The nursing shortage in the United States of America: an integrative review of the literature

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Aim. The aims of this paper are to review the literature to determine what factors are contributing to the nursing shortage in the United States of America (USA) and discuss possible solutions to this current and future nursing shortage.

Background. The need for nurses is often depicted as cyclical in nature. Throughout history, the USA has experienced a series of nursing surpluses and shortages. However, the current shortage has been characterized as being unlike those experienced in the past. Trends of an ageing Registered Nurse (RN) workforce and limited supply to fill the impending vacancies are some of the unique aspects that bring a new dimension to an old problem. Today's nursing shortage will not be resolved by simply returning to the solutions of yesteryear, and strategies to reduce its impact will have to be more creative and focus on the long-term.

Methods. Integrative literature review of published literature on the current nursing shortage in the USA from 1999 to 2001.

Discussion. Four main areas were identified as the major contributors to the nursing shortage in the USA: the ageing RN workforce; declining enrolment; the changing work climate; and the poor image of nursing. Solutions to the shortage followed similar themes to the contributing factors and encompassed four main areas: exploring recruitment efforts; exploring retainment efforts; improving the image of nursing; and supporting legislation that helps to rectify the shortage.

Conclusion. There is firm evidence that the USA amidst a nursing shortage. Much is known about the many contributing factors but now nurses need to become proactive to help secure the future of their workforce. By forming partnerships within the profession and with other influential parties, nurses can be in the forefront of resolving their workforce issues.

Keywords: nursing shortage, solutions, job satisfaction, integrative review, education, recruitment, retention, image, students, ageing RN workforce

Introduction

Without a doubt, the United States of America (USA) is experiencing a nursing shortage. Although some areas of the country are being affected at different rates and in various nursing specialty areas, it remains largely undisputed that there is national shortage of Registered Nurses (RNs). Furthermore, this trend is anticipated to worsen within the next decade. Considering the impact this prolonged shortage will have on the USA health care system, nursing and other health-related organizations have even brought their concerns to lawmakers in the central government for immediate
consideration. It is believed that this nursing shortage is unlike those experienced in the past [Sigma Theta Tau International (STTI) 2001]. Solutions to reverse its progress now, rather than face the brunt of a 20% deficit in RN workforce by the year 2020 (Buerhaus et al. 2000) are proposed. The purposes of this paper are to conduct a review of the literature to determine what factors are contributing to the nursing shortage in the USA and recommend possible solutions to rectify this potential health care crisis.

**Literature review**

A review of the literature was conducted via hand, internet, and database searches. The primary search engine used for the internet searches was provided by ‘Yahoo!’ at http://www.yahoo.com. Internet searches mainly generated resources from government or nursing professional organizations that offered news releases or publications on the nursing shortage situation. CINAHL and Medline were the primary databases used for the literature search. Key words such as ‘nursing shortage’, ‘ageing RN workforce’, and ‘solutions’ were used to enhance search methods. In addition, the reference sections of the original articles retrieved were reviewed for related literature that had been previously missed or omitted. The literature primarily focused on articles or newsletters within the last 4 years that researched or discussed the current nursing shortage in the USA. Literature was reviewed until saturation was achieved for all possible factors and/or solutions that could have an effect on the impending nursing shortage.

**Findings**

The review revealed two main themes regarding the current nursing shortage in the USA: factors that contribute to the shortage and possible solutions.

**Contributing factors to the nursing shortage**

In the past, causes of nursing shortages could be readily identified and rectified. For example, the growing population across the USA after World War II precipitated the need for more community hospitals staffed by licensed nurses, and shortages in the 1970s and late 1980s were fueled by nurses’ dissatisfaction with working conditions and lack of professional autonomy (Alspach 2000). Unlike past shortages, the impending RN workforce crisis will not be ameliorated by ‘quick fixes’ and simple solutions. Although some of the factors that have contributed to the current RN workforce situation are the same as in past shortages, many factors have added an entirely new dimension to the current problem. These issues will be examined individually.

**Ageing RN workforce**

The RNs are the largest group of health professionals in the USA (USA Department of Labor 2002). Nursing experienced its largest influx of women into the profession during the 1960s and 1970s but, because of a proliferation of new career opportunities for women in the 1980s and 1990s, fewer women have entered the nursing profession since then. Consequently, the average age of RNs currently employed continues to rise and most middle-aged RNs born during the ‘baby boom’ generation (born between 1946 and 1964) who dominate the nursing workforce will reach retirement between 2005 and 2010 (Gabriel 2001). This means that the most experienced nurses, mainly middle-aged women, will be leaving the profession at an alarming rate and at a time when demand is highest.

In a study by Buerhaus et al. (2000), some troubling results regarding the implications of an ageing RN workforce were found. Based on a retrospective cohort analysis of RN employment trends in the USA between 1973 and 1998, they were able to make a reliable estimation of the future RN workforce. It was forecast that within the next 10 years the average age of RNs would be 45-4 years, with more than 40% older than age 50 years. For example, the average age of nurses in Ohio is 47 [Ohio Hospital Association (OHA) 2001a]. Therefore, some states may experience the effects of the ageing RN workforce before other areas of the country.

**Impact on nurse educators**

The ageing RN workforce also impacts the nation’s supply of nursing educators. Although this teaching workforce has remained stable for most of the 20th century (Brendtro & Hegge 2000), the impending retirement of the ‘greying professoriate’ will leave many programmes with fewer nursing educators (Hinshaw 2001). Not only are these educators ageing but the average age of nurses in general is also increasing, partly because most nurses attend graduate school and enter academia later in their careers than those in other professions (Hinshaw 2001). However, this trend of older nurses pursuing graduate degrees may be indicative of an increasing average age of those who pursue nursing as a non-traditional student or as a second degree. The greatest challenge will be to attract qualified nurses to teaching positions in the midst of a nursing shortage. Also contributing to the problem of dwindling teacher numbers are unrealistic expectations, non-competitive salaries and lack of support, which often hinder educators recruitment and retention (Brendtro & Hegge 2000). Unfortunately, the scarcity of
nursing educators will limit student enrolments and decrease the number of nursing graduates (Hinshaw 2001). This will lead to increasing use of non-doctorally prepared educators and will decrease the supply of RNs in the workforce.

