The American Nurses’ Association in Washington

VIRGINIA L. BAUKNECHT
Washington, D.C.

In her capacity as communications coordinator, the author presents an overview of the American Nurses’ Association’s government relations activities in Washington, D.C. She highlights some of the legislation being introduced that is pertinent to nursing and explains ANA’s role in attempting to shape this legislation.

What are some of the activities of the Washington D.C. office of the American Nurses’ Association (ANA)?

I know that many nurse anesthetists are members of both ANA and AANA. But, even so, you may not know that ANA opened its Washington office 26 years ago in 1951; and, there have been many changes since then.

Congress has expanded greatly in this century, especially in the past 25 years. Congress long ago outgrew the Capitol building itself. It now has five huge office buildings, is constructing a sixth, and is looking for space for a seventh. Total operating costs for Congress and its supporting agencies now exceed $1 billion a year. There are nearly 20,000 Senate and House employees. In 1955, there were 5,500 or about one-fourth as many as today.

There are 22 committees in the House and 18 in the Senate. However, a lot of the real work—the actual drafting and agreement on bills for action by the full House or Senate—is done in subcommittee. There are 189 subcommittees in the House and 112 in the Senate.

There are about 25,000 bills introduced in the two-year period that makes up a Congress. Of those, only about 700 actually become law.

The only bills that are guaranteed enactment are those necessary to keep the government going—such as appropriations. Most others, if they are to command any real attention, must be a White House proposal or must be backed by a large segment of the Congress. And, members of Congress usually support a bill if a large segment of the public—or their constituents—are supporting it.

You have heard the story of the man found hitting his mule over the head with a two-by-four. When asked how that was going to make the animal move, he said, “First you have to get his attention.” The U.S. government, as you well know, is into practically everything. The issues are so numerous and so complex that Congress can deal only with those that are the most urgent and command the greatest public interest. So, first you have to get Congress’ attention.

That brings me to why ANA has an office in Washington. And, I sometimes feel that we are literally hitting them over the head!

ANA’s Washington office

We have a professional staff of
seven: the director; two lobbyists, who work on legislation and maintain contacts with The Hill; and two persons who work with the administrative agencies monitoring rules and regulations and attending meetings at HEW and other committee meetings. There also is an attorney, (who joined our staff when he was a student) who does bill analyses and some of the background research that we need. I am the communications person, which means that I am likely to be involved in just about anything.

The Washington office does not make policy. We get policy direction from the ANA House of Delegates and Board of Directors. We look to the commissions and divisions for the expertise which is needed in the development of statements and testimony. For example, if a bill deals with health care for the aging, we would refer it to the Division on Gerontological Nursing, if it has to do with education, we would look to the Commission on Education, and so on. Of course, when you get to broad areas such as national health insurance, then we need guidance and data from all units.

Likewise, in presenting testimony before a Congressional committee, we try to get nurses who are working in the areas that the legislation deals with. For example, a nurse practitioner from North Carolina recently gave the ANA testimony on rural health clinic reimbursement before the House Commerce Health Subcommittee. Again, if it is major legislation which covers broad policy areas, such as national health insurance, then we need guidance and data from all units.

Now, in theory, the preceding is how it is supposed to work. And sometimes, it even does; but, frequently it does not. Committees may postpone scheduled hearings, or they may set up hearings on very short notice.

I remember one instance when a committee staffer called on Tuesday and asked if we would testify on Friday at 9 a.m. Sometimes the notice time is even shorter. In a case like that, we usually put something together fast in the Washington office. We do a hasty check with the Kansas City office, get in touch with someone we think will be a good witness and hope that that person can make arrangements to be away from his or her job for a day or two on very short notice. We then put the testimony in final form, make 40 or 50 copies (or whatever number the committee requires for advance delivery), write a summary, say a brief prayer or a longer one if we have time, and go up to The Hill.

