NURSE PARTICIPATION IN HOSPITAL DECISION MAKING

POTENTIAL IMPACT ON THE NURSING SHORTAGE

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EXECUTIVE SUMMARY

PURPOSE

The purposes of this inspection were to (1) determine the extent to which nurses participate in hospital decision making through representation on hospital governing bodies and key committees and (2) describe techniques used by hospitals to retain and recruit nurses. This report presents our findings on hospital decision making. Hospital recruitment and retention techniques are described in a separate report.

BACKGROUND

The demand for registered nurses (RNs) has fluctuated over the years -- from a shortage in the 1960s to a surplus in the mid-1970s and back to a shortage at the present time. Even though 80 percent of the nation's two million RNs are employed, hospitals are now experiencing the most severe shortage of RNs in recent history. Because of increased patient acuity, hospitals need more nurses than ever before; at the same time, more nurses are choosing to work in other health care settings. According to American Hospital Association (AHA) surveys, hospital RN vacancies more than doubled from 4.4 percent in 1983 to 11.3 percent by December 1987.

There is widespread agreement on the major factors which contribute to the current shortage. They include:

- salary compression and limited advancement opportunities;
- changing work schedules, including required night and weekend shifts, without adequate compensation;
- frustration due to having to cope with sicker patients and shorter stays;
- lack of recognition and respect for nurses as part of a professional health care team;
- lack of autonomy in making patient care decisions; and
- fewer students opting for nursing careers because of expanded opportunities in other professions.

At an October 1987 hearing on the Nursing Shortage held by the Senate Finance Committee's Subcommittee on Health, witnesses from nursing and health care organizations cited low pay, poor working conditions and lack of input into managerial decisions as issues faced by the nursing profession. In December 1987, Health and Human Services (HHS) Secretary Otis Bowen appointed a special Commission to study the nursing shortage and provide him with a

report and corrective action plan. The Commission is headed by Carolyne K. Davis, Ph.D., former Administrator of the Health Care Financing Administration.

This inspection was initiated at the Commission's request. It was conducted in two phases between April and September 1988. Phase One was a telephone survey to chief executive officers (CEOs) and chief nursing officers (CNOs) at a random sample of 93 hospitals throughout the U.S. Thirty-one hospitals were contacted in each of three strata: (1) hospitals with 500 or more beds, (2) urban hospitals with fewer than 500 beds, and (3) rural hospitals with fewer than 500 beds. Phase Two consisted of visits to a small number of hospitals around the country which have developed strategies and techniques to recruit and retain nurses. This report presents the findings of the telephone survey. Results of the hospital visits are contained in a companion report to be issued in the near future.

FINDINGS

- The CEOs are the only members of hospital management who consistently attend governing body meetings. Over half of all CEOs are voting members, while an additional one-third participate in a non-voting capacity.

- One-third of CNOs attend governing body meetings regularly and another one-third attend when invited. Fewer than 2 percent of all CNOs vote. Similarly, while other hospital management positions may sometimes attend governing body meetings, they rarely vote.

- While one-fifth of governing bodies include nurses from the local community, most are selected for reasons other than their nursing backgrounds.

- More CNOs serve on planning and joint conference than on executive or finance committees. Five percent of CNOs are members of their hospital executive committees, but none vote. Six percent serve on the finance committee. Five of the six vote.

- In contrast, a CNO has a 50 percent chance of being on the joint conference committee, and one chance in three of sitting on the planning committee. Over half of the CNOs on these committees vote.

- The majority of CNOs report directly to CEOs. Most of the remainder are one level down in the organization, reporting to either chief operations officers or executive vice presidents.

- According to CEOs, 57 percent of CNOs are paid more than other management officials at the same organizational level, and another 40 percent are paid the same. Only 3 percent are compensated at a lower level.

- Three-quarters of CNOs indicated that nursing budgets are prepared at the unit level, while 18 percent prepare the budgets themselves. Eighty percent control the nursing budgets once approved.

- Virtually all CNOs control the hiring and firing of nursing staff. Nearly half have delegated these authorities to the unit level.

- Nearly 60 percent of CEOs and 85 percent of CNOs believe that input into decision making has a positive effect on nurse retention. Many view it as a relatively minor consideration, however, as compared to salaries, educational benefits and autonomy on the unit.

