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## Nursing for the Future, from the Past: Two Reports on Nursing from the Institute of Medicine

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**Abstract:** In 2010, the Institute of Medicine, in association with the Robert Wood Johnson Foundation, released a major study of the nursing profession. The Institute of Medicine last published a major, broad-based study of the nursing profession in 1983. This brief historical analysis examines the context and key recommendations for each report and provides concrete examples of outcomes of the 1983 report. We argue that despite similarities in context and recommendations, the two reports differ in target audience and implementation strategies, and that nursing is currently better positioned to use the report as a blueprint to improve patient care, as well as garner outside support, than it was in 1983.

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**Full text:** Nursing is a frequently studied profession. Since the 1923 Goldmark Report funded by the Rockefeller Foundation, numerous public and private commissions and task forces have examined all aspects of the nursing profession--its education system, diversity, clinical practice boundaries, workforce capacity, and relationship to the public it serves ( <sup>Committee for the Study of Nursing Education, 1923</sup> ). One reason for this incredible attention (it should be noted that the medical profession is similarly studied) is that the public perceives nursing care of the sick and support of the well as vital social services ( <sup>Fagin & Lynaugh, 1992</sup> ). Over the past 90 years, that same public also viewed nursing as troubled and has continuously sought to better understand what the profession can do to improve patient care.

The frequent calls for studies and recommendations related to nursing practice may indicate failures of the study process, such as the exclusion of nurses from study committees, and the inability of the profession itself to follow through with study recommendations and redirect the focus of recommendations from nurses to patient care. Context is also a factor. Studies are commissioned and shaped by the politics of the time and the status of the nursing profession within a historical moment. What gets studied and by whom is a matter of political choice that may or may not be related to what should be studied ( <sup>de la Peña, 2010</sup> ). The motives behind study objectives must also be considered. A study commissioned by an interest group of hospital administrators will likely make different recommendations than one by a nursing professional organization or by federal legislators with budget concerns.

At the end of 2010, the Institute of Medicine (IOM), one of the most respected analytical bodies in the United States, released a major study of the nursing profession, *The Future of Nursing: Leading Change, Advancing Health* . The report provided recommendations to transform the nursing profession to better meet the immense health care needs of the United States. The IOM last published its major, broad-based study of the nursing profession, *Nursing and Nursing Education: Public Policies and Private Actions* , almost 27 years ago ( <sup>IOM, 1983</sup> ). In the period between the two reports, the IOM released numerous reports focusing on particular aspects of nursing, but none were as focused as the 1983 report. Amid the activity and discussion generated by the *Future of Nursing* report ( <sup>IOM, 2010</sup> ), some have questioned whether this report is different from the 1983 report or whether this particular historic moment is simply more of the "same old, same old." But will it and can it be more of the same?

In this article, we set forth the context and some of the key recommendations of each report, and in the case of the 1983 report, we provide concrete examples of some of the outcomes. This article is not an in-depth historical analysis but provides the key facts needed to compare and contrast the two reports and show that,

although there are similarities in the context and recommendations of the reports, the target audience and the implementation strategies are very different and nursing is currently better positioned to support itself and garner outside support than in 1983.

### **Nursing and Nursing Education Public Policies and Private Actions, 1983**

As part of the Nurse Training Act of 1979, Congress charged the National Academy of Sciences to convene a planning group to develop a study of the nursing profession. The study, after 2 years of negotiation over costs and planning, was commissioned in 1981 and released in 1983. Although there were several congressional charges, the primary focus and underlying political thrust was to determine the need for continued federal support for nursing education. Two additional purposes were included in the mandate: to make recommendations for improving the distribution of nurses in medically underserved areas, and to determine the rates of and reasons for the high turnover of nurses and develop recommendations to improve retention of nurses ( <sup>IOM, 1983</sup> ).

This Congressional charge came at a particularly difficult time for the nursing profession and health care institutions in general. In the late 1970s and early 1980s, the country was gripped by the high jobless rates, climbing interest rates, and growing federal deficit of a recession. After the Carter years of failed attempts to control health care costs, Ronald Reagan (1981--1988) was overwhelmingly elected on a platform based on conservative party ideology that promoted smaller government and severe federal budget cuts.

