about cost. In this context, there is a perception that CON regulations may not be needed as much as they were previously to control hospital cost growth. As a result of managed care plan growth as well as implementation of PPS, demand for inpatient hospital care has decreased appreciably. Third, as discussed later, a substantial amount of empirical evidence accumulated by the early 1980s indicating that CON regulations were ineffective in cost containment. Research findings *per se* did not contribute to the demise of CON laws, but such findings probably coincided with

1. At various times, six different states had adopted this approach, with New York being the most recent to abandon it (on 30 June 1996).

experience-based impressions of policy makers and experts in the field. Fourth, the federal law requiring states to have CON regulations expired in 1986. Since then, fifteen states have dropped CON regulations for hospital services; about half of these have retained CON regulations for nursing homes.

Policy makers in many other states have been reluctant to drop CON laws because of a concern that removing them would lead to a surge in health care spending, including both capital expenditures (initially, subsequent to removal of CON laws) followed by increased operating expenses. Some largely anecdotal accounts of surges following removal of CON laws were reported (Simpson 1986; Lewin-ICF 1992b). Although PPS and managed care have changed incentives, these forces may be insufficient to offset the other inflationary factors that preceded these more recent developments. Second, there is concern that without restraint by CON regulations, market forces will exacerbate an existing maldistribution of facilities, thus placing a greater burden on the disadvantaged. Some observers are also worried that for-profit providers would benefit disproportionately from removal of CON regulations. Some view this as troublesome since for-profit facilities may be less willing to provide uncompensated care. Some studies have shown this to be so (see references in Kuttner 1996), but other studies indicate that the contribution to uncompensated or indigent care is about equal, whether measured in terms of the self-pay share of patients, the bad debt-charity care share of charges, or the share of revenue accounted for by Medicaid (see Sloan's 1988 review). Proliferation of low-volume facilities also is a concern on the grounds that high volume is associated with higher quality of care, at least for some procedures (Luft et al. 1990).

Absent from these policy discussions to date has been systematic empirical evidence of the experiences in states that have lifted CON regulations. Did a surge in spending occur? If so, for which types of facilities and services did the surge occur? Did removal of CON regulations open the doors to the for-profits? Conversely, did removal of CON regulations have beneficial effects, such as increasing price competition through promoting growth of managed care, which may have been restrained previously because of CON entry barriers? Compared with other approaches to cost containment, how well do CON regulations perform? This is an old question, but the track record for comparing alternative approaches to cost containment is now far longer than when most studies were conducted during the 1970s and 1980s. Furthermore, it is now possible to follow the experience of states that dropped CON instead of simply com-

paring states with CON to those that had not yet adopted it. Finally, for the first time, a fourteen-year, continuous time series of state per capita health spending data has become available from the U.S. Health Care Financing Administration (HCFA).²

This article provides new empirical evidence about these issues with regard to acute care services. In focusing on acute care services, we exclude nursing homes, hospices, and home health care, but we do include ambulatory surgery and visits to physicians' offices as well as to hospitals. Using a state time series of cross-sections, we assess the effects of lifting CON through 1993. The success of CON in cost containment is compared with other approaches. We show that mature CON programs are associated with a modest (5 percent) long-term reduction in acute care spending per capita, but with no significant reduction in total per capita spending. We also found no evidence of a surge in acquisition of facilities or in costs following removal of CON.

Our empirical specification is followed by a discussion of findings on CON, other regulatory programs, competition, control variables on expenditures on acute care services, hospital beds, service intensity, and profitability, diffusion of technology, and industry organization. We then evaluate our results, compare our findings with those from previous studies, and discuss previous research on effects of CON on quality and access. Although we do not present any new direct evidence about quality and access, these issues are clearly germane to states' decisions about whether CON should be retained.

Empirical Specification

Dependent Variables

We specified equations for the following dependent variables. To measure the effects of CON and other factors on per capita health spending, we defined dependent variables for (1) total expenditures on personal health care services; (2) total acute care expenditures (defined as total spending minus nursing and home health expenditures); (3) expenditures on hospital care; and (4) expenditures on physicians' services per person

2. These data have not been published, but can be obtained by sending a blank diskette to Anna Long in the Health Care Financing Administration's Office of National Health Statistics, Office of the Actuary, Room N3-02-02, 7500 Security Boulevard, Baltimore, MD 21244-1805.

for a state's resident population. We also obtained estimates of Medicare spending per elderly enrollee, including total Medicare expenses and Part A and Part B expenditures.³ Unpublished estimates of personal health care expenditures by state and year in total and by component were obtained from HCFA for 1980–1993.⁴ We also analyzed Medicare expenditures for 1980–1993. All monetarily expressed variables were deflated by the all-items Consumer Price Index.

