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Survey shows New Zealand worst at training own nurses

The world's supply of nurses appears insufficient to meet global needs now and in the future. Nursing shortages in developed countries have accelerated international nurse recruitment and migration sparking debate about the consequences for both the sending and receiving countries and for the meeting of global health needs. The policy in New Zealand and other developed countries seems to be to recruit from overseas. Without an increased supply of nurses, a policy that seems doomed to fail.

As Hugh Ross so eloquently pointed out in his June seminar presentation, the NHS has been aggressively trying to increase nursing numbers. While there have been attempts to train more nurses and attract home based nurses back into the nursing workforce, they have an explicit policy of active international recruitment from certain source countries. In 2002 more nurses joined the UK register from overseas than from education sources within Britain. Some sectors of the UK health system have developed a high level of dependencies on foreign trained nurses and are thus motivated to sponsor extended work permits. One in four nurses in London are from overseas and some private health care organisations are staffed by up to 60% overseas trained nurses. The main sources are the Philippines, South Africa and Australia, with a sizeable increase from India, Zimbabwe and other African countries.

From a global perspective the controversy centres on the risk that escalating requirement for nurses in developed countries will deplete the supply in less developed countries, thus crippling their health care system. For example, the 2003 World Health Report concludes that Botswana's commitment to providing free antiretroviral therapy for all eligible citizens has been undermined not be financing but by a severe shortage of health personnel. International nurse recruitment will not serve the long term needs of developed countries if it prevents them from addressing the root causes of domestic nurse shortages.

A common view is that we are losing a high proportion of our nursing workforce to other developed countries and Hugh noted that he had been challenged by a number of New Zealanders on the ethics of the NHS recruiting from abroad. A paper, *Trends in International Nurse Migration,* in the July issue of Health Affairs by Linda Aiken, James Buchanan, Julie Sochalski, Barbara Nichols and Mary Powell explores emerging patters in international nurse migration and offers a perspective where New Zealand is seen as having the highest reliance on foreign nurses.

The study focuses on English speaking countries that are actively engaged in recruiting nurses from developing countries: the United States, Canada, the United Kingdom, Ireland, Australia and New Zealand. All of these countries, other than New Zealand and Ireland, have large nurse workforces. New Zealand is included because of its high dependence on nurses trained in other countries

Country Registered Nurse Workforce and Foreign Nurses' Contributions

Host Country	Number of RNs in workforce	Predicted shortfall (shortfall year)	Foreign nurses as a percentage of workforce
US	2,202,000	275,000 (2010)	4
UK	500,000	53,000 (2010)	8
Ireland	49,400	10,000 (2008)	8
Canada	230,000	78,000 (2011)	6
Australia	179,200	40,000 (2010)	Not available
New Zealand	33,100	Not available	23

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and Ireland was included because of its recent escalation of nurse immigration. Foreign trained nurses (many from other Commonwealth countries) are a large share of the nursing stock only in New Zealand.

Some undeveloped countries, despite their own domestic health needs, cannot create enough jobs for the health professionals they train, thus motivating them to emigrate. Remittance income from nurses is a major source of hard currency for developing countries and has motivated the Philippines to train nurses for export. Poor wages, poorly funded health systems, safety concerns and other factors "push" nurses to leave developing countries. Factors that "pull" nurses to developed countries include higher wages, better living and working conditions, and opportunities for advancing their education and expertise. Common wisdom is that few nurses from developing countries ever return to their country of origin.

Despite widely held assumptions, the United States is not the largest importer of nurses. While the number of foreign trained nurses in the U.S. increased from 6 per 100 in 1998 to 14 per 100 in 2002, licensure requirements and restrictive immigration policies have limited their entrance.

In the UK, in response to controversy over the large number of nurses who have emigrated from sub Sahara Africa, the UK Department of Health published an ethics code in 1999 that prohibits the NHS from the direct recruitment of nurses from Africa. However, African nurses are still entering Britain via private sector recruitment and eventually finding jobs in the NHS.

