ALASKA LEGISLATURE COMMITTEE FILES 2007-2008 SL&C 12606

compared with 25 percent in 1980. According to Buerhaus et al in their 2000 JAMA article, by 2020 a shortage of more than 400,000 RN's is possible. The Bureau of Labor Statistics estimates that the United States will need an additional 1.1 million registered nurses by 2014.

Ann Converso, Vice-President of the UAN, when addressing the 6th International Conference on Occupational Stress and Health, March 2, 2006 noted: **"In one of the latest Institute of Medicine reports, they found that work shifts longer than twelve hours per day endanger patient safety due to fatigue, causing reduced attention span and capacity to catch errors. However, the same study found that 27 percent of full-time hospital and nursing home nurses reported working more than 13 consecutive hours one or more times per week. The IOM recommends that states prohibit nurses from working more than 12 hours in a 24 hour period or more than 60 hours per week."**

Through it all, the worst case scenario is a tired, over-extended health care professional administering care to a patient.

Statement of the Problem

In October of 2007, the Alaska Statewide Nurses Conference was held in Anchorage. Over 120 nurses attended over a three day period representing RN's from Kotzebue to Ketchikan. Every staff nurse in attendance agreed that mandatory overtime is a curtailment to the working environment. Over 50 nurses (a majority of the staff nurses present) indicated that not only have they been asked to work overtime in the past three months, many indicated they had to take mandatory call. Several nurses indicated that "not only does it mess with your family life; you really worry about patient safety when you're so exhausted." In the instance of mandatory call, the RN may or may not be called to work, but must curtail personal/family time above and beyond the normal work time just in case they're needed for work. In many cases, the callback occurs within a few hours of completing a regular-12 hour shift – resulting in working more than 14 hours within a 24-hour period. Most facilities do provide incentives for on-call pay and on-call return to work status, but it continues to remain a way to staff facilities across the state without hiring more RN's.

Upon further questioning of the staff nurses at the Statewide Conference, 100 percent indicated that mandatory overtime, if used and maintained in their workplace, would cause them to leave the profession early and/or look for employment elsewhere. Several nurses with spouses in other professions noted their spouses have time curtailments in their work areas for safety, especially pilots and truck drivers. "You'd think the same people who set those limits would worry if their grandmother was in the hospital being treated by someone who had been there for over 14 hours." one nurse said. At meetings held between AaNA members, staff, hospital managers and administrators during the fall and winter of 2007, no one could say overtime does not exist and no one could guarantee mandatory overtime or mandatory call didn't occur at times.

In her testimony to the House Ways and Means Committee in Washington, D.C., Mary Foley, President of the American Nurses Association, stated, "By far the riskiest result of understaffing is the abuse of mandatory overtime as a staffing tool" (2002). According to a study published by the American Association of Nurse Executives, 61 percent of respondent RN's said they had observed increases in overtime or double shifts during the past year (2002).

Solutions

Around the country, **California, Washington, Oregon, Missouri, Texas, Connecticut, Illinois, Maine, Minnesota, New Hampshire, New Jersey, and West Virginia have all passed legislation limiting nurses to 12 hour shifts with mandatory rest periods prior to another work time. Rhode Island's legislature just passed the same legislation on an override of a governor's veto.** New York and Pennsylvania are poised to pass the legislation this year. Congress has HR2122 and S1842 pending with the support of the United American Nurses and the American Nurses Association.

"In the long term, the future of the nursing profession is related to its ability to attract more young nurses, to support the careers of current nurses, and to create more jobs for nurses with higher wages, and greater responsibilities. Such efforts can be successful only if the positions students are training to fill are sufficiently attractive, as compared with the alternatives in other fields." (Steinbrook, 2002)

In Alaska we are on the cusp of a legislative effort to begin making a true commitment to the professional registered nurse. **The current version of Senate Bill 28 actually provides for an extended work period up to 14 hours to assist hospitals that routinely schedule nurses for 12-hour shifts. The legislation also provides for an exemption from this limitation to address legitimate, unforeseeable emergencies. The Alaska Nurses Association urges the passing of this legislation as an effort to retain nurses in the state, increase the incentives to new nurses, and most importantly assist with improved patient safety.**

References

Health Policy Report

NURSING IN THE CROSSFIRE

ROBERT STEINBROOK, M.D.

What is exceptional in nursing is the nature of the work: the continuous and intimate association with pain and not infrequent contact with death. . . . Not every man or woman would feel themselves able to undertake the duties of a nurse.

Brian Abel-Smith,
A History of the Nursing Profession, 1960.[1]

NURSING is an embattled profession. Many nurses who work in hospitals feel that they are overworked and often unable to provide good patient care. The young people who traditionally have embarked on careers in nursing are increasingly choosing other fields, such as medicine or business, in which the pay and working conditions are better. Nurses who begin their careers in hospitals frequently leave for other positions. As the population ages, the demand for nurses is expected to grow rapidly. But because relatively few young people are entering nursing, severe shortages are anticipated by the end of the decade — unless this trend is reversed.

A 1996 Institute of Medicine report concluded that, although higher levels of staffing by nurses in nursing homes were linked to higher-quality care, the overall data for hospitals were not good enough to "isolate a number-of-RNs effect."[2] In this issue of the *Journal*, Needleman and colleagues[3] report that, in the United States, a higher proportion of hours of nursing care provided by registered nurses (registered-nurse–hours) and a greater number of registered-nurse–hours per day are associated with better outcomes for hospitalized patients. Among medical patients, these outcomes were a shorter length of stay and lower rates of urinary tract infection and upper gastrointestinal bleeding. A higher proportion of registered-nurse–hours was also associated with lower rates of pneumonia, of shock or cardiac arrest, and of death from five causes considered together — pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis. The findings for surgical patients were similar, although fewer significant associations were found. The study found no evidence of an association between a greater number of hours of care per day provided by licensed practical nurses or hours of care per day provided by nurses' aides and better outcomes.

The study by Needleman et al. focuses attention both on the effect of nursing care on health outcomes and on efforts to increase the level of staffing by registered nurses in hospitals[4-6]; such efforts include instituting minimal staffing ratios and prohibiting mandatory overtime, except in emergencies. In this report, I discuss some of the key issues for the nursing profession.

BACKGROUND

The problems facing registered nurses are longstanding.[7,8] Registered nurses represent the largest single health care profession in the United States. People usually become registered nurses by completing an associate's-degree program at a community college, a diploma program administered at a hospital, or a baccalaureate degree program at a college or university and then obtaining a state license. During the past 25 years, the number of diploma programs has sharply declined. A 2000 survey of registered nurses who had recently completed their initial nursing education showed that more than half had graduated from an associate's-degree program and about two fifths from a baccalaureate program.[9] Licensed practical nurses account for about one quarter of the nurse work force. They typically have a high-school diploma and are trained in a one-year program at a technical or vocational school or a community or junior college.

Every four years, the National Sample Survey of Registered Nurses provides a statistical snapshot of the profession.[9] In 2000, there were an estimated 2,694,540 persons with a license to practice as registered nurses in the United States. An estimated 82 percent were employed in nursing, and of these, 28 percent were working on a part-time basis. Of the registered nurses employed in nursing, 1,300,323 (59 percent) worked in hospitals. The unemployment rate for registered nurses was about 1 percent.[10] An estimated 95 percent of the nurses were women, 72 percent were married, and 87 percent were white. Their average age was 45 years. Thirty-four percent reported their highest level of education as an associate's degree, 22 percent as graduation from a nursing diploma program, 33 percent as a bachelor's degree, and 10 percent as a master's or doctoral degree. Seven percent were practicing or prepared to practice in an advanced practice role, such as clinical nurse specialist, nurse anesthetist, nurse midwife, or nurse practitioner.

Between 1983 and 2000, the staffing levels of registered nurses in hospitals increased by 37 percent (Fig. 1). The staffing levels of licensed practical nurses decreased by 46 percent. The average daily census of hospitalized patients fluctuated but decreased overall. Through 1993, the ratio of registered nurses to patients increased, but it may merely have kept pace with increases in the severity of patients' conditions.[11] Although the ratio of registered nurses to hospitalized

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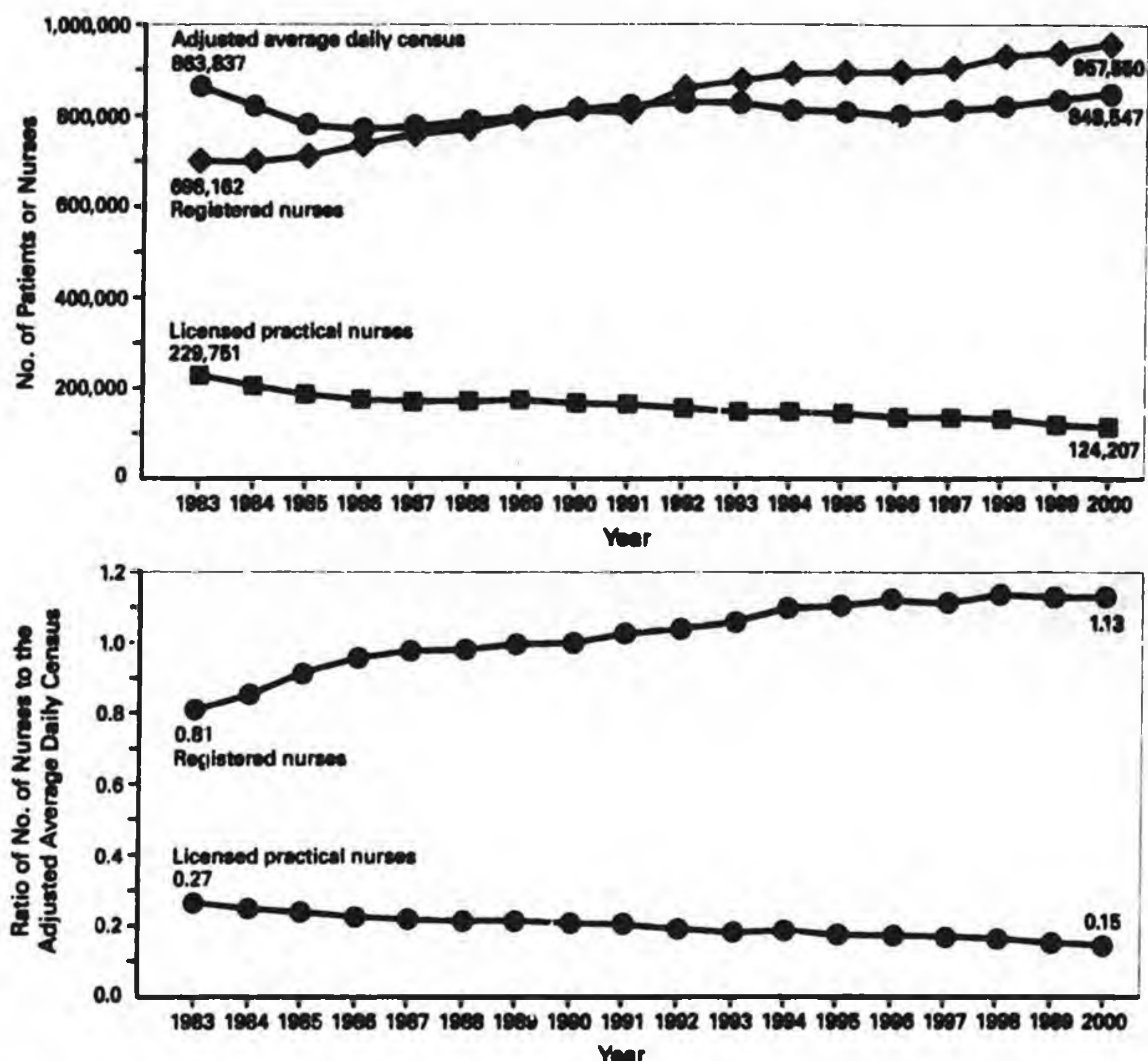

Figure 1. Levels of Staffing by Nurses in Registered Community Hospitals in the United States, 1983 to 2000.

Absolute numbers are shown in the top panel, and ratios in the lower panel. The number of hospitalized patients, the number of registered nurses, and the ratio of registered nurses to patients have increased. The number of licensed practical nurses and the ratio of licensed practical nurses to patients have decreased. The number of registered nurses and the number of licensed practical nurses shown are full-time equivalents. The adjusted average daily census was calculated by dividing the number of inpatient-days by the number of days in the reporting period. Registered community hospitals (short-term general and specialty hospitals that are registered with the American Hospital Association) are included; federal hospitals are not included. Data are from the American Hospital Association, Health Forum, AHA Annual Survey of Hospitals, 1983–2000.

patients remained relatively constant between 1994 and 2000, there are no recent data on staffing that adjust for the severity of patients' illnesses as well as their shorter lengths of stay.

