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Nurses and Health Care Insurance in Western Pennsylvania: A Qualitative Study of the Personal and Professional Effects of the Absence of Health Care Insurance

Diana L. Rupert
Indiana University of Pennsylvania

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NURSES AND HEALTH CARE INSURANCE IN WESTERN PENNSYLVANIA: A
QUALITATIVE STUDY OF THE PERSONAL AND PROFESSIONAL EFFECTS OF
THE ABSENCE OF HEALTH CARE INSURANCE

A Dissertation

Submitted to the School of Graduate Studies and Research

In Partial Fulfillment of the

Requirements for the Degree

Doctor of Philosophy

Diana L. Rupert

Indiana University of Pennsylvania

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Indiana University of Pennsylvania
The School of Graduate Studies and Research
Department of Sociology

We hereby approve the dissertation of

Diana L. Rupert

Candidate for the degree of Doctor of Philosophy

Mary Jane Kuffner Hirt, Ph.D.
Professor of Political Science, Advisor

David Chambers, Ph.D.
Professor of Political Science

Susan J. Martin, Ph.D.
Professor of Political Science

ACCEPTED

Timothy P. Mack, Ph.D.
Dean
The School of Graduate Studies and
Research

Title: Nurses and Health Care Insurance in Western Pennsylvania: A Qualitative Study of the Personal and Professional Effects of the Absence of Health Care Insurance

Author: Diana L. Rupert

Dissertation Chair: Dr. Mary Jane Kuffner Hirt

Dissertation Committee Members: Dr. David Chambers
Dr. Susan J. Martin

Forty-six million people in the United States have an absence of health care insurance coverage (U.S. Census Bureau, 2008). A segment of that population is nurses, employed at various points on the nursing career ladder, their spouses, and their dependent children. This qualitative study explores the perceptions of uninsured nurses at various points on the nursing career ladder and relates their phenomenological perspective. The study compares nurses struggling with health care insurance with the uninsured general population. Finally, nurses are asked to assess various political options and select that which would best fit their circumstance.

Nurses have similar feelings of struggling physically and psychologically with the absence of health care insurance coverage. Nurses report the lack is disheartening, embarrassing, and a worry affecting health care decisions and lifestyle choices. Nurses sacrifice their health or that of their loved ones using practices of splitting medications, forgoing annual check-ups, delaying diagnostic testing, and waiting for medical consultation until a condition is exacerbated, realizing that this is a gamble. Nurses do use their knowledge of disease processes and pharmacology to self-diagnose, self-medicate, and use their relationship with physicians to request medical treatment. Nurses

believe all should have basic health care coverage. Pay to play or employer sponsored insurance is the most selected policy option, depending upon the cost.

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This dissertation is dedicated to my parents, Donald and Dorothy Hill, whose faith in me throughout my life has given me the confidence to accomplish all that I have.

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CHAPTER 1

INTRODUCTION

It was a typical summer day. Patrick left for the baseball field to watch a friend play. Little did I know that the events of that day would stir a passion and outrage in me that has lasted over 10 years. I was finishing my master's degree in nursing education and my husband worked for a small business. Patrick would sustain a moderate concussion from a blow to the temple before returning home and exhibit signs of a stroke. Usual protocol would be to immediately take the seven year old to the emergency room for a CT scan, checking for bleeding on the brain. I, being a nurse, kept Patrick home utilizing my skills to closely assess and monitor him. Many called to check on his status and asked why he was not taken to the emergency room. It was at that time I had to explain that, due to a one time emergency room visit classified as a preexisting condition of "asthma." Patrick was denied affordable health care coverage.

My family had always been covered under a comprehensive health insurance plan. Initially, my husband carried the health care insurance and then, once I became a registered nurse in June 1990, I carried the health care insurance coverage. Unfortunately, I was laid off from a nursing instructor's position in 1999 where I carried the health care benefits. The COBRA policy cost almost \$800 per month which I initially paid. I also worked in a casual position at the local home health agency, but its cost for insurance was over \$800 for health care coverage only. We found family health care coverage privately only to learn that Patrick would have to be placed separately on an unaffordable policy. The difficult decision was made to carry the health care insurance

on everyone, except Patrick, as I would be gaining family coverage via full-time employment soon.

Since that experience, health care benefits for me have been a crucial factor in deciding my place of employment. To me, the cost and quality of health care benefits are more important than salary. It is a common perception to think that all who work in health care have excellent health care benefits and that benefits are extended to all family members. One would assume that the nurse taking care of a patient would also have the same, if not better, health care coverage. Unfortunately, this is a misconception. The health care industry is a business which must control costs to maintain a positive bottom line. Reimbursements have not kept up with costs and inflation especially in government programs (Medicare and Medicaid). Health care facilities must manage the escalating costs of providing health care coverage to employees, thus, health care coverage limitations and cost sharing is an economic reality, shuffling any increased cost to the employee. It is at that time employees decide if they are able to afford the rising costs. The employees decide if it is in their best interest to absorb the increased cost of health care coverage, change jobs to another with better salary and benefits, or leave the nursing profession entirely (Farrell & Dawson, 2007).

Focus of Inquiry

The United States has 46 million citizens without health care insurance (U.S. Census Bureau, 2008). Nurses are a unique segment of that population. Nurses are vital members of the health care team at a time in history when there are more individuals requiring care and fewer nurses. The nursing profession has a documented nursing shortage caused by

recruitment and retention issues (Hassmiller & Cozine, 2006). Issues of an aging nursing workforce, fewer nurses entering the profession, and high turnover in all areas of the nursing career ladder have made the nursing shortage a topic on the national agenda. One area where nurses, in general, have expressed dissatisfaction is the provision of health care insurance for themselves and their families (Farrell & Dawson, 2007).

A nursing career ladder delineates different job descriptions, education, pay/compensation packages and employment opportunities (See Table 1). The nursing career ladder begins with the certified nurse aide (CNA), then the practical nurse (PN), then the registered nurse (RN), then the Bachelor's degree in nursing (BSN), and then advanced practice degrees including master's degree in nursing specialties (MSN).



Figure 1. Nursing career ladder. Figure obtained from Google images at www.googleimages.com

Nurse Aide/Certified Nurse Aide/Direct Care Worker

Nursing has a career ladder starting with the direct care worker (DCW) or more commonly called nurse aide (NA). Nurse aides have a minimum of 75 hours but an average of 120 hours of training and most pass a state certified exam, making them a certified nurse aide (CNA). Nurse aides work throughout the health care system but more often are found working with the elderly population in long term care and home health agencies where there is greatest need for assistance with personal care. Nurse aides have a physically demanding job as they assist their patients with activities of daily living. Two in five CNAs lack health insurance (Health Care for Health Care Workers, 2007). In Pennsylvania, this translates into approximately 50,000 CNA's (Lawless, 2007).

Nurse aides/direct care workers with a starting salary of \$8/hour and an average salary of approximately \$10 an hour are unable to meet the health care coverage financial demands (Paraprofessional Health Care Institute, 2006). The average annual salary of a full-time nurse aide/direct care worker is \$20,800. Low pay and lack of affordable health care insurance benefits mean that many leave nursing for better paying non-nursing jobs with benefits. Furthermore, more than 60% of caregivers (30,000 employees) are employed part-time, and therefore not eligible for insurance coverage associated with full time employment. In addition, 80% to 90% (40,000-45,000) of CNAs are women (Harris-Kojetin, Lipson, Fielding, Kiefer, & Stone, 2004).

Licensed Practical Nurse

A licensed practical nurse (LPN) has a one year, post secondary education with successful state board exam licensure. The LPN is commonly called the bedside nurse as typical job responsibilities include medication administration, wound care, and various nursing skills such as enemas, foley catheter placement or tracheotomy care. The LPN earns \$13-\$16 an hour (\$27,000-\$33,000 annually) working primarily in long term care, assistive living facilities, home health, doctors' offices, and less frequently, in the acute care setting. The accessibility and affordability of health care coverage typically depends on the LPN's employment setting (hospital, long term care, personal care home, physician office) and classification (public, private, or nonprofit) and the employment status (full-time, part-time, or temporary, per diem).

Registered Nurse

The RN is the manager in charge of the delivery and delegation of nursing care. The RN has a two year associate degree, hospital based diploma, or four year bachelors degree and successfully completed the state board licensure exam. Job responsibilities depend on the position but typically include assessment of the patient, planning of nursing care, implementing physician/nursing orders, and evaluation of care. The registered nurse earns a starting salary of \$20/hour and an average salary \$24 an hour (\$50,000 annually) (www.payscale.com obtained on March 1, 2010). The registered nurse is uniquely qualified to care for a patient with multiple organ compromise or the management of nursing units.

RNs are found in all health care settings but acute care settings are the primary employment site. More RNs are employed in the acute care setting where benefits are

typically offered with an employment package. Spetz and Adams (2006) state that registered nurses are more likely to accept an employer's health care plan, if offered, as 69% enrolled as compared to 55% of other health care workers. In 2003, approximately 5% percent of all RNs were uninsured (Spetz & Adams, 2006). RNs command higher salaries making it less difficult to bear copayments, deductibles, and premium sharing that may be a requirement of health care coverage. Reimbursement of facilities for patient care is at a higher level in the acute care setting from the government and private insurers giving more money to be allowed for salary and benefits (Kovner & Harrington, 2002).

Nurses who are uninsured are forced to exist in competing paradigms of providing care to those with health care insurance while being employed by organizations that do not provide coverage as an affordable benefit. In recognizing this unique population of nurses who truly understand the crucial need for maintaining health care coverage, could health care coverage be a pivotal factor in increasing health care worker satisfaction which in turn would reduce frequent turnover and increase recruitment (Health Care for Health Care Workers, 2007)? Langan, Tadych, and Kao (2007) asked inactive RNs what motivational factors would attract them to return to working. Results indicated that more money, improved working conditions, employer paid refresher courses, and health insurance would motivate them to return to practice. Fraleigh (2009) reported in an RN Magazine 2009 Nurse Benefits Survey also reported that of the 24 dimensions that play a role in job satisfaction, 60% of the workers surveyed assigned benefits the highest rating of very important. Resolving the issue of health care coverage then would ultimately help to resolve the bigger issue of the nursing shortage.

Table 1

Comparison of Nursing Career Ladder, Educational Level, Starting Salary,

Median Salary and Employment Area

Nursing career ladder	Educational level	Starting salary-Regional	Median salary-National	Employment areas
Nurse aide (NA) or Certified nurse aide (CNA) or Direct Care Worker (DCW)	120 hour class and completion of a written and clinical exam. Educated in community programs, at hospitals or at Vocational-Technical Schools	\$8/hour \$16,640 annually	\$11.46/hour \$23,837 annually	Long term care, assistive living, home health, hospitals
Licensed practical nurse (LPN)	1 year full-time program and completion of licensure exam Educated primarily in Vocational-Technical Schools and community colleges	\$13/hour \$27,040 annually	\$17.82/hour \$37,066 annually	Long term care, assistive living, home health, doctors offices, hospitals
Registered nurse (RN)	2-4 year nursing diploma/degree and completion of licensure exam Educated at hospitals in hospital based diploma schools of nursing, community colleges for 2 year associate's degree and university settings for the 4 year bachelor's degrees	\$20/hour \$41,600 annually	\$27.20/hour \$56,576 annually	Hospitals, long term care, home health, doctor's offices

Note. Starting salary based on regional data. Median salary based on Bureau of Labor Statistics.

The various roles represented by the nursing career ladder are crucial to meet the needs of the most vulnerable citizens. In the general population, having the ability to pay for health care means very little if there are not enough trained professionals to provide care in the time of need. Recognizing the concerns of the nursing profession, health care workers and meeting their needs may allow the health care workers to better meet the needs of others. While issues of the uninsured such as repercussions from delaying needed care and medical bill debt have been well documented with supporting research analysis, little attention in the current debate has been paid to the nationally proposed policy options for health insurance, and how these policy options might impact the various levels of nurses working in health care. Utilizing the nursing career ladder is an opportunity to explore how nurses at various points on the ladder experience a lack of health insurance, and how they perceive various policy options that may meet their needs.

Statement of Purpose

The purpose of this research study was to determine the effects of not having health insurance on nurses currently employed at various points on the nursing career ladder, their spouses, or dependent children. The research questions included:

1. What are the experiences of health care workers, who are employed along various points of the nursing career ladder, in relation to health insurance?
2. Which policy options do the uninsured health care workers identify as being most helpful in meeting the needs to obtain health care insurance?
3. To what extent does employer provided health care insurance play a role in determining nurses career decisions?

4. What differences, if any, are there between uninsured nurses and the general population?

The specific objectives of this study were to: (a) assess the factors that contribute to the nurse's lack of health care coverage; (b) understand the nurse's perspectives and the challenges caused by the absence of health care coverage; (c) consider to what extent employer provided health care insurance plays in their decisions regarding employment; and, (d) examine how various policy options may address nurses' needs for health care coverage.

Potential benefits of the study include: (a) providing an insight into the life and experiences of nurses as workers who must deal with maintaining health care coverage; (b) identifying a way to reduce the number of nurses who do not have health care coverage; (c) identifying ways of recruiting and retaining nurses, particularly LPN and CNA positions where the problem is most prevalent.

Operational Definitions

Defined contribution. Where an employer establishes a standard monetary amount available to employees for health care coverage and allows the employees to make choices among various health insurance designs with any overages coming from the employee's pocket (Nolin & Killackey, 2002).

Employer sponsored health insurance with an employee premium share.

Employers provide and maintain group health insurance for their employees with a set division of costs between employer and employee.

Fair share or pay to play. States use their taxing authority to encourage employers to provide health insurance to their workers. If the employers do not provide

health insurance coverage, the employees are placed in a state insurance group and the employers will be charged a fee for the coverage.

Health tax credit. Families/individuals are permitted to deduct a predetermined dollar value from their federal income tax liability and then use the money to purchase health care coverage.

Health savings account. Employer held accounts where employees contribute pre-tax dollars to spend on health care costs. Typically, a companion to high deductible insurance plans to obtain lower monthly premiums (Sinnott, 2004).

High deductible health plans. Plans which require a minimum deductible of \$1,100 for single coverage and \$2,200 for family coverage (U.S. Office of Personnel Management, 2007).

Job satisfaction. The individual's perceived attitude and level of happiness of an individual with his/her job.

Licensed practical nurse (LPN). Typically called the bedside nurse, the licensed practical nurse has one year post-secondary training in many of the technical skills of nursing and is licensed a practitioner. The LPN must follow the scope of practice for practical nursing in the state of their licensure. An LPN typically works in long term care, a physician's office, an insurance company, or a community hospital.

Nurse aide or certified nurse aide (CNA) or direct care worker. Nurse aides are at least 16 years of age and assist the nurse in providing personal care to the patient. A certified nurse aide has completed a 120 hour program and has been tested (both written exam and technical skill or competency exam) by a state approved examiner. A nurse

aide works in a variety of settings such as acute care, long term care, home health, or personal care /assisted living facilities.

Nursing shortage. An overarching imbalance of supply and demand attributed to demographics, qualifications, availability, and willingness to do work (Kimball & O'Neil, 2002). In the July/August 2009 *Health Affairs*, Dr. Peter Buerhaus and his coauthors found that despite the current easing of the nursing shortage due to the recession, the U.S. nursing shortage is projected to grow to 260,000 registered nurses by 2025. The LPN shortage for 2010 is expected to be twice as high as predicted and expected to grow through 2016 by 1500 jobs (Pennsylvania Center for Workforce Development, 2009).

Registered nurse. A registered nurse is a licensed health care professional who works in conjunction with the physician to deliver health care services which meet the patient's needs. The registered nurse assesses patient systems, plans, implements, and evaluates care. Registered nurses must follow the scope of practice for registered nursing in the state of their licensure. A registered nurse may work in any health care facility, but typically works in acute care settings, doctors' offices, home health, or long term care.

Recruitment. The process of identifying and hiring the best qualified candidate for a job vacancy in the most timely and cost efficient manner.

Retention. The extent to which nurses remain in their present employment positions (Ellenbecker, 2004)

Small employer. An entity with fewer than 200 full-time workers on the regular payroll. The population was chosen because firms employing less than 200 workers are less likely to offer health insurance than larger employers, the proportion of firms of this

size offering health benefit plans has declined in past years (Kaiser Family Foundation, 2007), and firms of this size employ approximately half of the workers in the United States (Helfand, Sadeghi, & Talan, 2007).

Underinsured. Individuals who have health insurance plans but whose medical expenses (excluding premiums) amount to 10% or more of their post-tax income, or 5% or more of their income if that income is below 200% of the federal poverty level (Agency for Health Care Research and Quality, 2009).

Uninsured. Having no health care coverage due to the coverage being not accessible or not affordable.

Universal coverage. Medical insurance that all citizens of a state/country have. The government functions as the nation's insurer and provides taxpayer sponsored medical coverage.

Timelines outlining the historical events of nursing, the evolution of health care insurance, and development of our public policies will be presented in the literature review. Interestingly, all three timelines have intersected within the past 100 years as health care has rapidly made life saving advances, reimbursements for health care services have dramatically increased, and nursing has grown in task and function. Currently, the future is uncertain as health care reform has the potential to change the landscape of the delivery of care and the reimbursement of services. How each American will fit into the new system will soon to be defined.

In conclusion, I have personal experience of having a son that did not have health insurance coverage when in need and this motivates me to discover the experience of others. My experience has changed my perception of nursing and the health care system. The

purpose of this research study was to determine the effects of not having health insurance on nurses currently employed at various points on the nursing career ladder, their spouses, or dependent children.

CHAPTER 2

LITERATURE REVIEW

The inimitable circumstance experienced by nurses providing care to others, and yet not being able to access that care in their own time of need must be understood in order to fully appreciate the environment in which they work. Nurses provide care to patients of all ages, socioeconomic backgrounds, ethnicities, gender, and ability to pay. Nurses also provide care in a variety of health care settings providing various opportunities for work. Nurses, through their work, realize the importance of health care coverage and the uncertainty of any one person's health status at a given time.

History of Health Care, Nursing, and Health Care Insurance

Health insurance has continuously been a topic on the national agenda since the 1940s (Transcript from the PBS Special: Health Care Crisis, November, 2000). With the current life expectancy at 77.8 years (National Center on Health Care Statistics, 2007) and chronic illness management, disease specific medications and advances in medical procedures, individuals require consistent health insurance to afford current treatment. All of the advancements in the modern world can significantly affect one's health, if one has access to it.

The absence of universal health care coverage in the United States has forced many working Americans, who are unable to shoulder the expense of private insurance, to join the 46 million uninsured Americans (U.S. Census Bureau, August 2008). Furthermore, recent research by the Kaiser Family Foundation (2007) noted that the uninsured are predominantly low income working families where nearly two-thirds

(64%) have incomes below 200% of the poverty level (or less than \$30,000 per year for a family of three in 2002). Many, nationally and internationally, question why the United States is the only industrialized country that does not provide health care coverage for its citizens (Vladeck, 2003). Bodenheimer and Grumbach (1998) believe health care coverage, whether public or private, is the key factor in making health care accessible. Policy makers and citizens find it difficult to think that policies can be written to cover the health care needs of a diverse population. The answer to the question of policy formation and equity may lie in the history of the formation of our health care practices and policies dating back to America's "founding fathers."

Health Care of the 17th and 18th Century

Even though the American Indians had ritual health care practices prior to the colonists' arrival, documented health care began in America with the first settlers. Colonists endured a long arduous journey to the new world in unsanitary conditions which lead to such diseases as typhus and scurvy. During the initial stages of the settlement and within certain regions, the rise in the death rates was phenomenal. Mechanic (1983) contends although the first settlers were somewhat immune to certain diseases that decimated the Indians in North America, the settlers did not escape unscathed. Families, usually the women of the family, cared for family members throughout their disease process which many times resulted in the demise. Golenski (1991) noted that there was a paternalistic view in the colonies as the men decided the best interests of the family and the women completed the tasks that were set before them. Within these tasks were health care responsibilities. If no family was available to care for

the needs of the infirmed, a kind individual, a church member, or the authorities of the town may have cared for the individual (Tice & Perkins, 2002). Limited medical professionals were found in the early colonial days. The average rate of population growth was 3% and if a male survived to the age of 21, the life expectancy was in the 60s (Mechanic, 1983).

The American population grew quickly, even more quickly than the population in Europe. Interestingly, mortality rates in children were low compared to their counterparts in Europe where half of all children died before reaching their 21st birthday (Mechanic, 1983). In Andover and Plymouth, 9 out of 10 children born before 1700 survived to the age of 20 (Mechanic, 1983). Age specific life expectancy of adults in Andover and Plymouth were not dissimilar from rates in modern day America. Epidemics and the spread of disease were limited as colonists kept to themselves. The longevity and general healthy life in 18th Century America allowed health care to be provided by families with limited medical intervention (Mechanic, 1983).

Local governments maintained and oversaw the health status of their citizens. Many miles could exist between the doctor and patient. Access to doctors included the doctor traveling to the patient's home or the patient being brought to the doctor's office. Patients and families often waited too long to seek medical attention creating serious consequences. Hospitals were few and health insurance was nonexistent. Benjamin Franklin, the founder of the Pennsylvania Hospital in Philadelphia in 1792, called hospitals "the sinks of human life" as hospitals were places for the homeless poor and insane to die (Rhodes, 1992). Doctors made visits to homes of the infirmed and were

paid according to mutual agreement. Payments consisted of bartering work around the doctor's house, livestock, food, or money.

The ideology of paying one's debts came from a deeply rooted Protestant work ethic. Individuals placed value on supporting oneself and family. This work ethic is stated as laissez-faire socially, meaning social support of the needy was not within community policy. The notion that hard work could make one successful and thus government support is not necessary was pervasive (Biar, 2007). Many of the ideas for health care were influenced by the home mother country of England, Spain, or France (Mechanic, 1983).

At the end of the century, in 1798, Congress created the Marine Hospital Service to provide for sick and disabled seaman. It is the first prepaid medical care program in the United States and is financed with a compulsory employer tax. The marine hospital was located at Castle Island in Boston Harbor.

Health Care of the 19th Century

Nursing in the early 1800s was considered undesirable for respectable women. Early signs of a nursing profession began as those with financial means could employ women from the ranks of the poor to do the job of caring for the wealthy sick (Mechanic, 1983). Some caretakers were even conscripted from penitentiaries and almshouses. The early 1800s were considered a dark period of nursing where nursing conditions were at their worst and the public perception of nursing was at its lowest.

The work of Florence Nightingale, a brilliant, visionary nurse significantly changed the perception by the mid-1800s (Kalich & Kalich, 2004). Florence

Nightingale, known as the lady with a lamp, cared for injured soldiers during the Crimean War, where nurses ultimately reduced the death rate by 70%. She was an author, theorist, and statistician who changed the thought and method of nursing care. Nightingale established the first formal schools of nursing, including the first three hospital schools in the United States. She established the basis for the first home nursing service. As a result of the advancement within nursing, the establishment of organized nurse training schools and the contribution of the religious orders, nursing created an image in the later half of the 1800s of women who were conservative, loyal, docile, submissive, and dedicated to service above personal needs and/or desires (Judd, Sitzman, & Davis, 2010). In 1862, the New England Hospital for Women and Children opened its own nurse training program, and in 1868 the American Medical Association (AMA) advocated for the training of nurses (Donahue, 1996). A pride in nursing was established as a new public image arose leading nursing to a middle-class realm of respectability (Judd, Sitzman, & Davis, 2010).