Declining enrolment
It is projected that employment opportunities for RNs will grow faster than in the average occupation up to the year 2010 (USA Department of Labor 2002). This growing trend, coupled with a worsening nursing shortage, will result in far more job vacancies than RNs can fill. Since 1995, enrolments in entry-level baccalaureate programmes in nursing have declined by 21.1% and the number of graduating nurses who took the national licensure examination decreased by 26% from 1995 to 2001 [American Association of Colleges of Nursing (AACN) 2001a]. Enrolments in RN-to-baccalaureate and graduate programmes also continue to decline or are struggling to maintain current numbers (AACN 2001b). Although USA nursing colleges and universities have experienced a slight increase in enrolment of 3.7% over the past year, this increase is still insufficient to meet projected future workforce demands (AACN 2001b).

Because of the proliferation of new career opportunities for women, who make up more than 90% of the RN workforce (AACN 2000), education in the field of nursing is no longer the prominent choice. In reality, the total population of RNs is growing at its slowest rate in 20 years (AACN 2001a, b). However, there has been a slight increase in the number of men and those from minority ethnic groups entering the nursing profession. According to the Health Resources and Services Administration’s (HRSA) (2001a) national sample survey of RN, 5.9% of RNs employed are men; this is an increase from 3.4% in 1996 (HRSA 2001b). Furthermore, 12.3% of all RNs reported being from one or more racial or ethnic minority backgrounds, and this is an increase from 10% in 1996 (HRSA 2001b). Overall, these increases are marginal at best. Many schools of nursing and state nursing organizations have begun to assess their current nursing employment situation through the assembly of task forces, coalitions, and local surveys so that they can begin to project future workforce needs and shortages [Woods et al. 2000, Brewer & Kovner 2001, Massachusetts Nurses’ Association (MNA) 2001, South Dakota Nurses’ Association (SDNA) 2001]. The data reveal that fewer people are choosing nursing as a career and that nursing schools are perplexed as to how they can meet the challenge to increase public interest in the nursing workforce.

Changing work climate
Once again, there are many elements that affect overall satisfaction with the RN work climate. The greater life expectancy of individuals with acute and chronic conditions requires more complex nursing care (Heller & Nichols 2001). Further, managed care has reduced length of stays for patients, leaving RNs to care for and stabilize patients in a shorter period of time (Leigh & Krier 2001). There is also a concern that as nursing becomes more specialized, there will be fewer experienced and competent nurses in nursing specialty areas (MNA 2001) such as critical care (Diehl-Oplinger & Kaminski 2001). It is believed that these changes, among other contributing factors affecting the RN work climate, have contributed to a decrease in overall health care quality (American Health Consultants 2001).

The American Nurses Association (ANA) (2001a) conducted a national internet survey, in which approximately 7300 nurses participated, to study nurses’ opinions of their working conditions. Seventy-five per cent of the respondents stated that the quality of nursing care had declined in their work setting over the past 2 years. Because of increased patient load and decreased time to provide direct patient care, close to 50% of those surveyed were said to be less satisfied in their jobs (ANA 2001a). In addition, 40–60% of respondents reported that they frequently skipped meals and breaks to care for patients, felt increased pressure to accomplish their work, and participated in mandatory overtime. As a result, many of these factors have contributed to nurses’ increased dissatisfaction with their work environment.

International situation
A large study has been conducted on nurses’ reports on hospital care in five countries: USA, Canada, England, Scotland, and Germany (Aiken et al. 2001). Based on reports from 43,000 nurses in more than 700 hospitals, similar and confirming data were revealed. Reports of low morale, job dissatisfaction, burnout and intent to leave their current employers were common across the sample. Further, nurses reported that they experienced increases in workload and non-nursing tasks and a decrease in their ability to complete nursing tasks fully. The researchers concluded that if inadequate staffing becomes chronic, the quality of care delivered would be compromised and result in adverse patient outcomes.

Williams (2001) attributed this increase in demanding workloads to sicker patients, an ageing population, decreased support in nursing roles, and hospital cost-cutting. In fact, it was repeated assertions that today’s nurses are overburdened, overworked and overstressed that led to a survey conducted by ANA of the health and safety of RNs in their current health care environments (ANA 2001b). This online health and safety survey attracted 4826 respondents from across the
USA and represented a cross-section of nurses from various age groups, years of experience and work environments. It revealed that the top three health and safety concerns of those who responded were acute/chronic effects of stress and overwork (70.5%); a disabling back injury (59.4%); and becoming infected with human immunodeficiency virus (HIV) or hepatitis from a needlestick injury (45.3%). In addition, 80% of nurses surveyed indicated that they did not feel entirely safe in their current workplace. Although there is evidence that there are nurses who are primarily satisfied by the patient care they provide (McNeese-Smith 1999), nursing roles are becoming increasingly strained. Consequently, it is evident that there are many variables that contribute to the changing RN work climate, and at present it appears that most nurses are not satisfied with these changes.

**Poor image of nursing**

Throughout history, stereotypical and negative portrayals of nurses such as the physician’s handmaiden have continued to dominate society’s perceptions of the nursing profession. Although nurses are ranked very highly as a trusted profession in the USA, they are often undervalued and there is still a lack of understanding about what they really ‘do’ (Nevidjon & Erickson 2001). This confusion could be a result of awarding RN licensure to graduates from three different levels of educational preparation: a 2-year associate degree, a 3-year diploma or a 4-year baccalaureate degree. This variety of educational pathways has led many students and school guidance counsellors not to value nursing as an intellectual enterprise (Williams 2001). Furthermore, having three levels of entry creates a disincentive to attracting people to a 4-year baccalaureate programme when they could qualify in 2 years (Bednash 2000). Although there are no current trends to limit the type of entry into nursing, the different levels of education attained in nursing should be recognized and nursing as a profession valued as a whole.