DISSATISFACTION AMONG NURSES

Nursing "is a very stressful job with a very flat career path," according to Frank Sloan of Duke University, who was the cochair of the committee of the Institute of Medicine that reported on nursing in 1996.[2] "Women are finding many other choices." Registered nurses are discontented for many reasons, including inadequate levels of staffing for both nurses and support staff and excessive workloads. Because hospitalizations are shorter, nurses spend a higher percentage of their time admitting and discharging patients and teaching them what they need to do after they go home. The discontent is part of a broader malaise that

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also affects physicians and others who work in hospitals. According to the April 2002 report of the American Hospital Association's Commission on Workforce for Hospitals and Health Systems, "Most health care workers entered their professions to 'make a difference' through personal interaction with people in need. Today, many in direct patient care feel tired and burned-out from a stressful, often understaffed environment, with little or no time to experience the one-on-one caring that should be the heart of hospital employment."[12]

According to Linda H. Aiken of the University of Pennsylvania School of Nursing, "There is the sense that nursing is becoming an impossible job, and that nurses have no control over things that are required to provide good patient care. Yet nurses are accountable for the health and welfare of their patients." The perception is that physicians and hospital administrators often treat registered nurses as workers, not as clinicians and peers, and when possible seek to replace them with less skilled and cheaper personnel, such as licensed practical nurses and aides.

Nurses who begin their careers in hospitals frequently leave for other positions. A large survey of nurses in Pennsylvania, conducted in 1998 and 1999, found that 41 percent were dissatisfied with their present job and that 23 percent of those surveyed were planning to leave this job within the next year.[13] Only about a third agreed with the statements that "there are enough registered nurses to provide high-quality care," "there are enough staff to get the work done," and "the administration listens and responds to nurses' concerns." In a national survey of working nurses conducted in 2001 and 2002, 29 percent of the respondents said they were dissatisfied with their current position; 23 percent were dissatisfied with being a nurse.[14]

Financial Issues

In recent years, wages for registered nurses have been relatively flat as compared with the rate of inflation (Fig. 2). In 2000, the average annual salary of a registered nurse employed full-time was $46,782.[9] Between 1980 and 1992, real annual salaries for registered nurses increased by nearly $6,000. Between 1992 and 2000, however, they increased by only about $200.

Organizing Nurses

Working conditions have been a key issue in recent nursing strikes,[4] such as a bitter two-month strike at the Oregon Health and Science University that ended in February.[15] The ferment within the profession has led to increased interest in collective bargaining. For example, the California Nurses Association has an alliance with the United Steelworkers union. In 2000,

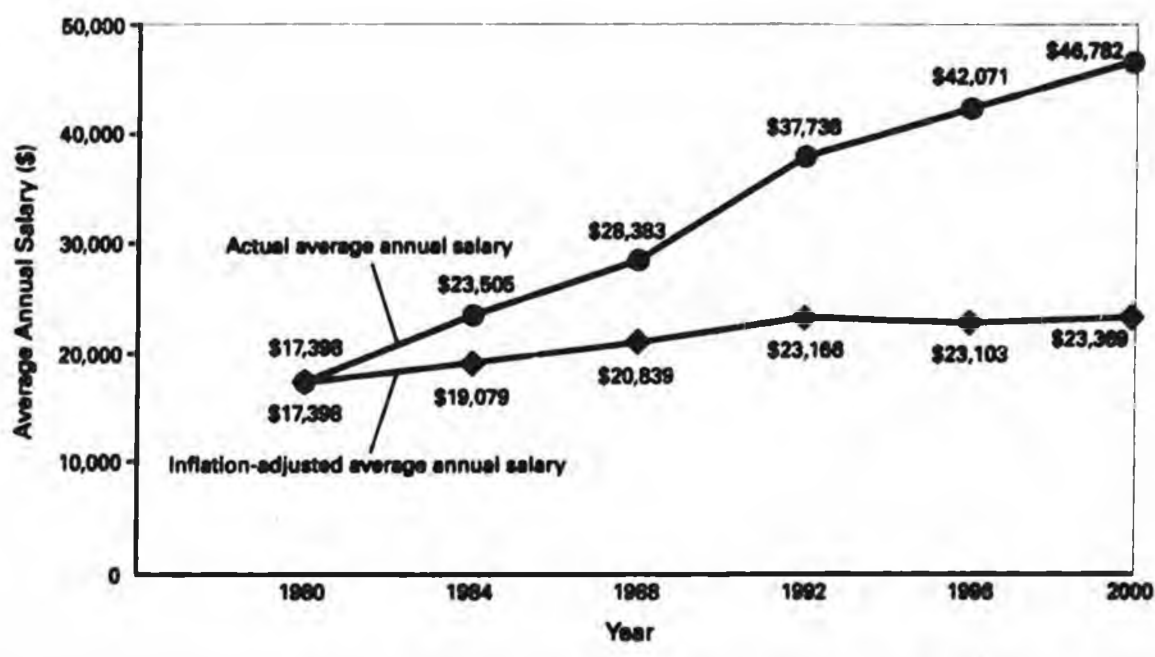

Figure 2. Actual and Inflation-Adjusted Average Annual Salaries of Full-Time Registered Nurses in the United States, 1980 to 2000. Adapted from the National Sample Survey of Registered Nurses, March 2000.[9]

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17 percent of registered nurses who were employed in nursing were members of a union, and 19 percent were covered by a collective bargaining agreement.[16] Although these percentages are similar to those for 1990 and 1995, the number of union members has increased — from about 275,000 in 1990 to about 350,000 in 2000 — because of the growth in the number of nurses.

There is also a schism between two groups that represent registered nurses. The American Nurses Association, the largest group, has been criticized for being too moderate. The California Nurses Association, a particularly aggressive and politically active group, left the American Nurses Association in 1995. The Massachusetts Nurses Association left in 2001. State nurses associations in California, Massachusetts, Maine, Missouri, and Pennsylvania are forming a new group, the American Association of Registered Nurses. This group will compete with the American Nurses Association in representing nurses at the national level.[17]

SHORTAGES OF NURSES

Since World War II, hospitals in the United States have coped with cyclical shortages of nurses. The shortages have generally been related to economic factors. When the overall economy declines, married nurses and working mothers, who represent a substantial portion of the workforce, are more likely to seek work or increase their hours; in better economic times they may be less likely to work or may only work part-time.[12] As in other fields, higher wages and better jobs encourage more nurses to seek employment.

In the 1990s, the growth of managed care slowed employment growth for registered nurses in hospitals, particularly in states such as California.[18,19] There was a surplus of registered nurses; some nurses lost their jobs, and some new nurses were unable to find jobs. Although hospitals were still hiring more registered nurses (Fig. 1), it seemed that they might need fewer in the long term. Enrollment in nursing schools declined (Fig. 3).

Measuring the Shortages

Shortages of hospital nurses are sometimes difficult to evaluate.[20] Among the potential measures of a shortage are reports by hospital officials or nurses, the vacancy rate for nursing positions, the turnover

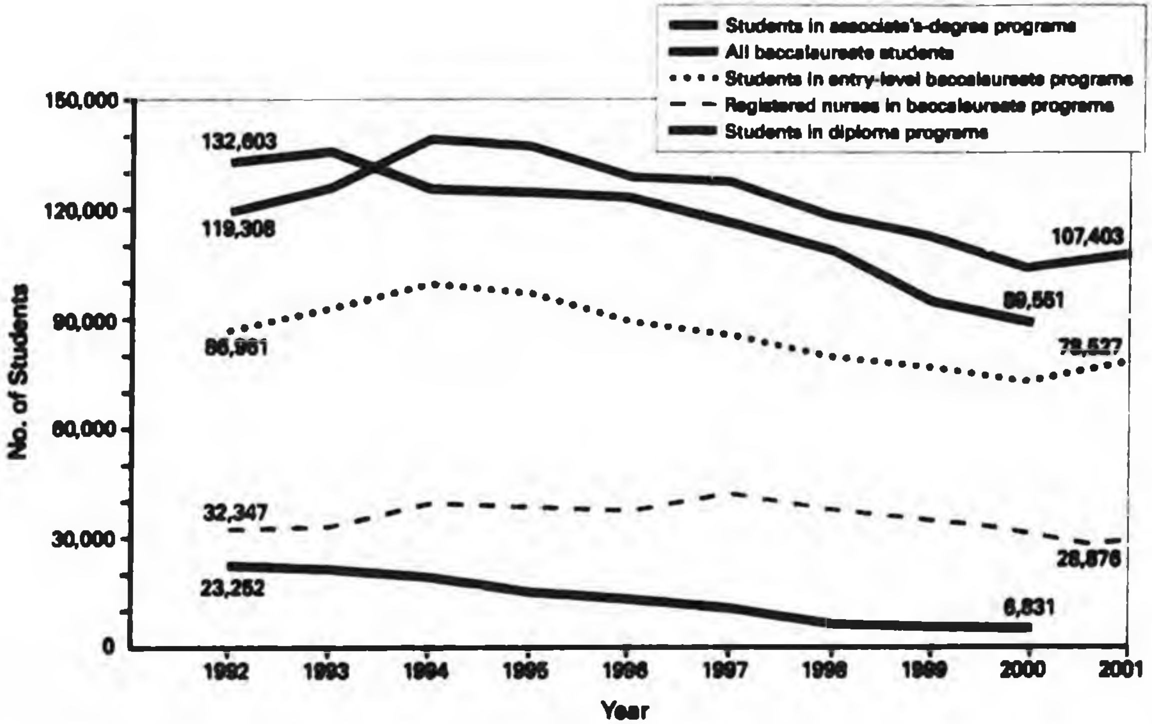

Figure 3. Enrollment in Educational Programs to Train Registered Nurses in the United States.

Baccalaureate programs for registered nurses allow nurses who have a nursing diploma or associate's degree to earn a bachelor's degree. The number of all baccalaureate students is the number of students in entry-level programs plus the number of registered nurses in baccalaureate programs. Data for baccalaureate programs are from the American Association of Colleges of Nursing. Data for associate's-degree and diploma programs are from the National League for Nursing; their data for 1997 through 2000 are preliminary.

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rate for these positions, the number of nurses at a hospital after adjustment for the number of inpatients and the case mix, and the supply of registered nurses per 100,000 population. Although there is no gold standard, a recent study found the strongest relations between reports by hospital officials or nurses of a moderate or severe nursing shortage and job-vacancy rates.[20] Differences in the supply of nurses per capita did not predict which regions would have a majority of hospitals reporting shortages.

The number of employed registered nurses per capita varies widely from state to state (Fig. 4). In 2000, the national average was 782 employed nurses per 100,000 population. California had only 544, whereas Massachusetts had 1194 and Pennsylvania had 1010.[9] These variations have been cited as evidence of regional shortages of nurses, particularly in states with a low supply of nurses, such as California,[21] Nevada,[22] and Texas.[23] The demand for hospital-based nurses, however, reflects many factors, including the number of hospital beds, the average length of stay, the specific medical services offered, population growth, and the number of elderly residents. Although Florida has 785 nurses per 100,000 population — about the national average — the supply has been considered inadequate because the state has the highest percentage of elderly persons in the nation.[24] Because a low supply of nurses may reflect a low demand — not an unmet demand — for hospital-based nurses, the importance of the variations in and of themselves is uncertain.

The Current Shortage

The current shortage of nurses began in 1998 in intensive care units and operating rooms.[25] It has since spread to labor-and-delivery units and general medical and surgical wards. The shortage is widespread throughout the country.