OBSERVATIONS

- While CNOs seldom vote on governing bodies, they do not appear to have been singled out for exclusion from governing body deliberations because, except for CEOs, very few other hospital management officials are voting members.

- The status, autonomy and span of control of today's CNOs appear to be greater than in the past.

- The majority of respondents believe, and we agree, that input into patient care and management decisions result in a sense of control in the workplace and a stake in the success and well-being of the organization which should ultimately have a positive effect on nurse retention.

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INTRODUCTION

BACKGROUND

The demand for nursing services has fluctuated over the years -- from a shortage in the 1960s to a surplus in the mid-1970s and back to a shortage at the present time. Despite the fact that 80 percent of the nation's 2.1 million registered nurses (RNs) are working, hospitals are now experiencing the most severe shortage of RNs in the history of the industry. Because of significantly increased patient acuity, hospitals need more nurses than ever before; at the same time, more nurses are choosing to work in other health care settings. Surveys conducted by the American Hospital Association (AHA) found that vacant RN positions more than doubled from 4.4 percent in 1985 to 11.3 percent by the end of 1987.

Numerous factors have been cited as contributing to the hospital nursing shortage. Among the most common are:

- salary compression and limited advancement opportunities;
- changing work schedules, including required night and weekend shifts, without adequate compensation;
- frustration and burnout due to having to cope with sicker patients and frequent patient turnover;
- little recognition and respect for nurses as part of a professional health care team;
- perceptions that quality of care has suffered since the advent of the Medicare Prospective Payment System (PPS);
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- lack of autonomy in making patient care decisions; and
- fewer students opting for careers in nursing.

Nurses have traditionally been the lowest paid, least respected professional members of hospital health care teams. In most hospitals, the chief nursing officer (CNO) has not had equal status with other hospital managers with comparable responsibilities. In January 1988, the Wisconsin Organization of Nurse Executives surveyed its membership to determine the extent of nursing input to hospital boards. The survey found that 37 percent of nurse executives are expected to attend board meetings regularly, and 41 percent are expected to attend some or all hospital board committee meetings.

At a hearing on the Nursing Shortage held by the Senate Finance Committee's Subcommittee on Health in October 1987, witnesses cited low pay, unsatisfactory working conditions and lack of input in managerial decisions as issues faced by the nursing profession. Some health care professionals believe that representation of nurses and nursing executives on hospital governing bodies and key hospital committees may have a positive effect on nurse recruitment and retention.

In December 1987, Health and Human Services (HHS) Secretary Otis Bowen appointed a special Commission to study the nursing shortage and provide him with a report and corrective action plan. The Commission is headed by Carolyne K. Davis, Ph.D., former Administrator of the Health Care Financing Administration.

PURPOSE

This inspection was initiated at the request of Dr. Davis. Its purposes were to (1) determine the extent to which nurses are represented on governing bodies and policy-making committees in hospitals around the country and (2) describe strategies and techniques used by hospitals to recruit and retain nurses.

METHODOLOGY

The inspection was carried out in two phases. Phase One consisted of a telephone survey to a random sample of 93 hospitals selected from the universe of all Medicare-certified acute care non-specialty hospitals in the U.S. The sample contained three strata: (1) hospitals with 500 or more beds, (2) urban hospitals with fewer than 500 beds and (3) rural hospitals with fewer than 500 beds. Thirty-one hospitals were contacted in each stratum. At each hospital, we interviewed the chief executive officer (CEO) and the Chief Nursing Officer (CNO). We asked each group questions on topics about which we thought they would be knowledgeable. This report contains the results of our telephone survey.

Phase Two consisted of on-site visits to a small number of hospitals, most recommended by State Nurses Associations, which have developed strategies to attract and retain nurses. The results of Phase Two are presented in a companion report entitled, "Hospital Best Practices in Nurse Recruitment and Retention."

Additional detail on the characteristics of our study sample appear in the appendix. The percentages cited throughout this report, unless otherwise noted, are weighted averages which represent national projections of our actual sample findings to the universe of all Medicare-certified acute care non-specialty hospitals in the U.S.

FINDINGS

NURSE PARTICIPATION IN HOSPITAL GOVERNING BODIES

The term governing body refers to the policy making body of a hospital or other institution. It may also be called the governing board, board of trustees, board of directors or board of managers. In addition to establishing policy, the governing body is responsible for maintaining quality patient care and providing for institutional management and planning.