The data reveal that there will be a mass departure of RNs from the workplace over the next 10–20 years, in addition to the continuous attrition of those currently employed who leave nursing for various reasons. Furthermore, fewer people are choosing nursing as a career and the image of nursing has been deteriorating. Based on projected nursing shortage statistics, there is an immediate need for a call to action to protect and support the nursing profession.

**Possible solutions to the nursing shortage**

Nursing has been plagued with numerous shortsighted solutions throughout its revolving cycle of workforce shortages, but over the long-term these have failed to sustain it as a rewarding profession (Williams 2001). Many efforts have been made at local (by individual nursing programmes and hospitals), state (by various state nursing associations and legislature), and federal level (involving the US Senate and various national committees) to alleviate strains on the current and future workforce.

Amongst these are potential and realistic solutions which have generated hope for significant change in the nursing workforce.

**Recruitment efforts**

Efforts to increase enrolment in nursing programmes are evidenced across the country. Recruitment strategies identified in the literature range from those by local hospitals and schools of nursing to state-wide nursing associations. Many believe that recruitment initiatives need to focus predominantly on attracting more young people, including men and people from minority ethnic groups to the nursing profession. There is a need for more young persons to choose nursing as a career option because they are the future of nursing. The recruitment of students, often referred to as the need for ‘priming the pipeline’, has been identified as a possible long-term solution to the nursing shortage. Nevidjon and Erickson (2001) have acknowledged this recruitment priority, even stating that children must be reached earlier than high school because ‘students often have their minds made up by fifth grade about desirable and undesirable careers’ (para 17).

Because students are considering their careers at earlier ages, children at grade school levels need to gain awareness of the advantages and opportunities of selecting a career in nursing. For example, the University of Maryland School of Nursing has developed what they call a ‘career academy’, which helps prepare high school students for college by integrating career themes into their academic courses (Thompson et al. 2001). The prenursing academy curriculum begins the summer before high school and continues until graduation from high school. Learning opportunities include discussions of nursing in contemporary society, investigating community problems, the science of nursing, and hands-on experience such as experience in simulation laboratories and internships. It is hoped that early exposure to the challenges and realities of nursing will recruit more young people into the profession.

There is evidence of other successful efforts to recruit middle and high school students into nursing. For example, the USA Department of Health and Human Services (2001) division of Health Resources and Service Administration has awarded over $201 million dollars in grant money to 82 colleges, universities and other organizations to help increase the enrolment of students in baccalaureate and advanced level nursing programmes. Nursing associations such as the
National League for Nurses (NLN) have also advocated the need for increased funding for loan and scholarship programmes to bring in more young people (NLN 2001). Some schools of nursing have developed partnerships with health-related workplaces to increase monetary incentives and financial support to enter the nursing profession (Heller & Nichols 2001). The availability of such grants and loans should help to remove some of the financial barriers to nursing education and ensure students that they can receive financial assistance during their studies. A policy statement developed by an alliance of four autonomous nursing organizations [AACN, ANA, American Organization of Nurse Executives (AONE) and NLN], known as the Tri-Council, also supports this notion of reaching out to America’s youth through schools, counsellors, youth organizations and other outlets to encourage a more diverse population of nursing students (AONE 2001). This also includes encouraging more men and people from ethnic minorities to enter the profession, because nurses are genuinely committed to increasing the diversity of the RN workforce (Sullivan 2000).

Therefore, to help increase the enrolment from this diverse learning community, nursing programmes must be committed to providing flexible educational opportunities for their students. Strategies such as adaptable scheduling (including evening and weekend classes), providing accelerated programmes, and expanding educational access to underserved geographical regions via distance or web-enhanced learning (Heller & Nichols 2001) may help to narrow the gap by offering ‘user-friendly’ education to today’s adult learners. According to Beck (2000), effective recruitment strategies should be based on the reasons students chose nursing in the first place. In a study using focus groups and questionnaires, Hemsley-Brown and Foskett (1999) found that most young people based their decision on interest and enjoyment or having a desire to help people. Perceived salary was not a significant factor in their decision to choose or reject nursing. However, in a grounded theory study conducted by Boughn (2001), interviews with 12 male and 16 female nursing students did reveal differences in expectations about salary. More males clearly indicated that they chose nursing because they expected good wages. However, both groups demonstrated comparable commitment to caring for others as their major motivation. Therefore, it is imperative that clear and realistic images of nursing are conveyed when recruiting both men and women into the profession.

**Reaching unemployed and immigrant nurses**

There is also a fairly large percentage of licensed RNs who are unemployed or working in non-nursing fields. In 2000, approximately 18.3% of the RN workforce was not employed as nurses (HRSA 2001a). Thus, there appears to be a substantial supply that employers can tap into and re-recruit into the RN labour market. These ‘re-entry’ nurses are an important resource because they have many assets such life experience and maturity (Domrose 2001); what they lack may be current nursing knowledge and skills. Therefore, employers should advertise that they offer nursing refresher programmes or other re-training opportunities to attract RNs who have been out of practice for a period of time. These same educational opportunities should also be provided to foreign nurses as an incentive to work in the USA. In addition to easing the immigration of nurses from other countries (Brewer & Kovner 2001), preparatory courses for the nursing licensure examination, extensive orientation programmes and, if needed, courses in English as a second language should be offered free-of-charge. There is also interest in creating innovative recruitment strategies to attract currently employed individuals to choose nursing as a second career (Second-Career Nurses 2001).