Dependent variables for hospital supply were beds per 1,000 state residents; for service intensity, the dependent variables were expense per adjusted (for outpatient volume) patient day and per adjusted admission; the dependent variable for hospital profits was the ratio of total revenue to total expense. The revenue measure was for funds actually received by hospitals during the fiscal year, not for hospital charges. Data for these dependent variables for 1976–1993 came from the American Hospital Association's *Hospital Statistics* (AHA 1977–1994).

To measure the influence of CON and other factors on the variable diffusion of technology, we defined dependent variables for (1) the number of hospitals with open-heart surgery units (1980–1993), (2) for hospitals with organ transplant units (1980–1993), (3) for hospitals with ambulatory surgery units (1983–1993), and (4) for all ambulatory surgery units, including freestanding facilities, per one million state residents (1983–1993). The different time periods we studied were dictated

3. Our figure for total Medicare per elderly enrollee equals the sum of the per enrollee estimates for Part A and Part B. Given that not all Part A eligibles receive Part B, our figure is slightly different from the HCFA-reported state level estimates of total spending per enrollee who was eligible for either Part A or Part B during the year. This latter figure will fluctuate based on changes in the mix of Part A and Part B eligibles, so we sought a slightly more stable measure that can be interpreted as estimated spending for an elderly enrollee who had enrolled in both Part A and Part B.

4. Most readers may be aware that these HCFA estimates measure spending by place of service, so our measure of spending per state resident is not intended to be an accurate measure of resource consumption by residents in that state, given that many residents may cross state borders to seek care. HCFA is still working on the development of residence-adjusted per capita spending figures. However, even if these were available, we believe they would not have been appropriate for our analysis insofar as the impact of a state's CON should be reflected in all spending within its own borders, not just that of its own citizens. Given that our method in essence measures the influence of various factors on year-to-year changes in per capita spending, the measure we have chosen would be unsuitable only if there were large year-to-year variations in the extent of border-crossing, which seems improbable. On the other hand, we also recognize that if CON regulations had the effect of driving citizens to neighboring states to seek care, our analysis of HCFA data would not be able to detect it. Part of our motivation in also analyzing Medicare spending per eligible person—which is a residence-adjusted measure of spending—was to see whether we got consistent results using both place-of-service and place-of-residence measures of per capita spending.

by data availability.⁵ Information on the first three variables came from the *Hospital Statistics* (AHA 1977–1994). Data for the fourth came from the SMG Marketing Group (1984–1995). For the variable industry organization, we defined dependent variables for the for-profit share of hospital beds⁶ for 1976–1993 based on *Hospital Statistics* and the HMO enrollments as a fraction of the state population, information taken from the Group Health Association of America's *National Directory of HMOs* (GHAA 1977–1994). We used data for 1976–1993 in our analysis of HMO market share.

Examining Certificate-of-Need Laws

Four binary variables represented certificate-of-need laws: pre-CON—the year before and the first year CON was implemented; young CON—the first two years postimplementation; mature CON—the remaining years CON was in effect; and CON lifted—the first three years after the CON law was dropped. Pre-CON was included to capture anticipatory effects of CON. There is some empirical evidence that hospitals began some capital projects in anticipation of CON (Sloan and Steinwald 1980a). Once enacted, CON laws plausibly had greater effects after they had been in place for a number of years. The variable CON lifted was included to determine whether there was a surge in hospital investment (and consequently in hospital costliness) immediately after CON laws were dropped.

If CON laws constrain hospital investment and cost, the savings may be offset by greater expenditures in other parts of the health care sector, as others have argued (see e.g., Finkler 1987). By including analysis of the ambulatory sector and of total health care expenditures, we were able to examine this possibility.

Program age is only one aspect of CON programs that is heterogeneous. Programs also logically differ in *stringency*, which reflects the scope of coverage and the difficulty applicants have in securing certificates of need. In an alternative specification, we used a CON stringency

5. Because our observational unit was the state, our diffusion measures were based on counts of the number of facilities offering a particular service. At a lower level of aggregation, it would be useful to study whether additional units opened where existing units were, or where the facility was the first of its kind in the area.