In 2001, the mean vacancy rate for registered-nurse positions at a given hospital was 13 percent. Fifteen percent of hospitals reported vacancy rates of 20 percent or more.[26] Mean vacancy rates were 11 percent in the Northeast and Midwest, 13 percent in the South, and 15 percent in the West. There were about 126,000 vacant positions nationwide.[27] Eighty-two percent of hospitals reported that it was more difficult to recruit registered nurses in 2001 than it had been in 1999; 1 percent said that it was less diffi-

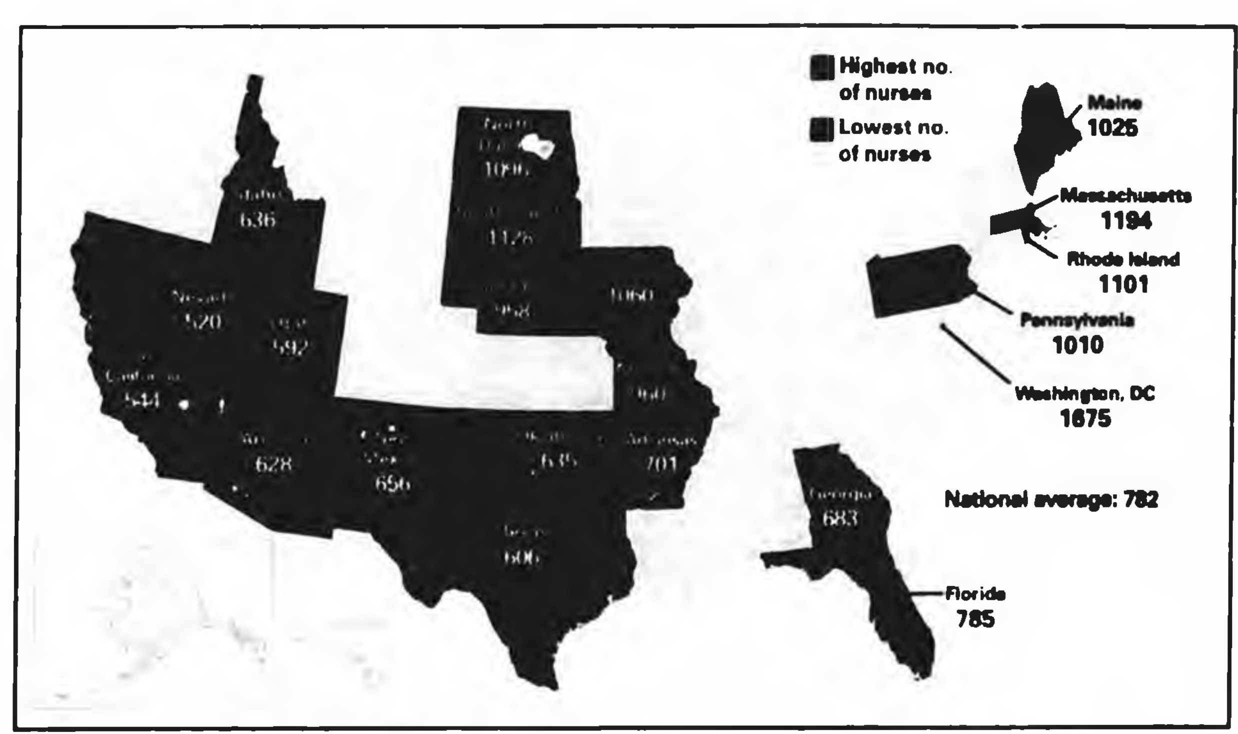

Figure 4. Employed Registered Nurses per 100,000 Population.

Both nurses who work full-time and those who work part-time are included. Data are from the National Sample Survey of Registered Nurses: March 2000.[9]

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cult.[26] According to a 2001 survey of chief executive officers of hospitals, 84 percent of hospitals had shortages of registered nurses; the next most frequently cited job categories with shortages were radiology and nuclear imaging (71 percent) and pharmacy (46 percent).[12] Of registered nurses working in nursing who were surveyed in 2001 and 2002, 95 percent thought there was a shortage of nurses, and 88 percent thought that the supply of registered nurses working in patient care in their community was lower than the demand.[14] National data about the current shortage of nurses are corroborated by reports from various states, including California,[6,21] Florida,[24] Maryland,[28] Nevada,[29] New York,[30] and Texas.[23]

The current shortage of nurses, albeit severe, may be similar to cyclical shortages that have occurred during the past 50 years. Better wages and better jobs, as well as better marketing of nursing schools and of nursing as a career, increased availability of training programs, and changes in the general economy, may encourage more students to enter nursing programs and bring more current nurses back into the job market. If these short-term factors are addressed, the current shortage should abate.

The Long-Term Shortage

Many predictions of long-term shortages or surpluses of physicians or other health care workers have turned out to be wrong. Nevertheless, there is the potential for a long-term shortage of nurses. This possibility reflects changing demographic and other factors, such as the decreased attractiveness of careers in health care to those entering employment and the dissatisfaction of people who currently work in hospitals.[11,31] According to the workforce commission of the American Hospital Association, shortages of nurses and other employees "reflect fundamental changes in population demographics, career expectations, work attitudes and worker dissatisfaction. The shortages will not disappear with the current or the next economic downturn."[12]

Both the registered-nurse workforce and the general population are rapidly aging. As members of the "baby boom" generation begin to retire, the demand for nurses is expected to increase rapidly.[32] Between 2000 and 2010, the occupation of registered nurse will be one of the five occupations with the greatest growth in the number of jobs, according to the Bureau of Labor Statistics. It is projected that during this period, there will be 1,000,400 job openings for registered nurses, including 561,000 new positions.[33]

Younger nurses are more likely than older nurses to work in hospitals. In 2000, only 9 percent of registered nurses were less than 30 years of age, as compared with 25 percent in 1980 (Fig. 5). About a third of registered nurses were 50 years of age or older.[9] A related issue is that nursing, particularly in a hospital, can be physically demanding and lead to occupational injuries, particularly for older nurses.[2] By 2020, a shortage of more than 400,000 registered nurses is possible.[32] One analysis concluded: "The evidence suggests a not-too-distant collision between the aging and shrinking RN workforce and the increasing demand driven (among other things) by the expanding population of Medicare beneficiaries."[34]

MINIMAL NURSE-STAFFING RATIOS

In 1999, the California legislature, prompted by concern about the effects of decreased levels of staffing by nurses on the quality of care, required the state Department of Health Services to establish minimal staffing ratios of nurses to patients according to the types of licensed-nurse classification and hospital unit.[35,36] In January 2002, Governor Gray Davis announced the proposed ratios (Table 1).[37] The actual regulations are likely to be finalized later this year, after public comments and hearings, and to take effect by July 2003.

The staffing ratios have been the subject of sharp disputes between the California Nurses Association, which worked for years to pass the legislation, and the California Healthcare Association, which represents hospitals in the state and has opposed the approach.[38] The nurses' association advocated a minimal ratio of 1 nurse to 3 patients on medical–surgical units; the hospital association advocated a minimal ratio of 1:10.

The proposed ratios include a minimum of one nurse to six patients on general medical–surgical units (Table 1). This minimum would change to one nurse to five patients 12 to 18 months after the regulations go into effect. Although most of the nurses are likely to be registered nurses, the extent to which licensed practical nurses could be substituted is not yet clear. For labor-and-delivery units, the minimal staffing ratio is one nurse to two patients. Intensive care units are already subject to a minimum of one nurse to two patients. The ratios are meant to be minimums; hospitals are expected to increase levels of staffing when patients require additional care.

Complying with the Ratios

California has 470 hospitals, according to the California Healthcare Association. Fifteen percent of hospitals with medical–surgical units would not be in compliance with the initial ratio if it took effect now, and 36 percent would not be in compliance with the final ratio, according to Joanne Spetz of the Center for California Health Workforce Studies at the University of California, San Francisco.[39] Fifteen percent of hospitals with labor-and-delivery units would not be in compliance with the proposed ratio.

Spetz predicted that the cost of implementing the

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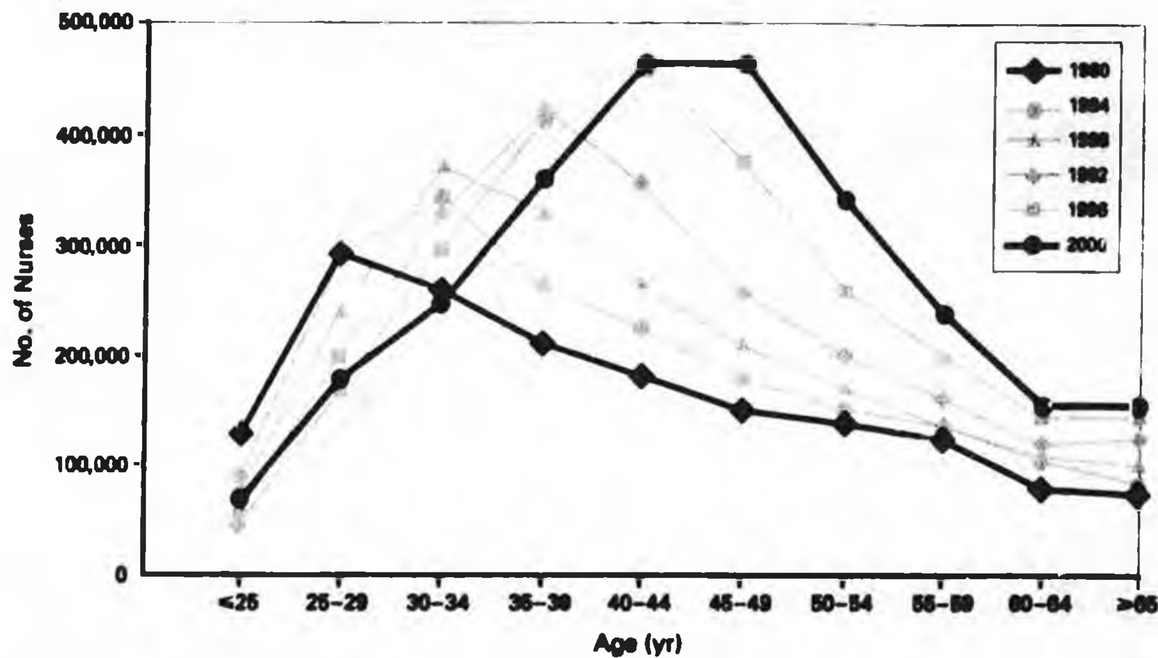

Figure 5. Age Distribution of Registered Nurses in the United States, 1980 through 2000.
Adapted from the National Sample Survey of Registered Nurses: March 2000.[9]

recommendations would be "rather small," because many hospitals would have to hire few, if any, additional nurses. She estimated the annual per-hospital increase in expenditures for nursing as $143,846 (1.0 percent) for the initial ratios and $217,210 (1.7 percent) for the final ratios.[39] The California Healthcare Association has not prepared per-hospital estimates. It has estimated that if 5000 additional registered nurses are required statewide, the annual cost might be $400 million. It is possible, however, that the costs of hiring additional nurses may be offset if patients have fewer complications and adverse events and therefore leave the hospital sooner.

Reaction to the Ratios

According to Rose Ann DeMoro, the executive director of the California Nurses Association, minimal nurse-staffing ratios "are a dramatic step forward for hospitals in California" and will help to "create conditions in hospitals for nurses to return." Jan Emerson, vice president of external affairs at the California Healthcare Association, said that although "the hospital industry agrees with the notion that more nurses is probably a good thing," the minimal staffing ratios could have "serious unintended consequences." These include an inability to find qualified registered nurses, which may force hospitals to eliminate beds and reduce access to care. The proposed ratios also raise practical issues, such as whether the level of staffing is required around the clock.

The new American Association of Registered Nurses is encouraging other states to enact similar legislation. Mary Foley, the president of the American Nurses Association, said that her organization was "not opposed to the California bill but did not support it enthusiastically." She said that, although "10 to 12 patients per nurse is horrible," safe medical and nursing care is "not just a matter of numbers." Aiken, of the University of Pennsylvania School of Nursing, predicted that unless a "floor" for staffing is established, "we are not going to be able to stop the flight of nurses from hospitals. . . . If it is feasible to implement the ratios, a lot of other states may follow."

MANDATORY OVERTIME

Some people like to work overtime, because they can make more money or take other time off. Others prefer to work on a regular schedule. Although it might seem inefficient and expensive for an employer to hire too few employees and then pay higher wages for overtime, this approach reduces the number of permanent employees and is one way to cope with vacancies.