In addition to economic pressures, Americans experienced a growing primary care shortage as physicians continued to train as specialists in rising numbers, motivated by better payment and work-life quality compared with primary care providers ( <sup>Fairman, 2008</sup> ). Most payouts from the federal entitlement programs Medicare and Medicaid and private insurers went to acute care hospitals and the medical education programs found in acute care academic health systems. Hard fought, but in comparison little, funding went to chronic care, except for targeted programs, such as end-stage renal disease management. Health care expenditures were skyrocketing due to rapidly changing highly complex treatments and patients and a payment system that supported acute care. Of most concern were the rising Medicare costs of the aging population ( <sup>Mayes, 2007</sup> ).

During the life of the IOM committee that worked on the 1983 report (1981--1983), Congress debated and negotiated the prospective payment system (PPS), one of the most important payment reforms since the creation of Medicare and Medicaid in 1965. The committee was caught between the traditional payment system, with its particular procedure-based requirements for nursing, and the oncoming PPS that demanded nurses with the skills and knowledge to move patients quickly through the medical system. Ultimately, the committee deliberated and crafted recommendations that were based on traditional systems of Medicare service reimbursement. PPS was signed into law in 1983, the same year the IOM report was released ( <sup>Mayes, 2007</sup> ).

One of the contentious issues debated by the committee was whether there were enough nurses to provide the care needs of the nation. Although many states had gathered various types of data to answer this question over the previous 5 years and a handful of other studies were in progress by groups such as the National Commission on Nursing, the only data the committee had available to answer their charge were based on supply and demand issues, such as the general numbers of nurses produced by education programs and hospital nursing staff vacancies. Although hospitals, physicians, and nurses proclaimed a shortage and had been doing so over the span of the decade, the problem, as Congress realized, seemed to be maldistribution and poor use of available resources (e.g., demographic shortages in rural and poor urban areas and in small community hospitals; in competency and functional areas such as public health, intensive care, and expanded practice; and faculty), concepts that were hard to measure and use for projections ( <sup>IOM, 1983</sup> ). From another perspective, many researchers, such as Linda Aiken and Claire Fagin, believed that nursing resources could be better utilized and that funding should be based on the skills and knowledge needed to care for a growing chronically ill population rather than targeting funding only to increase the numbers of nurses ( <sup>Lynaugh & Brush, 1996</sup> ). These tensions would shape the committee's deliberations and recommendations.

By including the maldistribution of nurses in the charge, Congress showed it understood some of the complexities of nursing supply and demand, as well as the politics of workforce shortages. But by asking the committee to examine retention and turnover from the vantage point of keeping nurses in the profession, Congress showed its traditional leanings toward working women as a temporary workforce. At this point, approximately 75% of nurses were in active practice, more than any other traditionally female profession, and the reasons for turnover probably had more to do with work conditions than loss due to marriage ( <sup>Aiken, 1981</sup> ). Ideological positions also shaped how the committee approached the nurse shortage and thus the nursing education funding issue. Influential economists such as Uwe Reinhardt promoted a limited government and did not believe the federal government should be funding the health professions ( <sup>Lynaugh & Brush, 1996</sup> ). Instead, Reinhardt argued, the private sector and states (even though the states were experiencing grave economic downturns) should be responsible. These arguments were picked up by other powerful conservative stakeholders and business leaders and managed to get the ears of influential congressmen as the committee was being organized ( <sup>Lynaugh & Brush, 1996</sup> ).

The question of the federal role in funding nursing education was not a new one, but until the early 1970s funding for nursing education had not faced significant challenge. The federal government had a long history of funding nursing education from the Cadet Nurse Corps during World War II to the 1964 Nurse Training Act ( <sup>Public Health Service Act, 1964</sup> ) and its subsequent renewals every 2 years. As a result of the 1964 Nurse Training Act alone, the government had pumped almost \$2 billion into nursing education. Nursing was a popular funding target, but as the economy took a downward turn during the presidencies of Nixon, Ford, and Carter, nursing funding programs were scrutinized. All three presidents, under pressure from mounting health care costs, attempted to veto funds during successive Nurse Training Act renewals. Their efforts resulted in changes in funding, which mainly halted or minimized capitation grants for undergraduate education, construction funds, and diploma school support. Funding for graduate nursing education for faculty preparation, nurse practitioner training, and nursing research remained, albeit at lower levels ( <sup>Lynaugh, 2008</sup> ).