For years Ireland produced more nurses than it could employ. Now, following the Irish economic boom the number of jobs nursing jobs available exceeds the domestic supply. Rather than being a source country, Ireland has become a major host and actively recruits from overseas, particularly from the Philippines. Ireland is now a major destination for UK rather then vice versa.

Registered Nurses to population ratios among major host and source countries for foreign nurses

Host country	RNs per 100,000 population	Source country	RNs per 100,000 population
US	782	South Africa	472
UK	847	Philippines	418
Ireland	804	Zimbabwe	129
Canada	741	Nigeria	66
Australia	941	India	45
New Zealand	841		

By design and with the support of the government, the Philippines is the leading primary source country for nurses. Their development plan views overseas employment as a key source of economic growth through the remittances the nurses send home while working in other countries. No other country produces more nurses than are needed for their own health care systems at a level of education that meets the requirements of developed countries. It is estimated that 85% of employed Filipino nurses are working internationally. Currently there are 30,000 unfilled nursing positions in the Philippines and a growing debate that the country's health care quality could be threatened by the global demand for their nurses. Common destinations for Filipino nurses are the UK, Saudi Arabia, Ireland, Singapore and the United States.

A number of less developed countries such as India, China and some of the newly independent states of the former Soviet Union aspire to follow the Philippines and train nurses for export. That model is built on private education and faces challenges of a lack of capital to build an appropriate nursing education infrastructure that meets Western standards and through the emigration of nurse faculty and leaders to developed countries.

Aiken et al consider that the developed countries growing dependence on foreign trained nurses is largely symptomatic of failed policies and an underinvestment in nursing. Developed countries have not done all they can to create a sustainable professional nurse workforce that meets their needs. In 2003 more than 11,000 qualified students were turned away from US nursing schools through a lack of capacity. In the 1990s the UK greatly reduced the number of new nurses being trained. While there have been recent policy interventions to reverse the downward trend, the UK is still dealing with the underinvestment in nursing education. Sustained underinvestment in nursing education is a theme across all the countries that are now turning to aggressive international recruitment.

The work environment of nurses in developed countries – especially in hospitals is deficient in many correctable ways. Nurses, who are presumably in short supply, are spending an inordinate amount of time in non nursing tasks as a result of poor work design, and underinvestment in information and other nurse saving technologies. High levels of nurse burnout, dissatisfaction, and turnover have added to the perception of nursing shortages.

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Ethical recruiting guidelines provide a strategy for responsibly managing international nurse recruitment. However, the first test case – the UK Department of Health guidelines has been disappointing. Since the guidelines were established in 1999 there has been a greatly increased outflow of nurses from sub Sahara Africa to the UK and emigration from South Africa has quadrupled. The challenge is enforcement of the guidelines, particularly difficult considering the private entrepreneurial nature of international recruitment.

The most promising strategy for achieving balance is for each country to have an adequate and sustainable source of health professionals. A two pronged strategy is required. First, developed countries must be more diligent in exploring options to stabilise and increase the domestic supply of nurses and moderate demand through strategic investments. Second, even without the exodus of so many qualified health professionals to work in developed countries, most less developed countries do not have the healthcare workforce capacity to respond to the health problems of their citizens that can also threaten global health. Making health, especially nursing, a legitimate focus of international aid and democracy building is necessary.

Countries that use the most nurses should make the biggest investment in their own nursing education and in the developing countries from which they recruit nurses. This could be done by investing international aid in nursing education to help build sustainable nursing education infrastructures.

Scheme to process NHS clinical tests in India

In England the government is considering shipping blood and urine samples from NHS patients to India for clinical tests in order to cut costs. Indian laboratory technicians can be hired for as little as £4,000 a year, and the savings would more than make up for the cost of flying samples across the world. Test results could be emailed back to UK hospitals.

Private sector hospitals are already conducting trials of the service, which could reduce costs by as much as a third. The company behind the scheme, Indian clinical testing firm SRL Ranbaxy, is now targeting the public sector and has already pitched to ministers. The Department of Health is in the middle of a "modernisation" project in pathology, and has decided to ship some MRI scans to Belgium for analysis, which could cut costs by half.