Overtime has unique aspects in health care. Physi-

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TABLE 1. PROPOSED MINIMAL NURSE-STAFFING RATIOS FOR HOSPITAL UNITS IN CALIFORNIA.*

HOSPITAL UNIT	PROPOSED RATIO OF NURSES TO PATIENTS
Intensive or critical care†	1:2
Neonatal intensive care†	1:2
Intermediate care nursery†	1:4
Labor and delivery	1:2
Postanesthesia care	1:2
Emergency department	
General	1:4‡
Critical care	1:2
Trauma	1:1
Pediatrics	1:4
Step-down with telemetry	1:4
Specialty care (oncology)	1:5
General medical–surgical	1:6§
Behavioral health or psychiatric	1:6

*Data are staffing ratios proposed by the California Department of Health Services in January 2002[47] under Assembly Bill 394, which was signed into law in 1999.[38] The actual regulations — which have yet to be finalized — are to take effect in 2003. Although most of the nurses are expected to be registered nurses, the proposed ratios do not specify when licensed practical nurses can be used. Not all types of hospital units are listed.

†Minimal nurse-to-patient ratios are already in place for hese units by California statute, regulations, or both.

‡Triage, radiology, or other specialty nurses are considered to represent an additional workforce; they are not included in this ratio.

§This ratio is an initial ratio; a ratio of 1:5 is to be phased in 12 to 18 months after the effective date of the regulations.

cians and nurses have professional obligations to care for their patients and not abandon them. Although overtime is essential in emergencies, there is concern that hospitals, like other businesses, are using it instead to compensate for inadequate levels of staffing. Exhausted nurses, like exhausted physicians, can pose safety risks. "By far the riskiest result of understaffing is the abuse of mandatory overtime as a staffing tool," Foley of the American Nurses Association stated in congressional testimony in March of this year.[40] Many nurses, she said, are being required to work some mandatory or unplanned overtime every month or face dismissal for insubordination or being reported to the state board of nursing for abandonment of patients.

In the recent national survey of working nurses,[14] 61 percent of respondents said they had observed increases in overtime or double shifts during the past year. Forty-eight percent said that "the amount of overtime required" had increased, 6 percent said it had decreased, and 45 percent said it had remained the same. Forty-five percent said working overtime was "strictly voluntary," 32 percent said it was "voluntary but feels like it is required," and 20 percent said it was "required" (Buerhaus P, Vanderbilt University School of Nursing: personal communication). A national survey of oncology nurses, conducted in 2000, had similar findings (Buerhaus P: personal communication).[41]

As of early May 2002, six states had enacted laws that ban or limit mandatory overtime, except in emergencies — Maine,[42] Maryland,[43] Minnesota,[44] Oregon,[45] New Jersey,[46] and Washington.[47] The Washington law prohibits hospitals from requiring nurses who care for patients from working more than 12 hours in a 24-hour period or more than 80 hours in a period of 14 consecutive days. Many of the other laws have similar provisions. More states are likely to enact such laws, which are backed by the American Nurses Association and other nursing organizations.

POTENTIAL SOLUTIONS

A major goal of minimal nurse-staffing ratios or the prohibition of mandatory overtime is to improve the quality of care. These measures may exacerbate shortages in the short term because hospitals will most likely have to hire more registered nurses. However, if they help to make hospitals more attractive places to work, they may make it easier to recruit nurses. Their actual effects will not be clear for at least several years.

The potential solutions to the shortage of nurses and related problems include expanding enrollment in nursing schools and bringing more men and members of minority groups into the profession.[21,34] They also include developing incentives to encourage nurses who work part-time to work more hours, offering better salaries, providing more regular work hours, and restructuring hospitals to make the work environment more attractive. In its recent report, the workforce commission of the American Hospital Association emphasized the need to make hospital work more meaningful and rewarding.[12] Still other approaches, such as recruiting more nurses from overseas[48] or encouraging affluent patients to hire their own nurses,[49] are less likely to have broad effects. Some combination of these approaches is likely to be most effective.

Financial incentives may be particularly important. Many hospitals are paying nurses signing bonuses of $1,000 to $5,000 or more and are temporarily filling vacant positions with registry or traveling nurses.[14,26] In Boston, Tufts–New England Medical Center has agreed to raise nurses' pay 18 to 23 percent over a period of 23 months.[5] Nurses at the Oregon Health and Science University will receive at least a 20 percent raise over a three-year period.[50]

The American Nurses Credentialing Center, a subsidiary of the American Nurses Association, has developed the "magnet nursing services recognition pro-

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gram" for hospitals that meet quality standards and provide nurses with more responsibilities, autonomy, and opportunities to participate in policy decisions. Studies suggest that nurses in such hospitals have greater job satisfaction, and the hospitals are less likely to have difficulty hiring and retaining nurses.[51] As part of the new contract for nurses, the Oregon Health and Science University agreed to seek "magnet" status.

Enrollment in associate's-degree programs for nurses decreased through 2000, according to preliminary data (Fig. 3). One encouraging sign, however, is that enrollment in baccalaureate programs, which appeal to younger students,[52] has increased[53] (Fig. 3). The increase — in 2001 — ended a six-year period of declining enrollment. The Nurse Reinvestment Act would authorize federal funding for scholarships and loan repayments for nurses who agree to work after graduation in areas where there are shortages, as well as for public-service announcements that would promote nursing as a career.[54] The Bush administration has announced the availability of grants and has proposed extending loan-repayment programs.[55] In California, Governor Davis has proposed a $60 million initiative for the nurse workforce that expands training programs for nurses.[56]

THE FUTURE

Nurses who work in hospitals are apprehensive about the future. Hospitals employ many more registered nurses than physicians and cannot function without them. At a time of serious financial constraints, however, they must often choose between hiring more nurses and launching or maintaining other programs that may improve patient care, such as computerized order-entry systems.[57] Some of the issues raised by nurses about hospital staffing reflect their interest in their own financial and job security. Yet there is ample evidence of a broader unease.

Many tensions will be difficult, if not impossible, to resolve, particularly if additional funds do not become available. For example, within the nursing profession, higher-quality care may mean a better-educated workforce, with a higher percentage of nurses with bachelor's or advanced degrees. Such a workforce, however, would expect more responsibility and greater independence and would be more expensive to hire and retain.

In the long term, the future of the nursing profession is related to its ability to attract more young nurses, to support the careers of current nurses, and to create more jobs for nurses with higher wages and greater responsibilities. Such efforts can be successful only if the positions students are training to fill are sufficiently attractive, as compared with the alternatives in other fields. "Nursing is a worthy career," said Foley, the president of the American Nurses Association. "It should not be considered secondary or inferior. We want nursing back on the list of career choices for bright young men and women who are looking at health care."

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Press Releases & Statements

UAN gives a voice to the issues that are important to staff nurses. Here's what UAN staff nurses are saying to the media, Congress and the public:

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FOR IMMEDIATE RELEASE: March 2nd 2006

UAN VP Converso's remarks to the Sixth International Conference on Stress and Health

THE OCCUPATIONAL SAFETY AND HEALTH IMPACTS OF INADEQUATE STAFFING AND MANDATORY OVERTIME ON REGISTERED NURSE

Ann Converso, RN, Vice President
United American Nurses, AFL-CIO

The Sixth International Conference on Occupational Stress and Health
March 2, 2006

Long hours of work, mandatory overtime, and inadequate staffing cause extreme stress to nurses, impacting their physical and mental health. They also ultimately affect the quality of patient care. Like many other industrialized nations, the United States is experiencing a severe shortage of nurses that will intensify as the baby boom

generation ages, with shortages currently in at least 30 states according to the Health Resources and Services Administration. The Bureau of Labor Statistics estimates that the United States will need an additional 1.1 million registered nurses by 2014.

At the same time, health care costs continue to rise. Managed care compels hospitals to discharge patients more rapidly, resulting in higher patient acuity levels. Hospitals attempt to control labor costs by reducing the number of registered nurses they employ. But cutting the number of nurses at the bedside is counterproductive as overworked nurses get injured or burned out and leave the profession6exacerbating the shortage of nurses.

A 2003 study by Aiken with Clarke, Sloane, Sochalski, and Silber found that higher emotional exhaustion and greater job dissatisfaction were strongly associated with higher nurse-to-patient ratios. Each additional patient per nurse correlated to a 23 percent increased risk of burnout, as well as a 15 percent increase in the risk of job dissatisfaction. Among the nurses surveyed in this study, 43 percent reporting job burnout and dissatisfaction stated that they intended to leave their current position within the year. When the United American Nurses surveyed hospital nurses in 2002 about staffing and job satisfaction issues, a third said they were likely to leave the profession within five years due to frustration about inadequate staffing and mandatory overtime.

How bad is the situation? Unfortunately, we do not have systematic national data on nurse-to-patient ratios and the hours worked by nurses. We are looking forward to a NIOSH study on the combined influence of shift work and overtime on nursesí health and safety.

In the interim, some studies on patient safety have shed light on nurse-to-patient ratios and hours of work. Patient safety has gotten a lot of attention since the Institute of Medicine announced in 1999 that approximately 98,000 people in the United States die annually due to hospital errors. In 2003, the IOM surveyed the literature on factors in the nursing profession and the impact on patient safety. They concluded that there is ample evidence that leaner nurse staffing and long work shifts are associated with errors and adverse reactions, such as post-operative infections, pneumonia, urinary tract infections, and increased length of hospital stay.

The IOM found that while the average registered nurse-to-patient ratio in medical-surgical units is one-to-six, 23

percent of hospitals reported that day shift registered nurses in medical-surgical units were responsible for seven to twelve patients. Night shift nurse-to-patient ratios are likely to be even poorer. In contrast to those staffing ratios, Aikenís study found that for each additional patient over four in a nurseís workload, the risk of death increased by seven percent for surgical patients.

The Institute of Medicine also found that work shifts longer than twelve hours per day endanger patient safety due to fatigue, causing reduced attention span and capacity to catch errors. However, the same study found that 27 percent of full-time hospital and nursing home nurses reported working more than 13 consecutive hours one or more times per week. The IOM recommends that states prohibit nurses from working more than 12 hours in a 24-hour period or more than 60 hours per week.

However, available data suggest that hospital staff nurses are working longer hours, with fewer breaks, with little time for recovery between shifts. A 2004 study by Rogers with Hwang, Scott, Aiken, and Dinges on the impact of long working hours on patient safety reveals excessively long work shifts among hospital nurses. In this study, 393 Registered nurses were asked to log their actual work times over a four-week period, providing 5,317 work shifts over 28 consecutive days to analyze.

- On average, the nurses in the study worked 55 minutes beyond their scheduled shift, of 8.5 or 12.5 hours. (An extra 30 minutes for the handover period at the end of shifts is already built into the schedule.)

- Nurses reported leaving work at the end of the scheduled shift less than 20 percent of the time during the study.

- Although 31 percent of the shifts were scheduled for 12.5 or more hours, the percentage of shifts that the nurses actually worked 12.5 or more hours was 39 percent.

- Fourteen percent of the respondents reported working 16 or more consecutive hours at least once during the four-week period. The longest shift recorded was 23 hours, 40 minutes.

- Almost two-thirds of the nurses worked overtime ten or more times during the period, and a third reported working overtime each day during the 28-day period.

- Not surprisingly, the risk of making an error increased with longer work hours and was three times higher when nurses worked 12.5 or more hours. Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled.

In addition to the pressure that registered nurses face to work overtime, many are required to be on call, especially those in specialized units. There is also anecdotal evidence that 24-hour shifts are becoming more common, particularly in emergency departments and on units where nurses self-schedule.

Beyond long work shifts and mandatory overtime, nurses face other scheduling issues that cause fatigue and stress as a result of being shift workers in a 24-hour-a-day industry. Nurses working night shifts struggle against their circadian rhythm, our biological tendency to sleep at night and be active during the day. The circadian rhythm makes it difficult to get enough restorative rest during the day and often requires night shift workers to miss out on activities with family and friends. Bureau of Labor Statistics injury data indicate that the risk of injury for all workers is substantially higher during the night shift than during the day or evening shifts. Risk of injury is nearly three times greater very early in the morning than at mid-afternoon, the low and high points of the circadian cycle.

Nurses have an even harder time if they work rotating schedules which prevent them from getting adequate rest between shifts. They are not just tired from not having enough sleep between shiftsótheir bodies have not had enough time to recuperate from the previous shift.