Health and health care changed during the 1800s. As the colonies developed economically, there was a rise in population with urban ports giving access to people from distant lands. Specifically, millions of immigrants from Europe and the Mediterranean entered through Ellis Island and other ports along the East Coast. Individuals from Japan and China entered through the Pacific coast at San Francisco. The commercial contacts spread infectious diseases throughout the colonies, and a growing population provided a pool of susceptible persons to sustain the infectious pathogens. This brought periodic epidemics that in Europe caused high mortality rates especially among the young (Mechanic, 1983). Population growth and foreign trade

undoubtedly increased conditions conducive to the spread of epidemic diseases.

Smallpox, measles, and diphtheria were noted in localized areas throughout the colonies with the effects of the epidemic deadly for largely the young (Popenoe, 1995). The colonies learned of isolation and infection control.

Health Care in the Middle 19th Century

Medical knowledge expanded when the complexity of the relationship between disease and the environment was exposed during the malaria outbreak in the Upper Mississippi Valley (Mechanic, 1983). It was noted that dark, warm conditions in the South harbored mosquitoes that spread the disease. Health care professionals, mostly doctors, at that time correlated problems with drainage and sanitation as factors in the spread of the disease. As those within the Mississippi Valley contended with malaria, cholera erupted in New York City. During the epidemic of 1866, New York City established a metropolitan Board of Health whose interventions helped to contain the disease. Local and state governments were formed with expanded duties including maintaining health of their people. This was very difficult as immigrants were flooding into the United States and brought various diseases from their journeys. Poor and crowded living conditions also spread disease and death (Tice & Perkins, 2002). Elderly, sick, blind, mentally and physically handicapped, widowed, and children were all housed together in barely sanitary conditions (Tice & Perkins, 2002). Limited government support was supplied. Yellow fever and tuberculosis also brought illness and death to the region. Many communities adopted legislation providing for quarantines during epidemics and regulated occupations that allegedly posed a threat to health.

Health Care in the Late 19th Century

Families remained as caregivers of the infirmed which increased the number of family members contracting the illness. Several children in families would be affected by the same disease process. Frequent death affected child rearing. Parents were more aloof from their children, anticipating childhood death and resigned themselves to it.

A few more nursing schools were established across the country, the Army and Navy Nursing Corps was founded, and the first American Journal of Nursing was published all increasing respectability. Discussion focused on training needs and was mainly dictated by physicians. Since nursing services were becoming more diverse, there arose a need to educate nurses in a variety of settings. Nurses, mostly female, provided personal care as was ordered by the male physician continuing the paternalistic ideology. A physician's practice depended upon private paying patients and/or services that could repay them for their service. The physicians had the power to decide if care would be provided.

Health Care from 1900-1950

By the 1900s, the American Medical Association (AMA) became one of the most powerful groups in the country. Membership increased from approximately 8,000 physicians in 1900 to 70,000 in 1910 (Transcript from PBS documentary: Health Care Crisis: November, 2000). Doctors were no longer expected to provide care without financial reimbursement. During the early 1920s, hospitals were being built and costs began to rise, particularly those for extended stays. By 1929, illnesses requiring hospitalization accounted for 50% of all medical expenditures (Ginter, Swayne, &

Duncan, 2002). Due to changes in population and industry, however, hospitals became central to medical practice and education between 1870 and 1910 (Rhodes, 1992). This transformation is attributed to the demands of the industrializing capitalist society which brought large numbers of people into the urban setting and away from the rural areas where people practiced “self-sufficiency” in caring for the sick (Rhodes, 1992). Within hospitals, individuals found specialized care and technical competence that was not available to the family doctor practicing in the patient’s home. Specialization also meant division of labor, and nursing during this period became a trained profession.

Debate about health care insurance increased but was often dismissed by the AMA. Just before 1900, the Pacific Railroad was the first company to consider the health care of their employees. Progressive health care reformers spoke of the need for health care coverage. In 1920, General Motors signed a contract with Metropolitan Life to insure 180,000 workers. These efforts were seen as “radical” and there was no strong effort to change health insurance. Unfortunately the attempt was stalled for lack of popular support, and the final proposal was eventually opposed not only by business and the AMA, but by Samuel Gompers, the president of the American Federation of Labor. The great labor leader saw the proposal as a threat to the developing notion of union sponsored insurance programs, which was intended to build union membership (Merrill, 1994).

In response to the need for health care, health care emerged to be more formal and organized. America’s hospitals have grown as modern scientific institutions valuing antiseptics and cleanliness and using medications for the relief of pain. Higher education for nurses in a university setting was established in 1909. Nurses continued to be the

hand maiden of the doctor but maintained total care of the patient when hospitalized.

When World War I began in 1914, nursing answered the call to the battlefield.

Approximately 23,000 nurses were appointed to serve during World War I in both the Army and Navy Corps, with nearly 10,000 serving overseas. Several nurses received distinguished honors for their courage, valor, and noncombat service (Judd, Sitzman, & Davis, 2010).

Communities played a large role in the structure of health care organizations (Janeway, 1995). By the mid-20th century, there was a great awakening where private charitable institutions began to establish specialized institutions for children, invalids, mentally ill, and the elderly to move them from wretched living conditions. Because certain types of needy had become too costly for the local government, state governments established insane asylums and jails (Tice & Perkins, 2002). Organizations were often created in response to a crisis in the community. The missions of many developing hospitals were often influenced or structured around the community. Because most hospitals were reflections of their communities, the values and ideals set forth by the mission of the hospital were brought forth by the leaders in the community (Mechanic, 1983). As leaders in the community, these individuals, almost entirely male, held the power to decide the policies of health care within their community. Health care organizations were based on the premise of “not for profit” as reducing human suffering and caring for the infirmed were considered to be part of the community caring for its own (Mechanic, 1983). While physicians were paid a good salary in an occupation that held prestige and influence, nurses, entirely women or others in the religious order, were paid a meager salary and had limited influence in promoting and defining health care. By

the 1920s the hard core of today's health industry--physicians, hospitals, medical education, state licensing, and some early medical research successes--was pretty much in place (Califano, 1986). Califano asserts that what was needed was a money tree, a system to finance the business of medicine and health care.

President Theodore Roosevelt in 1912 was the first president to call for national health insurance at the Bull Moose Party convention. He felt that there should be a minimum level of coverage for every American. Later, President Franklin Roosevelt advanced sweeping reforms known as the New Deal to create jobs and to provide direct public assistance. Roosevelt actions recognized the plight of the elderly, the low paid worker with family responsibilities and the ill which stimulated him to call for federal government action (Merrill, 1994). He did so at a time when Americans were desperate for assistance to survive and health care on the job was a life or death concern for American workers and their unions. Industrial accidents and deaths on the job were at epidemic levels at the beginning of the 20th Century (Starr, 1982). There was no health insurance and injured workers and their families were often left destitute. Leaders at this time worked with unions and public health advocates to formulate a new, state-based approach which became worker's compensation (Propenoe, 1995). This first attempt at health insurance guaranteed immediate, no fault health care and income support to injured workers. All states eventually enacted laws requiring businesses to purchase worker's compensation insurance coverage for their employees. This marked the earliest American health insurance for injuries on the job.

The Great Depression of 1929 became the "grim reaper" of private fortunes and plunged the poor into even deeper greater depths (Harris & Maloney, 1999; Mason,

Talbott, & Leavitt, 2007). The relationship between the environment and human problems including illness could not have been more clear. People went to hospitals only in dire emergencies as they could not pay their hospital bills. Existing government agencies and private charities were vastly inadequate to meet the need. Individuals who held the ideology that human illness and misfortune stemmed from human inadequacy were forced to reexamine their philosophy. Spurred by the ravages of the depression, potential patients and hospital administrators began to look for some way to pay and be paid. Prior to the 1930s, there was virtually no health insurance in the United States. A direct fee system, a medical care system in which patients pay directly for the services of doctors and hospitals, was present (Macionis, 2006). All citizens were of the uninsured. Americans personally paid more than 90% of their hospital and doctors' bills (Califano, 1986). There was limited support for health insurance, partially because, unlike Europe, America had no tradition of broad based social insurance programs, and partially because the need was not perceived as acute. Physicians' charges were low and hospitals still provided charitable care. Those who had status and money were in control and decided the needs for the majority.

Labor's drive for health insurance did not stop once the worker's compensation laws were passed. Health insurance for medical need was a political topic throughout the United States as access to the new and developing health care was expensive and reserved for those who could afford the service (Stern, 2003). Health care insurance became an industry within the health care industry. Unions, working on behalf of the working public, did not have the bargaining power to compel employers to buy health insurance for workers and their families, nor did they have the political power to

convince states or the federal government to cover their citizens. However, the unions did have enough resources to buy insurance for their members. The Union Labor Life Insurance Company was incorporated in 1925 and chartered by the American Federation of Labor to make life and health insurance available to union members in the construction industry (Stern, 2003).

Communities also began to develop “community wide plans” in California. Under it, participating hospitals in a given area agreed to provide services to subscribers, who paid their premiums to the plan rather than to individual hospitals. The community wide concept eliminated any competition among the participating hospitals. Hospitals in other areas embraced such plans and marketed them on a not-for-profit basis. These plans became extensions of modern Blue Cross plans (Califano, 1986).

The continued Great Depression and the election of Franklin D. Roosevelt in 1932 gave labor an opportunity to make health insurance a national priority (Stern, 2003). Following the Great Depression, states scrambled to be able to provide social programs for its citizens. Masses of individuals were forced to accept the necessity of federal action and assistance (Ginzberg, 1977). President Roosevelt, the father of the Social Security Act and by extension the grandfather of Medicare and Medicaid, was an advocate of the poor and social programs (Propenoe, 1995). As progress was being made for national health insurance, the American Medical Association, a powerful lobbying group, and the business leaders threatened to oppose the Social Security Act; thus, another controversial policy, universal health insurance, was taken off the table. The AMA stood firm that it did not want the government regulating health care. Social

Security was established as the retired insurance for all Americans and would become an incremental strategy to secure health insurance for all people over age 65 (Kovner, 1990).

Responding to the need for health insurance, Blue Cross plans similar to the California programs, were first created when Texas hospitals proposed that school teachers pay \$0.50 per week to a nonprofit, state chartered company to guarantee payment of hospital bills (Califano, 1986; Mechanic, 1983). This private health insurance company, founded on the heels of Roosevelt's social programs, was the creation of surgeons. This move began a national trend featuring health insurance as a part of collective bargaining for unions that did not own their own health and welfare insurance plans. Health insurance as a fringe benefit became a priority and would cover the workers and their families. These individuals would have the opportunities to take advantage of the health care advances, if needed. By 1937, Blue Cross plans had 800,000 subscribers, while competing plans set up by individual hospitals had only 125,000 subscribers (Califano, 1986).

In the face of federally mandated wage and price controls during World War II, employers began to offer health insurance to attract workers in a tight labor market (Stern, 2003). Corporate employers tended to prefer commercial insurers to Blue Cross and Blue Shield plans based on their rates on the age and health of the particular group covered. For most corporations, this meant lower rates. Commercial insurers also offered more flexibility and variety of types of coverage. Eventually, as the corporate group insurance market expanded, Blue Cross and Blue Shield began adjusting their plans for employers in an attempt to compete with other insurance companies (Merrill, 1994).

Nursing education throughout the period adopted a standardized curriculum and established educational reform. The Association of Collegiate School is formed. A standardized licensure exam was refined to assess minimal competency requirements for the licensed (LPN & RN) nursing professionals. Nursing diversified to not only include hospital nursing, but home health nursing, public health nursing and nursing in physicians' offices. Nursing continued to evolve in responsibility as medical advances stormed ahead. The Nurse Training Act of 1943 was established offering free training for nurses. This public acknowledgement of the role of the nurse included \$13 million allocated in training funds.

Medical advances of the discovery of penicillin saved many lives and streptomycin and isoniazid were not far behind to temper tuberculosis. Citizens, now viewing health care as a necessity, pushed for guaranteed health care as a right for all not simply those who could afford the coverage or those employed by a company that provided the benefit. Self-employed workers such as farmers, butchers, tailors, or small business owners also needed to be able to obtain health coverage. Few policy makers were expressing their needs. Bayer, Caplan, and Daniels (1983) analyzed data which reported the poor tend to be sicker than the nonpoor, inequality in the frequency of physician visits is greater in those without access to health insurance, and preventative services are significantly decreased in the uninsured population.

President Truman developed a national health insurance plan following his arrival in office. His plan, focusing on state and federal government regulation of the health care industry, was widely opposed by those in health care, politics, and the large lobbying groups for hospitals and physicians (Mechanic, 1983). Throughout the early 20th

Century, those in political power, typically the white male, were reluctant to establish a public health plan that would need to be paid by all citizens in order that all citizens would have health care coverage (Tice & Perkins, 2002). Many felt that their vision was limited due to the fact health care was paid for and available to them. Although President Truman's national health insurance plan was defeated in 1949, the Internal Revenue Service reaffirmed employers' health care costs would be tax deductible in 1954 (Califano, 1986; Harris & Maloney, 1999). The employer based health insurance was born out of the Congressional defeat of the national health insurance, and the unions went back to the bargaining table to win their struggles for health care. The framework for the labor's health insurance agenda revolved around collective bargaining and would serve as the leverage point to expand coverage at each workplace (Stern, 2003). Clearly, the labor union championed the rights of health care coverage for the working class and their families; however, those without access to health care coverage remained unable to obtain services needed due to their status. The Blues, Blue Cross and Blue Shield, grew rapidly springing forth in the capitalistic, entrepreneurial society and initiated the rise of commercial health insurance (Califano, 1986). These "for profit" entities provided health care coverage for those that were working and able to afford the premiums. Most services in the indemnity plans were covered for the individual (Califano, 1986). Different levels of coverage were developed depending on the premiums that were being paid. The drive for national health care insurance had faltered with the New Deal and the Fair Deal, yet it remained a central and compelling part of the labor's agenda for reform (Harris & Maloney, 1999).

Health Care from 1951-2000

By 1950, annual health care expenditures “consumed” \$82 per capita which represented 4.4% of the gross national product (Janeway, 1995). Throughout the 1960s and 1970s, business and labor kept extending health care insurance coverage and benefits and eliminating worker incentives to seek efficient care and physician incentives to hold down fees and hospitalization (Califano, 1986).

For the first three quarters of the 19th Century, medical professionals were not in charge of the hospitals. Early European hospitals did play a role in medical education and research, although American and European doctors took little interest in hospital administration. The industrial civilization of the 20th Century brought the greatest health advance in the history of mankind. Technological advances played a major role in changing surgery. With the advent of painkilling medications and aseptic technique, successful surgeries increased. The modern hospital, the professionalism of doctors and nurses, and effective pharmaceuticals have dramatically altered mortality rates and improved the quality of life. In the United States in a little over 80 years, longevity increased from 47 years in 1890 to 73 years in 1977 (U.S. Department of Health and Human Services, 1981). Science and technology have been able to prevent and eliminate some communicable disease, especially childhood diseases. There is no doubt that application of immunizing agents has been the main factor in the control of disease. This included organizing health services. With an increased demand for health care, there became a growing division between those able to afford and have access to health care services and those who cannot. Health care officials acknowledged that to decrease the spread of diseases, all must be immunized and have access to life saving medications to

decrease the spread of the infectious agents. Public health clinics were state sponsored and free to those qualifying. At this point, a basic understanding of the need for health insurance was evident.

Without understanding the ultimate financial ramifications, big business and big labor offered to pay all deductibles, copayments, hospital and doctors' bills for their employees (Califano, 1986). The first dollar coverage, as they became known, rendered the cost of the doctor or hospital irrelevant to the patient they insured. Moreover, as corporate and individual income and payroll taxes increased, deductible, nontaxable health care benefits became better than money. The employment relationship became the crux of the source of health care benefits for working Americans and their families (Califano, 1986; Stern, 2003). Remarkably, in negotiating health care plans, big companies and big unions set no limits on dollar amounts or provided benefits. Costs continued to increase and the health care industry grew.

Labor's next opportunity to win health care reform came with the election of John F. Kennedy. Kennedy acknowledged the rise in health costs and anticipated the cost to the elderly and small business owners. Speaking on the 25th anniversary of the passage of the Social Security Act, John F. Kennedy stated, "no costs have increased more rapidly in the past decade than the cost of medical care. And no group of Americans has felt the impact of these skyrocketing costs than our older citizens" (Janeway, 1995). Kennedy also was interested in creating a national health care plan. He was moved by the working poor who did not have access to health care insurance. He saw those individuals as they struggled without even the basic health care services. Kennedy formulated the Health Security Plan which was a single payer health plan. The plan won support from unions

and mounted a national campaign. Senator Edward Kennedy was the lead sponsor for the plan. Once again, the campaign did not have the support of business or the AMA. It also had a new opponent, the commercial insurance industry which was well established thanks to labor's success at winning coverage during collective bargaining. Within less than 20 years, annual health care costs had increased to \$143 per capita and 5.3% of the gross national product (Janeway, 1995).

President Kennedy also believed there was a scarcity of qualified nurses and primary care providers in many areas of the country (Judd, Sitzman, & Davis, 2010). He further suggested that those deficiencies impeded enhancement of national health care. Colleges graduated nurses with associate degrees in two years to infuse nurses quickly into the health care industry. President Lyndon B. Johnson agreed that the national nursing shortage created a number of concerns for the nation. To promote the profession of nursing and raise awareness for the need of nursing, Johnson continued Title VIII, the Nurse Training Act of 1964. This became a very important piece of legislation as it gave access to training programs for all who may be interested. This was particularly helpful to minorities and the poor.

President Lyndon B. Johnson also negotiated Medicare and Medicaid in 1965. These programs guaranteed health care coverage to those over 65 years of age and also health care coverage to the poor within income guidelines and without regard to age. While the total expenditures for the two programs have grown at about the same rate through the 1980's, Medicaid has been subjected to extensive criticism and reduction in benefits and eligibility; however, Medicare has been accepted as an entitlement (Mechanic, 1983). Medicare Part A is a hospital insurance plan financed largely through

Social Security taxes from employers and employees. Medicare Part B insures the elderly for physician services and is paid for by federal taxes and monthly premiums from the beneficiaries (Bodenheimer & Grumbach, 1998). Furthermore, since Medicare, a national program, is largely financed through Social Security taxes, it has been largely insulated from state and local debates over budget distribution. Medicaid is a joint federal and state program that provides health insurance for certain low income populations (Rajan, 1998). Medicare, as well as Social Security, is viewed as an essential component of the elderly's retirement planning. While many utilized Medicare as the only health care coverage, not all health related costs were covered. In contrast, Medicaid coverage is more comprehensive. Interestingly, the elderly poor are often more of the Medicaid population than the poor of other age groups. In fact, a larger proportion of Medicaid expenditures have consistently gone to the elderly than to the Aid to Families with Dependent Children (Holahan, 1975). Other elderly elect to continue traditional health insurance plans to offset the "gap" in Medicare coverage (Bodenheimer & Grumbach, 1998). The general emphasis within this time period began focusing on utilization regulation as the cost of health care continues to rise.

Reimbursement for the government sponsored plan included meeting the hospital's demands for reimbursement of reasonable costs. Physician reimbursements were to be reasonable and customary and in line with those in the prevailing community (Califano, 1986). This cost based reimbursement style was widely used in the hospital industry. The government turned over the responsibility of auditing and paying doctor and hospitals to the insurance industry and even allowed the hospitals the right to pick who would audit them.

President Nixon declared a health care crisis in 1974 and proposed a “pay or play” system to encourage all employers to provide health care benefits to the employee and the employee’s family (Rosenau, 1994; Trattner, 1999). Hawaii and Massachusetts were two states that adopted such policies requiring employers to provide insurance for their workers or pay into a public state insurance fund (Rosenau, 1994). Simultaneously, Nixon was also the first United States President to endorse the benefits of Health Maintenance Organizations (HMOs). HMOs were popular in the conservative administration since they were potentially less costly than traditional methods of organizing the delivery of medical services (Trattner, 1999). HMOs needed to sell its products to the consumers so free enterprise and competition were maintained. HMOs provide comprehensive medical services for a fixed payment. Nixon postulated that the philosophy of the Health Maintenance Organizations could revolutionize the health care market with a minimum of government regulation and interference. It was not until 1973, however, that Congress passed the Health Maintenance Act authorizing \$375 million to promote the expansion of HMOs (Califano, 1986). While the bill authorizes subsidies to HMOs to help with their start up costs, it also placed strict conditions on eligibility. HMOs had to provide a basic package of services, have periodic open enrollment, and charge the same premium to everyone whether they joined individually or in groups (Califano, 1986).

Many insurance companies and physicians strongly opposed the development of HMOs. American physicians have always fought the threat of the “fee for service” standard. Physicians and patients struggled with preauthorization of medical care as they felt their control was taken from their health care decisions. Some insurance companies

saw HMOs as competitors for consumers choosing between purchases of prepaid medical care or insurance (Kovner, 1990). HMOs also struggled to be competitive. People with costly medical problems have incentives to join HMOs and have their care covered without coinsurance, deductibles, or benefit ceilings. Because of the restrictions and limitations placed by the federal government, only 11 of the nation's 173 HMOs had even applied for federal support (Mechanic, 1983). Although HMOs had a slow start, many saw the HMO philosophy as the new trend in health care management.

For government, the cost of public programs for medical care financing was financially draining. President Carter in the 1970s outlined cost containment options which left many in government and health care on the defensive (Trattner, 1999). Carter pressed that there was little change without incremental experimentation. Rising government budgets, coupled with increasingly frequent charges of waste and inefficiency in governmental bureaucracies, have led to procompetitive logic which would enhance consumer sovereignty (Trattner, 1999). Carter stated that the market for medical care is no different than other markets. If consumers face incentives that encourage sensible decisions about the amount and level of insurance needed, they will change their consumption patterns and consequently alter the medical-care system. Carter based his assumptions on the public rise in Medicaid costs, private health insurance premium rises, and number of uninsured and underinsured individuals.

Reagan limited health care spending and social programs citing fiscal responsibility and individual responsibility in providing for their family. Skocpol (1997) contends that Reagan practiced "benign neglect" of domestic social problems. A patchwork system of programs was noted and coverage was "hit or miss" depending

upon where one works, lives, and what is earned. Companies and the federal government were beginning to feel the pressure of the burden of health care costs and pushed for changes in legislation. Reagan placed restriction on health care access and increased the number of uninsured individuals (Harrington & Pellow, 2001). Reagan's hard line approach was supposed to limit federal spending and give the burden of the uninsured back to the states to decide their welfare. One trend of a number of states in the 1980s was the mandating of benefits, or states requiring health insurance for everyone. An early innovator, which required health insurance be provided by all employers, is the state of Hawaii, which passed legislation in 1974 (Kronenfeld, 1993). Estimates in 1987 stated that 87% of Hawaii's residents are insured another 7% are covered by Medicaid and their state health program covered almost all others (Kronenfeld, 1993).