Chief executive officers are consistently represented on governing bodies.

Chief Executive Officers are the only members of hospital management who consistently attend meetings of the governing body. Eighty percent of rural CEOs and nearly 90 percent of urban CEOs are represented on their hospital governing bodies. Overall, some 85 percent of CEOs are members of their hospital governing bodies.

According to CEOs, other hospital management positions, including executive vice-presidents, chiefs of staff, chief operations/financial officers and CNOs are occasionally represented on governing bodies.

Most chief nursing officers attend at least some governing body meetings.

We asked CEOs and CNOs to characterize CNO participation in hospital governing bodies by selecting one of three options: (1) expected to attend regularly, (2) expected to attend when invited and (3) not expected to attend or participate. These categories are similar to those used by the AHA Center for Nursing in its 1988 Hospital Nursing Personnel Survey. The following chart provides a breakdown of responses received.

CNO ATTENDANCE AT GOVERNING BODY MEETINGS
CEO & CNO RESPONSES
(In Percentages)

	CNO Attends Regularly		*CNO Attends When Invited*		*CNO Does Not Attend*	
	CEO	CNO	CEO	CNO	CEO	CNO
STRATUM						
500+	51.6	58.1	32.3	35.5	16.2	6.5
Urban	34.5	38.7	37.9	41.9	27.6	19.4
Rural	34.5	41.9	27.6	32.3	37.9	25.8
WEIGHTED AVERAGES	35.6	41.5	32.7	37.0	31.9	21.6

According to CEOs, 68 percent of CNOs are expected to attend governing body meetings regularly or when invited. In contrast, nearly 80 percent of CNOs responded that they attend at least some governing body meetings. Apparently, CNOs feel that they have more opportunities for direct input to governing body proceedings than expressed by CEOs.

Chief executive officers are usually the only members of hospital management who vote on governing bodies.

As shown in the following chart, the CEO has one chance in two of voting on the governing body. However, other hospital management officials, including the Chief Operations or Financial Officer (COO/CFO) and the CNO, rarely vote.

VOTING MEMBERS OF HOSPITAL GOVERNING BODIES MANAGEMENT POSITIONS IDENTIFIED BY CEOs (In Percentages)

	CEOs		*CNOs*		*COOs/CFOs*	
	Members	*Vote*	*Members*	*Vote*	*Members*	*Vote*
STRATUM						
500+	83.9	48.4	9.7	3.2	12.6	9.7
Urban	93.1	69.0	10.3	0.0	20.7	6.9
Rural	79.3	37.9	10.3	3.4	13.8	0.0
WEIGHTED AVERAGES	86.0	53.0	10.3	1.8	17.6	3.8

Few governing bodies have nursing advisory committees.

Governing bodies in urban hospitals and large hospitals are twice as likely to have a nursing advisory committee as rural hospitals. Thirteen percent of large hospitals and 14 percent of urban hospitals reported that their governing bodies have nursing advisory committees, compared with 7 percent of rural hospitals. Overall, 10 hospitals, just over 10 percent of the survey respondents, have such committees. Three of the ten, all with over 500 beds, are affiliated with nursing schools and are therefore required to have nursing advisory committees by the Joint Commission of Accreditation of Healthcare Organizations.

Community nurses occasionally serve on governing bodies.

One-fifth of governing bodies include nurse members from the local community. However, most are selected for reasons other than their nursing backgrounds. We asked CEOs at hospitals with no local nurse on the governing body whether they had ever considered recommending that one be appointed. Eleven percent, most of them in urban hospitals, said they had considered this.

Some respondents commented on this issue. The CEO at a large hospital stated, "We have considered appointing a community nurse to the Board, and are now trying to identify a person of the right stature." A rural CEO said, "The most important consideration in the selection of board members is their managerial ability. That's a problem with nurses today; they are not taught managerial skills." Several respondents indicated they had not considered appointing a nurse from the local community because board members are appointed by local or State government officials.

CHIEF NURSING OFFICER PARTICIPATION ON KEY HOSPITAL COMMITTEES

Respondents were asked to identify the most influential committees in their hospitals, and then to indicate whether the CNOs were members and if they vote. The committees named most frequently were executive, finance, planning and joint conference. All are committees of the governing body.

