

## **Alleviating the U.S. Nursing Shortage: Improving Our Immigration and Healthcare Systems at the same time**

An excerpt from the White House website: **“Improve Our Immigration System:** Fix the dysfunctional immigration bureaucracy and increase the number of legal immigrants to keep families together and meet the demand for jobs that employers cannot fill.”

**Visa Numbers Needed for Registered Nurses:** There is no better place to start than by addressing the lack of visas for Registered Nurses (“RNs”). This deserves action now. To await a comprehensive solution to all the disparate issues and problems of our Immigration System, both for legal and illegal immigration, will likely result in the same outcome as 2007; that is, no overall agreement and still no visa numbers for RNs. The hospitals that recruited RNs prior to December 2006, when suddenly RN visa numbers dried up, are still in need of these resources because, as demonstrated below by data from the HRSA, the domestic supply has not increased in any meaningful way, and the retirements of veteran RNs will be on-going.

Source: U.S. Health and Human Service Administration  
Health Resources and Services Administration Report, September 2004

Comparing the baseline supply and demand projections suggests that the U.S. had a shortage of approximately 168,000 FTE RNs in 2003, implying that the current supply would have to increase by 9 percent to meet estimated demand. By 2020 the national shortage is projected to increase to more than 1 million FTE RNs, if current trends continue, suggesting that only 64 percent of projected demand will be met.

### **Projected U.S. FTE RN Supply, Demand, and Shortages**

	<b>2000</b>	<b>2005</b>	<b>2010</b>	<b>2015</b>	<b>2020</b>
Supply	1,890,700	1,942,500	1,941,200	1,569,800	1,808,000
Demand	2,001,500	2,161,300	2,347,000	2,569,800	2,824,900
Shortage	(110,800)	(218,800)	(405,800)	(683,700)	(1,106,900)
Supply/ Demand	94%	90%	83%	73%	64%
Demand Shortfall	6%	10%	17%	27%	36%

**Action Needed Not More Studies:** In the face of the data above compiled in 2004, the HRSA put out a request for proposal to conduct a 2-year study of the issue. The New York Center for Health Workforce Studies at SUNY Albany was selected to conduct this study.

The study is very well done and comprehensively documents the nursing shortage in the U.S. and many, if not all, of the contributing factors. However, the study did virtually nothing to increase the supply of U.S. nursing graduates or students entering U.S. nursing programs.

The results of that study were published in February 2007 and the numbers still tell the same story, a story that has not changed in the ensuing 2 years. A very telling table depicted “Active RNs in the U.S. by Age Group.” This table provides a very clear explanation as to why the RN shortage is bad now and is projected to get much worse over the next 11 years. It shows 56% of all Active RNs are over the age of 45 (and these statistics are 5 years old so the age is now probably closer to 50).

**The Aging RN Workforce:** The Bureau of Labor Statistics (BLS) say the U.S. will require 1.2 million new RNs by 2014 to meet the nursing needs of the country; 500,000 to replace those leaving the practice and an additional 700,000 to meet growing demands for nursing services.

#### **Age Group Table Statistics from the BLS, 2004**

<b>Age Group</b>	<b>Number of Active RNs</b>	<b>% of Active RNs</b>
< 25	59,574	2.5%
25-29	159,676	6.7%
30-34	221,051	9.2%
35-39	256,910	10.7%
40-44	360,146	15.0%
45-49	449,620	18.8%
50-54	406,748	17.0%
55-59	271,109	11.3%
60-64	136,190	5.7%
65+	75,305	3.1%

During the past year, directly related to our current economic disaster, some number of RNs have come “out of retirement” due to financial necessity but certainly not in sufficient numbers to eliminate the nurse shortfall which at present is between 300,000 and 400,000.

And at this moment, there is economic doom and gloom everywhere. We will hear of cutbacks in services and layoffs of all kinds of workers, including in our health care system. Many states and local municipalities have constitutional obligations to have balanced budgets. They cannot run with deficit spending. Health care is one of their largest budget items, and because of fixed costs related to bricks and mortar, if short-term cuts need to be made, the cuts will be people. But the cuts will be short-term. And the cuts are not related to the nationwide nursing shortage having been cured.

**The U.S. Door Is Currently Closed to International RNs:** Simultaneously over the last 2 years, a traditionally reliable source of RNs for U.S. healthcare facilities has been precluded from entering the U.S. to begin work. Although a relatively small percentage of the total U.S. nursing workforce, international RNs have been relied upon during past nursing shortages to fill some percentage of RN vacancies. This source has been cut off since December of 2006 when a special allocation of visa numbers for Schedule A, basically used for RNs and Physical Therapists, was depleted.