Kimball and O'Neil (2002) state the roots of the current nursing shortage started in the 1970s–1980s, with early attempts to control health care costs through the decreased number of health care beds, patient admissions, and lengths of stay. What resulted is the controlled utilization of health care services that decreased a need for nurses. As the system of managed care emerged, there were sharp reductions in the number of admissions and length of hospital stays. There were concomitant hospital closings and an overall decrease in the number of hospital beds. The nursing profession began to brace for an era of downsizing. Consultants erroneously suggested budget reductions through the use of unassisted personnel to perform duties once performed by nurses. The results were that between 1994–1996, there was a 3% decline in hospital registered nurse employment. While the hiring of nurses declined, a decreased emphasis of recruiting future nurses occurred, and at the same time there was attrition of experienced nurses

leaving a gap in future workforce (Nursing Executive Center, 2000). During this period, Buerhaus, Donelan, Ulrich, Kirby, Norman, and Dittus (2005) assert the apparent decline for the need for nurses was not a reality. In fact, there was an underlying, noncyclical reality of the increased need for nurses fueled by the needs of an aging population, an artificially depressed demand from managed care constraints, and a concomitant decreased supply of nurses.

Many changes have also occurred in the nursing profession as the complexity and acuity of patient care has forced nursing to redefine its processes. Developments in specialty medicine continued to change health care options creating numerous opportunities for nursing. Cohen (2007) suggested that there will be a need to change the nurse's image as nursing defines who it is. Changes in health care have ushered in an era of cost containment and efficiency of services. Within organizations that translates into utilizing the fewest material and human resources. Health care restructuring provides new ways of delivering care and saving money.

During the 1988 presidential election between the first George Bush and Michael Dukakis only a small minority of voters regarded health care an important issue in the election (Skocpol, 1997). Bush continued the same Reagan philosophy with few changes. Following the Gulf War in 1992, the country slipped into a recession. This downturn prodded many United States companies to implement strategies to downsize and promote efficiency. Health care costs have doubled at the rate of inflation (Transcript from the PBS Special: Health Care Crisis, November, 2000). Sixty percent of Americans at this time reported feeling fear that they might not have adequate health insurance in the future (Skocpol, 1997).

During the 1990s, hospitals experienced two major nursing shortages. The first shortage occurred in 1990-1992 and was marked by an 11% vacancy rate of unfilled, full-time RN positions (Buerhaus, et al., 2005). By the end of 1992, the shortage had ended. Only five years later though, hospitals began to feel another nursing shortage beginning when it was difficult to fill positions in intensive care units, operating rooms, and surgical units (Buerhaus, Staiger, & Auerbach, 2000). By 2001, the national average hospital RN vacancy rate was 13%. Unlike previous nursing shortages though, this shortage continued throughout the 1990s and is present today.

The current economic downturn affected all parts of the health care and business communities. Small businesses were unable to cover the cost of insurance premiums for their employees and were unwilling to continue to cover all copayments and deductibles for their employees. The cost of health care coverage began to shift to the consumer. While some consumers were able to shoulder the shifting cost of health care, others were not and were forced to become uninsured with the hopes of not needing health care. The cost of health insurance in the workplace was a substantial financial burden for both the employee and the employer, but remained a key fringe benefit, especially in large and unionized firms.

If health care coverage was not available through a group policy from an employer, families were hard pressed to find and pay for a policy in the individual insurance market. Most directly purchased policies were expensive and have more stipulations and limited benefits with out of pocket costs. Moreover, the cost of these policies are based on age and health risk, and any preexisting conditions generally exclude coverage.

The impact of the enormous changes occurring in business and industry in the late 20th Century was also reflected in the health care delivery system. The traditional medical model of a complex hospital system of sick care, a profusion of technology, and ethical questions of need vs. availability which could not have been anticipated at the beginning of the century indicated a serious need for health care reform. The United States was spending 13% of its gross national product on health care--a figure that caused great concern to government officials (Milstead, 2008). Cost containment began with a Congressional demand for prospective payments for Medicare recipients through diagnosis related groups (DRGs). Government funded Medicare adopted the payment system which specified specific diseases and allotted a monetary amount for the care needed. The responsibility of providing the needed care for the patient rested with the health care organization which understood the reimbursement. It was in the best interest of the health care organization to provide efficient, cost effective care to the patient (Milstead, 2008). Hospital lengths of stay, care needed, and services to be performed were all analyzed for medical need as the cost of the services were deducted from the reimbursement pot.

The DRG reimbursement system also had a profound effect on the nurse pay and staffing. This system produced a dampen effect on nurse salaries while salaries of nonnursing personnel grew at a substantially higher rate (Aiken, 1987). Aiken also identified cost containment measures at the hospital level as unfairly targeting nurses' salaries. Ultimately, Aiken states public policy members need a deeper understanding of the impact of cost containment strategies.

For the general population and amidst market changes, health care became less available and more insecure, as well as more costly, for a rising number of Americans. In the three decades before 1970s, employer based health plans and public plans covered a large portion of Americans (Skocpol, 1997). Medicare and Medicaid expanded services to the elderly and poor. But in the 1980s the coverage stopped growing and the ranks of the uninsured began to expand. Lack of insurance for some families was episodic as well as persistent. More than one in four Americans had no health insurance coverage at some point between 1987 and 1989, a time of a relatively low unemployment rate (Skocpol, 1997). In 1988, some 31.6 million Americans or 13% of the population under age 65 had no private or public health insurance; and most of these families had at least one person employed (Skocpol, 1997). Observers began to discuss the negative effects of “job lock” where people could not change jobs for the fear of losing their health insurance. Abbott (1995) defines the shifts in health care in the 1990s which includes: employers shifting more cost of benefits to their employees; managed care organizations growing larger and developing networks of associated providers; pharmaceutical industry’s major changes through mergers and alliances; and, hospital mergers and consolidations.

President William Jefferson Clinton took office in January of 1992 determined to solve two related crises in health care (Skocpol, 1997). The first was the growing number of Americans who lacked basic health care. The second was the spiral in health spending that threatened to bankrupt the government and cripple American industry (Califano, 1986; Eckholm, 1993). Clinton devised an unsurprising and simple answer: requiring all employers to cover their workers and their families, building on the system of employer coverage that is already widespread. Government would provide subsidies

for companies and individuals deemed too poor to bear the entire burden themselves. Clinton had a vision of cradle to grave coverage so no American would have to do without basic health care regardless of their health or employment status. Drawing on the “managed competition” proposal developed by market oriented health economists, Clinton would have most people obtain their health insurance through a new system of regional purchasing cooperatives, or “health alliances” run by the states. Cost containment, competition, and efficiency in the health care industry were critical elements behind the philosophy of the proposal (Skocpol, 1997). These would set standards under federal guidelines for local health plans and make a range of plans available to consumers to meet their needs. All plans would offer the same basic benefit package. Under the proposal, everyone would be required to carry health insurance and to contribute to its cost, with governmental subsidies to help the poor. All employers would be required to contribute for workers and their families, with employers paying 80% of the cost of premiums and workers 20% (Skocpol, 1997).

The theory is that health plans--affiliated groups of physicians and hospitals, often organized by insurers--would compete for customers on the basis of price and quality. The plan also included caps on the growth of health premiums, bringing them in line with the general inflation rate. Overseeing national spending trends would be the role of a powerful new National Health Board. For as strong as the plan looked on paper, the mandatory employer payment became the Achilles’ heel of the proposal, for it aroused the opposition of thousands of small business owners who said they could not afford to pay the price. Skocpol (1997) refers to this as the “failed” Health Security Plan.

Clinton was able to create a Health Insurance Portability and Accountability Act (HIPAA) to increase the number of persons who have and maintain access to health insurance (Nichols & Blumberg, 1998). This is similar to the goal that has been discussed in state legislatures with small group and individual market reforms. The primary method of increasing access under HIPAA and most existing state laws is to make it more difficult for insurers to segment insurance risk pools and deny or revoke access to specific individuals or groups based on the status of their health (Nichols & Blumberg, 1998). Within this new policy, a vision of state and federal authority over the health insurance community is achieved. Some opponents view this legislation as the “first national health policy with such far reaching implications,” others view this legislation as an excuse to extend federal regulation (Nichols & Blumberg, 1998).

For the 37 million reported Americans who lacked health insurance, and the tens of million more who found themselves in jeopardy of losing health insurance when they changed jobs (prior to HIPAA) or developed a serious disease, the appeal of Clinton’s proposal and its guaranteed coverage was obvious (Eckholm, 1993). In 1995, 14% of Whites were uninsured, compared with 21% of African American, and 33% of Latinos (Bodenheimer & Grumbach, 1998). The proportion of the uninsured population decreases as income rises. The majority of Americans who are adequately insured already and happy with their own doctors may have a harder time deciding how they feel about this plan. Historically, Americans, lead by the AMA and lobbying groups for insurance companies, have not been willing to concede their own health care or provide financially for others so that all American have health care coverage. Those in political power continue to have the ability to make decisions regarding the needs of others without

understanding their plight. By the end of the decade, 44 million Americans or 16% of the population were without health insurance (Transcript from the PBS Special: Health Care Crisis, November, 2000).

Health Care from 2000-Present

At the turn of the 21 Century, America's boardrooms, employers large and small, face skyrocketing health costs increases. The nation's largest health care purchaser, the Federal Employee Health Benefits Program, announced premium increases of more than 10% for three consecutive years (Stern, 2003). Vladeck (2003) reports the California Public Employees Retirement System, the nation's second largest purchaser of health care insurance benefits, had to accept premium increases averaging 25%. Throughout the states, governors and state legislators must contend with revenue shortfalls combined with rising Medicaid budgets. The average state Medicaid spending increased by 25% between fiscal year 2000 and fiscal year 2002 (Stern, 2003). Simultaneously, across America's landscape, working families are discussing how to contend with rising out-of-pocket insurance costs coupled with stagnating wages and job insecurity. The working public must deal with the corporate boardroom response to rising health care costs, which, at least in part, has been to pass the costs on to the workers in order to maintain the bottom line (Abbott, 1995, Harrington & Estes, 2008). The result is a growing number of individuals who risk becoming part of the expanding class of the underinsured. In addition, some states have limited public assistance with health care (Bodenheimer & Grumbach, 1998; Harrington & Estes, 2008).

Schoen concluded from her 2005 study on the underinsured, “When you compare underinsured adults, they look quite a bit like the uninsured.” The Agency for Health care Research and Quality (2007) reports that 17.1 million people under age 65 were underinsured in 2003, including 9.3 people with employer-based insurance (obtained at www.cms.hhs.gov/nationalhealthexpendituredata on September 30, 2009). Similar characteristics between the uninsured and underinsured population includes going without health care, not filling prescriptions, and not getting treatments or diagnostic procedures. These decisions are made because individuals have a high yearly deductible or the out of pocket co-payments are not affordable. The change in the marketplace trend toward higher deductible coverage threatens to increase the number of underinsured, although it may make a dent in the uninsured.

Individuals obtain health insurance from different places (See Figure 2). Nationally in 2003, 174 million people (61% of the population) received medical care benefits from a family member’s employer or labor union (Macionis, 2006). Another 26 million people (9% of the population) purchased private insurance independently. Although a total of 69% of the population has private insurance, few programs pay all medical costs (U.S. Census Bureau, 2004). Copayments for office visits, laboratory testing, diagnostic procedures, and outpatient services such as physical therapy impact the bottom line cost of health care for the patient. Medicare pays a predetermined portion of the medical costs for those over age 65 which, in 2003, covered 39 million (14 % of the population) (Macionis, 2006). Medicaid provides benefits to 36 million Americans (12% of the population). An additional 10 million veterans (4% of the population) are eligible for free care in federal government operated hospitals. Forty-five million people

(almost 16% of the population) have no medical coverage at all, even though 74% of these people are working (U.S. Census Bureau, 2004).

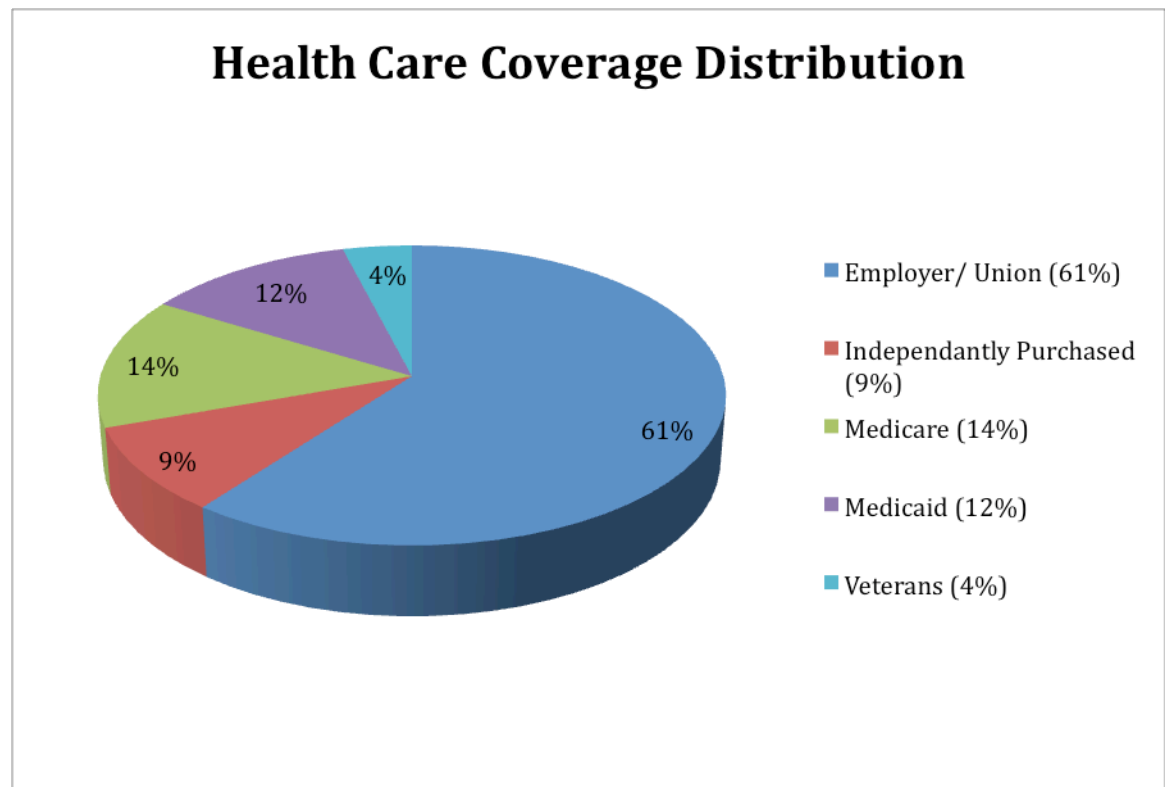


Figure 2. 2003 Health care coverage distribution.

President George W. Bush promoted health care as important on his domestic agenda. He, too, included government subsidies for small businesses that provide health insurance to their workers. A Medicare rescue plan was developed as the future of maintaining the Social Security entitlement was unsure. President Bush was able to include prescription drug assistance to senior citizens on Medicare. This was the first attempt to include prescription drug coverage for this population, a population where medication is of vital importance. Bush's plan used competition among drug companies

to provide discounts on prescription medication. This plan was accepted with the blessings of the American Association of Retired Persons (AARP), however, many felt that the plan did not extend far enough and was only helpful for a minority of seniors (Retrieved November 22, 2004, from <http://www.aarp.com/newsletter>)

President Barack Obama and Congress are currently proceeding forward with his opportunity to impact health care policy. Obama has set covering all Americans with health care insurance as one of his priorities. On his www.barackobama.com/issues/health-care website, he states:

If you already have health care insurance through your employer, nothing will change for you except the price of your premium may go down. If you are one of the millions of Americans who do not have health care insurance, you will be offered an affordable plan that federal employees from the postal worker in Iowa to the congressman in Washington has. If you cannot afford this plan, you will receive a subsidy to help pay for it. If you are a small business, the plan will not create any additional burdens. The small business will have tax credits that will cover up to 50% of the costs.

Time will tell if these ideas will be accepted and implemented. The discussion continues in the legislature and town hall meetings across the country.

In conclusion, many ask why the United States, considered a wealthy nation, does not have a universal, government operated medical insurance. Macionis (2006) contends that our culture stresses self reliance and limited government. Also, political support for a national medical program has not been strong, even among labor unions, which have historically concentrated on winning medical care benefits from employers. Furthermore,

the AMA and the insurance industry have strongly and consistently opposed national health care (Pear, 2009; Starr, 1982). Medical expenditures have increased from \$12 billion in 1950 to more than \$1.4 trillion in 2002 (Macionis, 2006). This amounts to more than \$4,000 per person, more than any other nation spends on medical care.

Current Health Care Arena

The population of the United States according to the U.S. Census Bureau, Population Division is 304,059,724. The National Coalition on Health Care (2009) documents that most Americans (58.5%) have health insurance through their employers. But, employment is no longer a guarantee of health insurance coverage. Gould (2009) reports the share of Americans with employment based coverage continued to erode for the eighth consecutive year in a row from 59.3% of Americans covered in 2007 to 58.5% in 2008. Due to the economic climate and sharp rise in unemployment in 2008-2009, a further increase in unemployment is anticipated. Holahan and Garrett (2009) and Cawley and Simon (2005) report that one percentage point increase in the unemployment rate is associated with a 0.9% to 1.0% decline in employment based coverage of those under 65 years old. In addition, there is an increasing reliance on contract or part-time workers who are not eligible for full coverage, meaning fewer workers are eligible for coverage or have to contribute a large share of the premium. Also, many small business owners cannot afford the rising health care premiums leaving little alternatives other than to pass the increase on to their employees or to not offer health care benefits. In general, companies that do offer health insurance often require employees to financially contribute to their coverage.

According to the Harry J. Kaiser Family Foundation Employee Health Benefits Survey (2008), employees have seen their annual share of employer based coverage increase from \$1543 to \$3354. As a result of all of the above considerations, many Americans have lost their health insurance or opted to not take advantage of their employer based health insurance because they cannot afford their premium share. Documented by the U.S. Census Bureau (2008) from their Income, Poverty, and Health Insurance, 47 million Americans do not have health insurance coverage. The largest majority of the uninsured (80%) are native or naturalized citizens. The Henry J. Kaiser Family Foundation (2006) reported that 8 of 10 uninsured come from working families with almost 70% coming from a family where one worker is employed full-time and 11% from families with part-time workers. Nearly 40% of the uninsured population resides in households who earn over \$50,000/year or more meaning that the middle income families can not afford health care insurance payments even when offered by their employers. According to the Kaiser Employee Health Benefits 2008 Annual Survey, employee spending on health care coverage has increased 120% between 2000-2006.

Schur, Berk, and Yegian (2004) conducted a survey to assess opinions on mandated employer health insurance coverage. Interestingly, the results stated approximately 50% of all working age adults indicated they believed that all employers should offer health insurance to all workers. One-quarter of the respondents opted for a less inclusive mandate requiring coverage be offered for permanent, full-time employees. Another 10% voiced support of the mandate but for only large employers. Nationally, only 10% stated that employers should not be mandated to provide health insurance

coverage. National attention by politicians and the general public has made health care reform one of the most important topics of the current political agenda.

On September 17, 2009, Kathleen Sebelius, Health and Human Services Secretary, released state statistics on the uninsured. Sebelius states, “The results of the analysis are sobering and confirm that health insurance reform cannot wait another year. Our health care system has reached a breaking point. The status quo is unsustainable, and continuing to delay reform is not an option” (Health and Human Services Press Release, September 17, 2009). Republican and Democratic leaders agree there is a significant problem with the health care system, however, the United States of America’s two main political parties have philosophical differences regarding the accessibility, structure, and funding of health care coverage. Much of the differences are carried through from fundamental principles of the parties. The Republican ideals stress individual responsibility and limited government influence. Democratic ideals outline personal liberties for all. President Barack Obama is challenging both political parties to establish a bipartisan proposal with goals of covering the uninsured, reducing health care costs, and securing Medicare and Medicaid.

The Republican Party states on its website (2009) that there are a number of political areas and common ground to work with President Obama to improve the health care of Americans ([www.gop.gov/solutions/health care](http://www.gop.gov/solutions/health%20care)). The Republicans have ideas of how to reach the goals beginning with lowering health care costs to eliminate the unnecessary overspending in the current system. To lower these costs, the Republican plan increases “fairness” in the tax code by extending tax savings (similar to those for employers) to those who currently do not have employer provided health insurance

making private insurance the individuals only option. This provision would provide an “above the line” deduction that is equal to the cost of individual or family insurance premium. This plan also includes immediate substantial financial assistance through new refundable and advanceable tax credits to low and moderate income Americans. Health savings accounts also are promoted to establish pre-tax accounts to pay for medical expenses. Furthermore, the plan supports those between the age of 55-64 (pre-retirement/retirement age) who may change or lose their jobs with increased tax credit support. Providing the tax credits allow the individuals to purchase the health care coverage which best meets their needs. It also allows competition among plans to maintain competitive rates. The plan allows health care coverage regardless of pre-existing conditions.

Along the same philosophy, small businesses, associations, and organizations will be able to cooperatively purchase insurance at lower cost. This opportunity makes the purchase of health care coverage for employers and employees more reasonable particularly to small business budgets. Again, small businesses would have administrative tax incentives to help support the cost of covering the employees. Another feature of the Republican plan includes the purchase of health insurance across state lines to increase competition and consumer choice.

Another factor of this plan implements comprehensive medical liability reform that will reduce costly, unnecessary, defensive medicine practiced by doctors trying to protect themselves against overzealous trial lawyers. Doctors and patients will have the decision making power to determine care for specific patient outcomes. Additionally, the plan provides Medicare and Medicaid additional authority and resources to stop waste,

fraud, and abuse that cost taxpayer dollars every year. Focusing on billing overpayments and regulatory inaccuracies, the plan provides for a monitoring system of records. Also, the plan gives financial help to caregivers who provide in home care to loved ones.

The Democratic proposal to cover all Americans includes a “play or pay” employer mandate to move toward universal coverage. The reemergence of the “play or pay” policy is a testament to the enduring political appeal of building on the status quo: employer sponsored insurance which has been the cornerstone of the health care system since the 1940s and now covers 160 million nonelderly Americans (Oberlander, 2007). “Play or pay” models enable reformers to finance universal coverage mainly through employer payments rather than creating a publicly funded system that would require new broad-based taxes.

Although the Democratic plans would retain private insurance, a public option would be offered by the government to run alongside private options (www.BarackObama.com). This government run plan would help to curtail rising health care costs. Payment for the public option would come from taxes on those individuals with an income of over \$1 million and by rolling back tax cuts for the wealthy enacted by the George W. Bush administration. Insurance across all plans would be tightly regulated to ensure that all Americans would have access to health care, regardless of their health status. The public option is currently highly controversial. Several townhall meetings across the United States have produced emotionally charged discussions. Currently, Democrats contend there will be no health care reform without the public option.