Baccalaureate nursing education was under pressure in the 1970s. Most practicing nurses entered the profession through the diploma schools until the late 1980s. Between 10% and 20% of nurses continued their education after their first programs ( <sup>U.S. Department of Health and Human Services, 1988</sup> ). More nurses were needed to continue on to higher education to produce faculty, nurse scientists, nurse practitioners, clinical specialists, nurse anesthetists, and nurse midwives (*advanced practice nurse* was not a term used during this time). The push by the American Nurses Association (ANA) in 1965 to a two-tiered profession—technical (associate degree graduates) and professional (baccalaureate graduates)—was not supported by the American Hospital Association, the American Medical Association, and some nursing specialty organizations, thus preventing the resolution of the multi-tiered education entry point for nursing practice. The ANA's inability to develop a consensus for the education level needed by nurses also played out in congressional debates about funding, as multiple entry points for registered nurses diffused rather than targeted funding for nursing education until the late 1970s ( <sup>Fairman, 2008</sup> ).

The lack of support for baccalaureate nursing education was accentuated by the cuts to federal funding. Baccalaureate programs were expensive to develop. Community colleges, seeing professional programs as a way to improve their offerings, grew nursing programs at a faster rate and lower cost. Professional nursing was unable to negotiate differences between baccalaureate and associate degree nurses, except in the areas of specific knowledge (e.g., public health nursing, psychiatric nursing, and critical care nursing), which the associate degree programs did not address. The movement by health care institution administrators to funnel nurses with associate degrees into long-term care and nursing homes was an outcome of this debate, as the patients in these facilities were fairly stable and their needs compatible with the skills and knowledge of the graduates of these programs.

The first recommendation of the 1983 IOM report stipulated that no federal funding was needed to increase the

overall supply of registered nurses. The committee supported decreased funding for entry level nursing, a continuation of policies from previous decades, but it also supported increased funding for advanced education to produce faculty and advanced practitioners, especially for the long-term care market ( IOM, 1983 ). Most of the funding responsibilities were redirected to the states for targeted workforce issues. Although the committee discussed the economic troubles facing the states, there was no further consideration of their ability to assume greater responsibility for the nursing workforce. The Committee believed the aggregate supply of bedside nurses was adequate--there was no shortage in terms of supply, but they could not agree on the method for predicting need. To be fair, the committee would have been hard pressed to predict the shortage brought on just a few years later by PPS and diagnosis-related groups, which made hospitals more dependent on nurses with high level critical thinking skills to move patients faster through the hospital system, and to cope with higher levels of acuity. This was a very different paradigm of nurses' value to the institutions in which they worked and one that was difficult to analyze by typical supply and demand parameters.

Among the 21 other recommendations were two that addressed better opportunities for nurses to work in expanded practice, including the need for changes to state practice acts and a requirement for Medicare and Medicaid to pay for nurse practitioner and nurse midwife practice. New practice models, such as nurse-managed health centers and the use of nurse practitioners in long-term care were also supported. But the recommendations did not stray from the context of a traditional fee for service model despite concurrent Congressional debates to reform the payment system with PPS.

The committee included a recommendation in support of a center for nursing research to be established at a high level within the federal government to serve as a base for the growth of nursing research. The report added that such a center could "lead to a reduction in federal health care costs by lessening the length of hospital stay, minimizing the need for additional treatment, and preventing unnecessary or premature institutionalization in long-term care facilities" ( IOM, 1983 , p. 216). This entity would develop a growing cadre of nurse scientists who could more effectively study questions related to patient care and to the issues of workforce needs and, at the same time, help alleviate the faculty shortage. The report estimated there were only 180 nurses at the doctorate level in 1980 who identified research as their primary activity. Clearly, these numbers could not fill the growing demand in academic institutions for nurses with doctorates to conduct research and fill faculty positions ( IOM, 1983 ).

Perhaps notable by its absence, the IOM (1983) report did not link education to licensure or take a stand on requiring the baccalaureate degree for entry into practice. The report noted the importance of all three types of nursing education (diploma, associates degree, and baccalaureate degree) and declined to prioritize one type over the other. The report did recommend that state practice acts should be examined in light of the growing scope of practice debates for nurses in expanded practice. The committee's stand on nurse practitioners and other types of expanded nursing practice reflected nationwide debates over their safety, permanence (e.g., would they remain as vital if and when the primary care physician shortage abated), and basic beliefs about nurses' capabilities to practice at an expanded level. Their stand probably reflected the rapidly changing practice environment of the 1970s, and the confusion over the role reflected in the policy and practice debates over who (e.g., in medicine and its subspecialties, as well as nurses) had the authority to provide primary care. This was also an issue that might have benefitted from a presence of practicing nurses, as the nurses on the committee were primarily educators or administrators. The committee also declined to challenge the ability of institutions to keep wages depressed or recommendations aimed at better utilization of the nursing resources at hand. This was a committee that believed it did not have the evidence to make a stand on the more critical issues facing the nursing profession, issues that were tightly bound to the public's perception of middle class women and their work, education, and family duties.