An act of Congress is needed to address the lack of visa numbers to be used by our healthcare facilities to sponsor some number of international RNs to alleviate in part the shortage being faced every day on the floors of hospitals and nursing homes across the U.S. In the last 2 Congresses, in 2007 and 2008, Congress failed to enact legislation to address this problem. In 2007, this issue got caught up in the failed attempt at CIR (Comprehensive Immigration Reform). A late session attempt to fix the problem was passed in the Senate in 2007 but was not entertained in the House. A Bill was introduced in the House in April 2008, languished for a period of time, and then had a little bit of life breathed into it in the fall of 2008 when it got on the agenda of the Judiciary Committee 3 times; but alas, it was never acted upon.

**Every Year There Are Unused Employment-based Visa Numbers:** A frustrating aspect of the construct of our Immigration System is that every year there are tens of thousands of employment-based visa numbers that go unused. At present there are over 200,000 unused employment-based visa numbers from prior years. Some number of these visas could be designated for the sponsorship of Schedule A workers; Schedule A being the work groups designated by our own Department of Labor as shortage occupations in the U.S. with Schedule A workers being primarily Registered Nurses and Physical Therapists.

**HR5924, The Emergency Nursing Supply Relief Act:** This bill was introduced in the last Congress by Representatives Wexler of FL and Sensenbrenner of WI, with 21 co-sponsors; perhaps it would be reintroduced, debated, and enacted.

**Allow RNs to Temporarily Qualify for the H-1B Visa:** The Secretary of Homeland Security could declare RNs temporarily eligible for the H-1B visa through a USCIS field directive. No additional visas would be required as the majority of healthcare facilities are eligible for the cap-exempt H-1Bs so RNs would not compete for the 65,000 H-1B visas available each fiscal year. Such action would immediately open the door for international RNs to enter the U.S. to begin work with an adjustment of status to Permanent Residency occurring after entry.

**Near Fatal Impact on Infrastructure and Staffing Firms:** With no action by the Congress to remedy this visa situation for 2 years, besides the healthcare facilities not getting the resources they need, collateral damage has occurred and will continue to occur to the infrastructure integral to the supply of these precious resources to U.S. healthcare facilities.

The U.S. nursing establishment has established very stringent requirements that must be met by each individual wishing to enter the U.S. to be employed as a Registered Nurse. This is not a bad thing at all but the requirements and processes are quite complicated, involving education and experience verification, medical and criminal record clearances, U.S. nurse qualifying exam or exams, licensure requirements that may vary by state, a test of written and spoken English, and a visa screen process to qualify for a visa. All this is separate from the visa petition itself which starts with the USCIS and then moves to the State Department for final adjudication. All in all, there are 13 bureaucracies involved in getting one international RN to the U.S. to begin work.

**The Critical Role of Staffing Firms:** Most hospitals do not have the expertise or resources to handle these cumbersome and time-consuming processes themselves; most turn to Staffing Firms to do the recruitment and then to shepherd the selected candidates through the maze of requirements, the sea of paperwork and applications, staying on top of the processes every step of the way, keeping the candidates committed while all of this plays out, and getting them set up in the U.S. upon arrival.

These Staffing Firms are on the verge of collapse. Most firms are small entrepreneurial businesses, the backbone of our U.S. economy. They have spent years and lots of resources to develop methodologies for getting RNs to the U.S. in the most expeditious way possible with the greatest chance of success once here. All of this is at risk.

There are basically 2 business models for these firms: “direct placement” and “leasing with a path to permanent employment.”

“Direct placement” means the healthcare facility is the employer and visa sponsor. The Staffing Firm manages everything from selection to delivery of the RN to the facility to begin work. In most cases, payment for services rendered occurs when the RNs enter the U.S. to begin employment. Without visa numbers, with virtually no RN being able to enter for over 2 years, there has been no revenue for these Staffing Firms.

The “Leasing model” involves the Staffing Firm being the employer and visa sponsor and, then upon arrival in the U.S., leasing the RN to a healthcare facility for a period of time, which on average is 24 months, with the healthcare facility then having the right to hire at the conclusion of the lease period. Under this model, the Staffing Firm incurs all the expenses and only begins receiving revenue when the RN arrives to begin work. Again, without visa numbers and virtually no RNs being able to enter, it has been all expense and no revenue for these firms.