In addition, less visible cost cutting measures such as transferable electronic medical records and a focus on disease prevention and management are expected to save

money and improve patient care. Both parties acknowledge the improved effectiveness of having health record information readily available. Also, the economic impact of early detection of disease process and educated disease management has been a factor associated with reducing costs as well as in improving life expectancy.

Health Care Insurance Impact on Nursing

Nurses are not protected from the challenge of obtaining and maintaining health care insurance just because they work in the health care industry. Nurses uniquely understand the importance of health care insurance for early diagnosis of health concerns and health care prevention practices. Nurses also understand the financial consequences of not having health insurance for themselves and their families. Lacking health insurance personally puts nurses in a position of providing care to others while not having access to care themselves or for their dependents and families. Nurses then must educate on and work in an environment where “best practices” in health care are assumed but not necessarily followed on a personal basis.

The general public may assume that health care workers have low cost, comprehensive health insurance. This is not the case. Health care agencies are placed in the same health insurance pools as other employers and must pay similar premiums. Health care budgets are also impacted from rising costs of health care while insurance and government reimbursements have decreased. Health care employers have also had to make hard decisions regarding their ability to pay for health insurance for their employees and the employees’ dependents and families. In the long run, health care

facilities cannot afford to sustain health care benefit package increases that exceed reimbursement rate increases and the demand for cost containment.

A review of 7 diverse hospital groups (large versus small hospitals, systems versus free standing private institutions, rural versus urban in Western Pennsylvania) the following hospital based plans which include the University of Pittsburgh Medical Center, West Penn Allegheny Health System, Excelsa Health System, Conemaugh Health System, Indiana Regional Medical Center, Dubois Regional Medical Center, and Armstrong County Memorial Hospital require employee contribution to insurance premiums for individual employees with a higher contribution for dependent and family coverage. In addition, there are variable co-pays for the services provided. Thus, health care institutions have similar, and perhaps more costly benefits, when compared to other organizations such as manufacturing, business, and education. If health care providers improved their health care benefits, would recruitment and retention of nursing staff along nursing's career ladder increase?

It is not uncommon to pick up the newspaper and read an article about the nursing shortage which is expected to increase as the Baby Boomers age and requirements for health care increase. Cohen, Palumbo, and Rambur (2003) state there will be a doubling of the elderly population by 2030, while the pool of available nurses is expected to remain unchanged. The immediate cause of the nursing shortage is that fewer individuals are entering the nursing profession. During the last decade, enrollments in nursing programs have dropped by one-third, even as the need for nurses has increased (Macionis, 2006). Furthermore, the current student body is comprised of older students compared to previous nursing cohorts. Both the American Association of Colleges of

Nursing (AACN) (2003) and the American Hospital Association (AHA) (2006) have documented a five year increase in the average age of nursing students since 1977. The Nursing Executive Center (2003) concluded that demand for nursing services is projected to increase 36% by 2020, while the supply of nurses will remain essentially flat. A higher turnover rate, the rising age of nurses, a stressful work environment and job dissatisfaction all lead to a reduction in the nursing workforce.

Researchers and practitioners question the nature of the nursing shortage as being either cyclic or unique (Kimball & O'Neil, 2002; The Robert Wood Johnson Foundation, 2002; Upenieks, 2003). There is agreement that factors, such as changes in technology and the changing work environment, the advancement of women's rights, and the characterization of nursing have contributed to previous shortages. It also appears that the nursing profession has struggled to recover from earlier shortages, generating a larger cyclical event (The Robert Wood Johnson Foundation, 2002). Upenieks (2003) refers to the latest shortage unlike any other, noting that many variables play a significant role distinct from previous shortages. Further, Kimball and O'Neil (2002) conclude that market driven solutions of the past based on economic cycles, such as increasing pay, benefits, bonuses; utilizing agency overtime and foreign resources provided outside the organization; may provide only short term relief.

Gelinas and Bohlen (2002) assert that the nursing shortage is not a short-term problem, but rather a long term crisis, caused by shifts in our society and in health care. In addition, the authors believe that nursing is not an attractive career. Though there is demand for all levels of nursing's career ladder, those in Generation X and Y (those born after the mid-1960s) have more alluring professional opportunities such as physician,

lawyer, architect, or business leader, many of which can be more financially rewarding with more prestige and autonomy. Finally, the authors point out that women, who make up the largest percentage of nurses, now have opportunities outside of previously female dominated fields. Lastly, during the 1990s due to a general downsizing and restructuring of health care, nursing's job security was threatened as there were job losses and restructuring within health care. Though this period did not have losses of bedside nursing positions, nursing administration was affected during the restructuring.

The Nursing Executive Center (2003) indicates there is a sharp decline in the employment pool of nurses, fueled by a sharp increase in retirements, as incumbent nurses are older than the general population. Also, the nursing workforce is not replacing itself and the problem continues as the percentage of new nurses under 30 years old is declining. Furthermore, health providers increasingly face competition for nurses by employers outside the health care field. Law firms, the insurance industry, educational facilities, and software companies have offered nurses attractive, professional opportunities. Many non-nursing career options, once considered inaccessible to most women, have diminished the pool of applicants to nursing programs. With all of the opportunities for women, many suggest that nursing has too much responsibility and too much stress. Life or death decisions are made and consequences of human error can be personally devastating and career ending. In September 2009, the Bureau of Labor Statistics confirmed that 544,000 jobs have been added in the health care sector since the recession began emphasizing the point that while other employment opportunities were downsizing due to the economy, nursing continued to be unable to fill available positions

(www.bls.gov/news.release/pdf/empisit.pdf). This gap in nursing staff is seen on all levels of the career ladder.

Another problem facing nursing's career ladder is nurses leaving health care facilities or nurses leaving the profession. The national turnover rate for hospital nurses was 12% in 1996, 15% in 1999, 26% in 2000 (Larrabee, Janney, Ostrow, Withrow, Gerald, & Burant, 2003). The Joint Commission on Accreditation of Health Care Organization (JCAHO) (2009), documented the turnover rate in the article *Health Care at the Crossroads* from 18% to 26% in 2002 and in 2009 reports the turnover rate to be 20%. Job burnout and dissatisfaction are driving forces that prompt nurses to leave their jobs and many leave the profession entirely (Aiken, Clarke, & Sloane, 2002; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken, Clarke, Sochalski, Busse, Clark, Giovannetti, 2001; Buerhaus, et al., 2005). High turnover rates are noted at all levels of the nursing career ladder and high position vacancy rates affect access to health care (American Hospital Association [AHA], 2006; American Organization of Nurse Executives, 2008). Various studies have reported correlations between adequate staffing levels and safe patient care (Agency for Health Care Research and Quality, 2004; Kaiser Family Foundation, 2004; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). Furthermore, high turnover rates have financial ramifications. For example, JCAHO (2009) reports the average cost to replace a nurse equals their yearly salary which averages between \$39,000-\$47,110 (obtained on January 25, 2009 from www.jcahocommission.org/NR/rdonlyres/health_care_at_the_crossroads). Retention, now more than ever, has become an important issue to health care organizations. Once an organization hires and orients an employee, it wants to keep that employee.

The nursing shortage statistics at all levels of the nursing career ladder are telling. In the July/August 2009 *Health Affairs*, Dr. Peter Buerhaus and coauthors found that despite the current easing of the nursing shortage due to the recession, the U.S. nursing shortage is projected to grow to 260,000 registered nurses by 2025. A shortage of this magnitude would be twice as large as any nursing shortage experienced in this country since the mid-1960s. Albaugh (2003) contends the shortage itself is the greatest potential threat to nursing. Nurses cite shortage-related issues as challenging to the body, mind, and spirit of nursing (Nathanial, 2004). According to the AHA (2006), U.S. hospitals need approximately 118, 000 RNs to fill the current vacant positions nationwide. According to the Pennsylvania Center for Workforce Development 2009 report, the RN shortage is to continue while the LPN shortage for 2010 is expected to be twice as high as predicted and expected to grow through 2016. According to the U.S. Bureau of Labor Statistics, more than 1.2 million new and replacement RNs will be needed by 2014 (Hecker, 2005). Unfortunately, in 2005, U.S. nursing schools rejected 41,683 qualified applicants due to an insufficient number of faculty, clinical sites, preceptors, classroom space, and budget restraints (American Association of Colleges of Nursing, 2005).

With fewer nurses entering the workforce causing a disproportionately aging workforce with fewer candidates to fill positions, the average age of the nurse is steadily increasing. The average age of the nurse in 2004 was 47 years, up from 45 years in 2000 (Department of Health and Human Services, 2000, 2004). According to the 2004 National Sample Survey of RNs, the total number of RNs is growing at the slowest rate in 20 years. Looking back to 1980, the survey reported the largest age group of nurses was in the 25-29 age category, compared to the 45-49 age category in 2004. According

to Michigan's Center for Nursing's 2008 survey, the average age for an RN is 50 and the average age for an LPN is 51 giving concern that the average age the nursing professionals continues to rise (www.michigancenterfornursing.org/mimages/nursingsurvey08.pdg obtained October 9, 2009). Because of the physical demands of the profession, few nurses work past their mid-fifties (Kimball & O'Neil, 2002). On the nursing career ladder, the NA position requires the most physical demanding job duties on a repetitive basis. LPNs and bedside RNs also have physically demanding responsibilities throughout the work day. Cordeniz (2002) reports that 60% of the current nursing workforce is expected to retire within 15 years. Furthermore, fewer new graduates are entering the profession (Cordeniz, 2002; Laschinger, Finegan, Shamain, & Wick, 2002).

Another source contributing to the nursing shortage is that only 58% of the total RN population in the United States works full-time in nursing. Of those nurses employed, 56% worked in hospitals compared to 59% in March 2000 (Albaugh, 2003). Fewer full-time workers mean that it takes more workers to cover the available positions. Some nurses do work up to full-time hours regularly but are not offered full-time benefits as an institutional cost savings measure. Using the hours per week criteria to delineate who is offered a variety of hygiene factors is a common practice and adds to the discussion of the fairness of working an individual full- or part-time. Nursing constitutes only one of several workforces in the hospital environment; still, it plays a significant part of hospital operations. While there are shortages in other vital health care positions such as pharmacists, respiratory therapist and medical technologists, nurses allege a higher degree of dissatisfaction (Albaugh, 2003).

Nursing Professionals Feel Job Dissatisfaction

Across the United States, nurses report job dissatisfaction as the primary contributor to both job and professional turnover. Many nurses on nursing's career ladder report that negative effects of the nursing shortage on the job cause the dissatisfaction (Aiken, et al., 2002; Burke, 2003; Macionis, 2006; Parsons, 1998). Professional demands have increased the need for nurses throughout health care. There has been a proliferation of technological and environmental changes in the nursing profession. Nurses are being assigned more patients per shift than in the past, which has contributed to many poor patient outcomes such as patient death, injury, or a permanent loss of function (Joint Committee on Accreditation of Health Care Organizations, 2002). In fact, the National Institute of Nursing Research (NINR) has reported that each additional patient assigned to a nurse is related to a 23% increased risk of nurse burnout and a 15% increased risk of job dissatisfaction (Cook & McIntyre, 2002). Aiken, et al. (2001) found that 19% of U.S. nurses under 30 reported extensive career dissatisfaction. Koukkanen, Leino-Kilpi, and Katajisto (2003) findings agree with Price (2002) noting that a significant sample of nurses between 21-40 years old were either dissatisfied or had considered leaving the profession within one year.

The United States Department of Health and Human Resources: Health Resources and Services Administration (HRSA, 2004) and conclusions from its Bureau of National Center for Health Workforce Analysis (2002) predict a shortage of nurses greater than one million by the year 2020. A confluence of factors, including changing demographics, supply and demand issues at all levels of the career ladder, and an inadequate amount of

resource allocation supports this prediction. Furthermore, it has been a trend to hire workers at a part-time status and then work the nurse nearly full-time hours thus avoiding the high costs of benefits, especially in these difficult economic times. According to the United States Department of Labor, benefits combined make up 30% of the total compensation package. As of December 2008, it is estimated that benefits cost employers approximately \$8.81/hour (U.S. Department of Labor, December 2008 Employer Cost for Employee Compensation Survey).

Job dissatisfaction is also evident as nurses dissuade younger generations from entering the nursing profession. Aiken, et al. (2001), reports that nurses are not always supportive of others in the nursing profession. Bartholomew's 2007 study entitled "A Study of Nurse to Nurse Hostility: Why Nurses Eat Their Young" reveals that 60% of new graduates leave their first position within six months because of some form of horizontal hostility. Qualitative Data from the Minnesota Department of Health (September, 2003) survey reveal the following participant nurse statements: "I wouldn't tell my worst enemy to go into nursing. The chronic short staffing, coupled with life or death responsibilities, is killing. Adding to this, there is little respect from any quarter." "I am so glad that I am no longer a nurse. Too often other nurses are vindictive and petty towards each other [and] not supportive."

Job dissatisfaction is not a single entity but refers to a panacea of events and circumstances contributing to the current nursing shortage. In addition to the nursing shortage, other researchers report that shortage-related retention issues contribute to recruitment challenges across health care (Joshua-Amadi, 2003; Laschinger, Finegan, Shamain, 2002). Thus, recruitment and then retention are key factors in the nursing

shortage. The body of literature on nursing dissatisfaction is extensive, but no one factor has been singled out as the key to becoming satisfied with the career choice, nor one event that propels a nurse to change their employment. While some issues in health care such as the amount of time that a hospital is open to care for patients cannot change, there are factors that make a difference to the nurse. Joshua-Amadi (2003) reported that basic needs for health care workers such as salary and benefits are not being met. For example: In nearly two-thirds of the states, average hourly wages for nurse aides at the minimum wage threshold were below 200% of the Federal Poverty Line wage (\$20, 800) for individuals in one person households working full-time. Some of the individuals, particularly those with dependents, are earning near poverty level wages (Toleos, 2009).

While many nurses may be employed at one health care facility, salary and benefit packages may entice them to leave that facility and move to another (Joshua-Amadi, 2003). This fact illuminates the importance of salary and benefits to the nurse. Not only does the NA scrutinize salary and benefits, the LPN and the RN do as well. Young nurses with starting salaries, escalating employee share of health care costs coupled with working part-time hours set even an average RN unable to afford the cost of health care coverage. The research is conflicting regarding pay as the sole indicator of job satisfaction.

Research findings by Joshua-Amadi (2003) emphasized a belief by nurses that their efforts should be rewarded with equitable pay based on competence rather than role. Brown, Sturman, and Simmering (2003) attest that increased pay levels ensured a more qualified and motivated staff. Fung-Kam (1998) noted that low pay was correlated to dissatisfaction among nurses, as pay is an indicator of professional status. Gurley,

Spence, Briner, and Edwards (2003), found contradictory findings in their mixed methodology study. Qualitative findings revealed that nurses felt an increase in compensation would improve overall satisfaction though quantitative results revealed no differences between actual and perceived satisfaction related to higher wages. Chu, Hsu, Price, and Lee (2003) also found that pay alone to be the only variable not demonstrating a significant correlation to job satisfaction. Benefits, however, proved to be consistently ranked as related to job satisfaction and also ranked in some studies higher than salary (JayRay, 2002; Joshua-Amadi, 2003)

Aiken, et al. (2001) noted that the shortage is diminishing quality patient care, as staff shortages and increased job duties create an environment of stress that results in serious errors injuring or contributing to patient death. In turn, this creates a perception of poor patient care. Outcomes of flawed patient perceptions can generate licensure complaints and increasing legal actions. Hochwarter, Kiewitz, and Stoner (2004) found task efficacy to be a variable strongly associated with job satisfaction. Nurses state that patient care is their first priority (Price, 2002). Not feeling that you have provided the best care leads to job dissatisfaction.

Conclusion

In summary, current indications are that the nursing shortage is here to stay. Aside from the operating challenges, health care facilities are spending millions of dollars on a revolving door of nurse recruiting efforts, sign-on bonuses, overtime, and nurse agency fees. While there is much adversity in the health care workplace, nurses often state their patients are a source of job satisfaction and remain the pivotal reason they

remain in health care. Many nurses continue on the nursing's career ladder starting as a NA and continuing to become a RN. As graduate nurses seek their first employment, the retention of nurses will be a crucial problem that requires long-term solutions for health care facilities to maintain appropriate levels of staffing and optimal levels of quality care. While health care facilities may concentrate on recruitment, retention efforts are just as important. Could ensuring low cost health care benefits to nurses and their families provide coverage to an uninsured portion of society and increase satisfaction and improve retention of the health care worker?

CHAPTER 3

METHODOLOGY

The purpose of this research study was to determine the effects of not having health insurance on nurses currently employed at various points on the nursing career ladder, their spouses, or dependent children. The research questions included:

1. What are the experiences of health care workers, who are employed along various points of the nursing career ladder, in relation to health insurance?
2. Which policy options do the uninsured health care workers identify as being most helpful in meeting the needs to obtain health care insurance?
3. To what extent does employer provided health care insurance play a role in determining nurses career decisions?
4. What differences, if any, are there between uninsured nurses and the general population?

The specific objectives of this study were to: (a) assess the factors that contribute to the nurse's lack of health care coverage; (b) understand the nurse's perspectives and the challenges caused by the absence of health care coverage; (c) consider to what extent employer provided health care insurance plays in their decisions regarding employment; and, (d) examine how various policy options may address nurses needs for health care coverage.

Naturalistic Approach

I employed a naturalistic approach that seeks to understand phenomena in context specific settings where the researcher does not attempt to manipulate the phenomena of interest. Qualitative methodology using semi-structured interviews allowed for the

participant's thoughts, feelings, and experiences to be communicated in a way that would not be feasible using other research methods.

Choice of Paradigm and Considerations

The selection of the paradigm is derived from the beliefs and worldview of the researcher. Qualitative research situates the researcher as the instrument. Therefore, the questions asked, topics investigated, and methods employed must be a natural outgrowth of the researcher's experience, interests, and values. The selection of the appropriate research method relies on the intended purpose and study design (Blaikie, 2000; Cresswell & Clark, 2007; Silverman, 2004). For the purposes of this phenomenological research, I chose a qualitative methodology for providing a "lived experience" of the participants' reality in their own words. Qualitative research is not new to the nursing profession. While nursing has struggled with being a profession, and being defined as a science with the need to develop scientific knowledge, some scholars have argued against using an entirely quantitative paradigm and for the use of a sociological perspective to fully understand the concept under study.

Overview of Qualitative Research: Benefits, Limitations, and Assumptions

Over the last several decades, the utility of qualitative methodology has increased in both application and scope. The methodology has expanded to include a wide variety of research areas, while refining and strengthening its strategy. There has been increased research awareness that flexible methods can more fully appreciate the complex, social concepts that exist in social policy fields to understand complex behaviors, needs, systems, and cultures which cannot be explained by statistics (Ritchie & Spencer, 2002).

Researchers, specifically social scientists, have increasingly used the qualitative methodology as a means of understanding the phenomenology of human actions. A benefit of selecting qualitative methodology is the use of rich description to understand human phenomenon through inductive, naturalistic, and personal prolonged engagement. The qualitative study is a robust interpretation of social worlds. This action makes the research most reflective of the true picture.

I used qualitative research in conjunction with theory development and exploration, validating generalizations, and/or appraising outliers. Theory development and exploration are generated through the narrative dialogue which is emphasized in qualitative research. Qualitative research does not attempt to structure or control the data. Rather, it utilizes a subjectivist epistemological approach to capture a unique perspective or phenomena from the participants by seeking to discover an understanding of their experiences and perceptions.

One of the greatest strengths of qualitative research is the ability to explore marginal differences. This feature sets qualitative research apart from quantitative research as qualitative research provides a richer perception of the participant's reality. Research participants comprised of humans each with a unique perception cannot be controlled through rigid, structured experimentation. Typical Likert surveys, common in quantitative research, often fail to capture the thoughts, emotions, and experiences of research subjects adequately (Cresswell & Clark, 2007). This failure of quantitative research is the strength of the qualitative epistemology that captures the essence of qualitative research and provides the full understanding of the phenomena. The ability to "uncover the hidden meaning" of research participants by creating and developing an

understanding of actors in social situations empowers the voice of the participants to be more fully understood.

Recognized assumptions and limitations of qualitative research include:

1. Both researcher and participant can agree on common interpretations of words as an accurate reflection of the truth as narrated from participant to researcher (Moustakas, 1994);
2. Contradictions, bias, and subjective reality are inherent in the participant's world, making qualitative methodology appear somewhat irresolute;
3. Researchers assumptions may influence either research outcomes and/or participant responses;
4. Participants may bolster their responses to create a heightened sense of reality; and,
5. Participants may limit their responses based on a perceived threat and therefore may be unwilling or unable to engage in dialogue.

Misunderstandings, commonly referred to as dialectical paths, may occur frequently as the researcher and the participant may perceive words and body language differently (Moustakas, 1994). The researcher must ensure a clear understanding of the intentionality and meaning behind each participant's words. This includes quelling any temptation to lead a participant, finish sentences for the participant, or imply any meaning into a word, phrase, or body language that can lead the researcher into assumptions. Moreover, subjects may fear scrutiny from employers by divulging information and dissatisfaction regarding existing or the lack of health care coverage.

Purposive Sampling

I purposefully sampled a group of nurses who provided rich data on their experiences with health care coverage. Through a semi-structured interview, I asked the nurses questions about their experiences and had the interview data transcribed and analyzed. Questions regarding health care policy options enabled individual identification of the policies which would best meet their needs. The settings for the interviews were quiet and free of distraction.

Assumptions and limitations were mitigated through the use of validity measures common to qualitative research: credibility, transferability, dependability, and confirmability (Cresswell & Clark, 2007).

1. *Credibility*: establishes realistic or believable results achieved through the use of detailed narrative and direct quotations as told or narrated by the participant. Moreover, it ensures that researchers and participants internalize a universal understanding of words and their meanings;
2. *Transferability*: includes identifying appropriate research context and assumptions central to the research question or situation. Furthermore, it ensures that participant experiences are transferred or shared by other nurses;
3. *Dependability*: data analysis reveals patterns and themes making the research findings dependable; and
4. *Confirmability*: established through the process of member checking data as it emerges, confirming the accuracy of the participant dialogue.

These four validity measures are unique criteria, and represent standards reflective of the distinctive nature of the qualitative methodology. Developed by qualitative researchers, these processes counter the claims by quantitative researchers that the qualitative methodology lacks testable validity.

Research Design

Kvale and Brinkmann (2008) proposes seven stages for designing and implementing a qualitative study. As part of a rigorous, systematic approach to research, I have embraced the structure Kvale prescribed, while allowing the research to deviate from predetermined courses as outlined in the interview guide.

The first two stages involved thematizing and designing the study. This stage can be as basic as exploring the purposes of the study and creating interview questions to secure funding for necessary resources. Having a general framework for the study allowed others to judge potential needs. Funding for supplies, transcription services, and travel expenses was helpful. The third step involved the interview process and refining the instrument. Within qualitative research, the interviewer is the instrument and an integral part of the investigation. Data is mediated through the human instrument, rather than through surveys or machines (Guba & Lincoln, 1981).

The next step concerned transcribing, where the interview was transformed from speech to text to enable deeper analysis by the researcher. The fifth and sixth steps were analyzing and verifying. While both were covered in-depth, verification related to the ethical responsibility of the research to report knowledge that had been secured and verified throughout the research process. Follow Kvale's structure confirmed the nature

of the process to provide accurate data. The final stage is reporting of the research.