So what happens to these nurses who work such long hours and difficult schedules? We know that long hours of work, night shifts, or rotating shifts increase nursesí risk of musculoskeletal injuries by reducing the recovery time between shifts that nurses need to allow their backs to rest and heal. Nurses develop musculoskeletal injuries through the cumulative effect of repetitive actions, lifting

and transferring patients, moving heavy, awkward equipment, and stretching to work in poorly designed spaces. The Bureau of Labor Statistics, which ranks occupations sustaining the most musculoskeletal injuries, ranked registered nursing eighth among all jobs in 2003. Fifty-two percent of registered nurses have chronic back pain and 38 percent have pain severe enough to require leave from work. Research by Lipscomb, Trinkoff, Geiger-Brown, and Brady in 2002 found that:

- Registered nurses working twelve or more hours per shift were at increased risk for musculoskeletal disorders compared to those working eight-hour shifts.
- Registered nurses working twelve or more hours per day and 40 or more hours per week doubled their odds of getting a back, neck, or shoulder injury.
- Registered nurses working nights or weekends also significantly increased their risk of musculoskeletal injuries, due in part to lower staffing levels on those shifts.
- Registered nurses working rotating shifts had twice the number of reported accidents as those working day or night shifts only.
- Another study by Gold found that nurses working rotating shifts had twice the number of reported accidents or errors related to sleepiness than nurses who worked only a day or an evening shift.

Of course, nurses face a number of occupational hazards beside musculoskeletal disorders. In one study by Macias, the number of needlestick injuries and incidents of biological fluid exposure increased in the last two hours of twelve-hour shifts, but no increase in these incidents was found in the last two hours of eight-hour shifts.

Other research indicates that as health care workersí work hours increase, car crashes and occupational accidents increase. Ninety-six percent of Intensive Care Unit nurses reported car crashes or near misses while driving home

after a night shift in a study by Novak and Auvil-Novak in 1996.

We know less about the cardiovascular impacts or psychological stress caused by inadequate staffing and long working hours among nurses, although there has been research indicating that shifts longer than eight hours increase the incidence of smoking. Overtime has been associated with unhealthy weight gain among nurses. Overtime, shifts over eight hours, and night shifts and rotating shifts longer than eight hours have been associated with higher alcohol consumption among nurses.

However, we do knowóbecause nurses have been voting with their feet, whether through strikes or by leaving hospital employment or the professionóthat the environment they work in is stressful. In a 1999 study by the Minnesota Nurses Association, an affiliate of United American Nurses, registered nurses expressed escalating frustration and concern about their ability to provide safe care to patients under short staffing situations. They reported a decrease in organizational support and peer support.

What is the solution? Hospitals are not going to solve this problem on their ownóotherwise, it would already be fixed. Nurses who are on the frontlines must be part of the solution and have a voice in decision-making. UAN nurses have negotiated a variety of remedies through contract language, such as:

- a prohibition on mandatory overtime,
- specific nurse-to-patient ratios,
- the authority to close a department to new admissions when staffing ratios are too high to be safe for patients,
- and the power to determine staffing levels based on patient acuity rather than just the number of patients.

However, contract language is not enoughówe need a legislative solution for all nurses, not just those who have

union representation, and the state legislatures are beginning to address the issues.

Ten states have passed laws prohibiting the use of mandatory overtime for registered nurses and 14 other states have introduced legislation or are considering legislation on mandatory overtime. Illinoisí law ensures that a nurse will work no longer than four hours beyond the scheduled shift and requires an eight-hour rest period between shifts. Oregonís law prohibits hospitals from mandating nurses to work beyond 48 hours in a week or more than 12 consecutive hours in a 24-hour period.

Legislation requiring hospitals to develop and implement nurse staffing plans and include input from nurses has been passed in five states. Going beyond staffing plans, California enacted a nurse-to-patient ratio law in 1999, requiring one nurse for every six patients in medical-surgical units when it which went into effect in 2001. The law also provided that the ratio would be strengthened to one nurse for every five medical-surgical patients in 2005.

The United American Nurses supports two federal bills which would prohibit mandatory overtime and create minimum staffing ratios. The Safe Nursing and Patient Care Act of 2005, introduced by Senator Edward Kennedy, Democrat of Massachusetts and Representative Pete Stark, Democrat of California, would set strict limits on mandatory overtime for nurses. Nurses could not be forced to work beyond their scheduled shift, except in the event of a state of emergency declared by a local, state, or federal government. The bill also provides nurses with whistleblower protections.

UAN also supports the Nurse Staffing Standards for Patient Safety and Quality Care Act of 2005, sponsored by Representative Janice Schakowsky, which would establish federal minimum staffing nurse-to-patient ratios in all hospitals that receive federal funding, except during a declared emergency. This bill gives registered nurses and other health care workers a real voice in providing quality, safe health care. The bill also provides real penalties to hospitals that fail to comply and nurse whistleblower protections.

There are some people who say that staffing ratios wonít work6that hospitals canít hire nurses who donít exist6and that employing more registered nurses will increase health care costs even faster. But preliminary evidence from California and the state of Victoria in Australia, where ratios have been implemented, show that nurses who left

the profession will return, students will apply for nursing school, and nurses who are stressed will stay.

And a 2006 study by Needleman with Buerhaus, Stewart, Zelevinsky, and Mattke indicates that there is a business case for staffing ratios. They found that increasing the use of RNs to care for patients reduced costs by reducing patient complications and deaths and reducing patientsí time spent in the hospital.

Nursing, unlike other professions that impact public safety such as pilots and air traffic controllers, has been operating for generations without rules preventing them from working under unsafe conditionsóworking understaffed and fatigued. That needs to changeóconditions have only been getting worse due to the huge changes in health care and will worsen even more with the shortage of nurses. Nurses have been pushed too faróand we will no longer tolerate working understaffed and exhaustedóit is unsafe for our patients and it is unsafe for us.

Link to other years' news releases and statements:

- **2007**
- **2005**
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UPdate

News for UAN Union Nurses • January 2008

KY and WV Nurses Win for Patients, Communities

A majority of the 600-plus KNA and WVNA/UAN nurses at nine Appalachian Regional Healthcare facilities who went out on strike Oct. 1 ratified a new contract and back to work settlement with ARH Dec. 22. Throughout the strike, nurses maintained their steadfast dedication to safe patient care, despite the presence of 147 permanent replacement nurses, Yessin Associates union-busters and armed security guards on-hand to intimidate picketers.

Nurses received support from far and wide, with governors in both states getting personally involved in the resolution of negotiations this month. Religious leaders in Appalachia also publicly pressed ARH to fairly settle the contract and remove the replacement nurses that were brought in. In addition, nurses on the line received encouraging news on a prior arbitration case, as a federal appeals judge again ruled that ARH must pay upwards of $3 million to nurses who worked under an old contract provision—bargained in 2001 to improve nurse recruitment at ARH—under which nurses received 40 hours of pay for 36 hours worked. ARH had unilaterally suspended the provision. UAN has supported the striking nurses with on-the-ground staff assistance, technical and legal assistance in negotiations, monetary contributions and holiday gifts, strategic communications support and coordination of support coming from AFL-CIO and other unions. We thank nurses across UAN's state Affiliates and beyond who supported the striking ARH nurses in so many ways. To send your good wishes to these courageous nurses, email UANInfo@UANNurse.org; messages will be forwarded.

Detroit Nurses Rally for Right to Organize

RNs at the Detroit Medical Center currently seeking a union with the Michigan Nurses Association/UAN rallied on International Human Rights Day Dec. 10 to speak out against DMC's corporate campaign against the basic right to organize. "We want to form a union because union membership provides a voice on the job and the protections needed to be an effective patient advocate. Belonging to a union will help us build a better life for ourselves and our families," said DMC's Ceferina Sharpe, RN. "This is America and our basic rights should count for more, not less!" Nurses at DMC have filed charges with the National Labor Relations Board for illegally interrogating RNs about the union, spying on nurses and threatening discipline for those nurses who distribute pro-union literature.

Promoting Women Leaders in Unions

A new report from the Institute for Women's Policy Research outlines strategies to promote women's leadership in labor unions. To view the report, go to www.iwpr.org/pdf/I917_RIB.pdf.

Mandatory OT Watch: Win in RI

Overriding a veto by the governor, Rhode Island legislators used a one-day session to enact legislation banning hospitals from requiring nurses and CNAs to work beyond their 8, 10 or 12-hour shift except in unforeseeable emergencies. The new law also states that no health care facility shall require an employee to work more than 12 consecutive hours and may not punish nurses who refuse overtime, under penalty of fines.

TheUnionShop
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The AFL-CIO Retail Store for Activists

New Year's Resolution? Buy Union!

Support union-made goods in 2008 by doing your shopping at the AFL-CIO Union Shop: https://unionshop.aflcio.org/ind[illegible]

Contact UAN: the national union for RNs
800-924-8283 • UANinfo@uannurse.org

by Kathleen Gettys, RN

Senator Bettye Davis has introduced SB 28 which would prohibit mandatory overtime and place limits on the numbers of hours registered nurses can safely work before threats to patient safety occurs. The AaNA believes the elimination of mandatory overtime and extended working hours for RNs is a critical step to improving the quality of healthcare and reducing the number of medical errors that occur every year.

Kathleen Gettys, RN

SB 28 meets the *public policy goal* to safeguard registered nurses health and general well being, as well as protecting their patients. SB 28 *excludes* any unforeseen declared national, state or municipal emergency or a catastrophic event. SB 28 *prohibits* an employer from forcing a nurse to work hours in excess of an agreed upon, predetermined, regularly scheduled full-time or part-time schedule unless the employee consents to work and *sets a maximum* number of hours the nurse can safely practice. SB 28 *protects* the RNs job and prohibits retaliation against them for refusal to work overtime or reporting employer violations under this law. SB 28 will be *enforced* by penalties for violations. SB 28 *supports* nurses who are aware of the perils of long duty shifts and believe patient care would be compromised if forced to work overtime.

Overtime and Staffing

In the United States the average number of overtime hours worked annually has steadily increased over the past two decades. Almost one third of the workforce regularly works more than 40-hours [illegible] has been [illegible] healthcare.

Nurses have reported a dramatic [illegible] the use of overtime as a staffing tool [illegible] this jeopardizes patient safety and quality of care provided to their patients. Today, overtime whether voluntary or mandatory is the most common method facilities use to cover staffing insufficiencies. The Institute of Medicine (IOM) has estimated as many as 98,000 hospitalized Americans die each year as a result of errors in their care. The IOM illustrated that mandatory overtime is a serious contributing factor to medical errors. The IOM's *Save a 100,000 Lives Campaign* stated, "all overtime by nurses should be eliminated." A study examining long working hours of nurses in Health Affairs, July of 2004 revealed that the likelihood of making an error was three times higher when RNs worked shifts lasting longer than 12 hours or when they worked more than 40 hours per week.

At one of Alaska's major medical centers, nurses recognized the potential hazards of long working hours and are in the arbitration phase in order to settle a dispute pertaining to [illegible] who are not receiving their contractual breaks and lunches. Every time nurses who work [illegible] hours do not receive their meal periods, they enter in to an extended duty day of 12.5 hours. At the same medical facility, staffing insufficiencies have resulted in the hospital declining vacation requests for most of nurses on a large unit for the months of November and December of this year. Vacation denials have caused RNs to pick up extra shifts to support their co-workers much to the disadvantage of their own personal health and potential dangers to patient care.

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THE ALASKA NURSE
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- ❑ **Action Alerts**—If you would like political action alerts for National and State legislative issues involving nursing and health care issues.

Taskforce E-mail Pools

Taskforce E-mail Pool members will receive requests to work on a variety of projects on nursing issues, and may choose to participate in only the projects that interest them.

- ❑ **Professional Nursing Practice Issues**—Taskforces will consider issues relating to AaNA's policy on RN practice and other professional issues.
- ❑ **Health and Safety Issues**—Taskforces will consider safety and health issues of nurses and patients.
- ❑ **AaNA Event Planning**—Taskforces will plan events such as the AaNA Fall Retreat, open house events, AaNA General Assembly, or other events for AaNA members.
- ❑ **Other interest?** Let us know what you would like to work on:____________

AaNA Committees

- ❑ **Legislative Committee**—Actively involved in reviewing and coordinating strategy and testimony for legislative issues related to health and nursing. Works closely with the AaNA Lobbyist. Usually meets on the second Monday of the month. Current Chair is Pat Senner.
- ❑ **Conference Planning Team**—Participates help plan the Alaska Statewide Nurses Conference. Roles include working with program planning, marketing, vendor and sponsor recruitment and onsite assistance.
- ❑ **Continuing Education Committee**—Members individually review applications for continuing education approval based on the established guidelines of the American Nurses Credentialing Center and in coordination with the CE Director. Makes recommendations for improvements in the application process. The current CE Director is Norma Monsen.
- ❑ **Alaska Nurse Newsletter Editorial Board**—Members work with the editor to recruit articles and pictures for the quarterly newsletter. The current editor is Lynn Hartz.