"We are exploring a number of options for the involvement of the independent sector in diagnostics as a whole," said a department spokesman. "Part of that could be the potential for outsourcing pathology ser vices, but it is at a very early stage." He said the department was not in negotiations with any company. However health department officials have met representatives of SRL Ranbaxy to hear how outsourcing to India could work. The trade secretary, Patricia Hewitt, also met the firm earlier this month.

The firm estimates that 40% of the pathology testing in the UK, which is worth about £2bn, has the potential to be outsourced to India. It would not be worthwhile for some simple tests such as haemoglobin counts to be outsourced, but for more complex tests the firm says it could cut costs by 20% to 30%. Laboratory technicians are paid from £4,000 to £15,000 in India, depending on experience.

The firm is conducting pilot tests for a "large hospital chain" in the UK. Mr Singh said the hospital chain appeared to be satisfied and he hoped to begin talks on a long-term deal shortly. "There seems to be great comfort that the quality standards might be matching or better than in the UK," he said. The samples would be flown to Bombay and sent to the company's main laboratories there, which already conduct clinical trials for large drugs firms. The labs are open around the clock and the tests would take a minimum of 48 hours. Mr Singh said the system could be quicker than keeping the testing within the UK.

"By the last quarter of this year, we will probably have pilots with three to four hospital systems," he said. "My sense, as soon as the idea gets established, is it might then be the right time to identify some of the NHS hospitals."

The 15,000-odd employees of pathology services in the UK look set to face competition from the east in the same way as workers in the information technology and call centre industry, where thousands of jobs have been moved to India. "Like the IT and services sector, Indian [healthcare] institutions have reached that maturity," Mr Singh said. "There are many opportunities in the supply of services, nursing, surgical services, many things we now supply to each other."

The company is also looking to develop its radiology testing capability. There is a backlog in testing in the UK, which could be outsourced more easily than traditional lab tests as the pictures could be emailed to India and results emailed back. SRL Ranbaxy conducts clinical tests for more than 600 hospitals in India. Last year it set up services in the Middle East. It is a division of Fortis Healthcare and is is associated with Ranbaxy, the Indian generic drug manufacturer, which is doing increasing amounts of research and development for western pharmaceutical companies.

Superbug Search Parties latest NHS Fad

Search parties are to be sent into hospitals unannounced every three months to see if they are clean, claims the Observer in its July 11 edition. Health Secretary John Reid is to send members of the public on to wards to check up on their cleanliness the latest attempt to cut down on the soaring rates of the hospital superbug MRSA. He also announced that every hospital will have a large notice board in one of its public spaces, showing its infection rates, in a bid to shame trusts into tackling the problem.

Members of the public on to wards to check up on their cleanliness

Patients will be encouraged to remind doctors to wash their hands

These moves were dismissed as gimmicks by campaigners, who said search parties made up of members of the public would not be able to tell whether MRSA was lurking or not. . Tony Field, chairman of the MRSA Support Group, which campaigns for more hygiene measures, said: 'Hospitals can only be clean if they employ enough cleaners to do a proper job.'

New figures out this week are expected to show another leap in the number of cases of MRSA. They are expected to show that the bug is a growing problem, despite a string of crackdowns on staff hygiene and ward cleanliness. It is a growing problem for the NHS, with more than 7,000 cases a year in England alone This month the Department of Health will 'name and shame' hospitals with the worst superbug infection rates, when new official figures for each trust in England and Wales are published by the National Audit Office.

John Reid is expected to say that plans to let patients choose from next year where to have an operation will force hospitals to clean up their act, since patients will boycott those with high infection rates.

Meanwhile, the Guardian on July 2nd reported that the drive to cut waiting lists by filling every hospital bed, together with shortages of doctors and nurses, is partly responsible for the alarming rise in the numbers of patients picking up infections, including MRSA, on the wards.

One in 10 patients now leaves hospital with an infection acquired there, and bugs resistant to common antibiotics such as MRSA are spreading between hospitals and nursing homes across the country, said Barry Cookson, director of healthcare associated infections at the Health Protection Agency.