Kvale and Brinkmann (2008) reminds that working toward the final report from the start of an interview study should contribute to a readable report of methodologically well substantiated, interesting findings.

Health care, traditionally rooted in the defined hard sciences, has been slow to transition to and accept qualitative research. The medical and scientific community, disliking its subjective nature, remains cynical at best of qualitative research (Malterud, 2001). This bias may contribute to the resistance on the part of health care researchers to review and accept qualitative research. As a part of health care, nursing has been equally reticent to adopt qualitative research as a valid means for theory exploration. Schwartz (1990) suggested that “the current body of nursing research is largely quantitative and as such is unbalanced and biased, based on exaggerated information or false positives to create appeals for more decision making influence” (p. 551). I believe that qualitative research strengthened my study allowing me to explore data in a different manner.

Grounded Theory—Foundation for Research

Grounded theory is one area in which nursing research has accepted the tenets as a valid, defensible data collection, and analysis method. Glaser and Strauss used grounded theory to explain social phenomenon in health care (Wilson & Hutchinson, 2006). Grounded theory follows a systematic approach to data collection and analysis, which may appeal to those who feel strongly about a more rigorous quantitative collection and analysis method. Characteristically, grounded theory is used to explore

topics in need of a new perspective (Franchuck, 2004), as well as assess the contribution of processes, activities, theories, and events (Cresswell & Clark, 2007).

Grounded theory emerged during the 1960s when Glaser and Strauss studied patient experiences. Their diverse backgrounds introduced the utilization of a systematic research method that could capture the experiences of research participants generating theory. Grounded theory addresses specific phenomenological needs through the development of substantive or formal theory. Ideally, grounded theory assesses responses grounded in the data generated from interviews, field notes, and observations to discover social behavior patterns of the participants, which in the end develops theory. Moustakas (1994) claims the use of grounded theory facilitates theory development based on the experiences of people.

The purpose of grounded theory is twofold: to explain human social behavior, and to modify and broaden existing theories (Glaser & Strauss, 1967). Data are vetted through coding and the subsequent review of field notes, developing either substantive or formal theory. Substantive theory relates to a conceptual area, whereas formal theory is grounded in a specific content topic.

The grounded theory method employs constant data comparison (Glaser & Strauss, 1967). Field research, interviews, and notes are used in a systematic method of data collection and analysis. Constant data comparison allows research to identify patterns and relationships within the data that may not reveal itself otherwise. Dick (2005) states that data analysis is an overlapping process of constant data comparison of collection, notetaking, and coding (both open and axial), and field notes, all occurring simultaneously.

The aim of the study was to explore the experiences of nurses who personally or their spouses and/or dependent children do not have health care coverage. In addition, this study explored the competing public policy options that nurses believe might meet their personal needs. This study adds to the body of knowledge regarding nursing, nursing recruitment and retention, and the phenomena of being uninsured in the United States. Therefore, the application of a qualitative methodology explored a particular personal situation of the nurse in greater depth using grounded theory, the proposed research strategy for this study.

Research Participants and Sampling Plan

This study adds to the body of knowledge by exploring the perceptions of nurses regarding health care insurance and the policy options which the participants believe would be most beneficial to them. In order to gain an understanding for generating effective solutions, research must begin by factoring in the voice of the primary actor: nurses who experience the absence of health care insurance either personally or through their spouses or dependents. It was the purpose and intent of this qualitative study to understand the unique perceptions of nurses through semi-structured, in-depth interviews.

The focus of the research participants were nurses at all levels of nursing career ladder, including NAs, LPNs, and RNs. Inclusion criteria included:

1. The individuals are currently nurses employed on the nursing career ladder;
2. The nurses have experienced a period of time when they personally, their spouses, or dependent children did not have health care coverage.

Grounded theorists suggest a sample size of 20 to 30 participants (Creswell & Clark, 2007; Franchuk, 2004), relative to the specific environment (Maxwell, 2005) or to the point of theoretical saturation. The number of participants reflects an assumption that data saturation can be reached. This research study had 30 research participants, stratified 10 on each level of nursing's career ladder. Purposeful samples as utilized are ideally suited for grounded theory research because of the constant data comparison required for adequate data analysis. Purposeful or criterion based selections are utilized in research settings where the participants are selected intentionally to reflect the unique experiences of their situations; and when their situations often cannot be explained or described by any other body of participants (Maxwell, 2005). The use of snowball sampling enabling participants to suggest potential participants also enhances data collection as those within health care in general or within the specific situation of study may know others struggling with health care coverage as well. Furthermore, by having a stratified sampling plan, diversity in the sample population can be ensured. The flexibility represented by a diverse sample embodies adequate theory development through data saturation.

Nationally, nurses on all levels of the career ladder experience an absence of health care insurance. The intent is to understand and identify comparable results by utilizing a stratified, purposeful sample representative of a larger population of nurses who do not have health care coverage. For this reason, nurses were recruited from the entire western Pennsylvania region. Also, there is no exclusion criteria based on types of employment settings. Diverse employment areas may generate unique experiences and

enable the researcher to produce a wider array of responses generating both transferability and dependability of the data and results.

Transferability is the degree to which results from the qualitative study can be transferred or generalized (Creswell & Clark, 2007). Dependability, derived from quantitative reliability, reflects how often the same result can be achieved more than once (Creswell & Clark). From a qualitative perspective, reliability is sometimes difficult to achieve because the individual perceptions of each participant may differ. While each research participant may eventually bring a unique perception, data analysis reveals patterns and themes making the research findings dependable across a heterogeneous sample (Maxwell, 2005).

It is a concern to this researcher that information related to health care coverage as a result of employment could result in uneasiness for the health care facilities or concern of retribution by an employee if they discussed the inadequacies of the health care coverage and how it impacted them. Due to these concerns, the burden fell to the researcher to ensure the nurses understood that all collected data would remain anonymous and confidential.

Due to the personal nature of the topic, a serious concern among nurses, confidentiality was guaranteed both verbally and in writing. This study adhered to the guidelines recognized at Indiana University of Pennsylvania and the Institutional Review Board (IRB). All appropriate procedures and applications were followed in accordance with IRB policy to ensure the privacy and confidentiality of participants. Furthermore, research participants completed a "Consent for Participation" form. The consent form presented detailed statements which outlined the intent and purpose of the research, the

researcher's contact information, the statement of confidentiality, and the participants' right to exit the study. Participants were informed of the research intent, interview procedures, time commitments, and research topic prior to research participation. Participants received signed copies of confidentiality agreements prior to the initial interview. Furthermore, they were assured their contributions were voluntary, and as such they were free to terminate participation at any time. The researcher provided personal contact information to all participants should they have questions. Participants may request a copy of the concluding findings if it has been requested.

Data Collection Methods

It was the intent of the researcher to explore the experiences of nurses on the nursing career ladder who personally, their spouses, or their dependent children did not have health care coverage. In an attempt to capture their experiences, a variety of tools were utilized to develop the rich, detailed narrative, content that is typical of qualitative research (Creswell & Clark, 2007). Primary data were collected through the interview process, enhanced, and supported by field notes and audio taped interviews.

Interviews provide qualitative researchers the vehicle with which to begin an analysis. By asking open-ended questions, responses which comprised the raw data for analysis were elicited. These response quotes became the narratives which revealed the participants' voices. Patton (2002) reflects on the role of quotations within interviewing: "Quotations reveal the respondents' levels of emotion, the way in which they have organized the world, their thoughts about what is happening, their experiences, and their basic perceptions" (p. 78).

Interview questions were designed to address research questions with one interview question specifically focused on a research question. To meet the challenges of developing appropriate questions to guide the interview, the interview questions proceeded through field-testing with three nurses (one health care employer, two nurses who have struggled with health care coverage in the past). Their input regarding question structure and word selection and word emphasis was helpful in clarifying meanings and improving question content. The interviews were conducted with the aid of an interview guide (Patton, 2002), listing essential questions that were asked of each participant to ensure consistency across interviews. The use of the interview questions is recommended to maintain a sense of control over the questioning process and data analysis. Additionally, semi-structured questions are a better tool for representative comparability because they allow the researcher to ask probing questions to clarify, add greater detail, or develop a new train of thought. The use of comparability is relevant for this research due in part to the potential number of different health care facilities and levels of nurses on the nursing career ladder. The data collection instrument (Appendix A) was developed by the researcher to account for each variable identified in the conceptual framework and literature review.

While the unstructured approach is considered ideal for exploring phenomena and developing theories, it is inherently challenging on many levels (Maxwell, 2005). Maxwell contended that an unstructured approach leads to volumes of data which can be overwhelming. The structured approach was not applied either as it fails to provide thorough researcher/participant interaction. Therefore, this researcher utilized a semi-

structured questionnaire to encourage dialogue yet remained focused and produced a reasonable amount of research data.

It is common for qualitative researchers to spend time with participants necessitating that the interview and the observation work in tandem. Interviews were conducted at the convenience of the participant and in a neutral environment such as my IUP office away from the eye of the work environment. A neutral environment enabled the participants to feel safe, comfortable, and at ease throughout the interview process. In this instance, the researcher was more likely to establish a rapport and observe subtle nuances such as body language, a telling and indicative sign of true feelings.

While participants may allude to or say something in an interview, most will have a difficult time maintaining what Addison (1989) referred to as a “calculated stance” since the participants understand the focus of the inquiry which can influence behavior (p. 42); therefore, the idea of immersion through observation has become increasingly important in qualitative studies to obtain the most biased free data. Qualitative researchers gain increased familiarity with the infrastructure they are observing. This leads to a deeper understanding of the participant’s common language after their experiences of cultural immersion.

The roles of the researcher consisted of interviewer, transcriber of a few transcripts, and data coder. I employed others to assist in the data transcription process. Subsequent to transcription by another, I listened to the recording and read the transcript to confirm that all aspects of the recording were included. Transcribed narrative was provided to the participants for feedback, validation of thoughts and member checking.

There were no events of participants requesting any follow-up after the interview. The only request was for a copy of the study results.

Data Analysis

Grounded theory relies heavily on the researcher to develop and prepare a rigorous data collection protocol (Creswell & Clark, 2007). Participant interviews were transcribed and then the field notes and researcher notes were added documenting verbal cues, body language, and researcher thoughts. Data from transcribed field notes were coded with the aid of a qualitative data coding package, NVivo. While coding is not a feature specific to grounded theory, it is central to the grounded theory strategy. Data analysis was an iterative process beginning with the data transcription. By either transcribing the data or confirming the transcribed data, the researcher gained a familiarity with the data and began assigning codes and memos, one of the first strategies of data analysis.

Data analysis was comprised of three specific methodological parts including identifying relevant data, organizing data, and drawing conclusions from the data. This began by identifying specific content areas in an organized network of themes. Once the original themes were organized, the coding process continued with a further differentiation of notable patterns and themes. The combined analysis and strategy produced research results that adequately captured and relayed the experiences of the participants without jeopardizing the validity of the data and/or the findings.

Data Coding

Data analysis was completed in overlapping steps. This is consistent with the simultaneous data collection and analysis process common in grounded theory, as recommended by Eaves (2001) and Dick (2005). The purpose of the overlapping data analysis steps is to reveal patterns and identify theories within the data. Data ordering, an important part of early data analysis was utilized to arrange data to facilitate easier analysis.

Constant Comparative Analysis

The foundation of qualitative data analysis is the practice of constant comparative analysis through the use of coding. Glasser (1965) states that the researcher takes one piece of data and compare it to all other pieces of data. Coding is a subjective process, in which the researcher creates, defines, and refines codes that are traceable to the data. These codes are then refined through the method of constant comparison, where the essential features of the data are explored. While the process of coding is subjective, codes have been developed through a systematic, robust analysis that provides the reader with a transparent and traceable route from the raw data to the codes developed. Codes are collected and a codebook is organized, allowing for the comparing and contrasting of like-minded data. Data ordering included reviewing and coding data from field notes. This method of data analysis is inductive as the researcher examines data critically and draws new meaning form the data. NVivo provides the ability to order the data cohesively and to tie the data to the research questions. Data ordering is consistent with

grounded theory, in part because it collects additional data to cover gaps while identifying additional areas for data saturation.

Data Management

One challenge for all researchers exists in how newly acquired data will be organized into a manageable system for analysis. Lending itself well to the goals and methods of this study, NVivo was utilized as a tool for both data storage and systematization. Each interview was transcribed, typed, and entered into the NVivo program. Once an interview transcript was entered, various levels of nodes (codes) were developed, organized and refined, per the process of constant comparison.

Data analysis uses open coding to develop concepts, categories, and properties and is designed to fracture data and rearrange it into categories (Maxwell, 2005).

Three sets of data analysis were used in the coding sequence.

1. Organizational coding develops broad areas or categories;
2. Substantive coding develops a broader sense of concepts and beliefs as they originate from the data organization; and,
3. Theoretical coding provides a more general framework representing the researcher's concepts which are developed by the substantive coding.

Substantive and theoretical codes were developed as central themes and patterns emerged from the initial organizational coding as developed and outlined by the researcher.

Triangulation

Triangulation uses a variety of data sources, such as the participants themselves to examine and validate data (Cresswell & Clark, 2007). Adding merit to validity,

triangulation is important because it helps readers establish accurate findings. Cresswell and Clark stressed the use of other validity checks such as member checking and rich, detailed narrative, both of which enhance the narrative setting culminating in a shared experience between participant and reader.

Transcribed narrative was provided to the participants for feedback, validation of thoughts, and member checking. These actions ensure that the recorded interviews and field notes documented accurate information. Member checks provide assurances to the researcher, participant, and research community that perceived or inferred participant intentions were accurately captured. These data collection techniques of triangulation ensured validation within the research.

In conclusion, I used qualitative methodology to provide answers to the research questions. Using an interview guide, I interviewed 30 nurses from all areas of the nursing career ladder. The interviews were transcribed and analyzed for themes with the assistance of NVivo software. Throughout the process, I was consistently self-conscious of the credibility, transferability, dependability and conformability of the data. I completed the data analysis and drew conclusions which are presented in Chapter 4.

CHAPTER 4

DATA ANALYSIS

The purpose of this research study was to determine the effects of not having health insurance on nurses currently employed at various points on the nursing career ladder, their spouses, or dependent children. The research questions included:

1. What are the experiences of health care workers, who are employed along various points of the nursing career ladder, in relation to health insurance?
2. Which policy options do the uninsured health care workers identify as being most helpful in meeting the need to obtain health care insurance?
3. To what extent does employer provided health care insurance play a role in determining nurses career decisions?
4. What differences, if any, are there between uninsured nurses and the general population?

The specific aims of this study were to: (a) assess the factors that contribute to the lack of health care coverage; (b) understand the health care worker's perspective and struggles with the absence of health care coverage; (c) consider to what extent employer provided health care insurance plays in their decisions regarding employment; and, (d) examine how various policy options may address nurses' needs for health care coverage.

Semi-structured interviews were conducted and audio taped with a purposive sample of 30 registered nurses, licensed practical nurses and nurse aides who work in health care. The interview data and field notes served as the basis for describing how health care workers perceive the lack of health care coverage. The data presents the story

of these nurses, using their own words, to express their underlying thoughts and experiences related to a lack of health care insurance. Participant experiences were drawn from a 30–45 minute interviews with the researcher. The transcripts were analyzed using NVivo software.

This chapter provides a description of the participant sample, information about the reasons for each participant's lack of health care coverage and reports the findings of the study. The data presented and themes examined are to be transparent to the reader, and the participants are drawn out of the text to be more than simply an interview number, but a person with experiences, attitudes, and beliefs. It is intended to have the reader understand the participant's plight.

Demographics

The sample consisted of 30 participants, with ten registered nurses (two associate's degree, six bachelor's degree, two master's degree), ten licensed practical nurses and ten nurse aides (eight with the nurse aide certification). (See Table 2)

All participants were identified by the researcher through personal contacts and snowball sampling. Participation in the study was voluntary. There were 28 female and two male participants. Most of the participants (11 of 30) work in long term care, seven work in home health, four work in personal care homes, three in a hospital, three work in other settings, and two work in a doctor's office. (See Table 3)

Table 2

Level of Education of Participants

Level of Education	Number Surveyed	Percentage
Nurse Aide	2	7%
Certified Nurse Aide	8	27%
Licensed Practical Nurse	10	33%
Registered Nurse-Diploma/Associates's Degree	2	7%
Registered Nurse-Bachelor's Degree	6	20%
Registered Nurse-Master's Degree	2	7%

N = 30.

Table 3

Work Setting of Participants

Work Setting	Number Surveyed	Percentage
Long Term Care	11	37%
Home Health	7	23%
Personal Care Homes	4	13%
Hospital Setting	3	10%
Other	3	10%
Doctor's Office	2	7%

N = 30

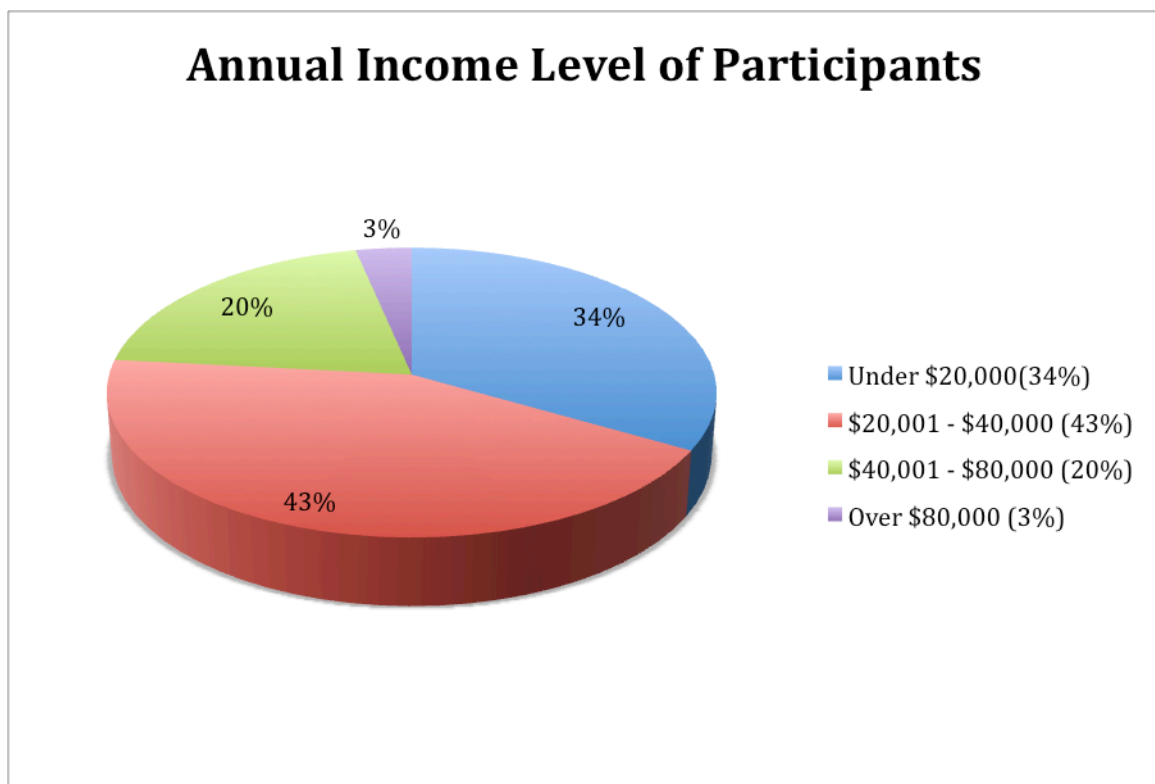


Figure 3. Annual income level of participants.

Interestingly, 13 of the participants report a household income in the \$40,001-\$80,000 range. Ten participants report a household income under \$20,000, six report incomes between \$20,001- \$40,000 while only one household income is over \$80,000. Most (25) of the participants worked in a rural setting with two participants stating an urban setting and three participants stating a suburban setting. (See Figure 1)

Table 4

Age of Participants

Age (Years)	Participants	Percentage
18 – 29	8	27%
30 – 39	11	37%
40 – 49	5	17%
50 – 64	6	20%
65 or Older	0	0%
N = 30		

Table 5

Health Care Experience of Participants

Years	Participants	Percentage
2 – 5	6	20%
6 – 10	10	33%
11 – 15	7	23%
16 – 20	3	10%
21 – 25	2	7%
26 – 30	1	3%
Over 30	1	3%
N = 30		

Who are the Uninsured in the Sample

Over 76% (23) of health care workers do not have health insurance. In three instances the nurses and their spouses not have health insurance. Six spouses of health care workers do not have health care insurance, principally because it was too expensive to place them on the health care worker's plan. Also, during the recession of 2009, the spouses of four participants (Interviewee RN1, RN6, LPN21, & RN25) lost their jobs which resulted in the loss of health care insurance for their families. One worker's husband died which caused her health benefits to be eliminated. Interviewee LPN10 and Interviewee CNA30 stated that divorce also contributed to the loss of health care insurance. The only instance of a dependent child without health care insurance reported occurred during the waiting period for enrollment in the Pennsylvania's Children's Health Insurance Plan (CHIP). All other statements about experiences of dependent children on the CHIP plan were positive and cited the numerous benefits of the plan and what a relief having the children on CHIP was to the family. (See Figure 4)

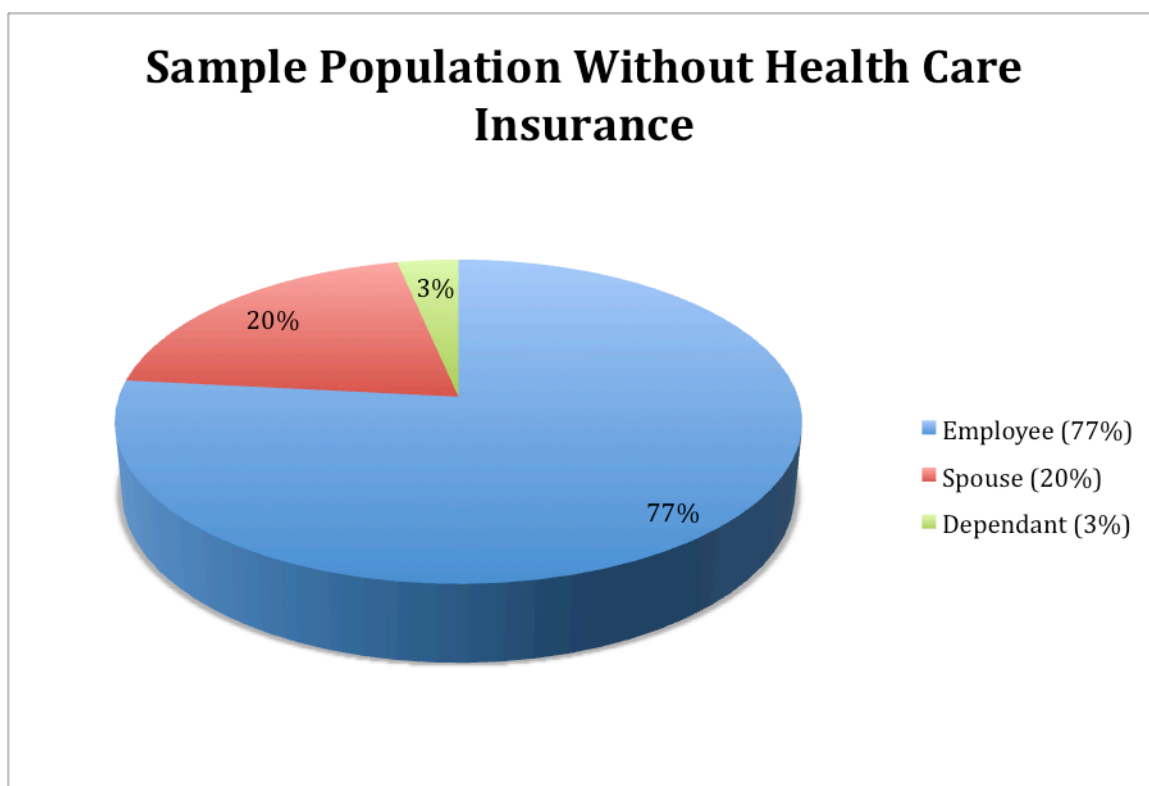


Figure 4. Sample population without health care insurance.