Return to: *AaNA, 3701 E. Tudor, Suite 208, Anchorage, AK 99507 or fax (907) 272-0292 or e-mail aknurse@aknurse.org and tell us your selection.*

Overtime/Long Work Shifts

Continued from page 1

Relationship of Overtime to Consumer Safety and Patient Safety

There are several industries in which employees' working hours are strictly regulated to protect the health and safety of the public as well as the employees who serve them. Unlike many other industries where public safety is a concern, healthcare is exempt from federal regulations that limit the use of overtime. With the exception of eleven states that have passed regulations to address the issue of mandatory overtime, long working hours and the number of hours that nurses may work in providing direct patient care is not regulated in the United States. Other states besides Alaska that are either lining up or have already introduced legislation banning the use of mandatory overtime are Hawaii, Missouri, Pennsylvania, Vermont, Florida, Iowa, New York, Rhode Island, Nevada, Georgia, Michigan, Ohio, Tennessee and Massachusetts.

Dangers of Overtime and Patient Safety

Overtime, whether mandatory or voluntary, contributes to poor quality patient care secondary to fatigue and loss of concentration ability. Threats to patient safety that are likely to result from extensive nursing overtime include the following: nurses being less alert to changes in patients' condition, slower reaction time, medication errors, adverse drug events, errors in clinical judgment, increase in nosocomial infections and an increase in decubiti.

The Institute of Medicine's report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, 2004, stated that long hours worked by some nurses pose some of the most serious threats to patient safety and that prolonged periods of wakefulness can produce effects that are similar to the effects produced by alcohol intoxication. This may include decreases in reaction time and the speed of mental processes. If you do not want a pilot flying a plane for more than 12 hours, why would you want a nurse to care for you when long working hours have illustrated the likelihood of a medical error? The Journal of American Medical Association in 2002 compared nurses to pilots monitoring their instruments.

Nurses constitute an around the clock surveillance system and are responsible for detection and prompt intervention when a patient's condition deteroriates.

Continued on page 10

20 MINUTES
• Blood pressure drops to normal
• Pulse rate drops to normal

1 YEAR
• Excess risk of coronary heart disease is half that of a smoker

SB

39

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/16/07

FURTHER: (Finance)

Date of 5-Day Notice: 1/18/07
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/1/07

Labor and Commerce Committee considered SENATE BILL NO. 39

SB 39 BUSINESS LICENSE FEE

"An Act relating to the amount of the state's business license fee."

and recommends:

[ ] be replaced with [ ] SCS or [✓] CS for Senate Bill 39 (L&C)

[ ] adopt previous [ ] SCS or [ ] CS ______ (______)

[ ] attached amendment(s)

[ ] adopt ______ Letter of Intent

[ ] further referral to ______ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR # ____

NEW FISCAL NOTE(S):

License	Commerce	1/29/07	✓		
E. Dev	Commerce	1/29/07	✓		
Advoc	Commerce	1/29/07	✓		
	Governor	1/30/07	✓		

PREVIOUS FISCAL NOTE(S):

[ ] APPROPRIATION - no fiscal note

[signature]	Bunde		✓		
[signature] Betty Davis	DAVIS	✓			
[signature]	STEVENS	✓			
[signature]	Hoffman	✓			
[signature] Ellis	Ellis	✓			
CHAIR					

ALASKA STATE LEGISLATURE

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Senator_Bill_Wielechowski@legis.state.ak.us

Co-chair
Joint Armed Services Committee

Member
Resources Committee
Judiciary Committee
Transportation Committee

SENATOR BILL WIELECHOWSKI

SPONSOR STATEMENT
SB 39

"An Act relating to the amount of the state's business license fee."

SB 39 will repeal the 300% increase in the cost of a state business license signed into law by former Governor Murkowski in 2003.

Since then, the number of licenses issued annually has dropped by nearly 10%, resulting in 6,425 fewer businesses in Alaska. The vast majority of businesses in Alaska have four or fewer employees. Small business is the foundation of Alaska's economy and Alaska has one of the highest unemployment rates in the nation. This bill will encourage small business growth and development.

This bill is supported by the Alaska Chapter of the National Federation of Independent Businesses, the largest small business advocacy group in the state. It would reinstate the $25 license fee that was charged to businesses prior to the 2003 increase. I encourage you to support this bill.

SB 39:

"An Act Relating to the Amount of the Business License Fee"

Background

- Business license fees were raised in 2003 at the request of then-Governor Murkowski from $25/year to $100/year, except for sole proprietors 65 or older. Their fee was set at $50/year.

- The increase has generated an average of $4.3 million in new annual state revenue. The operating cost of the Division of Corporations, Business and Professional Licensing is $1.2 million.

- From 2000-2003, the average number of licenses sold was 73,700. In 2005 and 2006 (after the increase went into effect) the average number sold dropped to 67,275. This amounts to a decrease of 6,425 licenses or almost 10%.

- Most licenses in Alaska are sold to small businesses. According to the Department of Labor, 66% of Alaska's 17,317 employers with at least one employee had average monthly employment of 5 or fewer in 2005.

- Small business is the economic foundation of the state, providing employment for 233,000 Alaskans or 99.7% of those employed in the private sector.

- The quadrupling of the fee in 2003 discourages the start-up of new businesses. Many small businesses have to buy multiple local, state and federal licenses. The cumulative effect of these fees is stifling.

- Alaska's 6.8% unemployment rate is one of the highest in the nation. In some areas of Alaska, the unemployment rate is much greater. Discouraging business start-up will only worsen this problem.

- The Alaska Chapter of the National Federal of Independent Businesses, with 2,500 members in Alaska, supports SB 39. They see this bill as a sign that the State of Alaska values small businesses.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 26, 2007

SUBJECT: Draft of CSSB 39(L&C) business licenses
(Work Order No. 24-LS0351\M)

TO: Senator Johnny Ellis
Chair of the Senate Labor & Commerce Committee
Attn: Dana

FROM: TB Theresa Bannister
Legislative Counsel

This memo accompanies a draft of the bill described above.

1. Other penalties. Please be aware that there are other penalties in the statutes that may be imposed for the failure to obtain a business license. In the general licensing provisions for occupational licenses, AS 08.01.102 imposes a citation for a violation of a license requirement under AS 43.70. In the provisions dealing with employment agencies, AS 23.15.390 requires compliance with AS 43.70, and, under AS 23.15.510, wilfully violating AS 23.15.390 is a misdemeanor. Depending on the interpretation of the provisions of the sport fishing operator license requirements, there may be a penalty (ranging from a violation to a misdemeanor) under AS 16.40.290 for not satisfying the AS 43.70 business license requirements established by AS 16.40.260.

2. Cross reference. It would be helpful to the clarity of AS 43.70.020(e) if language were added to indicate how the civil fine relates to the other penalties mentioned above. Is the civil fine in addition to the other penalties. Is it to be the exclusive penalty?

If I may be of further assistance, please advise.

TLB:med
07-044.med

Enclosure

25-LS0351\K
Bannister
1/30/07

CS FOR SENATE BILL NO. 39(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS WIELECHOWSKI, Wilken

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to business licenses, to the amount of the state's business license fee, to**
2 **the penalty for not obtaining a business license, and to business license penalties under**
3 **certain financial institution, occupational licensing, employment agency, and taxation**
4 **laws; and providing for an effective date."**

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

6 *** Section 1.** AS 06.01.035 is amended by adding a new subsection to read:
7 (j) Notwithstanding the other provisions of this section, the failure to have a
8 business license issued under AS 43.70.020 as required by AS 06.50.020(a) is not a
9 violation for the purposes of (a) and (e) - (g) of this section.
10 *** Sec. 2.** AS 08.01.102 is amended to read:
11 **Sec. 08.01.102. Citation for unlicensed practice or activity.** The department
12 may issue a citation for a violation of a license requirement under this chapter**, except**
13 **a requirement to have a license under** [OR] AS 43.70**,** if there is probable cause to
14 believe a person has practiced a profession or engaged in business for which a license

L

1 is required without holding the license. Each day a violation continues after a citation
2 for the violation has been issued constitutes a separate violation.
3 * **Sec. 3.** AS 16.40.290(a) is amended to read:
4 (a) Except as provided in (b) and (c) of this section, a person who knowingly
5 violates AS 16.40.260 - 16.40.299 or a regulation adopted under AS 16.40.260 -
6 16.40.299 is guilty of a class A misdemeanor. **However, this subsection does not**
7 **apply to the failure to hold a current business license under AS 16.40.260(a)(1) as**
8 **required under AS 43.70.**
9 * **Sec. 4.** AS 23.15.510 is amended to read:
10 **Sec. 23.15.510. Violations.** A person who wilfully violates any provision of
11 AS 23.15.330 - 23.15.520 is guilty of a misdemeanor, and upon conviction is
12 punishable by a fine of not more than $1,000, or by imprisonment for not more than
13 six months, or by both. **However, this section does not apply to the violation of the**
14 **requirement under AS 23.15.390 to comply with AS 43.70.**
15 * **Sec. 5.** AS 43.05.290(h) is amended to read:
16 (h) A person engaging in or attempting to engage in a business, trade,
17 profession, or occupation for which a license is required under this title, who wilfully
18 fails to obtain the license, is guilty of a misdemeanor [,] and, upon conviction, is
19 punishable by a fine of not more than $2,000, or by imprisonment for not more than
20 six months, or by both. **This subsection does not apply to a violation of**
21 **AS 43.70.020.**
22 * **Sec. 6.** AS 43.70.020 is amended by adding a new subsection to read:
23 (e) A person who knowingly violates this section is subject to a civil fine of
24 not more than $300.
25 * **Sec. 7.** AS 43.70.030(a) is amended to read:
26 (a) The fee for each business license is **$25 a** [$100 PER] year [, EXCEPT
27 THAT THE FEE IS $50 IF
28 (1) THE BUSINESS IS A SOLE PROPRIETORSHIP; AND
29 (2) THE SOLE PROPRIETOR IS 65 YEARS OF AGE OR OLDER
30 WHEN THE SOLE PROPRIETOR APPLIES FOR THE LICENSE OR WILL
31 REACH 65 YEARS OF AGE AT ANY TIME DURING THE YEAR FOR WHICH

1 THE LICENSE IS ISSUED].
2 * Sec. 8. The uncodified law of the State of Alaska is amended by adding a new section to
3 read:
4 TRANSITION: FEE. If a license issued under AS 43.70.020(a) is scheduled to expire
5 on January 1, 2008, and if the person to whom the license was issued wants to obtain a license
6 under AS 43.70.020(a) that lasts for the two years of 2008 and 2009, a person who is required
7 under AS 43.70.030, as that section exists before October 1, 2008, to pay
8 (1) $100 a year for the license may pay $125 for a two-year license instead of
9 $200;
10 (2) $50 a year for the license may pay $75 for a two-year license instead of
11 $100.
12 * Sec. 9. Section 7 of this Act takes effect October 1, 2008.

25-LS0351\M
Bannister
1/26/07

CS FOR SENATE BILL NO. 39(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS WIE LECHOWSKI, Wilken

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the amount of the state's business license fee and to a penalty for not**
2 **obtaining a business license; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 43.05.290(h) is amended to read:
5 (h) A person engaging in or attempting to engage in a business, trade,
6 profession, or occupation for which a license is required under this title, who wilfully
7 fails to obtain the license, is guilty of a misdemeanor [,] and, upon conviction, is
8 punishable by a fine of not more than $2,000, or by imprisonment for not more than
9 six months, or by both. **This subsection does not apply to a violation of**
10 **AS 43.70.020.**
11 *** Sec. 2.** AS 43.70.020 is amended by adding a new subsection to read:
12 (e) A person who knowingly violates this section is subject to a civil fine of
13 not more than $300.
14 *** Sec. 3.** AS 43.70.030(a) is amended to read:

1 (a) The fee for each business license is <u>$25 a</u> [$100 PER] year [, EXCEPT
2 THAT THE FEE IS $50 IF
3 (1) THE BUSINESS IS A SOLE PROPRIETORSHIP; AND
4 (2) THE SOLE PROPR'ETOR IS 65 YEARS OF AGE OR OLDER
5 WHEN THE SOLE PROPRIETOR APPLIES FOR THE LICENSE OR WILL
6 REACH 65 YEARS OF AGE AT ANY TIME DURING THE YEAR FOR WHICH
7 THE LICENSE IS ISSUED].
8 * **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to
9 read:
10 TRANSITION: FEE. If a license issued under AS 43.70.020(a) is scheduled to expire
11 on January 1, 2008, and if the person to whom the license was issued wants to obtain a license
12 under AS 43.70.020(a) that lasts for the two years of 2008 and 2009, a person who is required
13 under AS 43.70.030, as that section exists before October 1, 2008, to pay
14 (1) $100 a year for the license may pay $125 for a two-year license instead of
15 $200;
16 (2) $50 a year for the license may pay $75 for a two-year license instead of
17 $100.
18 * **Sec. 5.** Section 3 of this Act takes effect October 1, 2008.

