



Aiding and Abetting — Nursing Crises at Home and Abroad

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After what seemed like years of teleconferencing, protocol revisions, international travel, and training sessions, the staff at the HIV clinical care and research site in India, where we had worked for

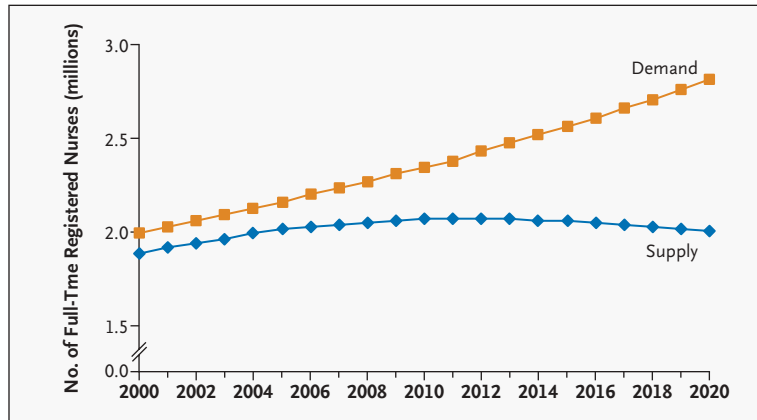
four years, was gearing up to start enrollment in a five-year international trial sponsored by the National Institutes of Health (NIH). But just months before it was to be launched, one of our lead research nurses, Ms. Rao (not her real name), who had been trained with NIH funds, quietly announced that she was leaving to pursue a job offer in the United States.

Many more nurses like Ms. Rao will now have the option of moving to the United States, thanks to a U.S. law that was passed earlier this year: the Emergency Supplemental Appropriations for Defense, the Global War on Terror, and Tsunami Relief. The law, which mainly funds military op-

erations and reconstruction, includes approval for 50,000 new visas for nurses and their family members. It was passed just a year after the Department of Labor abolished the time-consuming process of labor certification for foreign nurses migrating to the United States, which required assurances that wages and working conditions of U.S. workers would not be adversely affected by the hiring of foreign nationals for these positions. Since there is a recognized shortage of nurses in the United States, the new law facilitates the immigration of foreign nurses who are already certified by the Commission on Graduates in Foreign Nursing Schools, have

passed the National Council Licensure Examination for Registered Nurses, or hold a full and unrestricted license to practice nursing in the state of intended employment.

The shortage of nurses in the United States is a serious and growing problem, with 126,000 nursing positions currently unfilled in U.S. hospitals.¹ Compounding this problem is the fact that as baby boomers are growing older and their medical needs are increasing, enrollment in nursing schools is declining. Increasing demands on nurses, partially a result of the shortage of nurses, have led to early career burnout, with as many as 20 percent of nurses retiring early. The Department of Health and Human Services projects that by 2020, the shortage of registered nurses in relation to demand will reach 29 percent, with more than 1 million



Projected Supply of and Demand for Full-Time Registered Nurses in the United States, 2000–2020.

Data are from the Bureau of Health Professions.

nursing positions left open (see graph).¹

Free-market forces, which might be expected to correct this shortage, have failed to do so for several reasons. Despite financial incentives for nurses, the culture of nursing may not appeal to many Americans — in part because nurses are perceived as having inadequate input into health care decision making, public policy, and research. Nursing schools have also had difficulty recruiting and retaining the faculty necessary to build sustainable training institutions. Moreover, the nursing shortage is a global phenomenon, and given the high and rising cost of health care in the United States, the country will be hard pressed to compete in a globalized marketplace.

Faced with a growing demand for nurses and yet a shrinking supply, nurses have been working more hours. The number of nursing hours provided at a hospital is positively related to patient-safety outcomes.² Better levels of nurse staffing result in a decrease in the average length of hospital stays, as well as decreases in the rates of urinary tract infections,

pneumonia, shock, and episodes of upper gastrointestinal bleeding. High-quality nursing care also helps to keep chronically ill patients out of hospitals. The nursing shortage clearly affects the U.S. health care system and is an urgent problem in need of a solution.

Increasingly, the solution pursued has been to increase the flow of nurses into the United States from other countries. In the past decade or so, Indian, Filipino, and Canadian nurses, among others, have been actively recruited to meet the nursing demands of the United States and the United Kingdom. We were able to retrain a nurse to fill Ms. Rao's position, but in many cases, when the best-trained health care workers in a developing country are recruited away, gaping holes remain.