All nurses report the cost of health care insurance is unaffordable. COBRA benefits were reported as most expensive at a cost of between \$600 and \$1,200 per month depending on what benefits were included. Fourteen employed nurses report premium shares that range from \$125 per month for a single employee share to \$600 per month for family coverage. Three nurses indicated preexisting conditions as the reason why their health care coverage is unaffordable. Six of the 30 (20%) individuals currently had an outstanding health care debt that they could not pay. Lastly, many individuals without health care insurance stated they had applied for Pennsylvania's Adult Basic plan which is the adult version of the CHIP plan. Interviewees RN3, CNA9, LPN12, RN13, LPN14, CNA16, LPN23, LPN26, CNA30 stated they met all guidelines for the plan but were on a

waiting list. All acknowledged frustration about their inability to obtain benefits and the length of time they have been on the adult basic plan waiting list. According to the Adult Basic Annual Report (2008), the range of time that an individual has been on the waiting list has ranged from 3 months to 26 months. For individuals on the waiting list as of December 2008, the average time on the list was 11 months.

Research Findings

Semi-structured interview questions served as a basis to ask questions which, in turn, provided the answers for the research questions. Probing questions permitted further clarification of responses. Rich description of the concepts allowed the opportunity to seek themes when grouped with other organized data to explain phenomenon. Through constant comparison and theme analysis an understanding of the perceptions of the nurses was obtained.

The NVivo software provided the ability to store and organizes raw data. Transcript content as well as demographic data were analyzed in multiple ways to uncover unique relationships. NVivo systematically maintained the interview transcripts where I began to assign themes to begin coding responses.

Look for: Search In Internals Find Now Clear Options

internals

Name	Nodes	References	Created On	Created By	Modified On	Modified By
Interview # 27	22	35	12/28/2009 6:39 PM	DR	12/28/2009 11:02 PM	DR
Interview # 10 LPN	29	42	10/6/2009 8:46 AM	DR	12/26/2009 2:24 PM	DR
Interview # 11 RN	26	30	10/6/2009 8:45 AM	DR	10/6/2009 3:04 PM	DR
Interview # 12	23	28	10/6/2009 11:52 AM	DR	10/6/2009 3:04 PM	DR
Interview # 14	34	37	10/6/2009 2:40 PM	DR	10/29/2009 10:22 AM	DR
Interview # 15	27	35	1/1/2010 12:28 PM	DR	1/1/2010 2:22 PM	DR
Interview # 16	27	33	10/30/2009 2:55 PM	DR	10/30/2009 3:23 PM	DR
Interview # 17	8	10	10/6/2009 2:11 PM	DR	10/6/2009 3:04 PM	DR
Interview # 19	19	19	10/30/2009 2:29 PM	DR	10/30/2009 3:08 PM	DR
Interview # 21	27	35	12/31/2009 10:08 PM	DR	12/31/2009 10:56 PM	DR
Interview # 23 LPN	36	57	12/31/2009 2:33 PM	DR	12/31/2009 3:46 PM	DR
Interview # 24	27	31	12/31/2009 1:28 PM	DR	12/31/2009 3:46 PM	DR
Interview # 25 RN	29	31	12/29/2009 8:27 PM	DR	12/29/2009 10:07 PM	DR
Interview # 26	21	22	12/28/2009 9:33 PM	DR	12/29/2009 10:09 PM	DR
Interview # 28	19	25	12/28/2009 3:27 PM	DR	12/28/2009 11:02 PM	DR
Interview # 29 CNA	20	28	12/28/2009 2:52 PM	DR	12/28/2009 11:02 PM	DR
Interview # 3 NP	28	32	1/1/2010 11:48 AM	DR	1/1/2010 2:22 PM	DR
Interview # 30	31	37	12/28/2009 2:04 PM	DR	12/28/2009 11:02 PM	DR
Interview #1 RN	25	35	10/6/2009 8:38 AM	DR	1/1/2010 3:21 PM	DR
Interview #18	21	26	10/30/2009 1:55 PM	DR	10/30/2009 3:08 PM	DR
Interview #2 CNA	20	30	10/6/2009 8:33 AM	DR	10/6/2009 3:04 PM	DR
Interview #20	27	31	10/29/2009 9:05 AM	DR	10/29/2009 10:22 AM	DR
Interview #22	24	30	12/26/2009 1:21 PM	DR	12/26/2009 2:24 PM	DR
Interview #4	13	14	10/29/2009 9:04 AM	DR	10/29/2009 10:22 AM	DR

Interview # 11 RN

Lack health insurance- husband

Gamble

Anger at insurance companies

<Internals\Interview # 27> - \$ 1 reference coded [0.90% Coverage]

Figure 5. Interview data stored in NVivo.

A hierarchical coding system with axial coding using NVivo was established and queries were run to highlight comparisons of the observed themes (nodes) and specified attributes (demographic data). (See Figure 6 & 7) The discussion of the research findings was divided into individual circumstances and experiences as stated by those experiencing a lack of health care insurance and then a discussion of health care policy options.

Look for: Search In Free Nodes Find Now Clear Options

Name	Sources	References	Created On	Created By	Modified On	Modified By
Being a nurse impact decisions	15	17	10/6/2009 11:13 A	DR	12/31/2009 10:37 PM	DR
Advice for politician	10	17	12/28/2009 2:44 P	DR	1/1/2010 1:46 PM	DR
Anger at insurance companies	14	18	10/6/2009 11:12 A	DR	1/1/2010 12:05 PM	DR
Health insurance very expensive at work	17	20	10/6/2009 9:09 AM	DR	1/1/2010 12:01 PM	DR

Interview # 11 RN Lack health insurance- husband Gamble Anger at insurance companies

<Internals\Interview # 27> - \$ 1 reference coded [0.90% Coverage]

Reference 1 - 0.90% Coverage

I can not understand how things have gotten out of hand.

<Internals\Interview # 10 LPN> - \$ 2 references coded [3.80% Coverage]

Reference 1 - 1.25% Coverage

So, I mean, the other twenty percent I feel that if you're making payments or should be able to come a conclusion, look this is what I can afford, you've got eighty percent...

Reference 2 - 2.54% Coverage

I'd say the insurance companies themselves - the Blue Cross Blue Shield... I just feel that they get enough with the eighty percent, and it's overcharged as it is. I mean, how desperate do they need the other twenty percent? I mean, if you're making co-pays or if you make a-a lump sum, this is what I can afford, I think it should be acceptable then.

<Internals\Interview # 14> - \$ 2 references coded [6.99% Coverage]

Reference 1 - 1.81% Coverage

nces: 18 Unfiltered

Figure 6. NVivo example of axial coding with transcribed data.

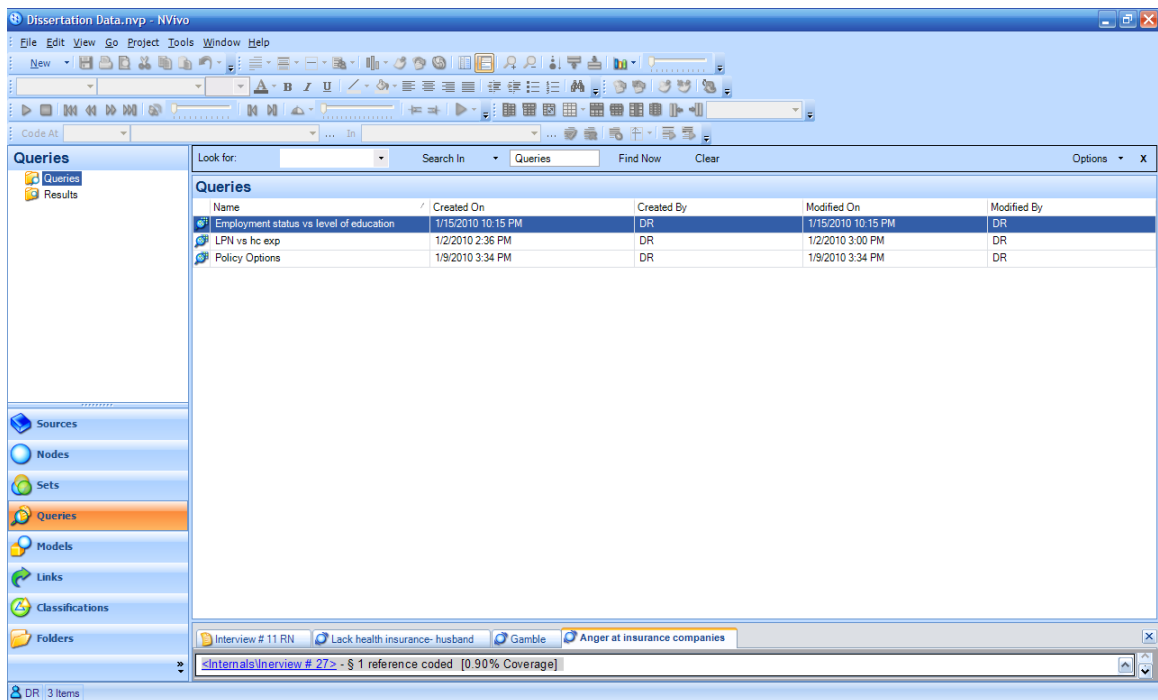


Figure 7. Queries linking attributes to data.

Part 1

Individual Circumstances and Experiences

Axial coding, important in grounded theory research, was used to cluster concepts which are focused around a central idea or theme. Themes were established within NVivo and when a concept arose in the interview data that would be categorized within a theme, the content was then copied from the text and pasted within that theme. Within the data under the specific theme, NVivo would state which interview the data was obtained and the reference coverage percent. In analysis, many repetitive themes were found to be present by statements from individuals at all levels of the nursing career ladder.

The following were classified according to a hierarchical order of tree nodes because of their common themes:

- Feelings related to lack of health care insurance;
- Greatest fear associated with not having health care insurance;
- Health care insurance expensive at work or not offered at all;
- Health care maintenance changes;
- Length of time without health care insurance; and,
- Decision to switch jobs for health care insurance/health care insurance is a top priority for employment.

Feelings Related to a Lack of Health Care Insurance

For some, a one word answer such as “depressing,” “very frustrated,” “stressful,” or “overwhelming,” was given. Interviewee CNA8 remarked that it crosses her mind

everyday. Interviewee CNA29 stated, “I worry. I feel guilty when I go to the doctors knowing that I am putting all the money in me and not my family.” CNA30 stated, “health care coverage is something that you should not have to do without. I need health care benefits.” LPN23 called the lack of health care coverage “embarrassing.” This LPN went on to state that she has a “fear of telling others but in an emergency situation she would have to.” LPN22 in tears stated, “It sucks. No one would want to be in my position. I feel like I’ve failed socially and for my kids. No one wants a handout but sometimes you have to give in.” RN25 stated, “It is a very sad and an uneasy feeling.” Interviewee RN11 stated, “Guilty (pause) I hate it. I would never have imagined not having health insurance. I have to find a way to get my family covered.” She went on to say, “I am also angry about my situation. I feel if two people work full-time like my husband and I, we should be entitled to affordable health care coverage.” Interviewee LPN12 stated:

It is a nervous thing. I mean, you as a nurse know, you need to have it done but to go to the doctors it is \$40. To have anything on top of that, you know its a couple hundred dollars. These days are not the best for our economy and those prices do not fit into my budget.

Interviewee CNA17 is a nursing student. She states the feelings of many students. “What really bothers me the most are the people who are on assistance and are getting the good health care coverage that I can’t qualify for as a student. I am a student and trying to better myself and there is nothing out there to affordably cover me.”

A free node theme grouped within the larger tree node hierarchy is the repeated heard word “gamble.” Thus, gamble was noted as a subtheme emerging within a theme.

Interviewee LPN14 used the term in this context, “I like the little clinics that you can go to if you get sick. I feel that I have saved money if I can just use them and decline health insurance. It is a gamble though.” Interviewee RN25 agreed that living without health insurance is “a gamble. I know it.” Interviewee RN3, a nurse practitioner, husband lost his job and health insurance leaving them currently without insurance states that she cannot pay the \$800/month family plan. “We are going to gamble our chances on, you know, if I don’t get sick then I’m OK in this situation.” Interviewee RN1 whose husband does not have health insurance but is in good health stated, “He is healthy so I do not know if it (the lack of health care coverage) is a good gamble or a bad gamble.” Interviewee CNA2 laments, “Not having health insurance is one of those things that is always in the back of your mind. You have to deal with it and take your chances.”

Greatest Fear Associated with Not Having Health Care Insurance

Interviewee CNA28 stated, “debt and death. I am afraid that he (her husband) would refuse to go to the hospital in the case of an emergency. I am also afraid of the expense of health care. We could lose our home.” Most other comments had the same theme ranging from “debt. I am young. I do not have large credit card debt and that type of thing. I know that hospitals will take care of me in the case of an emergency but how would I afford it?” Others are afraid that “something will be overlooked or wait too long for attention and then something terrible will happen.” Interviewees RN25 and RN3 agreed that an “emergency could cost you for some time financially and that even if you are young and in good health you could fall and break a bone thus needing to be hospitalized with diagnostic procedures and surgery.” Interviewee LPN26 commented

that her greatest fear is not having access to doctors when I need them. “I feel that currently . . . like I am embarrassed to call for an appointment. There is an embarrassment associated with not having health care insurance. It is like we don’t work and have to be taken care of.” Interviewee RN18 stated, “a bill . . . regretting the decision not to at all cost get coverage. But really we have a flawed system when professional people can not afford coverage. Especially people who provide the coverage.” Interviewee LPN5 provides a concrete example:

It’s a little scary because if something would happen to me, I would have to pay full price. Just to give you an example, to get the part-time job here I had to pay a physician in Indiana \$350 for the physical and hepatitis shots and the flu shots in order to work a part-time job. So it has taken me a little time to pay that back.

Health Care Insurance Expensive at Work or Not Offered at All

Part-time or per diem workers frequently do not have the opportunity to purchase employer sponsored health care insurance or cannot afford the premium share. CNA2 stated she works the weekend program which offers a higher salary but no benefits. She states, “I do not have the opportunity to have health care insurance through my employer.” Interviewee RN3 working at a physician’s office as a nurse practitioner states, “my employer is a physician who chose not to offer health care insurance to his employees because it was too expensive. Their spouses carried benefits so they did not offer it.” CNA13 & CNA16 who work at personal care homes state their employers do not offer health care insurance at all. Of those who do have the opportunity to purchase health care insurance the most common theme is that the premium share is too expensive.

Interviewee RN11 states, “I would really like my whole family to have health care insurance but can not afford the amount that would be taken from my check. That money goes to pay bills. I live paycheck to paycheck.” Home health CNA14 states, I gave up my health insurance when we needed to buy a car to get to work.” CNA2 provided details of her experience, “My last paycheck was \$344. That \$62.50 would cover an electric bill or gas bill.” Interviewee RN20 was honest when asked if she felt there was no way she could afford health care insurance. She replied:

Our income is my husband’s unemployment and my approximate \$1200 per month salary. We could go into debt, run up credit cards, etc. and sign up for health care insurance. It may come to that. I am currently just holding my breath. I guess that the answer is “yes” and “no.” Yes, we could have health care coverage if I spent a good bit of our living expenses on it. I would have to say what would you do? Sure we have a minor savings and own our own house but do you put that all on the line.”

Health Care Maintenance Changes

When asked if there had been any changes in what the nurses did to maintain their own health, Interviewee LPN10 stated:

Well, like my doctor told me the other day. She said, you waited too long to come in, you should have come in sooner. Well, when you need to save up money to come in and pay for an office visit and blood work . . . you wait as long as you possibly can. Which probably ends up causing, you know, more health problems in the end.

LPN10 stated that you cut back. “You take one pill every other day instead of every day. So I cut back on my medication which is probably the reason that I am hurting now.”

Seven Interviewees (1 RN, 4 LPNs, 2 CNAs) reported not having annual check-ups, bloodwork or doctor’s appointments due to the lack of health care coverage. Interviewee CNA13, at a long term facility stated:

It does really impact you because you can’t afford to do the stuff you need to do, even when you’re really sick. Its like pop some over the counters cause it is a hundred and some dollars to go to the doctor, then to get your prescription filled, its unreal.

One of the saddest statements was Interviewee RN1. She stated:

I actually . . . um . . . (hesitancy in speech) am having severe abdominal pain and I went and paid to see a doctor and he said that I would need an ultrasound of my gallbladder cause he thought that it was my gallbladder. He is probably right. I keep having pain. I’m just going to have to live with it until I can get insurance. It would take years to pay for a surgery bill.

When asked if they believed that not having medical care when needed impacts their work, every participant responded “yes.” Interviewee RN1 stated, “I recently had to call off three days in a row because of the flair up in my gallbladder pain.” Nurses state that the delivery of health care to their patients could be compromised due to the turnover of health care employees related to employment changes or health care concerns stemming from the nurse’s neglect of their own health.

Effects on leisure and recreational activities were noted by several nurses.

Interviewee RN11 said “when the kids wanted to be in physical activities, I try to steer

them away. So really, they are losing being a kid. It is not fair to them but I can't take a chance on them being hurt." Interviewee RN20 and Interviewee RN4 adds that they are "more cautious" since having a lack of health care coverage. Also, Interviewee LPN7 states that she has "fear of an accident." "Like getting injured for a period of time and not having insurance and not being able to go to work." Interviewee NA9 expressed similar feelings, "I do not do, like silly things, like sled riding. I wouldn't sled ride cause I'm a clutz (laughter). I am! I said, if I go down that hill, I'm gonna break my leg!" In addition, Interviewee RN1 changed employers do to more affordable health care insurance but stated that it came with inconveniences to her family. "We are still transitioning (to the new job) to be honest with you. Nobody seems to know what anybody's schedule is half the time. Nobody seems to know whether I am coming or going."

Length of Time without Health Care Insurance

Participants were asked for the length of time they or their spouse or dependent children did not have health care insurance. Responses ranged from six weeks to five years. Eleven (37%) of the 30 interviewees stated they have had inconsistent health care insurance for a period over two years. No one (0%) believed they had an immediate end to their health care difficulties.

Interviewee RN9 and LPN23 specifically spoke of how their family had inconsistent health insurance coverage growing up. Interviewee NA9 stated her feelings and regrets:

It really bothers me because I know there were times with my parents with changing jobs and having their own business and losing coverage and stuff. And, actually when my father was diagnosed with cancer, he did not have health care insurance. My mother bought new coverage and got a job right before he was diagnosed. He hurt himself in December but my mother's coverage did not start until April. He actually put off going to the hospital until April. He put it off because he thought that he separated his shoulder, but it was actually a lung tumor that was growing out into the left shoulder and that was causing all of his pain. So actually he put off three months of diagnosis and treatment because of not having health care coverage. Hindsight, did he die sooner than if they would have been treating him sooner. Who's to say.

Interviewee LPN23 had difficulty all of her life maintaining coverage. She stated:

I am used to hurrying up and getting a check-up and meds or my teeth checked before the end of the insurance. Just because I have coverage one day does not mean that I will keep it over the next several months.

She thought that nursing was a profession that ensured health care coverage. Interviewee RN15 remembers a time when he thought of dropping his health care coverage to use the money for other things. He states:

I remember a couple of years ago when I was paying out of pocket for health insurance and I was going to stop it and my mom talked me out of it and the very next day I ended up getting appendicitis and it was like \$11,000 so I keep having that running through my head.

Related Themes: Decision to Switch Jobs Related to Health Care Insurance/Health Care Insurance is a Top Priority for Employment

Though not on the interview guide, a recurrent theme which was highlighted when asking probing questions from all nurses on the career ladder was that participants were considering changing jobs to obtain health care coverage. Further information was obtained by asking probing questions. Interviewees LPN5, NA9, LPN10, CNA13, CNA16, and CNA27, realized that benefits are equally as important as pay. Interviewee CNA13 stated:

I think that health care is a priority. Because you could be making \$3 per hour more but if your health care is not very good, by the time you pay out of pocket for those medical expenses, it would be better off for you to have insurance to pay for your copays, you know, all of your procedures and everything than to make that three more dollars an hour in the end.

Interviewee LPN10 relates her personal story:

Oh, health care is going to be my top priority. In all honesty, with my health and medical problems, that (health care insurance) is something that is probably going to outweigh more than my pay. I had a tumor removed from behind my eye. I have to go to an ophthalmologist frequently. Health care is going to be one of my priorities in looking for a job.

Interviewee LPN10 combines the benefit/pay issue and the fact that health care will be a top priority when looking for a job. Interviewee RN11 stated, "I do not want to leave my current job but I have an interview next week at a hospital in hopes of gaining

employment with health care insurance coverage at an affordable cost.” Interviewee CNA16 agrees:

I am actively looking for another job. I have applied to other places and if I know someone that works there, I’ll ask them about the benefits and see if they have health insurance and how much they pay for it before I apply there.

Interviewee RN1 has already changed job primarily due to health care insurance concerns. She stated, “I gave up a very nice Monday through Friday daylight job. So I made the decision to switch jobs in order to have affordable insurance but we have elected not to put my husband on yet.” Interviewee RN20 not only talks about finding another job, she stated, “I have considered leaving a health care job altogether for a job in another field . . . even with all of my years of experience. I really do not want to do that. I love being a nurse.” Interviewee CNA22 talked of the importance of nursing in her life when she commented:

I sometimes think of looking for another job, one which gives me health care insurance but my work is so important and truly the constant in my life. I love the residents and they are good and caring. They ask me about my family and sometimes give me advice.

Interviewee LPN14 also stated:

I have considered leaving. It is so hard because I love where I work, what I do and the people that I work for. Truly, if the personal care home owners could afford the cost of health care insurance for us, they would do it in an instant. They used to cover 75% of the health care premium but with the rising costs just

couldn't afford it coming from their budget so had to pass the additional costs on to us workers.