**Continuing education**

Lastly, RNs should be encouraged to further their education and to pursue advanced degrees (certifications, Master’s or Doctorate degrees) in preparation for careers as nurse practitioners, nurse-midwives, instructors/professors, nurse anaesthetists, and a wide-range of other nursing careers. Some schools of nursing have responded by providing programmes that facilitate associate degree and diploma nurses to enter baccalaureate nursing programmes (Alspach 2000). The development of ‘fast-track’ graduate programmes would help those with bachelor’s degrees earn Master’s or Doctoral degrees more quickly (Brendtro & Hegge 2000). Often there is a time lag between earning a Bachelor degree and deciding to return to graduate school. Opportunities in higher education should be discussed with nursing students during their initial studies and they should be advised to pursue advanced degrees in nursing immediately after graduation. Financial support in the form of scholarships, grants and loans should be readily available to aid those pursuing higher education in nursing, in addition to offering competitive and lucrative salaries on entering the workforce. Support could also be given to non-tenured teachers who are employed full-time or part-time in academia and are concurrently studying in doctoral or postdoctoral programmes. To help retain and alleviate role strain in newly employed teachers, staff development strategies such as comprehensive orientation programmes, mentoring, and support for teaching, research and scholarly work would help to increase overall satisfaction and success in the academic role (Boyden 2000).
Retaining currently employed RNs

The RNs held approximately 2.2 million jobs in 2000; three of five of these were in hospitals and one in four RNs worked part-time (USA Department of Labor 2002). Because the average age of the RN workforce continues to rise, employers may have to be ergonomically sensitive to older RNs, who are more susceptible to certain injuries and have a reduced capacity to perform certain tasks (Buerhaus et al. 2000). However, although it is important to recognize the value of retaining experienced nurses in the workforce, attention must be given to all RNs who are currently employed.

To retain qualified nurses and to remain competitive in a changing labour market, employers need to improve personnel policies and benefits, provide opportunities for career advancement, lifelong learning and flexible work schedules, and develop retention strategies (Aiken et al. 2001). Contributions made by nurses must also be recognized and rewarded (Williams 2001). Furthermore, it is important that nurses be compensated accordingly based on their differing levels of preparation, responsibility, and performance (Williams 2001). The median annual pay of RNs was $44,840 in 2000 (USA Department of Labor 2002), and RN wages will need to rise to attract more people into the profession, but these effects will occur slowly (Buerhaus et al. 2000). Employers typically offer signing on bonuses and various incentives first because these strategies are less costly than general wage increases (Brewer & Kovner 2001), although it has been recognized that bonuses only provide short-term solutions (Aiken et al. 2001). It is anticipated that the supply and demand balance will be profoundly influenced by the baby boomer RN retirement in the next five to ten years (Minnick 2000). Only when the labour markets begin to respond to the imbalances of supply and demand in the nursing workforce will overall improvements in RN wages be seen.

Unfortunately, many of our experienced nurses have reached their maximum salary earnings in their workplaces. Often salaries do not continue to rise in proportion to years of experience, which hinders the capacity to increase earnings throughout employment (Mee & Carey 2001). Therefore, salary levels should not be fixed and should be commensurate with experience and increased skill level (Farella 2001). Recruitment bonuses may help attract RNs, but retention bonuses should be given to those who stay in their workplaces (Farella 2001). Employment agencies need to focus on making the nursing profession more ‘attractive’ to both younger and older generations. By offering competitive pay, flexible scheduling, and career advancement opportunities (Alexander 2001), employers must accommodate the workplace to fit the dynamic lifestyles of new graduates.

Improving the image of nursing

Improving the image of nursing is the single, most pivotal act that nurses can do to reframe and enhance the image of nursing. How nurses communicate their professional lives to family, friends and the general public conveys a genuine picture of how they feel about themselves as nurses. Recently, there has been stronger media interest in the work of nurses and, in particular, the effect of nursing on patient outcomes (Dean-Baar 2001). Nursing can also use marketing techniques and the media to strengthen and revitalize its public image.

It is essential that today’s young people are exposed to more positive and authentic images of nursing. Those who are not in touch with the current realities of the profession often misrepresent the reality of nurses. For example, most school guidance counsellors have outdated perceptions of nursing and may not perceive it as a professional career (Gabriel 2001). Hence, any steps to improve its image in the eyes of middle and high school students must include guidance counsellors who have influence over their career choices. Programmes such as introducing the world of nursing to middle school children by providing ‘career days’ or ‘shadow days’ for high school students have been found to be very successful (AACN 2000). This exposure to nursing in the form of ‘hands-on’ experiences helps show students some of the real aspects that a career in nursing has to offer. The distribution of printed or web-based career information to middle/high school students, adult learners, guidance counsellors, and other career educators can also help to improve the image of nursing (Texas Nurses’ Association 2001). Asking nurses and nursing students to become role models for nursing and speak with high school students about career options in nursing can help clarify many of the misconceptions about the profession (McDonald 2000, SDNA 2001). Exposing individuals and communities to the rewarding challenges that a career in nursing has to offer is key to improving the image of the profession.

A campaign entitled ‘Nurses for a Healthier Tomorrow’ (2001) is a coalition of 32 nursing and health care organizations who are working together to develop a campaign to improve the image of nursing. They have devised a campaign featuring the lives of real live nurses and entitled ‘Nursing. It’s Real. It’s Life’. Similarly, nursing organizations such as STTI have assisted the company Johnson & Johnson to launch ‘The Campaign for Nursing’s Future’ as a complement to ‘Nurses for a Healthier Tomorrow’, which includes television advertisements on the themes ‘I’m a Nurse’ and ‘They Dare to Care’ (STTI 2002). Farella (2001) has suggested that nursing organizations should buy ‘air time’ on children’s programming to exemplify the real-life goodness of nursing to children at younger ages. If the nursing profession can be enhanced in
Improving the image of nursing must begin within individuals and become unified with many voices from other nursing organizations. If nurses can make a difference in how nursing is perceived, then the profession can promote a heightened level of respect throughout the USA.

Support the passage and enactment of nursing shortage bills
It is obvious that the recurring nursing shortages are not only nursing’s problem; ultimately the viability and effectiveness of the USA health care system will be compromised and the nation as a whole will be affected (Williams 2001). The passage of the Staffing Ratio Law, AB 394, on 10 October 1999, which mandates safe nurse: patient ratios in the state of California, is a good example of how nurses acted as advocates for their profession (California Nurses Association 2002).

Over the past 2 years or so, many politicians and other advocates of nursing have come together to engage in discussions about the nursing shortage and its impact on America’s health care delivery system (Committee on Health, Education, Labor and Pension 2001, OHA 2001b). As a result of Senate hearings and other statewide discussions about the crisis, the Nurse Reinvestment Act was passed on 22 July 2002 and signed into law on 1 August 2002 (AACN 2002). This Act focuses on nurse recruitment and retention through the establishment of educational scholarships, retention grants, elder care training grants, supportive career ladder partnerships between nursing schools and practice settings, loan cancellation for nursing teachers, and public service announcements that promote the nursing profession. Although the passage of this law appears positive towards alleviating the nursing shortage, funding for Nurse Reinvestment Act programmes appears tenuous at best and at the time this paper was written, no funding was available for these Act programmes. According to the (AACN 2002), nurses can best respond by contacting their state legislators to ask for their support to enact this law by appropriating the necessary funding.