While few chief nursing officers are represented on finance and executive, they more frequently serve on joint conference and planning committees.

The executive committee is the senior committee of the governing body and may itself be a ruling body. Nearly 5 percent of CNOs serve on executive committees, but none vote.
The finance committee is responsible for managing the hospital's fiscal affairs. It monitors and approves hospital operating and capital budgets. Three-quarters of CEO respondents identified finance as an influential committee. About 6 percent of CNOs serve on this committee; fewer than 5 percent vote.

In contrast, 37 percent of CNOs are members of the planning committee. The planning committee formulates the hospital's strategic plan. It develops both long- and short-term objectives affecting internal and external hospital affairs. Overall, nearly one-quarter of all CNOs vote on the planning committee.

Similarly, CNOs have a 50 percent chance of serving on the joint conference committee. More than one-third of all CNOs are voting members. The joint conference committee provides a forum for the discussion of medical affairs. It is composed of governing body members and medical staff.

The chart on the following page presents additional detail on CNO participation on key hospital committees.

CNO PARTICIPATION ON INFLUENTIAL COMMITTEES

Committee	*Times Named*	*CNO Member*		*CNO Votes*	
Finance	67	4	6.0%	3	4.5%
Executive	43	2	4.7%	0	0.0%
Planning	46	17	37.0%	11	23.9%
Joint Conference	34	17	50.0%	12	35.3%

CHIEF NURSING OFFICER STATUS AND AUTONOMY IN HOSPITAL HIERARCHY

The majority of chief nursing officers report to the chief executive officer.

Seventy percent of CNOs indicated that they report directly to CEOs. Based on their verbal responses, CNOs in rural areas report directly to CEOs more than twice as often as their counterparts in urban hospitals with 500 or fewer beds.

Nearly half of the respondent hospitals also provided copies of their current organizational charts. A review of these charts showed nearly 60 percent of CNOs reporting to CEOs and 38 percent reporting to second level management. Over 70 percent are at an organizational level equal to or higher than the chief financial officer. Additional detail based on our review of hospital organization charts is provided below.

CNO LINES OF REPORTING
(N=45)

STRATUM	*Reports to CEO*	*Reports to 2nd level Mgmt*	*Other*
500+	6	10	2
Urban	11	6	0
Rural	9	1	0
TOTALS	26 (57.8%)	17 (37.8%)	2 (4.4%)

Most chief nursing officers are paid as much as or more than their management counterparts.

Based on CEO responses, some 57 percent CNOs are paid more than as other hospital management officials at the same organizational level and 39 percent are paid the same. Only 3 percent are compensated at a lower level.

Half of chief nursing officers supervise non-nursing departments.

About half of CNOs in each stratum supervise non-nursing as well as nursing services. Those departments cited most frequently are social services/discharge planning, quality assurance, rehabilitation and pharmacy. Others include housekeeping, central supply, home health, educational services and infection control. As shown below, nearly one-quarter of CNOs supervise four non-nursing services, while 10 percent supervise either one or two non-nursing departments.

NON-NURSING SERVICES REPORTING TO CNO
(In Percentages)

	Number of Services				
	0	1	2	3	4
STRATUM					
500+	51.6	16.1	9.7	0.0	22.6
Urban	51.6	3.2	9.7	9.7	25.8
Rural	45.2	9.7	12.9	3.2	29.0
WEIGHTED AVERAGES	51.2	9.7	9.9	4.7	24.5

Forty percent of chief nursing officers are masters prepared.

As shown on the following page, over 40 percent of CNOs have masters degrees and 3 percent have doctoral degrees. The CNOs in large and urban hospitals tend to have more formal education than CNOs in rural hospitals. One-fifth of CNOs in large hospitals have PhD degrees. Most CNOs with associate degrees or nursing diplomas are in rural hospitals.

CNO EDUCATIONAL LEVELS
(In Percentages)

STRATUM	*AD*	*Diploma*	*BS/BA*	*MS/MA*	*PhD*
500+	0.0	3.2	12.9	64.5	19.4
Urban	0.0	12.9	22.6	61.3	3.2
Rural	16.1	32.3	32.3	19.4	0.0
WEIGHTED AVERAGES	7.6	21.4	26.6	41.8	2.7

The CNO educational levels for large hospitals and urban hospitals in our survey compare favorably with results of the 1985 annual survey of the American Organization of Nurse Executives (AONE), whose membership consists primarily of CNOs from large hospitals in urban areas. In that survey, 59.8 percent of the respondents held masters degrees while 2.5 percent had completed their PhDs.