6. We recognize that our results might have been somewhat different if we had measured the for-profit share as a percentage of revenues or admissions. Our convention here is typical of previous analyses of CON regulations using state or regional data (see Noether 1988; Lanning, Morrissey, and Ohsfeldt 1991).

measure originally developed by Lewin-ICF (1992a).⁷ These measures took account of dollar thresholds used to determine whether a project was subject to CON review, in terms of the scope of specific categories of services subject to review. This produced a continuous numerical score that Lewin-ICF used to categorize states into three mutually exclusive categories: 1 = limited; 2 = moderate; 3 = stringent. These categorical scores were used in our analysis.⁸

Finally, for most of the observational period, states could adopt section 1122 programs at their option. Unlike CON, section 1122 allowed hospitals to make unapproved investments in plant, equipment, and services, but unless approved, there was no Medicare or Medicaid reimbursement for the capital expenditures associated with the projects. The section 1122 variable measured the fraction of hospital revenues from Medicare and Medicaid by state and year, only for the years that section 1122 was in effect in a given state.

Hospital Rate-Setting

An explanatory variable for Medicare Prospective Payment measured the fraction of hospital revenues covered by PPS by state and year. The variable accounts for the years the program was phased in (1984–1987) as well as the fraction of hospital revenue from Medicare by state and year. We also measured the fraction of hospital revenue covered by mandatory rate-setting programs.⁹ Following previous work by one of the authors (Sloan 1981), we distinguished between young rate-setting—the first three years of implementation—and mature rate-setting, the remaining years that CON laws were in effect. The variables were defined to reflect the fraction of revenue covered by the program.

7. More recent data for this measure are reported in Lewin-VHI (1995).

8. The Lewin-ICF methodology was not explained in enough detail to replicate the continuous scoring system. Because we had to interpolate figures for 1991 (based on reported figures for 1990 and 1992) and extrapolate to 1993 based on other available information about changes in thresholds, we were able to do so more reliably with the categorical data (whose values tended to be stable over time for any given state) than if we had attempted to replicate the continuous scoring system.

9. Previous work by Sloan (1981) examined a wider range of hospital rate-setting programs, including voluntary and advisory programs. Both theory and most evidence suggest that mandatory prospective rate-setting is the most effective form of hospital rate regulation (Biles, Shrum, and Atkinson 1980; Morriac, Sloan, and Mitchell 1983; Sloan 1983; Roako 1989).

Reimbursement

Explanatory variables were included to represent the fractions of hospital revenue that came from Medicare and from Medicaid programs, respectively.

Price Competition

The HMO share—calculated by dividing HMO enrollment by resident population on 1 July of each year—was used to represent the influence of managed care on hospital costs.¹⁰ These data were obtained from GHAA's *National Directory of HMOs*.

Area Characteristics

We controlled for other factors likely to affect the dependent variables: income per capita population (Bureau of Economic Analysis estimates); the ratio of general practitioners to all physicians; the fraction of population over age sixty-five (Bureau of the Census); the population density (Bureau of the Census); and the weekly wage paid to service workers (Bureau of Labor Statistics [BLS] 1976–1994).

Other Explanatory Variables

To capture omitted cross-sectional and intertemporal influences, we included state binary variables and a time trend. To conserve space, coefficients and standard errors on the intercept, state binary variables, and the Voluntary Effort (only included in analysis that spanned the 1970s but not presented because it is no longer of policy interest) are not presented in the tables shown here.¹¹ To allow us to distinguish between short- and long-run influences on explanatory variables, we included

10. Unfortunately, analogous data on PPO enrollments were not sufficiently reliable to use in our analysis because of changes in definitions over time. HMO share is not a perfect measure of price competition insofar as it does not take into account the nature of plans offered (e.g., group model versus independent practice association) or the aggressiveness of purchasers in the market, which strongly influences the degree to which HMO presence actually affects competition and hospital costs (Robinson 1995; Zwanziger and Melnick 1996). Despite its limitations, HMO share has been shown to be related to price (premium) levels in two different studies (Wholey, Feldman, and Christianson 1995; Feldstein and Wickizer 1995), so in the absence of a better measure, we feel justified in using it.

11. The Voluntary Effort was a voluntary cost-containment effort promoted by the American Hospital Association to diminish support for President Carter's proposed price controls on hospitals. This effort began in December 1977 and lasted until about 1980 (Sloan 1983).