It is important for nurses to act as advocates for their profession by keeping abreast of the issues surrounding the nursing shortage and by paying particular attention to the decisions that will be made by lawmakers in the coming months. If the government allocates funds to improve the current nursing situation, the implications for the nursing profession in terms of recruitment and retention could be tremendous.

Conclusion
It is obvious that the current nursing shortage is not being ignored: nursing and health-related organizations, the government, and nurses from every area of the discipline are addressing the problem through newsletters and articles,
research studies, coalitions, committees, hearings and bill proposals. Some of the factors contributing to the nursing shortage and potential solutions to address the problems are known. The bottom line is that nurses must act now; it is critical that they communicate and form partnerships with their employers, nursing associations, lawmakers, and other influential key players. If the vision is to help secure the future of the United States’ health care system, nurses should also ensure that there is continuous interest in their profession. As the largest group of health professionals in the USA, nurses now need to also have the leading voice and influence in the decisions regarding the future of the nursing profession.

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Commentary: an Australian perspective

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The global shortage of nursing highlights some common issues affecting nursing worldwide. The issues discussed by Janiszewski Goodin (2003) in the United States of America (USA) context, including the ageing of the nursing workforce, the decline in enrolments to nursing programmes, changing working conditions and the poor image of nursing, are all impacting on the ability to recruit and retain nurses, not just in the USA, but worldwide.

In Australia, the current average age of nurses is 41-6 years and this is comparable with Janiszewski Goodin’s statistics for the USA, and also with other countries, such as Canada (Australian Institute of Health and Welfare (AIHW) 2001,
Duffield & O’Brien-Pallas, 2002, Janiszewski Goodin, 2003). The decline in enrolments to nursing programmes also has been apparent in Australia for some years. Last year, however, the number of applicants to nursing programmes across Australia showed a sharp increase, to the point where many first preferences could not be met, and many applicants could not be offered a place. This increasing interest in nursing almost certainly reflects the success of the concerted and collective efforts that have been made by the nursing profession in our country, and through government-funded media programmes, to recruit students into nursing programmes and to raise the profile of nursing in the wider community.

Changing working conditions are having an impact on the profession’s ability to deliver nursing care to the standards now expected (Duffield & O’Brien-Pallas, 2002). In Australia, as in the USA, the day-to-day pressures on nurses have intensified as a result of increasing patient acuity and shorter hospital stays. Dissatisfaction with standards of care is clearly causing stress for many nurses, leading some to leave the profession and others, if they stay, to be projecting a poor image of nursing through open questioning of standards of practice. Another concern is the move towards substitution of registered nurses with unskilled workers, predominantly in the aged care sector, at a time when the patient complexity and acuity in these areas too has never been greater (Duffield, 2003). This appears to have increased both the workload and the dissatisfaction of registered nurses as their role has moved more to that of supervisor than primary caregiver.

Australia has other issues that are influencing the growing nursing shortage. These factors are associated with a nursing career structure that arguably is outdated and a health care system that is increasingly unable to cope with the growing demands. Three main issues that influence retention of the nursing workforce in Australia were identified by Duffield and O’Brien-Pallas (2002) as personal issues; management and organizational issues; and professional issues.

Personal issues relate to burnout and stress, and a lack of balance between home life and work demands. Legislative moves in Australia to ensure that employers provide a ‘family-friendly workplace’ are welcomed but, at the same time, difficult to balance against the demands of the 24 hour, 7 day a week service that nurses must provide. The models of rostering currently used in order to meet economic pressures on the industry make it difficult to incorporate the needs of a predominately female workforce, many with dependant children. The need for flexible rostering is paramount in the retention of nurses. Employing organizations have found it difficult to implement rostering with the degree of flexibility needed for nurses to meet both home and work demands. Perhaps there are lessons for Australia to learn from other countries that appear to have had considerable success in retaining nurses through the introduction of annualized hours. In Australia there has been a gradual change in the work ethic in society at large, with respect to the hours and shifts that employees are willing to work. An increasing number of nurses now consider part-time employment and minimal night duty as highly desirable.

In relation to organizational and management issues, the increasing occurrence of violence in the workplace, whether verbal, physical or horizontal, has become an important issue in the ability of organizations to retain their nurses in the workforce. An increase in behavioural problems in Australian society is reflected in rising admission rates of such individuals to acute care hospitals and, coupled with the ageing population, is resulting in serious pressure on acute care facilities and demands on nurses.

Increased consumer expectations are also adding new pressures as there is a lack of insight into the changing role of nurses by consumers, and other health care professional groups. Health care in the past was based on a model of dependence and consumers had the expectation that nurses would meet their every need. It used to be the norm that patients would be in hospital for days, both before and after surgery, for example for as long as 7–10 days after having a gallbladder removed. This allowed a very gentle recovery for patients, and one which was highly reliant on nursing care. Now, as many patients as possible are encouraged to undergo surgery as a day patient, and nursing care is very limited as patients are encouraged to look after themselves very soon after surgery. Nurses understand that this is beneficial for the patient in the longer term as there are fewer complications as a result of lessening the time a patient stays in hospital. Some patients, however, still have the expectation that nurses should be providing all of their care. This mismatch in expectations can lead in some cases to physical and verbal violence and, over time, it is one of the catalysts for nurses to leave nursing.