As a group, CNOs have fewer advanced degrees than CEOs. According to their own responses, 60 percent of CEOs are masters prepared, while 4 percent have doctoral degrees.

Nursing departments prepare and administer their own budgets.

Overall, nearly three-quarters of CNOs contacted indicated that budgets are prepared at the unit level and reviewed by the CNO. Eighteen percent reported that they prepare the nursing budgets themselves. Nine percent, mostly in rural hospitals, do not prepare their own budgets. Additional detail is provided in the following chart.

NURSING BUDGET PREPARATION
(In Percentages)
n=93

STRATUM	*Units Prepare CNO Reviews*	*CNO Prepares*	*Neither Prepares*
500+	93.5	6.5	0.0
Urban	83.9	9.7	6.0
Rural	58.1	29.0	12.9
WEIGHTED AVERAGES	72.4	18.6	9.1

Eighty percent of CNOs control nursing budgets once approved, and can reallocate funds among line items as needed. In large hospitals, all CNOs control the approved nursing budgets.

Chief nursing officers control hiring and firing of nurses.

Responsibility for hiring and firing nursing personnel clearly rests within the nursing department. Nearly half of CNOs have delegated hiring and firing authority to the unit level. One-quarter have also delegated authority to negotiate salaries to the unit level.

Hiring and firing is done at the unit level in nearly 90 percent of large hospitals and about two-thirds of urban hospitals. In rural hospitals, this authority generally rests with the CNO herself. One rural CNO in a very small hospital is also the head nurse of the hospital's single unit. She does not have firing authority. The one CNO in a large hospital who does not have firing authority attributed this to the provisions of the hospital's union contract. The chart below provides additional detail on hiring and firing authority.

HIRING AND FIRING AUTHORITY
(in Percentages)
N=93

	Unit Hires/Fires	*CNO Hires/Fires*	*Unit/CNO Hire Can't Fire*
STRATUM			
500+	87.1	9.7	3.2
Urban	64.5	35.5	0.0
Rural	25.8	71.0	3.2
WEIGHTED AVERAGES	47.7	50.6	1.7

INPUT INTO DECISION MAKING AS A FACTOR IN NURSE RETENTION

Most respondents think nurse input into decision making is important.

Nearly 60 percent of CEOs and 85 percent of CNOs believe that input into decision making has a positive effect on nurse retention. Many respondents indicated that this is just one of many factors, however, and not as important a consideration to RNs as salaries, educational benefits and autonomy on the unit.

The following quotes illustrate the range of opinions expressed by CEOs on the relationship between nurse participation in decision making and retention.

"Unless nurses feel they have some control over their occupational functions, why would they stay? I'm not the best person to say how to deliver care effectively. I can say, 'these are our financial restrictions,' and then ask nursing, 'what can we do within them?'

"My goal is to have an RN on the Board of Trustees and expand nurse participation to the executive committee. Nursing is half of the hospital staff and 90 percent of the patient care is delivered by RNs. They want and deserve more representation."

"Today's RN is not the same as 5-10 years ago. Today, RNs reflect the values of all women in the workforce. They want and need participation and control in the workplace, and are no longer willing to accept physicians' orders without question."

"I question the logical link between job satisfaction and participation in decision making. In my mind, the two are independent variables."

"Money is the main thing. Once that is satisfied, there is no difference between nursing and any other job. What keeps nurses on their job is the same thing that keeps other people on their jobs. If the job is made more attractive, more people will want to do it."

"The two factors are absolutely not related. People leave for other reasons. The big issue is money. Nurses are already part of decision making."

"Nurses are at a lower level where participation in hospital decision making just doesn't interest them."

"If nurses are involved in decision making, it should be in the nursing department, not on the governing body."

"Nurses are a very mixed up bunch of ladies who aren't interested in anything but money. They feel the hospital is there to provide them with a job, not to provide a service to the community."

The CNOs also commented on this issue:

"Nurses remain in organizations with healthy assertive nursing departments where they participate in decision making. Hospitals with low turnover and vacancy rates are already using nurses on decision making bodies."