Patients are frequently moved from one ward to another around the hospital, to make use of every available bed, allowing infection to spread. Often they are sent home so quickly after an operation that their infection is not spotted until they visit the GP, spreading the bug around the community and potentially to another hospital if they later get treatment elsewhere.

UK policy is to have 100% bed occupancy, but experience in Europe shows that where levels are above 85%, patient infections rise, said Professor Cookson. A National Audit Office report in 1999 recognised the significance of 85% bed occupancy, he said. He called for a national debate on the balance to be struck between keeping waiting lists short and reducing infections.

UK policy is to have 100% bed occupancy, but where levels are above 85%, patient infections rise.

This issue about bed capacity and throughput really does undermine best infection control practice

"We have got to get down to 85%," he said. "The government have clearly got their waiting list targets and have signed up to them. I think we should be entering into a national debate. Patients should realise that there is a certain safety level above which we start having problems."

Alison Holmes, a specialist in infectious disease at the Imperial College and Hammersmith Hospitals NHS Trust, said: "This issue about bed capacity and throughput really does undermine best infection control practice." While the failure of medical staff to wash their hands is a key factor, it is now clear that bed occupancy is related to the rise and rise of the number of infected patients.

Shortages of medical staff also lead to more infections, because each doctor and nurse has to deal with more patients, increasing the chance that they will pass a bug on from their hands. It ought to be possible to ring fence areas of the hospital for patients most vulnerable to infection, but pressures on space do not allow it.

There are now 17 different strains of MRSA. EMRSA (epidemic MRSA)-3 and EMRSA-16 which appear to have had their origins in the UK have caused outbreaks in Finland, EMRSA-16 has turned up in Gothenberg, Sweden, and EMRSA-15 and EMRSA-16 have been identified in the Netherlands. As well as reducing bed occupancy and addressing staff shortages, a cultural change is needed in hospitals over hand washing.

Patients should be encouraged to remind doctors to wash their hands, he said, and alcohol hand-rubs should be widely available. Professor Cookson and Dr Holmes backed the government's Winning Ways strategy to reduce infections, but said that the bed occupancy and staffing issues need to be addressed

Healthcare Reform: The "Market" offers no quick fix

The Economist in its July 15th edition finds healthcare in rich countries presents a paradox. On the one hand, advances in medicine are extending life and improving its quality—gains of great value to those who benefit from them. On the other hand, the evidence of error rates shows that hospitals and doctors routinely break the first rule of medicine, to do no harm. While the costs of health care spiral ever upwards, causing increasing alarm among individuals, employers and taxpayers, all containment strategies seem doomed to eventual failure. Summarising of a series of articles on health care in developed countries it offers no quick fixes and advises healthcare to carry on taking its medicine while change takes place.

Although medical care is now delivered through expensive, complex systems that require sophisticated management to avoid errors and ensure that patients get appropriate advice, tests and treatments, much health care is of poor quality. The Economist sees this as posing some troubling questions for the medical profession in rich countries. Noting that Doctors have traditionally treasured their independence and resisted outside interference, they advocate a shake-up in the medical world, led by the medical world. Doctors need to be able to work collaboratively in teams spanning professional boundaries and keeping costs as low as possible. Medical education, still locked in an old-fashioned apprenticeship model, needs to prepare doctors for these new demands. Teaching doctors how to deliver cost-effective care will require a transformation in medical training.

A long, cool self-appraisal by the medical profession is essential, but on its own it will not be sufficient. Rather, the Economist suggests that what is needed is a change in the structure of healthcare systems so that competitive pressures push them in a more useful direction, enhancing the power of purchasers and increasing competition in the supply of medical care. The traditional argument has been that health care is too important to leave to the market. The opposite holds true: it is too important not to be exposed to the market.