Professional issues affecting recruitment and retention of nurses in Australia are associated mainly with the perceived disparity between the standards of care that nurses themselves believe they should provide but which, in the current economic climate, they are unable to sustain. One could question whether nurses in Australia are being adequately prepared to work in environments with such high (and ever-increasing) patient acuity. The nursing profession in Australia needs to re-examine current nurse education provision in light of the changing health care system and re-orientate nurse education in order to produce a nursing workforce that is capable of meeting the changing needs of the industry and the community. Encouraging overseas educated nurses to practice in Australia also assists in meeting the multicultural
needs of the community and may temporarily contribute to decreasing the nursing shortage in Australia (Wickett & McCutcheon 2002). The number of overseas educated nurses assessed in South Australia as eligible to practice has increased from 103 in 1997/1998 to 135 in 2001/2002 with these nurses coming predominately from the United Kingdom (UK), Norway and South Africa (Nurses Board of South Australia 2003).

Nursing in Australia must also address its fragmented ‘professional voice’. The inability of specialized nursing groups to function cohesively has resulted in a profession that is inaudible collectively at the federal level. Another professional issue that requires addressing is the lack of opportunity in a relatively ‘flat’ career structure for horizontal movement in the nursing workforce. There is now a well-educated nursing workforce, with increasing numbers of registered nurses educated to Masters level, but there is a limited capacity to reward this with appropriate promotion in a career structure that still forces choice between clinical, management and academic fields of practice. There is a need for more joint appointments, for example between practice and the academic sector, and for more opportunities for nurses in practice to be offered variety and challenge, while staying at the same level, to add value to their role and to motivate them to stay in nursing.

This situation is now changing and there are now wider opportunities for nurses to move into expanded roles and into new and different areas, such as information technology, that are still directly related to the work of nurses.

Historically, nursing was a career for young women and with opportunities for promotion at a young age. Now, with the ageing nursing workforce, older woman who were discouraged from continuing to work are now encouraged to stay in the workforce to lessen the impact of the current shortage. The government in Australia is actively discouraging people from retiring, in all sectors, by removing the mandatory age of retirement. The longer retention of these experienced nurses should be of benefit to the nursing workforce in Australia and might avoid the rapid drain of experience from the profession that Janiszewski Goodin (2003) describes as a particular loss to the nursing workforce in the USA. There is still a significant difficulty in Australia, as in the USA, of attracting men into nursing as the profession is still considered to be female-centric. Nursing is a viable career for men in terms of salary and opportunity and yet the percentage of male nurses is only 7.9% of the national nursing workforce, which has barely shifted over the past decade despite increased unemployment levels among young males across Australia (AIHW 2001).

Australia does appear, then, to be experiencing many of the same trends and problems that Janiszewski Goodin (2003) describes in her account of the USA nursing shortage. There also appear to be some differences, as we have highlighted. However, it seems to be the case that different countries are grappling with similar problems with regard to the nursing shortage, and the differences lie mainly in the levels of intensity or importance of the various contributing factors.

References


Commentary: an English perspective

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The shortage of nurses in England is not new. Other parts of the United Kingdom (UK) are also affected by nursing shortage but, so far, the problem has been more acute and more widespread in England. The Department of Health has recognized for some time the problem of the shortage of nurses (and other health care professionals) and the National
Health Service (NHS) Plan [Department of Health (DOH) 2000] set new targets to increase the workforce capacity in all of the clinical professions. A report published by the Audit Commission (2002) drew attention to the seriousness of the workforce shortage, stating that ‘... the biggest constraint the NHS faces today is no longer a shortage of financial resources. It is shortage of human resources, the doctors, nurses, therapists, and other health care professionals...’.

The workforce shortage in the NHS as a whole has come about from a combination of factors, including poor workforce planning; reductions in training places in the 1980s and 1990s; the ageing workforce; requirements of the European Working Time Directives; and changes to the local population profiles. Some, but not all, of the factors involved are very much the same as those identified by Janiszewski Goodin (2003) in her analysis of the United States of America (USA) situation.

In the UK, there have been ups and downs in workforce numbers over the past two or three decades. The cycle of reductions followed by increases in the numbers of nurses during the 1980s and 1990s resulted in ‘catch up’ periods: indeed, figures for 2002 showed that the number of nurses on the register for England was at its highest since the last ‘peak’ in the 1990s (Buchan 2000). Despite this, the numbers today are nevertheless still below what they were in the mid-1990s. However, the key difference in the shortage phenomenon today is that ‘demand’ is growing faster than ‘supply’.

Another difference lies in the changing skill mix between registered and unregistered nursing staff. The proportion of unregistered staff in 1998 in England increased by 2%, reducing from 72% to 70% the percentage of registered staff. This is a continuing trend with a current growth rate in numbers of unregistered nurses of 3.2% per annum and this fits with the wider agenda on modernization of health services, changing roles in nursing, and the widening of access for entry to the nursing profession.

The age profile of the nursing profession also has changed, becoming steadily older than in the 1980s and the early 1990s. Prior to 1998/1999, 26% of the nursing workforce was under 30 years of age. Today only 13% of the nurses are under 30 and 58% are over 40 (Couch 2003). It is difficult to make a direct comparison with the data for the USA provided by Janiszewski Goodin (2003) but it would appear that the UK nursing profession probably has an even higher proportion of older nurses than is yet the case in the USA.

The reasons why nurses choose to leave the profession, however, appear to be very similar. A study undertaken by the Royal College of Nursing (RCN) in 1998 across 55 medical wards showed that the concerns nurses were voicing were about their increasing workload, the high vacancy levels, lack of empowerment, and dissatisfaction with pay (RCN 1998). A more recent study by the RCN found similar issues with some additional reasons for nurses either leaving or thinking of leaving, these including lack of support for caring responsibilities and bullying, and violence at work (RCN 2000).

Dissatisfaction with pay seems to be widespread among nurses and the high cost of living in the major cities, and London in particular, has been identified as a key factor (Finlayson et al. 2002). Housing costs are a particular pressure, and especially in London where a nurse would need to earn £60,000 a year (more than three times a starting salary) to afford the same standard of house that a nurse in Greater Manchester might be able to purchase. Despite pay increases, the starting salary in nursing is still between £1000 and £2000 per year less than employees in other public sector services, such as the police and the teaching profession.