25-LS0351\E
Bannister
1/25/07

CS FOR SENATE BILL NO. 39(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS WIELECHOWSKI, Wilken

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the amount of the state's business license fee; and providing for an**
2 **effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 43.70.030(a) is amended to read:
5 (a) The fee for each business license is **$25 a** [$100 PER] year [, EXCEPT
6 THAT THE FEE IS $50 IF
7 (1) THE BUSINESS IS A SOLE PROPRIETORSHIP; AND
8 (2) THE SOLE PROPRIETOR IS 65 YEARS OF AGE OR OLDER
9 WHEN THE SOLE PROPRIETOR APPLIES FOR THE LICENSE OR WILL
10 REACH 65 YEARS OF AGE AT ANY TIME DURING THE YEAR FOR WHICH
11 THE LICENSE IS ISSUED].
12 *** Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to
13 read:
14 TRANSITION: FEE. If a license issued under AS 43.70.020 is scheduled to expire on

1 January 1, 2008, and if the person to whom the license was issued wants to obtain a license
2 under AS 43.70.020 that lasts for the two years of 2008 and 2009, a person who is required
3 under AS 43.70.030, as that section exists before October 1, 2008, to pay

4 (1) $100 a year for the license may pay $125 for a two-year license instead of
5 $200;

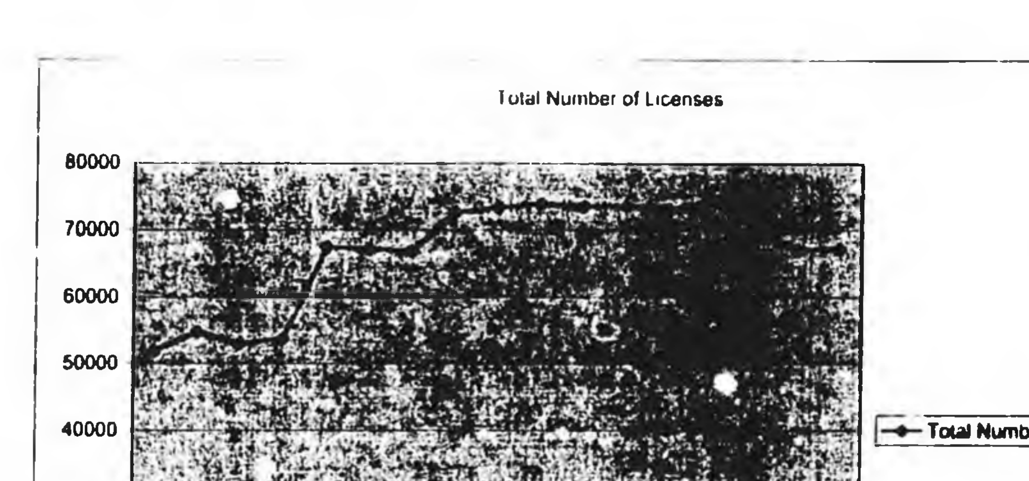
6 (2) $50 a year for the license may pay $75 for a two-year license instead of
7 $100.

8 * Sec. 3. Section 1 of this Act takes effect October 1, 2008.

Business License Sales & Revenue

Total Number Current Licenses	51960	54816	53124	53725	67500	67289	66949	72646	73348	73936	73540	73617	73047	[illegible]	[illegible]	[illegible]	67,321
Revenue Generated/Year											*2,025,138	$1,957,638	$2,086,[illegible]	$2,110,434	**[illegible]	***[illegible]	[illegible]
Cost for License/Year*	25	25	25	25	25	25	25	25	25	25	25	25	25	25	100	100	100
% Licenses Purchased/Renewed Online													9	14	14	18	36

*Cost of Business License/Year was $25 from 1949-2003
** Required Business Licenses To Be Purchased For Two Year
*** Allowed Business Licenses To Be Purchased For One or Two



DEWITT & DEWITT LLC
PO Box 34761
Juneau, AK 99803-4761

January 22, 2007

The Honorable Bill Wielechowski
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182

RE: Support for Senate Bill 39

Dear Senator Wielechowski:

On behalf of the Alaska Chapter of the National Federation of Independent Business, I wish to express our support for Senate Bill 39. The Alaska Chapter of the National Federation of Independent Business has 2,500 members, making it the largest small-business advocacy group in the state.

The 2003 increase in the Alaska Business License added an increased cost to the operations of small businesses. In a time when small businesses are facing significant increases in the cost of energy, workers' compensation insurance and many other basic cost of operation, such an increase was an indication that the State of Alaska had little concern for the small business operator.

The proposed return of the business license fee to $25 per year is a small indication that the State of Alaska values small businesses by reducing the cost of doing business in Alaska.

Sincerely yours,

Denny

Dennis L. DeWitt
State Director
Alaska Chapter of the National Federation of Independent Business

(907)723-6667 ddewitt@gci.net

Fax Cover Sheet

Anchorage Legislative Information Office
Office - (907) 269-0111 Fax - (907) 269-0229

To: Sen. Ellis (SLAC) **Fax:** 465-2529 **Phone:** ____________

From: Anchorage LIO

Instructions: in reference to SB 39 & SB 41

Date: 01/25/07 **Time:** 2:25 Pm

Number of Pages: 2 **(including cover sheet)**

January 25, 2007

Good Afternoon, my name is Greg Wuitschick and I own Alaska Tire World, I have been asked to speak today about SB39 and SB41. First I'm going to talk about SB39, business licenses going back to normal pricing.

Why should the SOA punish business owners by increased business license fees? When small business overhead goes up, so does the price of goods and services. Ultimately, the Alaskan consumer pays more. Why are we making life harder for Alaskan citizens? I urge you to change it back to where it was before and support SB39.

Now I would like to talk about SB41. Which I believe I believe has two parts. First, studded tire tax and second, what I call a point of sale tire tax.

Why does SOA need o tax the safety of our families during our winter months? Studded tires are designed for added traction for winter driving and when used properly, add safety to everyone on the road. We can use all the help we can get when it comes to driving on snow and ice, which we all know it can be very hazardous in our state. How can we tax safety? The $440,000.00 we raised by the tax seems like a small amount considering the training curve and frustration it takes to use the SOA's pers payment system. The SOA was minimal help when it came to filing the tire tax. A percentage of my customers could not afford the added tire tax, so their safety and the safety of their family is compromised by financial restraints that was imposed by SOA.

Next, I would like talk about what I call a point of sale tire tax. Why are we taxing ourselves more for tires? With the rising cost of energy prices and other soaring prices, it seems absurd to drive our Alaskan goods and services up in cost. Please support SB41. Thank you!

SB

41

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/16/07

FURTHER: (Transportation) Finance

Date of 5-Day Notice: 1/18/07
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/1/07

Labor and Commerce Committee considered SENATE BILL NO. 41

SB 41 REPEAL STUDDED TIRE FEE

"An Act repealing the fee imposed on the sale of studded tires."

and recommends:

[✓] be replaced with [ ] SCS or [✓] CS for Senate Bill 41 (L+C)

[ ] adopt previous [ ] SCS or [ ] CS ______ (______)

[ ] attached amendment(s)

[ ] adopt ______ Letter of Intent

[ ] further referral to ______ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Revenue	1/24/07	✓		
DOT+PF	1/24/07			✓

PREVIOUS FISCAL NOTE(S):

[ ] APPROPRIATION - no fiscal note

[signature]	Bunde		✓		
[signature]	DAVIS	✓			
[signature]	Stevens	✓			
[signature]	Hoffman	✓			
[signature]	Ellis	✓			
CHAIR					

ALASKA STATE LEGISLATURE

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Senator_Bill_Wielechowski@legis.state.ak.us

Co-chair
Joint Armed Services Committee

Member
Resources Committee
Judiciary Committee
Transportation Committee

SENATOR BILL WIELECHOWSKI

SPONSOR STATEMENT
SB 41

"An Act repealing the fee imposed on the sale of studded tires."

This bill would repeal the $5 per tire tax on studded tires adopted in 2003 at the request of former Governor Murkowski as a means to generate state revenue.

The tax has raised about $440,000 in revenue per year. However, the Alaska Department of Transportation, and numerous studies from all over the world show that the use of studded tires reduces the number of auto accidents and increases vehicle traction, braking and acceleration. In a recent study funded by the Alaska Legislature, entitled "Socio-Economic Effects of Studded Tire Use in Alaska" it was found that:

> [I]t seems that the use of studded tires has an overall positive impact on the Alaskan economy… The savings from avoided crashes are the most substantial impacts and benefit the broadest range of groups including the state government…[1]

Repealing this tire tax will make our roads safer by making it more affordable for working families to be able to purchase these tires. Please join me in supporting this bill.

[1] "Socio-Economic Effects of Studded Tire Use in Alaska", Hannele Zubeck, Ph.D, P.E., et. al., University of Alaska Anchorage, School of Engineering and Eric Larson, UAA, Institute of Socio-Economic Research, April 26, 2004 at xi.

25-LS0355\C
Bullock
1/22/07

CS FOR SENATE BILL NO. 41(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS WIELECHOWSKI, Wilken

A BILL

FOR AN ACT ENTITLED

1 **"An Act repealing fees imposed on the sale of new tires, the sale of certain studded tires,**
2 **and the installation of certain metal studs on tires; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 43.98.025 is repealed.
5 *** Sec. 2.** This Act takes effect July 1, 2007.

New Text Underlined [DELETED TEXT BRACKETED]

SB 41:

An Act Repealing the Fee Imposed on the Sale of Studded Tires

Background

- At the request of then-Governor Murkowski, a new fee of $5 per tire was imposed on the sale of studded tires, starting on July 1, 2004.
- In FY '05, this tax generated $436,440. In FY'06, it generated $446,771.
- The Department of Transportation and Public Facilities (DOT) reports that "a variety of Alaskan and international studies have demonstrated that traction on snow or ice can be improved with studs." Research also confirms that the severity of accidents is reduced by the use of studded tires.
- An average of 87 people die and 453 people suffer incapacitating injuries in Alaska each year in car crashes.
- One study, done in Minnesota after the use of studded tires was banned, showed that crashes on icy roadways more than doubled. (See attached graph.)
- All-season radials polish highway ice, while studded tires roughen the surface and improve traction for all vehicles. A 1996 DOT report notes that, if studs were prohibited in Alaska," a significant increase in accidents can be anticipated."
- While concern has been expressed over the additional wear studded tires can cause to highways, DOT indicates that there are a variety of ways this wear can be minimized.