Responses to the report were mixed, as is typically seen for reports of this breadth and focus ( "ANA, NLN praise," 1983 ; Bauknecht, 1983 ; McCarty, 1983 ). Readers specifically praised recommendations for increased funding for graduate

nursing, a center for nursing research, and upgrading of nursing home staff ("ANA analysis," 1983). The committee's decision not to support continued federal funding for general nursing education proved most controversial (Associated Press, 1983; IOM, 1983; "No nursing shortage," 1983; Varro, 1983). Although the committee finding that general nursing supply was adequate was in agreement with two previous reports to congress by the Secretary of Health and Human Services, many in the nursing community took issue, including the American Nurses Association (ANA), which believed the recommendation a short-sighted solution to a temporary economic situation ("ANA analysis," 1983; Jacox, 1983). Others were concerned the IOM discussion on the nursing shortage "may be read out of context and used to erode support for the education of nurses" in general and shift away from advanced education (Crosby, Fackeau, & Donley, 1983, p. 108).

Nursing leaders also charged that the 2-year study was poorly designed. Early on, the committee made a decision, because of lack of time and resources, to rely on workforce and cost data at hand, including previous studies, existing nurse sample surveys (from 1980), American Hospital Association data, and nursing professional organization data. In fact, decisions about which data sets to use to support their recommendations or whether to conduct their own study de novo became a political issue for the committee. Various members believed data sets could be used to support particular economic or workforce issues such as the need for more nurses in nursing homes or the dangers of eliminating the associate degree as a practice entry level. The committee's debates highlighted the disorganization and entrepreneurial character of workforce data collection in general (Aiken, 1983; IOM, 1982; Smith, 1983).

No matter how it was received or what it lacked, the 1983 report stimulated change in the nursing profession in the United States in many ways. The National Center for Nursing Research was founded in 1986 within the National Institutes of Health, with specific authorities to study disease prevention, health promotion, and nursing care of those with acute and chronic illnesses ("National Institute for Nursing," 1983). This entity became the National Institute for Nursing Research in 1993 and has supported almost two generations of nurse scholars and researchers.

Congress also seriously considered the recommendations of the report it had commissioned. The next extension of the Nurse Training Act after the release of the 1983 report was in 1985 and contained language that reflected the IOM committee recommendations. True to the recommendations of the 1983 report, the legislation contained minimal funding for entry-level nursing education, except for special projects for students from disadvantaged backgrounds. The report also recommended increased funding for the advanced education of nurses in masters and doctoral programs, including nurse practitioners and nurse midwives, faculty, and scientists. Congress supported advanced nursing education programs leading to masters and doctoral degrees and to the preparation of educators, consultants, researchers, or clinical specialists in the 1985 Nurse Training Act (Miller, 1985; Nurse Education Amendments of 1985). The numbers of nurse practitioners, clinical specialists, nurse anesthetists, and midwives increased rapidly in the 1980s. In 1970, there were approximately 250 nurse practitioners, and by 1980, more than 18,000 (School of Health Related Professions, State University of Buffalo, 1983). This could have, of course, been the result of a prior growth trend, but funding did play a role, as can be seen in the demise of the certificate programs over the decade (Crosby et al., 1983; Miller, 1985).

It is difficult to directly trace other changes in nursing in the United States that stemmed directly from the 1983 IOM report (IOM, 2010). In general, the 1983 report had little effect on the way nurses were educated and the diversity of the nursing workforce (Friss, 1994; McCarty, 1983). Nonetheless, the 1980s was a decade of change for nursing and health care in general. Changes in Medicare reimbursement related to PPS, continued growth in numbers of nurse practitioners and nurse midwives, technological advancements, growing hospital vacancies, and decreased enrollments in undergraduate programs were all concurrent with the IOM report release and related federal legislation (Aiken, 1983; "An examination," 1988; Mayes, 2007; Sultz, Henry, Bullough, Buck, & Kinyon, 1983). True to its history of inviting study, other reports of the nursing profession were released in the same timeframe, including "Nursing in Transition: Models for Successful Organizational Change," released in 1982 by the National Commission on