The government in the UK is attempting to address nursing and other health care workforce issues on a number of fronts. There has been an increase in NHS funding of 74% under the most recent comprehensive spending review and, with that increase in funding, targets to expand the workforce have been set in place. The target for nursing was initially an ‘extra’ 20,000 nurses for the UK and is now 35,000 (these figures refer to head counts rather than whole time equivalents). The target set for nursing was initially an ‘extra’ 20,000 which has since risen to 35,000. This target, whilst laudable, does not match the potential expansion that the additional funding could create: the estimated increase would be around 150,000 extra clinical staff of which 65,000 (43%) would be nursing.

The new Workforce Confederations across England with responsibility for commissioning nurse training have increased their commissioning numbers in 2002/2003 by 1540 students per year in response to the NHS Plan, and to date the majority of places have been filled. However, it is getting harder to attract these numbers of new recruits into nursing.

Other initiatives include overseas recruitment and attracting nurses not currently in work back into nursing. These efforts have brought some success. For the first time in 2001–2002, one-half of the 30,000 new nurses who joined the UK register were from overseas (Couch 2003). This is double the figure for the previous year. The problem here is understanding the longer term plans of these recruits from overseas and whether this strategy is sustainable for the future. And, in the return-to-practice campaign between February 1999 and March 2002, a total of 11,276 nurses returned to work in the UK. The majority of these, however, work part-time and the increasing element of part-time working in the nursing workforce, whilst valuable and important, is not without problems.
As well as increasing the health service workforce, the Department of Health has embarked on an ambitious human resource modernization programme (DOH 2002). There are four main pillars to this plan:

• Making the NHS a model ‘3’ star employer
• Ensuring the NHS provides a model career – skills escalator
• Improving staff morale
• Building people management skills.

Integrated in this HR plan are intentions to modernize the pay structure (DOH 1999: Agenda for change), in itself a huge change, as well as a funded strategy for child care support, and specific actions to improve the working lives of staff in the service.

The notion of a ‘skills escalator’ is about widening access to the health care professions and providing opportunities for employment and training to local people. The plan also states that opportunities must be provided for all current staff working in the health service to progress in their careers, if they wish to do so. One of the outcomes of these modernization initiatives is the increasing development of new roles, expanded roles and a broadening of roles. Alongside this, there is a new target, set in 2002, to increase the number of support workers by 29 000 across the UK. Specific targets for health care support workers have never been explicitly stated in the past. This new development acknowledges openly the increasing trend towards role diversification and the delegation of skills and competencies to support workers. At the same time developments are in progress on new advanced competencies for registered staff to accommodate shortages in some of the professions, particularly the medical profession.

The demographical data on unemployment across the country, especially in many inner cities, shows that there are local people in the communities who would be able, appropriate and available to enter into work and learning in the NHS. In Greater Manchester, the Workforce Confederation identified a future workforce shortage of up to 2000 front-line clinical staff by 2004/2005. This is despite increasing the training places for all the professions over the next few years. The members of the Confederation decided to take a radical and challenging step to address the shortfall. The demographic data on unemployment across the country, and especially in inner cities, shows that there are local people in the communities who would be able, appropriate, and available to enter into work and learning in the NHS. Market research in Manchester typified this, and the majority of people available were mature individuals who did not have the conventional educational requirements for the traditional professional courses. Therefore, the Confederation developed a new approach to attract extra staff into the service and into new ways of working. The project is called ‘Delivering the Workforce’ (Mullen 2003) and uses a work-based foundation degree as a basis for learning. A new role called Assistant Practitioner is being developed that will have skills that are patient focused. The skills will be devolved from the various professions, including nursing, in order to free up the time of the registered professionals to develop their roles as advanced practitioners. This in effect is the ‘skills escalator’, advocated by the Department of Health, being applied in reality. This approach does not appear to be one that is reflected in the USA analysis by Janiszewski Goodin (2003). Indeed there is no reference at all to issues relating to skill mix, modernization and or substitution in the USA workforce.

One last strand in the NHS modernization agenda is the drive towards ‘common learning’ programmes during pre- and postregistration training. There are four national pilot projects in England that are developing some common or shared learning opportunities for all health care professionals. The driver for developing these new ways of educating and training staff is to support the concept of building clinical teams that will deliver patient/client-focused services. In discussing the nursing shortage in the US, Janiszewski Goodin (2003) tends to treat the question of the nursing shortage in isolation whereas, in the UK, the new workforce initiatives are attempting to break away from the traditional professional boundaries and moving towards the concept of teams. The professional barriers and walls are quickly built up in traditional pre-registration preparation. The four shared learning pilots will examine if and how shared/common learning helps to create better team working, more flexibility, and better understanding between the different professions. This concept of shared/common learning with the wider clinical team is not reflected in the USA analysis.

The nursing shortage is still an issue for the NHS but, in the UK, the strategy now is not simply about ‘more nurses’ but, in a broader and more ambitious way, about re-focusing the skills of health care professionals on the needs of the service rather than the interests of individual professions. It is too early to judge whether the new ways of working that are evolving will result in improvement to services or whether the new strategies to retain and recruit staff will succeed in reducing the current shortages in clinical staff, and especially in nursing.

References
Commentary: a European perspective

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The problem of the shortage of nurses, and also of other health professionals, is global. Countries in the European Union (EU), as in North America, Canada, Australia and elsewhere, are all attempting to recruit more nurses, and are all recruiting from overseas, and largely from the same sources which, ultimately, will be finite. Thus, all countries are currently competing in the recruitment stakes and it is clear that recruitment from other countries is not the answer. This is ‘robbing Peter to pay Paul’; or, in other words, different countries are simply recruiting from each other and often taking the more experienced professionals where there currently happens to be a surplus of nurses (Gaillard et al. 2001). But these most experienced nurses are needed to develop the nursing services in their own health care systems for the longer term future. Overseas recruitment cannot be seen as the solution to the nursing shortage. It is, to say the least, unethical, and in many cases any existing surplus of nurses may be the result of an under-resourced and under-developed health service. The potentially damaging consequences of overseas recruitment needs to be taken into account in any strategy that may be developed worldwide to tackle the global problem of the nursing shortage. In her account of the nursing shortage in the USA, Janiszewski Goodin (2003) refers to forms of enticement to ‘ease’ the immigration of nurses from other countries, but she does not highlight the potentially damaging consequences worldwide of the strategy of overseas recruitment.