A free market approach is what one would expect to find in the Economist. Note, not a totally free market – one of partnership with the government because as it picks up so many of the bills it is intimately involved in all health-care markets. A constructive partnership where governments in upholding social values about equity in health care should be striving to promote competition instead of trying to supplant the market. For example, in Britain, a Labour government now sees no contradiction between its historic commitment to free services by doctors and hospitals and the pursuit of an internal market in the NHS. The Economist view is that in countries where there are competing insurers, governments can direct public money to poorer and sicker people so that they can afford insurance, organised in a way that fosters effective competition for better medical care.

Just because governments finance so much of health care, they do not necessarily have to provide it themselves, claims the Economist. The NHS employs 1.4m people, making it the world's third-biggest employer, surpassed only by China's Red Army and the Indian railways. This monolithic grip on the provision of medical care has inhibited the experiments that flourish when the ownership of hospitals is more varied, and has contributed to poor morale in the workforce.

A re-engineering of health care will certainly require a reform in the way that medical providers are paid. The aim is clear: to pay doctors for doing the right thing at the right time. The best way of getting there is less obvious. Fee-for-service payment promotes productivity but also encourages over-use; conversely, paying doctors a straight salary in heavily regulated markets may lead to underperformance, because it fails to reward productivity. Successful reform will involve remoulding payments systems so that they reward quality and performance. Moving towards more financial incentives in paying directly for better outcomes, in paying directly for steps that reduce costs of care.

There is no one-size-fits-all model of health care. Health systems have evolved in diverse ways

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New Zealand Institute of Health Management
A Branch of the Australian College of Health Service Executives

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Inform Editor Bruce Parkes

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that reflect individual countries' values and histories. The important thing is to change these structures so that they encourage medical providers to do better, not to rebuild them from scratch.

The difficulties of reform should not be underestimated. Today's medical-care systems are underpinned by powerful vested interests. Every dollar saved by using more cost-effective procedures is someone's dollar of income. But the prize of transforming today's health systems into the sort that will produce high-quality yet affordable health care is worth putting quite a few noses out of joint, says the Economist.

Innovations from Isolation

Wednesday September 29th — Friday October 1st
Rotorua Convention Centre

Following on from the very successful 2002 ACHSE:RACMA Joint Conference in Perth, NZIHM and RACMA are delighted to host a joint conference on this side of the Tasman. Managers and clinicians work in partnership as leaders in health care organisations through the world. This conference will provide a further opportunity to cement this relationship through shared professional development and networking.

The focus of the conference is on new developments and innovations in a variety of health management contexts. Keynote speakers from Hong Kong will share their SARS experiences, management and medical staff relations will feature highly, along with workforce planning, service reconfiguration and lessons from both those who have led large hospital redevelopments and those who are successfully providing community based services. With both keynote and concurrent sessions, this programme is sure to appeal to health managers in both line management and clinical leadership roles.

Register on line at **www.meetingsfirst.com.au/fsite/site/registration.asp** or download a form from **www.meetingsfirst.com.au/RegistrationForm.pdf**

Earlybird registration closes on August 27th

Seminar Programme

August 2nd

@ Cap Gemini ,18th Floor, 41 Shortland St
5:30p.m. for 6p.m.

Ethical Issues in the Treatment/Non-Treatment of Non-Residents
Jan Crosthwaite, Department of Philosophy, University of Auckland
Non Members Welcome

Cost
Members $20
Non Members $25

Our August seminar presenter Jan Crosthwaite is an Associate Professor in the Department of Philosophy at the University of Auckland. She has taught widely in Philosophy courses, but her current focus is applied ethics, particularly medical ethics and ethics of biotechnology. Following the Cartwright Inquiry she became interested in issues in medical ethics and Bioethics. She has published articles on sexual harassment, feminism and bioethics, the "expertise" of moral philosophers, and on teaching ethics of technology. Her current research interests are in ethical issues surrounding genetic technology, particularly the question of the basis on which societies should make decisions with respect to morally disputed issues. She has served as a moral philosopher on ethics committees, including the A+ Clinical Ethics Advisory Group, and has given talks on issues in health-care ethics to professional and community groups.

Our seminar programme is supported by

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by electronically
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or e-mail the Editor for more information at **admin@nzihm.org.nz**