"There is a relationship, but even with a voice in decision making, patient care nurses will still get frustrated and burn out because it's simply a tough job."

*"I'm not sure there is a relationship. Nurses **do** need more input into things that affect their own lives, but is that hospital decision making? It is more important to move decision making to the unit level and to seek input from staff nurses on how they can improve their own work as well as patient care."*

"All other things being equal, the major factor in nurse retention is autonomy in their clinical practice."

"They like participating, but other factors, such as money and recognition, are more important in retention."

Staff nurses want to serve on patient care and nursing practice committees.

Three-quarters of CEOs and over four-fifths of CNOs think that staff nurses are interested in serving on committees, particularly those dealing with patient care and nursing practice issues. Fewer nurses are interested in committees not directly work-related. Once on a committee, nurses continue to be interested if they believe that their participation can make a difference in hospital policies or procedures, and they see a positive effect on their practice. Three CNO comments illustrate the range of opinions expressed.

"A nurse's control over her environment and sense of self-esteem are enhanced by serving on a committee. To many nurses, committee membership is as important as salaries."

"Nurses don't realize how complex some issues can be. They agree to serve on a committee thinking it will lead to a better work environment or enhance their clinical practice. Then they get bogged down in issues they are not interested in. The issues they feel are important are so far down the agenda, they will never see the light of day. This can be extremely frustrating."

*"It really depends on the person. Most nurses just want to do their jobs and don't want to get involved. If they **did** get involved, they would get more job satisfaction."*

OBSERVATIONS

We found that while most CNOs participate to some degree in hospital governing body meetings, very few vote. It does not appear, however, that CNOs have been singled out for exclusion from governing body deliberations which are open to other comparable management officials, because other hospital management officials (except for CEOs) are rarely voting members. There is no indication that the percentage of voting CNO members will increase significantly in the near future.

Chief nursing officers are seldom represented on the two hospital committees where business and financial matters are discussed -- executive and finance -- but do participate in substantial proportions on the planning committee. Not surprisingly, there is also a high degree of representation on committees which have traditionally dealt with patient care issues which have always been nursing's primary concern.

The status, autonomy and span of control of today's CNOs appear to be greater than in years past. The majority are at the level of vice-president in the hospital organization, reporting directly to the CEO. Half supervise non-nursing as well as nursing services, and the majority are paid as much as or more than their organizational counterparts. The CNOs control nursing budgets and the hiring and firing of nursing staff. In large hospitals, these authorities have been further delegated to the unit level. These improvements in status may reflect hospitals' increased awareness of the critical role of nursing, but may also be the result of the efforts of a more sophisticated, better educated and better organized nursing profession.

Most respondents believe, and we agree, that input into decisions -- whether related to the care of individual patients, nursing policies and practices, or the hospital's future -- provides nurses with a sense of control over their work and a stake in the success and well-being of the organization as a whole. The Department may wish to consider further longitudinal research as a means to obtain definitive data on the impact of participation in decision making on nurses' employment decisions.

APPENDIX

CHARACTERISTICS OF THE INSPECTION SAMPLE

I. Hospital Universe and Respondents by Stratum

Stratum	*Universe of Hospitals*	*Respondents*	
		CEOs	*CNOs*
500+ Beds	369	31	31
Urban	2,686	29	31
Rural	2,718	29	31
Totals	5,773	89	93

II. Hospital Classification by Stratum (n=93)

Stratum	*Government*	*Non-Gov't Not for Profit*	*Investor Owned*
500+	16.1%	80.6%	3.2%
Urban	9.7%	77.4%	12.9%
Rural	41.9%	45.2%	12.9%
Weighted Averages	25.3%	62.5%	12.3%

III. Other Characteristics

- Eighteen (19.4 percent) of the sampled hospitals are religiously affiliated. Eleven of these are Catholic.
- Rural hospitals reported a mean vacancy rate of 13.2 percent while the mean rate for both urban and large hospitals is slightly over 12.6 percent. Overall, the mean vacancy rate is 12.9 percent.
- Eleven hospitals (11.8 percent) reported vacancy rates in excess of 25 percent. Seven of these are small hospitals in rural areas. Only one hospital has over 500 beds.
- Just over 40 percent have experienced a rise in vacancy rates and the same percentage have reduced vacancy rates during the past year. The remainder have stayed constant.