I mentioned a summary. In many instances, we do not read the full, formal statement, but summarize it for
the committee. The full statement does go into the formal record of the hearing. Most committees appreciate it if you keep your oral statement to a reasonable length. Some actually tell you in advance that there is a time limit of 10 minutes, 15 minutes, or whatever.

Testifying before congressional committees is actually a very small part of what we do, and public hearings constitute a very small part of what goes into the passage of legislation. Much of the legislative work goes on behind the scenes.

A great deal of our work—contrary to what many people think—is very routine. It involves a lot of reading that includes the daily monitoring of *The Congressional Record*, the official proceedings of House and Senate floor action; reading or scanning of numerous newsletters, publications of other groups and organizations; daily monitoring of *The Federal Register*, which publishes all rules and regulations promulgated by the executive branch that detail how a law will actually be administered.

The latter publication is particularly important, because you may discover that the department writing the regulations apparently thinks the law says something different from what you thought it said. So, if you have worked to get certain language in a law, you have to watch to make sure that it stays that way not only through the legislative process, but through the rule-making process, as well. ANA also prepares comments on these regulations. There is usually a 30- or 60-day comment period.

A big part of our job is to keep Congress informed about nursing’s interests. It is equally important to keep nurses informed about what Congress is doing. We do this through regular communications with state nurses’ associations and other units of ANA and on a broader level through news in *The American Nurse*. A column called “Capital Commentary,” which I write, appears in *The American Nurse* every month. *The American Journal of Nursing* also carries Washington news regularly.

All of this is a continuing process with a special push when a bill is coming to a vote. At that time, we contact nurses to get in touch with their representatives and senators. And, nurses are following through. We have often had Congressional staffs tell us, “We’re really hearing from the nurses”, or even sometimes, “Okay, how about calling off the nurses?” This is what counts.

The success of our efforts in Washington depends on nurses throughout the country. We can tell Congress that “this is nursing’s view on a given bill,” but if they do not hear from individual nurses backing up what we are saying, they simply will not pay much attention to us. I cannot overemphasize the importance of every nurse being informed—becoming interested and active in the legislative process. The stronger the voice—the louder the voice—the greater the impact we are going to have.

**Legislation of interest to nursing**

Heading the list of legislation of special interest to nursing is, of course, national health insurance. Obviously, if national health insurance is enacted, it is going to have a big impact on all health care providers. The American Nurses’ Association is on record as supporting the concept of national health insurance, though ANA has not endorsed any particular bill.

At the moment, there is really no action in Congress: The Carter administration doesn’t intend to introduce a bill until sometime in 1978. Other bills which have been introduced on the subject include:

- **Health security**, the Kennedy-Corman bill. This calls for comprehensive, mandatory coverage for everybody financed through general tax revenues and an employer-employee payroll tax. Nursing care is not specifically identified as a separate benefit under this plan.
- **The National Health Care Act of 1977** (Burleson, D-Tex.; McIntyre, D-N.H.). This is the health insurance industry bill, and not surprisingly it would
make use of approved private health insurance. Coverage would be voluntary. Physician-controlled nursing service would be a benefit.

The Comprehensive Health Care Insurance Act of 1977 (Carter, R-Ky.; Murphy, D-N.Y.; Hansen, R-Wyo.). This is the AMA-backed bill. It would provide for voluntary coverage under private health insurance plans. Private duty nursing care is specifically excluded from eligible benefits. "Nursing services" are included as a benefit to a hospital in-patient.

Other bills. Senator Javits and Representative Scheuer have introduced a bill to provide comprehensive benefits for mothers and for children through age 17.

Representative Dellums of California has introduced legislation for a national health service, which is different from national health insurance. It would put all health professionals on salary and remove profit-making from the country's health care system. A national health insurance advisory committee was appointed by Secretary Califano last April. It is holding hearings and visiting health care sites around the country. It is supposed to come up with a report that will be used in drafting the Administration's bill. There is one nurse on that committee, Ingeborg Mauksch, who is a professor and family nurse practitioner at the school of nursing, Vanderbilt University. She also is chairperson of the ANA Congress for Nursing Practice.