A related theme is that health care insurance is a top priority for employment. This theme was stated by those looking for a health care position. Interviewees RN19 and RN25 stated that health care is a first or second priority when searching for a position. "Most people are looking for permanent positions with benefits. There are not enough of good jobs, especially ones with a good base salary and benefits." Interviewee CNA27 lamented, "There are a lot of caring professions but I did feel that there were many benefits in nursing. Good wages, benefits, flexible hours. It is sad to find out that there are struggles too." Interviewee RN15 commented:

I'm really comfortable at my job and have autonomy but the health care, not the pay (emphasized), is the thing that is going to cause me to get another job eventually. So that would be my number one priority for leaving would be health benefits.

In conclusion, the statements of the employed nurses document the difficulties nurses on all levels of the career ladder experience. Several reasons exist causing a lack of health insurance (spouse's death or layoff, low wages prohibiting premium share, agencies not providing the opportunity for group insurance). Nurses also have stated the worry related to the absence of health care insurance and how it impacts their health.

Part II

Discussion of Health Care Policy Options

I believe it is important to learn from nurses who lack health care insurance for themselves, spouses or dependent children to understand how current proposals for national health care policy affect them. Health care policy options have been heatedly debated since the 1940s. When beginning the interview process in January 2009, the dimensions of health care policy options were very vague. During the interviews, I used cue cards to identify the key points of policy options. Over the next few months to the conclusion of the interview process in December 2009, much had changed in the discussion of national policy and interpretation of policy options. General statements of broad policy options such as universal coverage or tax credits gave way to specifics of the public option fueled by the media's perceptions and political party rhetoric. I believe the results of this section were influenced by the timing of the interview.

Health care reform has been a top consideration on President Barack Obama's agenda since his inauguration on January 21, 2009 and momentum is building for reform. Nurses with a lack of health care insurance coverage also have varied opinions regarding national health care coverage. Interestingly, anger at health care insurance companies and distrust of the government were persistent underlying themes that emerged from the dialogue. Field notes confirmed areas of passion in voice inflections and a change of posture. It is understood that this topic evokes strong feelings and concerns. Predetermined policy options were selected with objective definitions, without any reference to political party, placed on note cards for the interviewees to have a common

reference point to review and discuss. Specific personal thoughts on all policy options were requested as well as thoughts on the policy option that they felt best fit their needs.

Anger at the Health Care Insurance Companies

Much of the participant anger focused on the rising insurance premiums.

Interviewee LPN14 stated:

I would say that someone needs to stand up to the health insurance companies and make them limit their costs. They do not need to sponsor so many runs, senior expos, etc. I believe that it just can't be whatever the insurance company says . . . 4% increase, 8% increase. Someone needs to be accountable.

Interviewee NA16 stated:

Whenever you do get insurance you can't necessarily afford insurance. I ran into issues like that with my family members. After paying the premium share, there still are [sic] co-pays and deductibles.

Interviewee LPN23 stated that the insurance companies are "greedy" with the CEOs "making big bucks." Interviewee CNA28 did not believe health insurance companies are concerned with the best interests of the people. She stated, "You just can't trust them. They are out to make money at all expense." Interviewee CNA30 had strong feelings stating, "Hate them. Too big, too fat, too cold." Interviewee CNA27 cannot understand how things got so "out of hand." Interviewee LPN21 recognized that health care is expensive. "It shouldn't be this expensive but it is. It is also difficult to get reimbursement. I see it from all sides." Interviewee LPN5 agreed saying:

Everything is a business. It's a problem of supply and demand. The more people you have on your policy by rights, it (your premium) should be lower. It is not that way. I took the highest deductible, I think it was a \$6000 deductible, the highest deductible they offered and they are still adding \$100 more per month.

Interviewee RN18 summed it up by stating, "We really have a flawed system when professional people can not afford coverage, especially people who provide the care."

Distrust of the Government

Interviewee RN4, RN11, LPN14, RN20, LPN21, LPN22, and LPN26 all expressed concern with government sponsored health care. Perceptions of incompetence in administering such a program are noted in the following statements, "The government can't run the things we give it. I can't imagine the cost." "I do not want the government in health care. If the government set all regulations I believe that we would be restricted and reimbursements to health care providers would not be enough to operate." "The government's idea is to cut costs. What do you do when there are no costs to cut." "I do not trust the government not to change the rules." "I would really feel unsure of having coverage that is regulated by the government. Now you have it now you don't. I would rather have coverage that I purchased and agreed on all of the terms." "If you and I could run the plan I would feel really good about it, but based on the way that the government runs everything else. I do not like this plan." Interviewee CNA2 stated, "The biggest problem that I see with that type of plan is the moment that something good happens to the common person, the government sees it and bumps the prices up."

Nurses' Impression of Policy Options

Health care policy has been debated for decades. No clear policy option has been proposed to reduce the number of uninsured. John Kingdom (1995) argued that a change in how a problem is defined or perceived or a change in political power can open a “window of opportunity” for policy innovation. To successfully change policy, advocates must be organized to take advantage of a window when it opens, coupling their favored solution with the priorities of political leaders, organized interests, and public opinion. Kingdom also acknowledged the brief time that the policy window is open. If there is no movement on the policy, supporters must bide their time until the next opportunity comes along. In the past half century, there have only been two other viable opportunities to change health policy in relation to health care insurance, first in the early 1970s and again in the early 1990s.

With the heightened political debate and presidential mandate, I felt compelled to ask nurses for their reactions. The predominant health care policy options of 2009 were selected to discuss with the nurses. Grouped for ease of explanation and comparison purposes were health saving accounts and a health tax credits. Employer sponsored health insurance was contrasted with the fair share or pay to play policy option. Universal coverage was also discussed.

Health Savings Account

Health saving accounts are employer held accounts where employees contribute pre-tax dollars to spend on health care costs. This plan is a companion to high deductible insurance plans in order to obtain lower monthly premiums (Sinnett, 2004). The data

produced very little derivation in theme. Individuals stated two key points; the need to stretch their own money and the amount of money needed to even make a difference. The majority of interviewees who verbalize that they are living “paycheck to paycheck” scoffed at the notion of having money to place in a health savings account to purchase health care. Interviewee CNA28 emphatically stated:

Gimme a break. I am a CNA whose husband takes odd jobs to make ends meet.

Who are we kidding that there is extra money to budget for health care expenses.

There is no extra money (stated with emphasis and leaned closer to me with direct eye contact).

Interviewee CNA29 provided similar input with less emotion, “I see what they are saying about freedom of choice but I do not see how it can help someone with such a limited income. There is no way that I could save enough money to offset what I need.”

Interviewee RN25 stated, “It is unrealistic to think that people have money to put away.

It would have to be mandated in some way or withheld from their pay.” Interviewee

LPN26 stated, “It is another tax break for the rich. Who else could afford to hide money there?” Interviewee LPN7 stressed a point, “Ask how many people have money to put away in a savings account.”

Other interviewees seemed interested in the idea but unsure. Interviewee LPN23 stated, “I might be able to put \$20 per pay away but what will that help in the end. I really don’t have that much extra money, even if it is tax free, to put in the account.”

Interviewee LPN24 stated tentatively, “I think this might be ok. Well, I don’t know. It would take a lot of money.” Interviewee CNA27 agreed that it would be good to put

money away because it would be there when you needed it. I asked if she could put a regular dollar amount away now. She said with laughter, “No.”

Health Tax Credit

The health tax credit allows families or individuals to deduct a predetermined dollar value from their federal income tax liability and then use the money to purchase health care coverage. Nurses were less strong in their sentiments when describing their thoughts on a health tax credit. This option did not require the nurses to contribute their own money because it is a credit from the government making it more palatable than a health saving accounts. More nurses see the potential benefit but also identified the potential pitfalls. Interviewee RN11 stated:

It would be nice to have a good size refund but I can’t imagine it being enough to cover the costs for several months. We would have to be disciplined to spend the rebate only on health care. Many times we use the refund to pay down the credit card. We could not be tempted to do that, even though that is important too.

Interviewee LPN14 questions:

I can see where this would be good but do you think that people would really allot this money to pay for health care insurance? One would have to be very disciplined. This has possibilities but I do not think this would work for me.

Interviewee RN25 agrees, “Also giving money back to the people at tax time, to me (pause), does not mean that they will purchase health insurance coverage.” Another interview (RN20) was the most negative:

I think that politicians are crazy if they think a credit is going to help people.

People need help paying the monthly bill. Not a credit at tax time. Also, I do not know that people would use the credit for health care. I guess that sounds badly but there are people with all kinds of addictions and just because at that time they have money does not mean they will use it for that purpose.

Interviewee CNA27 expressed that it would be nice to make selections regarding your health care coverage that fit your circumstances. She continued, “I do have my doubts that it would work though.” Interviewee LPN13 and LPN24 stated:

I think that’s a good thing. I guess initially it would be hard, you know, to pay that first year, that first \$5000 to \$6000 but after that and having the credit, you know, I think it would be a good thing. Yes, I think it is doable.

Interviewee CNA2 simply stated, “That would be nice.”

Others still had doubts regarding the government changing the amount of the credit and the timing of the credit. Interviewee NA9 stated, “Can’t do it. If you would have to pay that monthly before the income tax return. I couldn’t see that happening. I live paycheck to paycheck. There is no money.” Interviewee LPN23 stated:

I love to get money back at tax time but don’t really trust that it would make a difference throughout the year and also the government can change that at any time. I don’t see where I would trust either of these.

Interviewee CNA13 questioned the amount of the credit:

I think it would work really well if you got enough to cover it all. Because, I mean, \$200 to \$3000 would not be enough so then what’s the use. You might as

well just use the money for expenses because you are not going to have insurance again.

Fair Share or Pay to Play

Fair share or pay to play refers to states using their taxing authority to encourage employers to provide health insurance to their workers. If the employers do not provide health insurance coverage, the employees will be placed in a state insurance group and the employers will be charged a fee for the coverage. Nurses across the career ladder have a more optimistic view of this plan because the state is also offering funds for those with a low income to help with the premium. They like the fact that their employer is forced to participate in some form but are unsure of an employee mandate to carry insurance. Interviewee RN11 stated:

I think that having the state in the mix is better than just giving the control to the employer. If the employers do not want or do not feel that benefits are part of employment then you are sunk Unless you have a union, which my employment agency does not. Everything is so unfair.

Interviewee LPN12 stated:

It gives everybody the opportunity to have (health care insurance), in one way or another, where your income per say isn't the only option or . . . they're not looking at that as part of your qualification. You're qualified either your employer helps you get it or they (the state) helps you get it.

The interviewee goes on and explained:

I have worked with a lot of people who don't have or haven't had health insurance at some point and work in health care. It's hard, you know they are sick. You know they need help and/or care or an antibiotic but they don't have coverage so they can't afford it. So that, to me, makes it OK to mandate the employer and the person for it is for their own good.

Employees are still concerned with the amount they would have to pay.

Interviewee CNA8 stated:

Like I said, it depends on how much I would have to pay. With the economy the way that it is and the people that I work with . . . they are their part time for a reason. They can't work full-time so like I said, it depends on how much it is.

Interviewee NA9 agrees but still thinks that it is a good idea. She stated, "Depends on much I will have to pay. That's really a determining factor. Also, having to pay upfront is difficult even though I will be reimbursed." One employee (Interviewee LPN5) stated that she liked the plan for the person (employee) but not the business.

Unfortunately, especially for small business owners, it makes it very difficult for them to keep that coverage because the cost of the coverage has been going up and up. A commercial plan for two people can be almost \$1200 per month. The money has to come from somewhere.

Interview LPN14 agreed and further emphasized:

Will you limit employees and give poor care? Will you charge more to the residents? Will you close the doors? And who would benefit from that? There are no easy answers here. I do not hold the business responsible.

Another group of workers was concerned about mandating people who can not afford a monthly premium. Interviewee RN15 and LPN24 do not think it is reasonable to mandate everyone to have health care insurance stating, “Every employee and employer has a different perspective.” Interviewee LPN23 states, “They cannot make me purchase health care insurance that I can not afford.”

Employer Sponsored Health Care Insurance

The employer sponsored health insurance market provides coverage to nearly two-thirds of the population under 65 years of age. Employers may choose whether to offer health insurance to their employees and employees may choose to enroll or forego enrollment. The employer would sponsor and maintain health insurance for their employees with potentially a set division of costs. Nurses are familiar with this type of coverage. There were two themes offered by the nurses, reasonable cost and if it is offered.

Interviewees CNA27, RN11, LPN14, LPN23, RN25, LPN26, CNA29, CNA2, LPN22 all agree that a reasonable cost to the employees is key to a nurse accepting the insurance. Comments including: “I like employee sponsored health insurance if the price of the insurance is reasonable.” “It is ok if it is a reasonable cost. It is not working the way that my employer splits it, especially with my pay.” “It is unreasonable for individuals who make take home pay of \$350 after taxes per week to pay \$250 for benefits out of that pay. How to make it fair and equitable to the population is the problem.”

I like this if it is reasonable. I just do not know what this would do to my employer. It is the same as the comments that I made in the fair share section. We currently have 12 residents and could have as many as 14. Our bottom line and budget are very narrow. Adding a couple hundred dollars per employee per month, I would imagine is not an option.

Of course, I like this if the cost is reasonably priced. It is great to have the employer provide the majority of the cost of the coverage. Unfortunately, the cost of the employer plans keeps rising so the employers especially in small health care businesses can't afford it. Those prices are passed on to people like me and we can't afford it (Voice getting louder).

“We are seeing more and more that there is a share in cost between the employer and the employee. Making it sometimes not even feasible to go with the employer based coverage.” Interviewee CNA2 provides a description of her experiences:

Most employers give you the minimum hours and shuffles the hours so they are only paying minimum hours, which are not enough for health care insurance.

Others keep you part-time. What you end up with is a very low paycheck. You would have to deduct 20–30% for health care insurance that you have to pay. It takes a good chunk out of your paycheck. You have to start deciding Do I need my medicine or do I need food or do I need to pay my bills so the heat stays on.

Nurses also need to have the opportunity to have health care insurance. Nurses report that some health care facilities are not offering the benefit. Interviewee CNA27 stated, “I could pay some for insurance, and would, if it was offered. I think that

everyone is used to this option.” Interviewee LPN12 stated that employer sponsored health insurance is good “if it is available.” Although there is a current nursing shortage, Interviewee CNA30 stated:

I still believe in this option but how can this system be working when there is so many uninsured. Also, with 10% unemployment . . . how can it work without a job? The economies are such that companies are freezing pay . . . huh unless you work for a bank . . . I think that this is the hardest time to be asking for employers to put out additional funds in light of the rising costs. Someone has to pay for the costs.

Interviewee LPN21 lamented, “You are not going to find free health insurance anymore.” Interview CNA2 and LPN22 pointed out: “Employer sponsored health insurance looks good but for many reasons is not working.”

Universal Coverage

For universal coverage, the government functions as the nation’s insurer and provides taxpayer sponsored medical coverage. The majority of the participants in the study support if not prefer a basic, across the board coverage such as a universal coverage. Many stated (13 out of 17 comments) that it is due to their experiences without health care that they feel this need. Interviewee CNA27 stated the typical theme:

After experiencing problems keeping health care coverage, I think that a basic coverage would be important. I would really not like it structured like other countries . . . due to waiting for care and limitations but I do feel that something like that would definitely benefit the population.

Interviewee LPN14 stated, “I like the idea of everyone having coverage. I just worry about the government in the health care business.” Interviewee RN15 revealed that:

The funny thing is that I was questioning the whole socialism debate and I am a diehard capitalist but when I lost my health care insurance that big time changed my mind. I actually voted for Obama because of that I want to try it (universal coverage) actually. I really do. I was a Republican but I had myself thinking, you know, you really don’t think about it until you are down. When you are down you say God Bless Medicaid. We had it for a couple of months and I don’t know what we would have done without it. So definitely I would love to give it (universal coverage) a chance.

Interviewee RN25 agreed:

I think more about it since not having health care insurance. I feel badly for people who do not have health care coverage and this is a regular somewhat chronic problem. I think that in nursing we see issues of not having health care insurance. We feel that pain. I feel that there is an end for me, God willing.

Interviewee RN19 agreed, “At times I almost think that universal coverage would be good. Maybe if everyone had the same plan it would be cutting back on preventable disease and illness.” Interviewee LPN23 likes the thought of everyone having to carry insurance. “I like the idea of the public option with the subsidized care.”

Themes comparing the Canadian policy to a universal coverage and/or the public option are strong as well as a strong governmental distrust as previously stated.

Interviewee NA16 is skeptical about universal coverage.

I kind of have some issues with that because I have heard that in Canada because everyone has health insurance that they all have to wait for surgeries and minor things and that they prioritize things and I don't want that to happen.

Interviewee RN4 is concerned as well:

It is so difficult because when you listen to what Canadians go through and for lack of a better word call it socialized medicine and the wait times to have surgery and those types of things. I was listening to Hannity on the radio and he was blasting the government controlled health care and those are my fears . . . that the quality of the care that we are used to having won't be there. We need to find a happy medium so the majority of issues such as surgery times and quality will be resolved.

Interviewee RN13 is concerned about physician participation when stating, "universal coverage would be my choice if every doctor would take it. At least then you would have something as long as you do not have to go five hours away for a doctor."

Employer sponsored health care insurance, pay to play policy, and universal coverage had the most favorable comments from nurses. Each policy option had strengths and areas of concern which indicates why there has been no agreement nationally on the best option for the country.

Advice for Policymakers

One of my probing questions was that I asked if there was advice that the nurse would give to the policy maker or politician. Several nurses wanted the politicians to

really understand the struggles of their constituents and “walk a mile in their shoes.”

Interviewee RN15 stated:

I would try to get them to realize how hard it is for a working class family to pay. I myself am not sure if I want universal coverage or a free market. The free market does not seem to be working. It needs fixed. I would say just try to see it through a person’s eyes that makes \$45,000 per year. They just have to look at the cost associated with it. Every two weeks you are paying your premium share and then you pay the co-pays and any fees.

Interviewee LPN21 and CNA2 agreed on “some sort of basic care.” Interviewee CNA27 continued:

From there, who pay and how much, I really don’t care. I think that health insurance companies could do a better job at cutting costs and eliminating waste. I appreciate them being corporate sponsors but they do not need to give \$20,000 for the Great Race. Instead, do something for the subscribers. Limit the double digit rate increase. Expand the programs that we already have like Medicare, Medicaid and the Adult Basic. See if we can fill in the gaps between those working with coverage and those that have government coverage. This will cover more people without creating a new system. Monitor the insurance companies. Add competition to the insurance company and minimize cost and CEO bonuses.

Interviewee RN25 stated:

Come with me and let me show you the effects of uninsurance. Let me have you meet the people that really need it and listen to their stories. Let’s get at least a basic level of coverage that people can utilize. And I am not saying for free. It

can cost a manageable price . . . which I am not sure what that manageable price is or who maintains it.

In conclusion, Interview RN1 sums it up best by saying:

One thing that I would say is that eventually every single person in the world is going to get sick or have something happen or they are going to need some sort of health care performed on them. Whether it be a hospital stay or labwork or a combination of things, it is not fair that people have to worry or not leave their house or not go to certain places because what if something happens to them and they can't afford to take care of it because they have no health care coverage. I think that is horrible. Health care is not something that we can live without, it is something that we need.

The themes that emerged of the struggles of nurses with an absence of health care insurance were similar to the general population but there were uniqueness in how the nurses handle the problem. Nurses problem solve and critically think through their situation by using their resources and expertise. They make judgments about the situation and choose the best course of action that is under their control.

Nurses expressed their concern with some of the most common policy options discussed. Health savings accounts and tax credits were not well received citing that their own contributions would not make a difference in their coverage. Nurses expressed concern regarding universal coverage but acknowledged the need for basic health care coverage. Employer sponsored health insurance and the pay to play option received the most support. Though most well understood, these options combine the employer portion paying for some of the health care insurance fee and then their being an employee

contribution. Nurses are in support of this option depending upon the premium share and copayments.

CHAPTER 5

CONCLUSION

Studying a specific group perspective is not always a straight forward, neat process, yet it is precisely what is needed to understand the reality of where the group's point of view lies. Exploring how people act, think, make decisions, and exist in the world, especially during times of need, showcases who they are and can help us understand how to help them. Lately, more scholars have utilized alternative paradigms to examine human behavior. Chapter 4 detailed participant experiences and attitudes concerning nurses' struggle with an absence of health care insurance. These stories often exposed the pain, disillusionment, and social conflict within the tangled themes. The goal of the following chapter is to assimilate the loose connections into a better understanding.

The purpose of this research study was to determine the effects of not having health insurance on nurses currently employed at various points on the nursing career ladder, their spouses, or dependent children. The research questions included:

1. What are the experiences of health care workers, who are employed at various points of the nursing career ladder, in relation to health insurance?
2. Which policy options do the uninsured health care workers identify as being most helpful in meeting the need to obtain health care insurance?
3. To what extent does employer provided health care insurance play a role in determining nurses career decisions?

4. What differences, if any, are there between uninsured nurses and the general population?

Central to the goal of scientific inquiry, I intended to link emergent themes from participant interview to established theory. This practice places my research in a broader context within future inquiry can be built. Furthermore, it is the strength of qualitative research and its capacity to produce concepts to inform our quest for knowledge. While many of the themes are interwoven, I drew them out independently and related them to the research questions.

What are the experiences of health care workers, who are employed along various points of the nursing career ladder in relation to health insurance?

I have learned through the research that nurses on all levels of the career ladder experience the absence of health care insurance in a similar nature no matter if they are employed as a nurse aide or master's prepared registered nurse. While pay levels vary greatly between a nurse aide and a registered nurse, still there is a connection that limits their ability to afford the health care coverage. Table 6 depicts how the percentage of the average health care cost impacts the annual and take home salary of specific nurses. The table accentuates the percent of income that is required to pay for one month of health care insurance for an individual or a family. It provides evidence that when nurses state they are not able to afford additional out of pocket expenses for health care, they are stating facts that are irrefutable.

Having no health care coverage, the nurses report personal struggles physically and psychologically which impact them daily. In general, nurses report that a lack of

Table 6

Impact of Health Care Coverage Plans on Income

Nursing Career Ladder	Hourly Rate (Average)	Gross Income (Month)	Take Home Income (Month)	Individual Plan Percentage of Take Home Income	Family Plan Percentage of Take Home Income
NA	\$10	\$1,743.00	\$1,478*	17%	36%
LPN	\$15	\$2,600.00	\$2,148*	12%	25%
RN	\$24	\$4,161.00	\$3,265*	8%	16%

Note. Take home income accounts for federal taxes, but not state or local. Percentages based on typical \$2,985 yearly rate for individual plan and \$6,328 yearly rate for family plan according to Americas Health Insurance Plans-Center for Policy and Research (2009). NA-Nurse Aide; LPN-Licensed Practical Nurse; and RN-Registered Nurse.

health care insurance is disheartening, embarrassing, and a worry which affects their health care decisions and lifestyle choices.