For years, the National Health Service (NHS) of the United Kingdom relied heavily on the direct recruitment of nurses from African countries such as Botswana, Ghana, Malawi, Nigeria, Kenya, South Africa, Zambia, and Zimbabwe — all former British colonies. These very countries have

been among those hit hardest by the HIV pandemic; some have a prevalence of HIV infection of 30 to 40 percent, with a majority of the young, working population debilitated by disease, and are reporting huge nursing shortages themselves. In 1999, Ghana's losses to emigration included 320 nurses — the same number of nurses certified in the country each year; twice as many were lost the following year.³ More than half the nursing positions in Kenya and Ghana remain unfilled. As a result, many health clinics in Kenya have closed and many others are severely understaffed.

The nursing shortage in the developing world is being felt more intensely even as increased foreign aid becomes available to provide drugs for millions of people with AIDS. If this funding is to accomplish its goal, more nurses are needed to dispense drugs, monitor patients, run clinical trials, and train new nurses. According to estimates by Harvard University's Joint Learning Initiative on Human Resources for Health and Development, sub-Saharan Africa's low-income countries will need to more than double their workforces in the coming years — by adding at least 620,000 nurses — to be able to tackle their severe health emergencies.⁴ It seems like a cruel joke to play: providing funds for AIDS care but simultaneously taking away the nurses who can give that care.

Although the British government promised in 2001 to stop the direct recruitment of nurses from countries with nursing shortages, large private-sector institutions continue to lure nurses from many African countries; 7000 African nurses have registered to work in the United Kingdom since

2001. Meanwhile, the NHS continues to recruit nurses from India, the Philippines, and Spain: countries that supposedly have a national surplus of nurses but that have regional or specialty-specific shortages. Private-sector hospitals in these countries tend to retain their nurses longer than public-sector hospitals do.⁵

Ironically, for every two nurses recruited from overseas to work in the United Kingdom, one nurse certified in the United Kingdom emigrates. Many of these nurses end up in the United States, along with nurses from other developed countries such as Canada, Ireland, and Australia, all of which have their own nursing shortages. In effect, the nursing crisis is global, with developed countries stealing nurses from one another and developing countries subsidizing richer countries with nurses they cannot afford to lose. Entire public health systems are at risk of collapse because of the growing shortage of nurses in the developing world.

For physicians who work internationally but are based in the United States, this situation poses an ethical quandary. How do we advocate for health policy that will ensure high-quality care by providing adequate numbers of nurses for our patients in the United States while making sure that Indian and African patients with HIV infection have nurses to care for them, too? The United Kingdom has recognized this tension, and its professional and government agencies have begun to discuss the issue. We in the United States need to advance our own discussion if we are to improve the quality of health care both here and abroad.

Today, health care is fundamentally international, and our health care systems can be strengthened by drawing on the global workforce. Nurses have the right to migrate; it would be foolish to confine health care workers to the countries of their training. However, the value of professional exchange should be weighed against the overall health consequences in a given country. Reducing the “pull” factors at home and the “push” factors abroad that are hastening the migration of nurses will be essential to ensuring the long-term stability of health care infrastructures around the world.

From a U.S. point of view, reducing the pull factors will involve adding to the workforce by training new nurses locally and retaining our current nurses. Since nurses are leaving the profession faster than ever before, even as the U.S. population is aging and requiring more nursing care, we don't believe that importing nurses from other countries will resolve our own crisis in the long term. Some states, such as California, that face especially acute shortages have already made a commitment to increase the educational capacity of their state institutions. Giving nurses key roles in making decisions about health care delivery and health policy and in leading health care research may enhance our ability to retain them. Other promising retention strategies include the creation of work environments that are challenging yet rewarding and the provision of lifelong career-development opportunities.

If health care initiatives in the developing world are to be successful, measures for alleviating

the push factors will also need to be included in global health programs. These measures could include allocating more funding to the whole health care sector so that health care professionals would have better working conditions and pay, increasing the recruitment and training of new nurses, and building the capacity for nursing education.

One thing is clear: the United States needs to start looking at the nursing shortage as a global problem to be addressed through a multifaceted approach with multilateral cooperation. The dialogue about the nursing shortage in the United States must acknowledge our global interconnectedness.

An interview with Dr. Chaguturu can be heard at www.nejm.org.

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