HEW Secretary Califano recently wrote to all state governors and to all members of the House and Senate asking their advice on what kind of a program we should have. He also issued instructions to the staffs of the regional HEW offices to hold public hearings or meetings on the subject; some 100 meetings were scheduled throughout the country.

The president and a number of members of Congress think that there has to be some reform of the present health care system before a national health insurance program gets under way, and so the legislation that was getting attention this fall was the hospital cost containment and the Medicare-Medicaid anti-fraud and reform bill.

The Administration's Cost Containment Bill (H.R. 6575 and S. 1391) would place an approximate 9% cap on hospital revenue increases and would set a limit on new capital expenditures. It includes provision for a pass-through for wage increases for nonsupervisory employees.

Four Congressional committees were considering the administration bill: in the House, the Health Subcommittee of the Ways and Means Committee and Health Subcommittee of Interstate and Foreign Commerce; and in the Senate, the Human Resources Committee, and the Senate Finance Committee. Chairman Rostenkowski of the Ways and Means Health Subcommittee introduced his own bill which would exempt about half of all hospitals from coverage. As of now, I would say there is a considerable difference of opinion on the legislation.

ANA submitted statements to the committees, supporting the general intent of the legislation but having several serious reservations about its specifics. For example, ANA questioned this across-the-board approach to acute care hospitals (which are not all the same), believing that the legislation can have limited value without some more fundamental reform of the system of health care delivery and reimbursement. It is, of course, intended as a "transition" measure, but as such, has no expiration date. ANA also is concerned that the cap could result in reductions in staff and services and endanger patient care.

ANA has spoken to a related bill, which I know nurse anesthetists have interest in—H.R. 1470, Senator Tal-madge's Medicare-Medicaid Administrative and Reimbursement Reform Act. Title I of that bill would seek to establish a new method of reimbursement for routine operating costs of hospitals under Medicare and Medicaid. Under routine operating costs, intern, resident and
medical personnel costs are excluded; nursing personnel costs are considered a part of routine operating costs. ANA recommended the separating out of nursing service from housekeeping, maintenance and other routine costs in order to “provide a truer financial picture.”

Under Section 11, which sets out criteria for determining reasonable charges for physicians’ services, ANA pointed out that “no mention is made of reimbursement for non-physician providers, despite the significant public and Congressional attention now focused on cost effective alternatives to physician-provided primary health care.”

There is a connection here with what I understand is your concern, that is Section 12 of the bill relating to reimbursement of anesthesiologists and other “hospital-associated physicians.” Here again: No mention is made of nurses—nurse anesthetists.

As you may have read in the newspapers, Ralph Nader’s health research group has asked Secretary Califano to amend the administration’s cost control proposal to put hospital-based physician specialists on salary. This suggestion was based on an HEW study, which says that hospital-based pathologists, radiologists, and anesthesiologists made more than twice as much money in fiscal 1975 as those on salary. This, of course, is not the first time that someone has suggested that physicians’ fees should be included in any consideration of cost control legislation.

On the matter of reimbursement, there have been bills introduced for reimbursement of nursing services. Senator Inouye has two bills in—one would provide for the inclusion of the services of “licensed registered” nurses under Medicare and Medicaid, and the other refers specifically to the services of psychiatric nurses.

Senator Inouye also has introduced bills for coverage of such services under CHAMPUS, (Civilian Health and Medical Program of the Uniformed Services). And, these bills are interesting, because the House and Senate Conference Reports on Defense Appropriations endorsed independent reimbursement for psychiatric nursing and nurse midwives services under CHAMPUS. Senator Inouye proposed this language for the conference report. It does make such payment permissible when the patient has been referred to one of these nurse specialists by a physician or clinical psychologist.

The reimbursement bill, which has gotten considerable attention by Congress, is the one to provide reimbursement under Medicare to rural health clinics for the services of nurse practitioners and physicians’ assistants without a requirement of direct supervision by a physician. Many of these clinics were started to supply health care in areas where there are no physicians, but they have a hard time making it financially because Medicare does not reimburse unless a physician is present.