In contrast, this issue is a major concern in the European context. The objective of the European Commission is to improve the efficiency, cost effectiveness and quality of health systems across Europe so that every country can meet the growing demands arising from population ageing and other factors, and thus ensure that all European citizens receive the highest quality of nursing care throughout the Region. The Standing Committee of Nurses of the EU (PCN) has brought to the attention of the European Commission, the European Parliament and the Council of Europe, the current critical shortage of nurses. Importantly, particular attention has been drawn to the actual and potential problems of competitive recruitment for scarce nursing resources and, therefore, the need for an ethical stance in the EU in relation to nurse recruitment.

The PCN is also concerned that, if no benchmarks exist to measure the nursing resource requirements to meet health service demands, it may prove difficult to assess whether particular countries actually do have a shortage (or a surplus) of nurses. In all countries in relation to the current labour crisis in all health professional groups, there is a lack of information about the number of health service employees, the future health care needs and the numbers of staff required for the delivery of services. Systematic information is needed about current nursing practice and how it is influenced by diversity of patient populations (age, demographic features, pathology, and need for care) and by variations in care currently provided (different nursing care, medical treatment) (De Raeve 1994). Countries should be assisted and encouraged to collate comparable quality data at local, national and European level. Guidelines on the aggregation of data should be provided and research into workforce analysis should be both quantitative and qualitative. Nursing data must be exploited for staffing projections and planning, and for budgeting and evidence-based nursing developments (Coenen & Schoneman 1995). Nurse managers need management tools to assist them in terms of proactively planning their strategies for the recruitment and retention of nurses. The availability of such information
should enhance the quality of future decisions and financial performance (i.e. cost effectiveness) and result ultimately in a better quality of care.

For these reasons, the PCN believes that there is an urgent need for a Workforce Monitoring Forum to be set up at EU level which could perform an important role in capturing information about nurses and nursing within Europe in order to make reliable predictions about future trends and needs. By doing this, the trend towards substitution of ‘expensive’ registered nurses with ‘cheaper’ care assistants or aides might be avoided.

The single market of the EU stands for liberalization to allow the free movement of goods and of the services of regulated professions. This liberal system also offers the opportunity for aggressive recruitment agencies to ‘poach’ nurses from other countries, often looking for the most experienced nursing resources which, in turn, may lead to the deterioration of their own health services. The PCN is concerned about the unethical practices in some recruitment agencies and the possible exploitation of migrant workers. The problems associated with international recruitment have led PCN, and also the ICN and individual countries, to examine the issues surrounding inter-country recruitment with the objective of drawing up ethical guidelines for the recruitment of nurses.

Ethical guidelines for best practice recruitment should include the following broad categories (Kennedy 2001):

• clear protocols for recruitment agencies,
• explicit criteria for the selection of nurses,
• full information from the recruiting country including details about working visas, work permits, registration contracts, accommodation, cost of living, salary, job descriptions and employee legislation,
• explicitation of the rights of employees,
• details of available orientation/induction programmes,
• details about the integration process,
• support for overseas nurses, both socially and within the workplace,
• opportunities for further education.

By following these guidelines, countries will be collaborating in sound and ethical recruitment practices across the European region. Information also can be shared about disreputable recruitment agencies, aggressive or unethical recruitment practices, excessive recruitment from developing countries, and lack of support for overseas recruits. Sharing good practices in recruitment and retention at a national and European level is an essential strategy for tackling the shared problem of the nursing shortage.

Improvements are also needed in more conventional recruitment strategies within countries, and there is the need to create incentives to improve staff retention and motivation. In order to improve staff retention, it is important to give nurses in their work environment the responsibility to identify the best working conditions that fit their local needs. Such support can be an important element in retaining and motivating nursing staff. A well-motivated, well-educated and adequately resourced workforce will be the key to success in dealing with the nursing shortage in Europe, as elsewhere in the world.

A number of strategies for the retention of nurses have been discussed by PCN-member associations and these include the following (Kennedy 2001):

• Pay in nursing is generally too low and organizations should work towards promoting a level of pay that promotes equality and reflects realistically the workload responsibilities. National Nursing Associations need to work with governments in seeking favourable pay and conditions of work, and salary is a priority in retaining nurses.
• Consideration also must be given to creating and funding more career opportunities and ongoing education for all nurses, especially older nurses, in view of the fact that the nursing workforce is ageing and, therefore, maximizing their contribution and motivation is of paramount importance.
• Strategies to attract returnees to the profession, for example through back-to-nursing courses, are also vital if the latent nursing workforce is to be re-captured and these returnee nurses need to be supported in the clinical areas.
• Nursing is predominantly a female profession with a high proportion of its members in their childbearing and childrearing years. These issues need to be addressed by the introduction of family-friendly initiatives; the provision of childcare and crèche facilities; and much greater flexibility in hours of work.
• Marketing initiatives need to seek to recruit more mature entrants to nursing, and especially more men.
• Continuing professional development needs to be seen as a key means of encouraging nurses to stay in nursing and creative ways to assist nurses to undertake further study need to be exploited, for example through study leave and the reimbursement of fees and other costs of study.

Many of these measures are touched on by Janiszewski Goodin (2003) in her analysis of the strategies being implemented in the USA to tackle their nursing shortage. In Europe, however, the nursing shortage is more than simply a workforce crisis. Europe has embarked on an ambitious agenda of social inclusion and health improvement, and PCN is supporting and facilitating these objectives by highlighting the strategic contribution that nurses can make, but only if there is a sufficient, effective, competent
and motivated workforce of nurses. This nursing workforce, with its competencies and its mobility, is essential within the single market of the EU, but it needs to be driven by concern about quality of care and the safety of patients. An ethical framework for nurse recruitment and retention, therefore, is a key requirement, and the basic assumption must be that all recruits to nursing have the qualifications and experience required to meet the criteria imposed by European legislation. Addressing the problem of the nursing shortage in Europe has to be tackled collectively or else some of its member countries will simply succeed only at the expense of other partners.

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