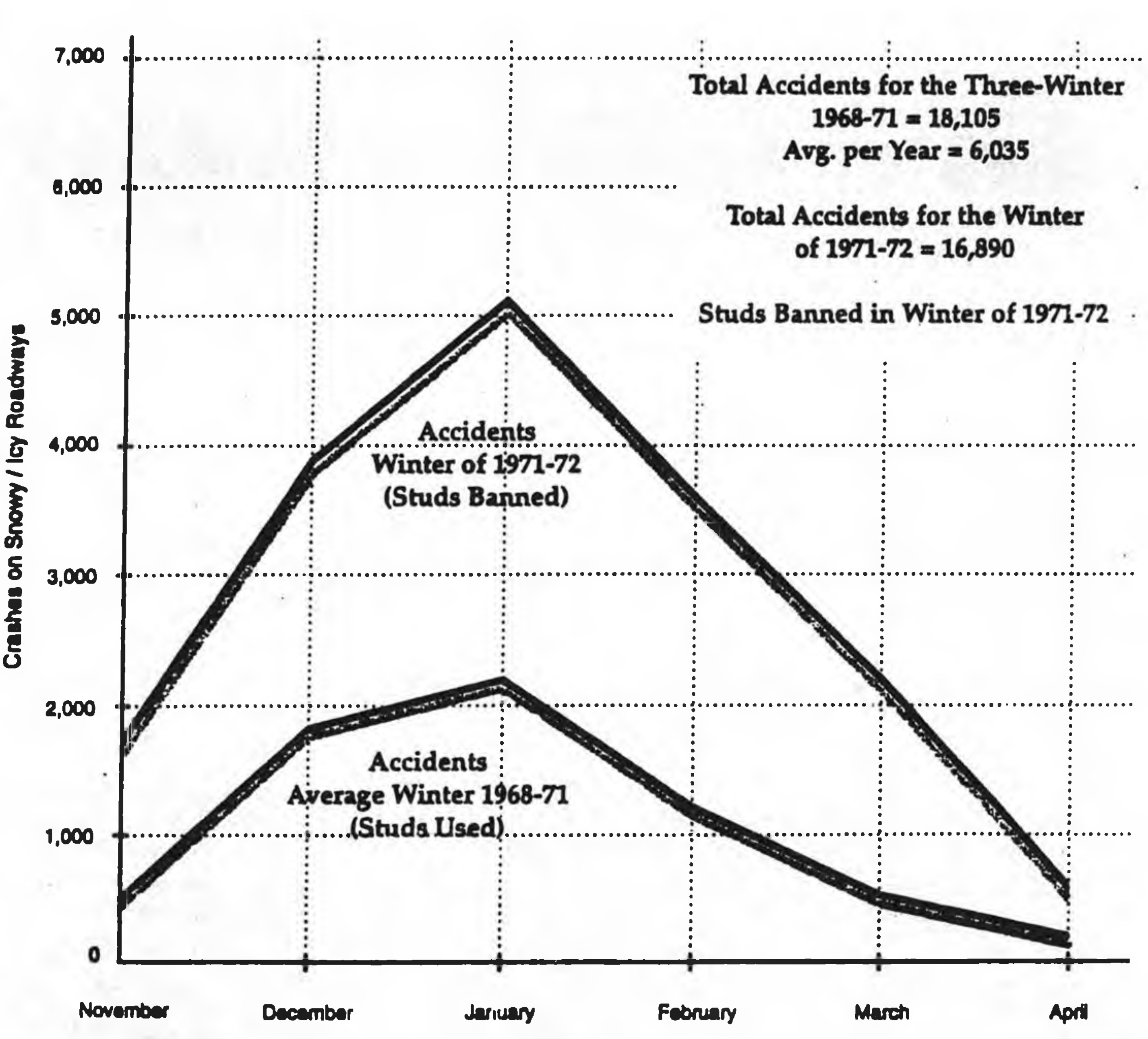
  Work with the public to encourage compliance with seasonal restrictions on the use of studs. According to DOT, 20% of Alaska pavement wear is caused by the 3-6% of vehicles that continue to use studs during the summer.

  Encourage use of lightweight studs, which reduce pavement wear by 50% compared with conventional studs. Lightweight and conventional studs offer virtually identical handling characteristics and stopping distances. In addition, there is no difference in retail cost between them, and both have a service life of 3-4 winters.

  Use wear-resistant Stone Mastic Asphalt with high-quality aggregates to reduce pavement wear an additional 30%.

- A 1996 DOT report states that "the mountainous terrain typical of Juneau and Anchorage provides a strong reason to continue allowing use of studded tires."

Accidents on Snowy/Icy Minnesota Roadways for the Three-Winters of 1968-71 and the Winter of 1971-72



SOCIO-ECONOMIC EFFECTS OF STUDDED TIRE USE IN ALASKA

EXECUTIVE SUMMARY

by

Hannele Zubeck, Ph.D., P.E., Lynn Aleshire, Susan Harvey, and Stan Porhola

University of Alaska Anchorage, School of Engineering
3211 Providence Drive, Anchorage, AK 99508

and

Eric Larson

University of Alaska Anchorage, Institute of Socio-Economic Research
3211 Providence Drive, Anchorage, AK 99508

April 26, 2004

The University of Alaska Anchorage conducted a study on the socio-economic effects of studded tire use on Alaska. The Alaska Legislature funded the study in Spring 2002. The objective was to investigate usage of studded tires, different tire and stud technologies, and effects of stud use on traffic safety, air quality, and pavement wear. The economic impact of these factors in Alaska was evaluated. This paper summarizes the findings of the final report. This executive summary and the entire 157-page final report can be downloaded at http://www.engr.uaa.alaska.edu/transportation/research/.

Technology to Provide Winter Traction: The winter tire technology improves continuously as the manufacturers release their newest tire models. Several tire manufacturers supply both factory-installed studded tires and non-studded winter tires in Northern Europe. A limited number of these are on the market in Alaska. According to the test results studded tires provide on average better traction on ice than non-studded friction tires. On snow or wet pavement there are no significant differences. Alternatives to winter tires, chains and special equipment, are currently not practical for Alaska, where snowy and icy roads occur regularly.

Regulatory Overview: Six states (Colorado, Kentucky, New Hampshire, New Mexico, Vermont, and Wyoming) allow virtually unrestricted use of studded tires on state roads and highways. Thirty-six states (including the District of Columbia) allow studded tires but restrict their use seasonally, geographically, or through equipment specifications. Seven states (Alabama, Florida, Hawaii, Illinois, Louisiana, Mississippi, and Texas) currently prohibit the use of studded tires under any circumstances; however, out of these states only Illinois has significant amount of ice and snow. Several states, including Minnesota and Wisconsin, prohibit studded tires with exceptions. Recent studies in

Finland and Japan found that prohibiting studs produces a net increase in total costs. Pavement repair costs are greatly reduced, but costs of accidents plus the increased requirement of surface applications to improve surface traction (e.g. sand, salt) result in an overall increased financial burden at the state level. These studies have lead to legislation that continues the use of studded tires during winter months, but limits that use to lightweight studs to minimize adverse effects.

Air Pollution Impact: There does not appear to be any human health benefit associated with banning studded tires in urban areas of Alaska. A reduction in roadway particulate levels due to the ban would be offset by increased dust levels due to increases in the volume of winter traction sand.

Traffic Safety: All but one of the studies reviewed concluded that studded tires reduce accident risk. Banning stud usage increases the overall cost despite the savings in road maintenance. The relationship between rutted pavement and summer hydroplaning accidents needs to be researched in Alaska, where the ruts sometimes exceed 25 mm.

Pavement Wear: Studded tires wear pavement surface and cause rutting. Rutting is also caused by plastic deformation due to heavy vehicles. The major part of rutting, however, is due to studded tires in regions where studded tires are used. Finland, Sweden and Norway have conducted a tremendous amount of research on studded tire issues. Each country reports that the significant problem of studded tire related pavement wear has been greatly reduced. They attribute their success mainly to wear resistant pavements, less aggressive studs and strictly enforced seasonal studded tire usage.

Stud Usage: The visual inspection and vehicle counting method was used to determine the stud usage rate in this study. Parked vehicles were visually inspected and counted in parking garages and in parking lots across Anchorage. In all, 2174 vehicles were surveyed, 214 in December, 550 in January, 950 in February, 240 in March and 220 in April. Several conclusions were made from the gathered data: Stud usage rates in Anchorage have remained about the same from February 1990 to February 2003. Usage rates for passenger cars, SUV's, trucks and vans are 59, 43, 40 and 60%, respectively. Based on the data from December 2002 to April 2003, the highest rate for studded tire usage was for January. Lightweight studs have been available for Anchorage since 1995. Twenty-night percent (29%) of studded tires have lightweight studs. Almost every vehicle with studs has them on all four tires.

Economic Impact: An effort was made to analyze the economic impact of studded tires in Alaska. With the information available and the assumptions stated in the report, it seems that the use of studded tires has an overall positive impact on Alaskan economy. Tire tax money moves from the hands of vehicle owners to the state government. The state government spends the money in another part of the Alaska economy. Therefore, the money moves from one part of the economy to another and the overall net economic impact on Alaska from the tire tax is small. The savings from avoided crashes are the most substantial impacts and benefit the broadest range of groups including the state government, vehicle owners, passengers, and insurance companies (and their policy

holders). The quality of life benefits of avoided crashes benefit mostly passengers and drivers of vehicles.

Recommendations: On the basis of this study, the following recommendations for Alaska are given for implementation:

- continue to study, test and apply wear-resistant asphalt mixtures, which have been proven to reduce the amount of rutting by studded tires.
- consider mandating the use of lightweight studs in the studded tires. which have been proven to reduce the amount of rutting by studded tires.
- develop a comprehensive winter road maintenance policy that would consider traffic safety, pavement wear and the health and environmental effect of winter traction sand and anti-icing agents.
- continue the enforcement of the seasonal restrictions on studded tire usage.
- consider reducing the winter speed limits on high trafficked urban highways.
- consider the pavement wear by studded tires in the geometric design of its roads and streets.

Further research is needed to

- determine the extent to which rutting contributes to summertime accidents.
- determine how much improved pavement materials and mix designs would reduce pavement wear in Alaska.
- determine how much would reduced winter speeds in urban areas reduce accidents and pavement wear.
- enforce criteria for acceptable rut depth triggering maintenance operations taking into considerations reduced accident rate.
- determine how much road wear is actually attributed "solely" to studded tire use, and how much road wear is attributed to heavy vehicle loads and non-studded tires.
- determine the winter traction of studded tires, friction tires and all-season tires with tire life (e.g. km/tire).
- directly compare site-specifically in Alaska's urban area the human health trade-off of increased respiratory risk of studded tire dust, versus the human health risk associated with a studded tire ban or decreased studded tire use. Additional research is necessary to speciate roadway dust samples and evaluate chemicals of concern to human health
- determine actual economic costs of owning and using studded tires more accurately using data from collected tire tax revenue.

Download the entire final report at:
http://www.engr.uaa.alaska.edu/transportation/research/.

Fax Cover Sheet

Anchorage Legislative Information Office
Office - (907) 269-0111 Fax - (907) 269-0229

To: Sen. Ellis (SLAC) **Fax:** 465-2529 **Phone:**

From: Anchorage LIO

Instructions: in reference to SB 39 & SB 41

Date: 01/25/07 **Time:** 2:25 PM

Number of Pages: 2 **(including cover sheet)**

January 25, 2007

Good Afternoon, my name is Greg Wuitschick and I own Alaska Tire World, I have been asked to speak today about SB39 and SB41. First I'm going to talk about SB39, business licenses going back to normal pricing.

Why should the SOA punish business owners by increased business license fees? When small business overhead goes up, so does the price of goods and services. Ultimately, the Alaskan consumer pays more. Why are we making life harder for Alaskan citizens? I urge you to change it back to where it was before and support SB39.

Now I would like to talk about SB41. Which I believe I believe has two parts. First, studded tire tax and second, what I call a point of sale tire tax.

Why does SOA need to tax the safety of our families during our winter months? Studded tires are designed for added traction for winter driving and when used properly, add safety to everyone on the road. We can use all the help we can get when it comes to driving on snow and ice, which we all know it can be very hazardous in our state. How can we tax safety? The $440,000.00 we raised by the tax seems like a small amount considering the training curve and frustration it takes to use the SOA's pers payment system. The SOA was minimal help when it came to filing the tire tax. A percentage of my customers could not afford the added tire tax, so their safety and the safety of their family is compromised by financial restraints that was imposed by SOA.

Next, I would like talk about what I call a point of sale tire tax. Why are we taxing ourselves more for tires? With the rising cost of energy prices and other soaring prices, it seems absurd to drive our Alaskan goods and services up in cost. Please support SB41. Thank you!

SB

59

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/07

FURTHER:

Date of 5-Day Notice: 2/1/07
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/8/07

Labor and Commerce Committee considered SENATE BILL NO. 59

SB 59 BROADCASTING PROMOTING CHARITABLE GAMING

"An Act relating to the use of broadcasting to promote charitable raffles and lotteries."

and recommends:

[ ] be replaced with [ ] SCS or [ ] CS ____________ (______)

[ ] adopt previous [ ] SCS or [ ] CS ____________ (______)

[ ] attached amendment(s)

[ ] adopt ____________ Letter of Intent

[ ] further referral to ____________ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Revenue	2/9/07			✓	

PREVIOUS FISCAL NOTE(S):

					FN#

[ ] **APPROPRIATION - no fiscal note**

[illegible]		✓			
[illegible]	Davis	✓			
[illegible]	Stevens	✓			
[illegible]		—			
CHAIR: [illegible]	Ellis	✓			