ANA has testified before three different committees on this legislation. ANA’s position is that such services should be reimbursable regardless of the setting, that is, urban as well as rural. ANA objected to the term physician extender that was used to describe both physicians’ assistants and nurse practitioners—and the Ways and Means Subcommittee changed this language to primary care practitioner. We also recommended removal of the requirement for physician supervision of nursing, replacing it with the language, “mutually agreed upon protocols and/or in accordance with state law.” This legislation also was reported just before the recess by the Finance Committee, which has jurisdiction in the Senate. They accepted the terms “nurse practitioner” and “physician assistant”, rather than “physician extender” or “primary care practitioner.”

Another piece of legislation that I would like to mention briefly is the PSRO Bill introduced by Representative Martha Keys of Kansas (H.R. 3167) and in the Senate by Senator Inouye (S. 223). The purpose of this bill is to
ensure the participation of registered nurses in Professional Standards Review Organizations at policy levels. It would require that at least 30% of local review board membership be comprised of RN's, that two RN's would be designated by each state nurses' association to serve on state PSRO councils, and would add three RN's to the National Standards Review Council, whose current membership is 11 physicians. (For AANA's support of this bill, see "Washington Scene" in this issue.)

**AANA's political action arm**

Another part of the AANA legislative program that I would like to just mention briefly is the political action aspect. I think it is pretty clear that any group that really wants to make its voice heard in decisions affecting health care has to get involved in politics. A lot of people still associate politics with a five-letter word, which is spelled d-i-r-t-y; but politics is really related to another simple five-letter word, p-o-w-e-r.

Nurses are the largest group of health professionals in this country, but their political clout, their power, is not what is should be in proportion to their numbers. That is because they have not moved to use it as many other groups have. However, they took a step in that direction, I think, in 1975 when AANA established N-CAP, the Nurses Coalition for Action in Politics, as a political action arm of AANA. Many other groups, such as doctors, dentists, labor unions, and teachers, have had political action committees for a long time. Nursing came late to this, but I think we are getting a good start.

N-CAP has two basic functions: (1) to endorse and support candidates for office, and (2) to encourage greater participation by nurses in politics, which can include anything from political education to running for office. A number of nurses are members of state legislatures. There are none in Congress—yet.

Nurses also have formed political action committees in 21 states. Last year for the first time, N-CAP endorsed and contributed to the campaigns of candidates for Congress. I would say that this alone helped to make candidates more aware of AANA and AANA's views on health issues. About 90% of those candidates endorsed were elected.

Nurses are learning to exercise power, and that is the key to effective action whether you are talking about national legislation or local hospital policy. Nurses should have a great deal more influence on both than they do currently. This is summed up in a quotation from an article by Mary Kelly Mullane, former dean at the University of Illinois College of Nursing, in the November, 1975 issue of *Nursing Outlook*: "The art of influencing policy, whether in government or in health care settings, can improve care for all, if nurses recognize and use this valuable skill."

Nurses are becoming better and better at using their legislative clout—in states as well as on the national scene—now they are starting to organize and use their political clout.

**AUTHOR**

Virginia L. Bauknecht holds a BA degree from Ohio Wesleyan University in Delaware, Ohio, and an MS in Journalism from the Medill School of Journalism at Northwestern University in Evanston, Illinois. She has served as public relations director of the Young Women's Christian Association of the City of New York; public relations director of the American Nurses' Association in New York City; and editor and writer, Communication and Publicity Department, McGraw-Hill Publishing Co., in New York City. She also worked as a reporter and feature writer for several daily newspapers in Ohio. She is a member of Phi Beta Kappa national honor fraternity, Public Relations Society of America, Women in Communications (formerly Theta Sigma Phi), and Women in Public Relations, Inc. She is presently communications coordinator for the American Nurses' Association, Government Relations Office, based in Washington D.C.

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