Nurses sacrifice their own health or that of their loved ones as they admittedly use health care practices of splitting medications, forgoing annual check-ups, delaying diagnostic testing and waiting for medical consultation until a condition is exacerbated. These behaviors were also noted by the Agency for Health Care Research and Quality (2007) as characteristics of the uninsured and underinsured population. For many nurses, the rollercoaster ride of the absence of health care coverage is a recurrent struggle as the quest for health care insurance can be obtained for a period of time and then dropped. Some nurses also report the struggle with health care insurance initially occurred during their childhood and lament having similar challenges in their adulthood. Nationally, a portion of the uninsured population reports a cyclic battle to maintain health care coverage (National Center on Health Care Statistics, 2007). Some nurses looked to stable nursing positions in health care as a means to having a good pay and dependable health care benefits. Nurses report being disheartened when they first learned that health care struggles exist in nursing as well. Nurses care for others and do not let their own circumstance affect the care given to their patients. Nurses identify the duty they have toward their patients in tandem with the injustice an absence of health care insurance coverage brings.

Which policy options do the uninsured health care workers identify as being most helpful in meeting the need to obtain health care insurance?

One of the biggest themes to emerge from the data is that these nurses live paycheck to paycheck with limited discretionary resources. The Kaiser Foundation

confirmed that nurse aides have a salary below the poverty level with tight financial budgets documented at the licensed practical nurse and registered nurse level as well. Salaries for registered nurses, while in the \$50,000 range prove inadequate to meet the demands of paying for health care, especially in single income homes. Policy options that require any significant personal funding essentially render the policy option unaffordable. Thus, health care savings accounts brought a strong emotional response as nurses frankly spoke of their inability to allot funds to this account and their perception that the small amount that they would be able to allot would have little impact on the overall ability to obtain health care coverage. Many viewed this option with a disgust and viewed it as proof that national legislature officials and the President have a lack of political understanding of the circumstances of being uninsured. Figure 8 and Figure 9 depict the distribution of remaining monthly income when considering the deduction of federal taxes and health care insurance.

Health tax credits brought a less charged response as the credit meant additional money that could, in theory, and be put toward health care. Realizing that the credit may or may not be sufficient to cover all of the health insurance premium, nurses question their ability to afford the coverage throughout the year which could possibly lead to another gap in coverage. Nurses also express concern in allocating those funds for health care only, in light of all of the other outstanding expenses. Few felt that this option, though interesting, would provide what is needed for those who are uninsured.

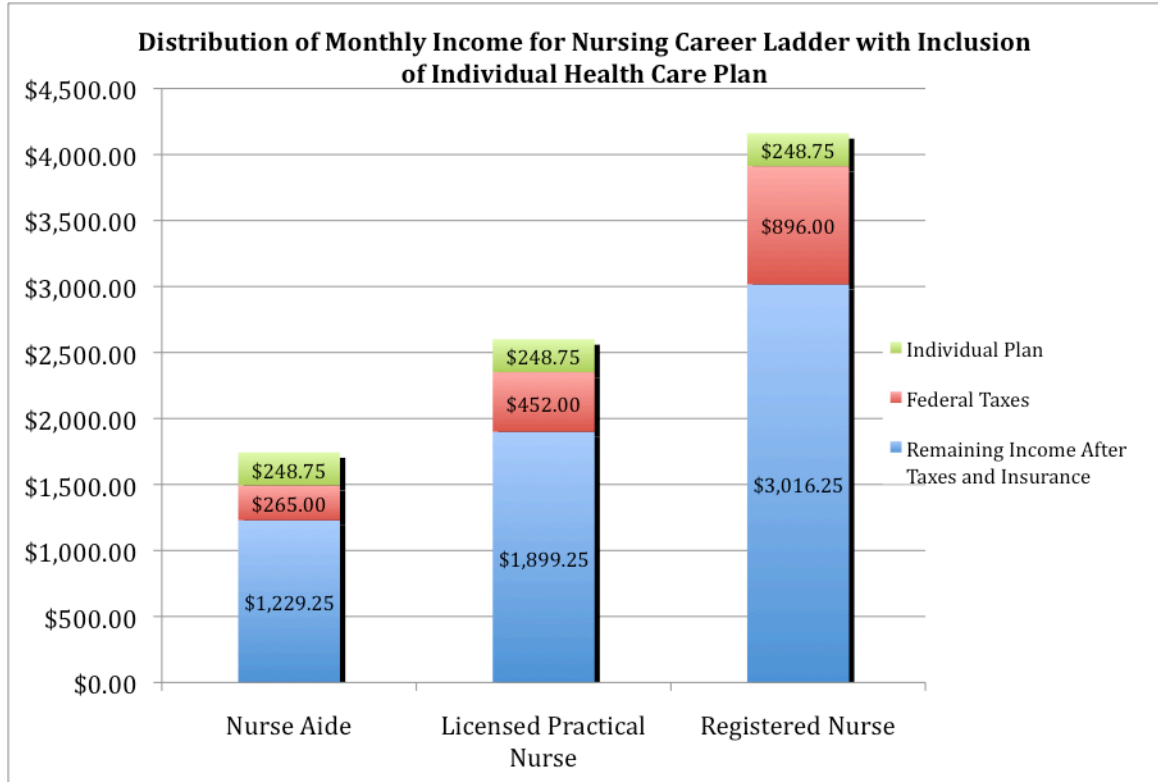


Figure 8. Distribution of monthly income for nursing career ladder with inclusion of individual health care plan.

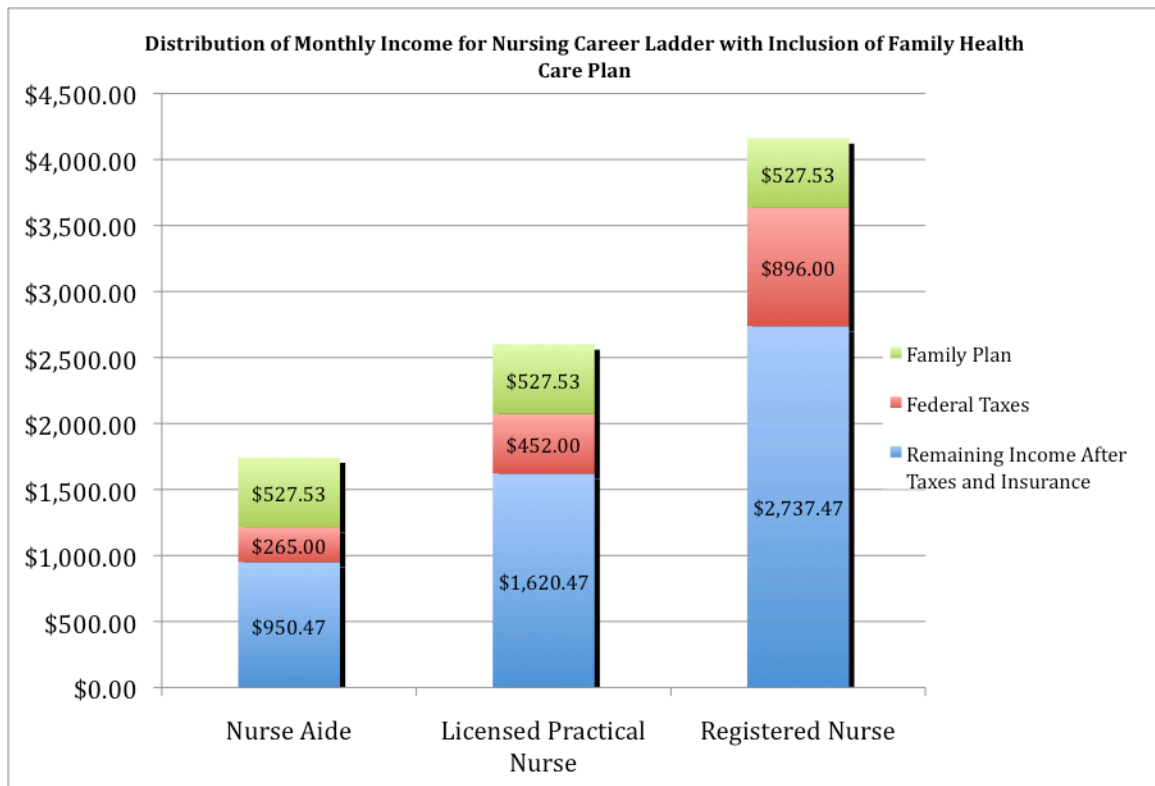


Figure 9. Distribution of monthly income for nursing career ladder with inclusion of family health care plan.

Though employer sponsored health insurance and the fair share/pay to play options rely on employment, nurses feel comfortable with these options. Nationally, there is also comfort in the employment based plans due to the tradition of the employer providing health care benefits from the 1930s through current time. While nurses generally approve of the pay to play's involvement of the state in programs that assist low income employees, some are concerned with the stipulation of mandating coverage and the cost that mandating insurance may have on the health care facility. Though they would appreciate having health care coverage provided, the nurses recognize the narrow profit margin and difficulty that some health care facilities especially long term care facilities and personal care homes have in meeting patient needs. Being patient advocates, nurses frequently consider patient needs as fundamental considerations and accept less for themselves.

Many nurses like the requirement to, at least, have a health care insurance option available regardless of your employment status. This gives the option of health care insurance without establishing a personal individual policy which is costly. However, both options success depends upon the premium share required.

As much as nurses and the general public are comfortable with employer based health care insurance, nurses are the first to recognize that something in the current system is making employer based coverage unsustainable by the employer, and further contribute to the rate of uninsured. The concerns of escalating costs have been well documented for the past half century. Nurses feel strongly that the rising health care costs and double digit premium increases have been cost prohibitive in providing the health care coverage and thus limit the number of nursing positions with health care

benefits. This recognition reflects the Kaiser Employee Health Benefits 2008 Annual Survey results which indicate employee spending on health care coverage has increased 120% between 2000-2006.

Universal coverage produced many themes among the nurses. Some nurses relate their struggle with health care insurance to their perspective that basic health care should be had by all. A struggle of the conservative, state based philosophy, individual freedom notion versus the liberal fairness, and equal benefits for all creates a challenge for nurses who encounter health care needs with limited options. Nurses empathize with the needs and struggles associated with absence of insurance on a personal and professional level. Though many felt no one should be without health care when needed, many voiced concerns regarding what the potential universal coverage may have for rationing of care and obtaining doctors, comparing the policy prospect to Canada's socialized medicine. Others have a distrust of the government and believe the government has no right to legislate health care policy. Some type of policy providing health care coverage for all has been on the political agenda since 1912 beginning with Theodore Roosevelt and extending through Harry Truman, John F. Kennedy, and Bill Clinton and Barack Obama today. Interestingly, none of the nurses discussed who would pay for the universal coverage costs unless I brought it up. All responded they felt it was acceptable to increase taxes to pay for the option.

To what extent, does employer provided health care insurance play a role in determining nurse's career decisions?

An overwhelming theme of the study was the importance that health care insurance played in a nurse's consideration of employment. Many stated it was one of

the top two considerations for employment if not the top. Decisions for employment frequently hinged on the availability and affordability of health care coverage. Some stated they consider the health care benefit as important as their pay, citing examples that poor health benefits actually cost you money in copays and higher premium shares in the long run. According to employmentspot.com, an Internet site giving advice to those looking for employment, health care benefits is crucial in the employment package (obtained at www.employmentspot.com on February 6, 2009). Basically, the psychological affect of a lack of health care insurance could develop into or further a physical condition such as anxiety disorder, stomach ulcers or irritable bowel syndrome causing loss of income and disruption of patient care. The majority of the nurses report a desire to maintain health care insurance long term.

Nurses generally reported loving their jobs and their patients. In many circumstances, nurses indicated concern for their patients, putting their own needs aside. Nurses do not want to leave their positions for another facility even though the new positions are less appealing but have health care coverage. Frequent nurse turnover in the health care facility could be caused by the absence of health care as nurses change positions in an effort to obtain better and more affordable health care. The additional cost of hiring and orienting nurses could be saved by increasing job satisfaction and offering affordable health care insurance. This single fact could save institutions thousands of dollars in recruitment and retention funds as the average cost to replace a nurse equals the yearly salary (JCAHO, 2009).

Some nurses reported having health care benefits through their spouse until a disruption of the spouse's employment which leave the nurse or spouse without health

care insurance. During the recession of 2009, several nurses reported economic circumstances caused their spouses to lose their jobs, leaving them without insurance. Currently, the national unemployment rate is 10% (www.cbsnews.com obtained on January 6, 2010). When asked why the spouse carried the benefits instead of the nurse, the nurse replied the health care benefits were either “better” or “less expensive.” The nurses then had to decide whether to pick up those health care benefits, if available.

What differences, if any, are there between uninsured nurses and the general population?

Nurses currently provide an essential service without which our society would be unable to exist. Nurses provide aid to all persons and give of themselves daily to the benefit of others. Yet, the care they provide via their dedicated service is unavailable to them. Nurses instruct on proper health care regimens that they may not follow due to their health care insurance status that places them in competing paradigms of providing care to those with health care insurance while being unable to provide needed health care coverage for themselves or their families.

Since health care coverage is unavailable to the nurses, nurses must use their own resources when medical attention is needed. Nurses use their judgment to self-medicate by purchasing over the counter medications and using homeopathic remedies. Nurses also ask doctors who are at the facility for advice and medications. Nurses have reported practices of removing stitches, nursing ailments at home, and self-diagnosing. Having these abilities can be beneficial if the nursing judgments are accurate and no specialized care is needed.

Nurses report the stress of dealing with health care issues while not having health care insurance. This cognitive dissonance gives an uncomfortable feeling for the health care worker caused by holding two contradictory ideas simultaneously. Teaching patients to best care for their health may not be what the health care worker practices. The dissonance may be expressed as guilt, anger, frustration or embarrassment. Themes of nurses' feelings, struggles and how they cope with a lack of health care coverage is no different than what is seen in the general population. All individuals have similar concerns of lacking health care when needed. One difference is the theme that nurses have an acute understanding that health care concerns can happen at any time and to anyone, thus one might argue their worry is more. Seeing men, women, and children develop health care issues without warning makes the theme of "gamble" also more real. Nurses understand it is a true gamble to not have coverage and risk all of the physical, emotional, and financial ramifications that follow.

While it is identified that hospitals often have a free care fund for the indigent, many nurses have middle income employment which dictates any medical debt may need to be repaid in its entirety. Thus, for nurses the potential for medical debt to cause the loss of their home is a reality. Nurses, especially NAs and LPNs, often are just exceeding the income limits for publically provided assistance. These individuals fall into a gap where they work at least full time hours plus overtime as much as possible to make ends meet, but are not able to afford their share of the cost of health care coverage.

In conclusion, nurses are a unique population of those uninsured. While there are many similarities to the general population, nurses experience and cope with the factor of being uninsured differently. Nurses work within the health care industry providing

services that many nurses can not access. Though living within contradiction, nurses continue to be a patient advocate having in order to act in the best interests of their patients. This study identifies the struggles and challenges of being a nurse who is uninsured.

Impact of Study

There are numerous studies that examine health care policy, the implications of the uninsured, and nursing recruitment and retention. This study was unique in its approach, notably, by examining the subject of health care insurance from the perspective of those who provide health care yet experience an absence of health care in their lives. The results of this study indicate that for all nurses on the career ladder, health care insurance is a primary concern which, many times, affects their employment decisions. Though only a limited number of nurses are uninsured, have an uninsured spouse or a dependent child, this population of nurses is not difficult to find. They can be found in every community. Although history has seen the ebb and flow of nursing shortages, making the profession more desirable and providing a self sustaining wage and benefit package may ensure a continuous supply of nurses in the future. The impact of this study is to draw awareness to this population of uninsured nurses and potentially decrease nursing turnover, increase workplace satisfaction and increase recruitment opportunities. Nationally, the impact of national health care insurance is to decrease the overall number of uninsured.

Further study of nurses and the availability of health care insurance is needed as society today moves further into the health care reform. Studying the impact of the

reform efforts on the general population and the impact on our health care environment and nursing personnel will provide useful data. While this approach has yielded significant findings, it is limited to its impact on nursing. Other health care occupations such as surgical technicians, phlebotomists, laboratory technicians, respiratory therapists or x-ray technicians may be affected. Also, health care policy in general could be transformed by the work of President Obama and Congress as they move closer to true health care reform.

While this study began with a simple premise of studying nurses who have an absence of health care insurance, it has also included a greater examination of the history and status of health care policy. This journey, facilitated by the experiences, attitudes, and insight of the 30 participants, provides many important observations about how individuals make decisions about health care. I am left with an overwhelming sense of sadness for the individuals who are currently affected by the absence of health care, but will remain hopeful about the resilience of the nurse and the future opportunities provided by health care facilities. While the voices of the participants were brutally honest about their perceptions and experiences, the attitudes exposed in their stories paint a challenging picture for those in health care administration as well as those involved in health care reform.

If I were to have the opportunity to design this study again, I would:

- add a question specifically asking if the participant has any opportunity to obtain health care insurance at their employment site, even if the participant deems the health care insurance unaffordable. If yes, what is the determining factor in

rejecting health care insurance coverage? Though this question was not on the interview guide, it regularly became a probing question.

- add a 40,001 – 60,000 household income category within the demographic section to further discriminate household incomes
- recruit my subjects and interview them over the period of two months, opposed to several months as was the case in this study. With the current health care debate, health care was continually in the media. Individuals were bombarded with messages from all political angles and philosophical bases. Also, politically feasible options for health care reform continued to evolve and change the details and components of the policy. I had to be general in my description and not relate the policy alternatives to specific currently evolving options.

Now that I have completed this qualitative exploratory study that assists in filling a gap in knowledge, another researcher could utilize these findings as a basis for a quantitative or mixed methods research design. Future research will benefit from the data obtained in this study.

Afterword

I will never forget my experience with the absence of health care insurance. Since that experience, I have taken an advocacy role with community leaders and legislators promoting affordable health care benefits. I have never had a period since when I did not have health care insurance for all in my family. Prior to that experience, I never considered what it would be like or how my life would change if I did not have health care insurance. Essentially, health care insurance, the type and quality is my first priority when reviewing a benefit package. I share my experience with my graduating

practical nursing, bachelor's degree and master's degree students as they are entering the employment world. Many do not realize the effect the benefits package has on the overall compensation package.

My son Patrick is a college freshman at Indiana University of Pennsylvania and plays on the hockey team. Though he was young when his concussion occurred, he does remember that day and all of the attention that was focused on him. He has had no ill effects from sustaining a concussion and not having health care insurance on that day. But, that experience changed my life forever.

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APPENDICES

APPENDIX A

Interview Guide for the Semi-Structured Interviews

Semi-Structured Interview Questions

1. Which level of nursing on the nursing career ladder are you employed?
2. How many hours do you currently work per week and what is your formal job classification (full-time, part-time, casual/per diem, temporary)?
3. When was the last time you or your uninsured family member had health insurance coverage, if ever?
4. What are your experiences related to the lack of health care insurance?
5. Has the lack of health care coverage ever influenced your decisions regarding health care?
6. What is your greatest fear regarding a lack of health insurance coverage?
7. What would you like to share with me regarding your status?

8. What would be something that you would like to tell the policymakers regarding being uninsured?
9. Which policy options, if any, do you identify as the option that would best suit your needs? Why did you choose this option?
10. Is there anything else that you would like to tell me?

Demographic Data

11. Gender Male Female

12. Highest education level

High School/GED

Postsecondary certification

Diploma Practical Nursing

Associates Degree/Diploma Hospital Based

Bachelor's Degree

Master's Degree

Doctorate

13. What is your age?

18-29 years

30-39 years

40-49 years

50-64 years

65 years or older

14. In which setting of health care are you currently employed, if any?

Hospital/acute care setting

Long term care

Home health

Personal care home

Physician's office

Other

Unemployed

15. How many years of experience do you have in health care?

In first year

2-5 years

6-10 years

11-15 years

16-20 years

21-25 years

25-30 years

Over 31 years

16. In what sector of health care is your current position?

Private

Public

Nonprofit

17. In which county do you reside? Is this a rural community, urban community, suburban community?

18. What is the category of your household income?

Under \$20,000

20,001-40,000

40,001-80,000

80,001-120,000

Over 120,000

APPENDIX B

Letter of Request Interviews

You are invited to participate in this research study. The following information is provided in order to help you to make an informed decision whether or not to participate. If you have any questions, please do not hesitate to ask. You are eligible to participate because you are an employed on the nursing career ladder and have experienced a gap in health care coverage for yourself or an immediate family member.

The purpose of this study is to understand the perception of the nurses on the nursing career ladder related to their experiences with health care coverage. In addition, the individual will be presented currently debated policy options and be asked to identify which policy option would best fit their personal situation.

Your participation in this study is voluntary. You are free to decide not to participate in this study or to withdraw at any time without adversely affecting your relationship with the research investigator at IUP. Your decision will not result in any loss of benefits to which you are otherwise entitled. If you choose to participate, you may withdraw at any time by notifying the researcher. Upon your request to withdraw, all information pertaining to you will be withdrawn and destroyed. The information you share will be kept confidential and will not be used to identify you or your health care status. The information provided will be considered only in combination with that of other participants. The information obtained in the study may be published in scientific journals or presented at scientific meetings but your identity will be kept confidential.

If you are willing to participate in their study, please sign the statement below. When you have completed the interview, you will be given an information sheet that will provide you with contact information if you wish to receive the results of the study.

Project Director: Mrs. Diana Rupert, RN, MSN, Doctoral Candidate

Nursing Faculty, Indiana University of Pennsylvania

214 Johnson Hall

Indiana, PA. 15705

724/357-3092

Faculty Sponsor: Dr. Mary Jane Kuffner Hirt, PhD.

Dissertation Committee Chair

102 Keith Annex

Indiana, PA. 15705

724/357-2290

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone:724/357-7730).

APPENDIX C

Informed Consent Form

Informed Consent Form

You are invited to participate in this research study. The following information is provided in order to help you to make an informed decision whether or not to participate. If you have any questions, please do not hesitate to ask. You are eligible to participate because you are an employed on the nursing career ladder and currently or within the last 12 months have had yourself or someone in your immediate family without health care insurance.

The purpose of this study is to understand the perception of the nurses on the nursing career ladder related to their experiences with health care coverage. In addition, the individual will have the opportunity to select which policy option would best suit their needs.

Your participation in this study is voluntary. You are free to decide not to participate in this study or to withdraw at any time without adversely affecting your relationship with the research investigator at IUP. Your decision will not result in any loss of benefits to which you are otherwise entitled. If you choose to participate, you may withdraw at any time by notifying the researcher. Upon your request to withdraw, all information pertaining to you will have no bearing on the study. The interview will be kept anonymous and the documentation will not be used to identify you and, subsequently, your health care status. The information provided will be considered only in combination with that of other participants. The information obtained in the study may be published in scientific journals or presented at scientific meetings but your identity will be kept confidential.

If you are willing to participate in their study, please sign the statement below. When you have completed the interview, you will be given an information sheet that will provide you with contact information if you wish to receive the results of the study.

_____	_____
Participant name	Date

Participant signature

Informed Consent Form (continued)

VOLUNTARY CONSENT FORM:

I have read and understand the information on the form and I consent to volunteer to be a subject in the study. I understand that my responses are completely confidential and that I have the right to withdraw at any time. I have received an unsigned copy of the Informed Consent Form to keep in my possession.

Name (PLEASE PRINT)

Signature

Date

Phone number or location where you can be reached

Best days and times to reach you

I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research.