Nursing, sponsored by the American Hospital Association, Hospital Research and Educational Trust, and American Hospital Supply Corporation ( <sup>National Commission on Nursing, 1982</sup> ). The National Commission on Nursing report contained similar recommendations for including nurses in hospital administration and optimizing utilization of nursing resources

### **The Future of Nursing: Leading Change, Advancing Health, 2010**

The origins of the *Future of Nursing* report ( <sup>2010</sup> ) are found outside of Congress and were not as closely tied to Congressional politics. In 2008, the leadership of the Robert Wood Johnson Foundation (RWJF) approached the IOM to propose a partnership between the two organizations to address the future of nursing and the need to transform the nursing profession. The RWJF, a private philanthropic foundation, had a long-standing commitment to ensure that nursing had the capacity in numbers and in skill competencies to meet the current and future health and health care needs of the public. The RWJF and the IOM established a 2-year Initiative on the Future of Nursing. The initial cornerstone of the Initiative was an 18-month consensus study, initiated to report on the future of nursing and outline a blueprint for action. This report was launched in October 2010, and a national summit was held 1 month later to bring together stakeholders to begin a dialogue about how to implement the recommendations. The RWJF then partnered with the AARP, the largest consumer group in the United States, to develop a plan for the implementation phase, including well-developed ideas about regional action committees that brought together nursing with public and private funders who would support the implementation phase. This process is currently ongoing.

The context for the 2010 report may appear, at first glance, to be similar to the context of the 1983 report. In 2008, more than 30 million Americans were uninsured, either by choice or because of their inability to afford health insurance. The country was gripped by economic problems brought on by spending for the wars in Iraq and Afghanistan and the Wall Street bailout brought on by, depending on the perspective, greedy bankers or Americans living beyond their means. Joblessness, mortgage crises, and a ballooning deficit made health care payment system reform a target of necessity. Like 1983, primary care providers were in short supply, and it seemed that even an increase in payment for services could not entice enough physicians into this practice area. Advanced practice nurses, who would provide critical access to patients for the primary care services demanded within a reformed health care system, were stymied in many states by local medical societies and insurers who fought against expanded scope of practice training acts and the inability to be recognized as primary care providers by insurance provider panels ( <sup>Fairman, Rowe, Hassmiller, &Shalala, 2011</sup> ).

Also similar to the early 1980s was the entrance of a new president who had aspirations to curb rising health care costs. Barack Obama, who came to office in 2008, campaigned to reform a health system that rewarded episodic rather than continuous care and favored specialty care over primary care, public health, and community-based care. Parallel to the negotiations related to PPS that occurred in the early 1980s, Congress was deep in health reform negotiations during the 2 years the RWJF-IOM committee was in action. The Affordable Care Act was passed in 2010 (but due to mid-term elections continues to be hotly debated) as the most far-reaching health reform bill since Medicare and Medicaid were founded in 1965.

In the decades between the reports, the nursing profession has continued to experience a severe faculty shortage that denied admission to nursing education programs for tens of thousands of qualified candidates each year. Evidence also pointed to a severe disconnect between the skills and knowledge of nurses prepared to work in acute care institutions and their ability to work within systems across types of care to provide greater continuity of services. The skill and knowledge mismatch was also apparent in the care required by the ever-growing needs of the population for chronic care, community-based care, mental health services, and public health. A maldistribution was still found in rural and poor urban areas and in certain functional areas such as critical care, mental health, and long-term care, but a generalized shortage based on supply and demand imbalances was not a critical issue. In fact, even though a shortage of nurses was predicted for 2020, new nurses seemed to be experiencing difficulties finding jobs as older nurses stayed in the workforce longer due to



economic factors.

The challenge to society posed by a profession that provided a critical social service, but was rooted in traditional means of education and practice that did not fit the needs of the public, can be seen in the committee's work charge. They were to:

reconceptualize the role of nurses within the context of the entire workforce, the shortage, societal issues, and current and future technology;

a. Expanding nursing faculty, increasing the capacity of nursing schools, and redesigning nursing education to assure that it can produce an adequate number of well prepared nurses able to meet current and future health care demands;

b. Examining innovative solutions related to care delivery and health professional education by focusing on nursing and the delivery of nursing services; and

c. Attracting and retaining well prepared nurses in multiple care settings, including acute, ambulatory, primary care, long term care, community and public health.

(IOM, 2010, p. xiii).

Similar to the 1983 report, the 2010 committee consisted of a majority of members who were not nurses. There were two critical differences: a nurse, Linda Burnes Bolton, was appointed Vice Chair of the committee, and some of the nurse members were newly minted faculty or practitioners. A nurse, Susan Hassmiller, on loan from the RWJF, served as Project Director. All of these nurses were influential in shaping the report.