With over a 2 year revenue drought, it is an industry that is literally running on vapors at this point. Without visa relief, many firms will be forced to close down their operations with the entrepreneurs and

people they employ joining the ranks of the unemployed. This significant supply chain infrastructure could be lost forever.

**Impact of No Visas on U.S. Competitiveness:** It is estimated that there could be currently as many as 20,000 international RNs with job offers in hand, in some stage of processing for the U.S. As these RNs fulfill the requirements for the U.S., they become more attractive to other countries also experiencing their own nursing shortages. The lack of U.S. visas is severely impacting our ability to compete for the best and brightest international RNs. And it is not as if these RNs will simply stay in their home countries. These RNs will end up working overseas, just not in the U.S. Thousands, from countries like India and the Philippines, are going elsewhere.

### **The Nursing Shortage: Effects on Patient Outcomes and the Economy**

Below are some excerpts from a December 5, 2008 memorandum from the Office of the Citizenship and Immigration Services Ombudsman. It documents other collateral damage related to the U.S. Nursing Shortage.

**Service to the Public and the Connection to the U.S. Economy:** RNs have a variety of employers, including public health facilities, long-term care facilities, and hospitals. They provide invaluable services to an aging U.S. population. The American Hospital Association reported on the impact that hospitals alone have on the U.S. health care and the economy: there are over 35 million people admitted, nearly 118 million people treated in emergency rooms, over 4 million babies delivered, and over 481 million outpatients treated each year. Further, hospitals are one of the largest private sector employers, employing more than 5 million people, and stimulating economic productivity. According to that report, when also accounting for hospital purchases of good and services from other businesses, hospitals support one of every 10 jobs in the U.S. and \$1.9 trillion dollars of economic activity. RNs are a significant factor in the success of hospitals and the health care industry.

**Threat to Patient Care and Patient Outcomes:** The shortage of RNs and an increased workload for current nurses is a threat to the quality of patient care. Looking at the impact of nurse staffing and how it relates to patient care, the American Association of Colleges of Nurses reported that an increase in RNs contributed to a decrease in hospital-related mortality and reduced lengths of patient stays, whereas inadequate staffing was reported to compromise patient safety. Furthermore, most RNs have voiced concerns that there is not enough time to maintain patient safety, detect complications early, and collaborate with team members.

**National Security Concerns:** Again from the CIS Ombudsman memo: The nursing shortage could result in serious national security and health concerns if there is a pandemic flu or other man-made or natural disaster, and the U.S. does not have adequate health care resources to respond.

Looking at the current nursing shortage statistics, on a day to day basis, most U.S. facilities are working "short." No way would most be prepared to respond to a disaster.

The main thrust of the CIS Ombudsman memorandum was on "Improving the Processing of Schedule A Nurse Visas." The process improvements cited certainly make good sense; however, with no visa numbers for Schedule A Nurses these process improvement recommendations do nothing to get RNs into the U.S. to begin work. And there has been very limited utilization of other visas for RNs, like the H-1B visa. Here are the numbers of RNs approved for H-1B visas over the last 3 years: 38 approved in 2006; 66 in 2007; and 136 in 2008.

**Let's Address This Problem Now:** A Bill like HR5924 or a USCIS field directive would open up the flow of these much needed professionals while longer term solutions to the nationwide RN shortage are worked on.

None of these solutions would preclude healthcare workers from being incorporated into a Comprehensive Immigration Reform package whenever it may come together in this Congress or in this first term.

A solution now is win-win all around:

- Healthcare institutions would have the opportunity to get the RNs they need; many RNs have already been recruited and sponsored; they are just stuck in their home countries needing a visa number and a U.S. Embassy Interview
- Staff to patient ratios would be improved thereby improving overall care and patient outcomes
- Staffing companies would be able to stay in business; after 2 years of no action on this, those of us still standing are at risk of having to cease operations and join the ranks of the unemployed
- The fees generated by these visa petitions will provide funding that the USCIS and State Department could no doubt use
- Arriving professionals and their families become, immediately upon arrival, tax payers and consumers in their communities
- Because of the shortage, these new entrants to the U.S. do not take jobs away from Americans
- Through ethical recruitment, from countries known to have a surplus of educated RNs, brain-drain need not be an issue
- And much needed financial help is provided to the struggling economies of the third world reliant on funds being sent back home by their citizens who work in the U.S. and elsewhere, particularly in our healthcare sector

Respectfully submitted,

Pat Kerrigan  
Chief Operating Officer  
Direct Source Healthcare  
212-255-2598