Eight recommendations with 42 subrecommendations resulted from committee deliberations. They were far reaching and touched on multiple partners and stakeholders, from the secretary's office of the Department of Health and Human Services to Federal Trade Commission to local college presidents. The recommendations were focused on what nurses needed to do to provide better patient care in the new systems and models that would be part of health reform. Similar to the 1983 committee, the 2010 committee was also linked in to the debates occurring in Congress over health reform. However, the 2010 report attempted to capture these debates so that the recommendations were appropriate for a reformed health care system. The committee identified four key areas that would support a transformed nursing profession to provide high quality, accessible patient care:

Nurses should practice to the fullest extent of the skills and knowledge; Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression; Nurses should be full partners, with physicians and other health care professionals in redesigning a reformed health care system; Effective workforce planning and policy making require better data collection and an improved information infrastructure.

(IOM, 2010, p. 4)

In the 2010 report, the issues had little to do with federal funding for nursing education in terms of improving supply, maldistribution, or retention. Issues related to federal funding still existed, but the committee addressed them indirectly as part of the effort needed to provide better access and higher quality of care to patients. By this time, federal funding for nursing education was targeted, for the most part, to programs for particular populations or settings, nursing research, and improving diversity, although graduate medical education training funds through hospitals still supported diploma programs. The committee also took a stand on the need for better educated nurses, recommending that 80% of nurses earn baccalaureate degrees by 2020. At this point, approximately 50% of nurses had baccalaureate degrees, making the recommendation bold and far reaching. The committee noted that the public needed better congruence of its health care needs with nurses' skills and knowledge; leadership, knowledge of systems, public health, community-based care, mental health, and end-of-life care were competencies found in baccalaureate programs. These skills and competencies were to be critical for nurses at all levels working within new models of care such as health care homes or accountable organizations, and the only way to increase the numbers of new faculty and researchers was to increase the

number of nurses who were moving faster through the education pipeline. The committee also recommended residencies for all new graduates of general and advanced practice programs as well as for those nurses who move to different clinical areas. And, finally, in contrast to the 1983 report, the 2010 committee took a very public stand on removing barriers to expanded nursing practice and the need for all providers to work together.

### **Conclusion**

Although the context and recommendations of the 1983 and 2010 IOM reports seem familiar, they are quite different. For one thing, the implementation strategy for the 2010 report is different in that it does not rely entirely on Congress (some of the recommendations will, of course, require Congressional action), but also on the partnerships nurses can develop at the state and national level with other stakeholders who believe in the potential of nursing to help reform the health care system. The Regional Action Committees have already shown the capability of bringing together insurers, corporate bodies, and others who will work to fund and move the recommendations to reality.

The 2010 committee strategically developed the recommendations to target a broader audience. Within each recommendation are specific audiences for action, such as the Federal Trade Commission or the Centers for Medicare and Medicaid Services. Implementation of the extensive report may take some time and will depend on parties who did not participate in, or solicit, the study process and report. Much work will be needed to generate momentum, collaboration, and participation in the implementation process, although early signs point to a general excitement and impetus to move the blueprint forward to realize public policy. This process was, of course, part of the RWJF plan from the start but will require efforts from a broad range of interest groups and the public for success. In contrast, in 1983, Congress was the intended audience of the IOM report, with some anticipation from the committee itself that the nursing profession would also take note and action. The 1983 report did not include organized plans for implementation, nor were there specific actors beyond Congress and the states named for the recommendations. Congressional members appropriated funding for the report with the expectation that particular findings might emerge, such as the decreased need for federal funding for entry level nursing education. But at the same time, Congress was able to act rather expeditiously in the Nurse Training Act of 1985 to mesh the study recommendations with public policy.

Over the past 27 years, the nursing profession has changed and currently inhabits a new status quo. Advanced practice nurses are now normative providers within the health system, and many policy makers realize their critical contributions to patient care. Primary care capacity cannot be built without them. Nurses have emerged as leaders in institutions and at critical policy levels, although they are still in the minority at many decision making tables. Increasing the numbers of nurses with baccalaureate degrees and, subsequently, graduate degrees will be difficult for sure. But there are many more ways today to make this happen. There is a growing realization in academic institutions that flexibility in education and support for career enhancement, as well as the social value of producing more nurse scientists, will benefit all.

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### **Footnote**

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