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**Lunch Keynote
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GAIL CHRISTOPHER: It's a great honor to introduce Congresswoman Donna Christensen, a representative from the Virgin Islands. Congresswoman Christensen chairs the Congressional Black Caucus's Health Brain Trust, which advocates for minority health issues both nationally and internationally. She is, in fact, the first female physician in the history of the US Congress, the first woman to represent an offshore territory, and the first woman delegate from the Virgin Islands. Congresswoman Christensen, in fact, herself embodies a whole range of stake-holder interest on this topic. As a health professional, she has had an up-close exposure to the effects of migration on Caribbean health systems. She is also familiar with the effects of recruitment of foreign-trained professionals to the Virgin Islands. And she has had a first-hand experience of migrating herself and knows the human rights implications of migration. As a member of a minority community, she is acutely aware of the under-representation of minorities in the health workforce, and as a result of her work in Congress, she knows the disparities issues inside out, including the

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relationship of disparities to workforce shortages, workforce composition, and to workforce cultural competency. As a national legislator, she has an in-depth knowledge of the challenges of formulating health policies in this country, as well as the health-related foreign policies that have come before her. In short, she embodies almost all of the complex issues that are at stake in this very fragmented policy arena.

It's with great pleasure and anticipation that I invite Congresswoman Christensen to share with us her reflections of the many political and personal implications of global health workforce shortages. Join me in welcoming her.

HONORABLE DONNA CHRISTENSEN: Thank you Gail. Good afternoon everyone. I wanted to thank you for inviting me to be a part of this forum on health and foreign policy, with the particular focus on migration and the global shortage of healthcare professionals. I have to confess up front that although conversations with Prime Ministers in the Caribbean and other administrators of government have often touched on this important and troubling issue, and although we have attempted to get Congress and the White House to respond to their requests, which have come from time to time for increased scholarship and training dollars in

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their own country, it hasn't been an issue that the Congressional Black Caucus's Health Brain Trust has focused on. So I not only thank you for your gracious invitation, but for providing an opportunity for me and for the CBC to take a closer look, to learn, and to broaden our agenda to include the issue of health for manpower migration and its impact on both the source and recipient countries. It really does have great bearing on not only our domestic, but our global health agenda. I especially wanted to thank and recognize Dr. Gail Christopher who is responsible for introducing me to you and who has long been a valued partner and an invaluable resource to the Congressional Black Caucus and our Health Brain Trust, and I look forward to the relationship with AcademyHealth, with Dr. Polly Pittman, with your researchers, your leaders and all of your partners, that I feel begins with the Congressional Black Caucus today.

As I began to think about the issue of the United States and the global health manpower shortage and the migration of health professionals globally, I found that I didn't have to look much further than my own home district of the US Virgin Islands. In a place as small as the Virgin Islands, which today boasts maybe 120,000 people, we have never been able to meet

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our health manpower needs, nor have we been able to attract back our health professionals who've gone abroad to study. So as far back as I can remember, we imported health professionals; we relied first on doctors mainly from the US mainland and, to a lesser extent, the Caribbean region. All of our nurse midwives, who have been the cornerstone of our labor and delivery service, came from the Eastern English-speaking Caribbean, and they are beginning to retire now. So unless we can train or recruit new ones, their leaving will leave a critical void in that service.

When I was in training here at GW and at Howard and returned home, it was mainly doctors that we needed back then, and we drew from the Philippines mostly, but also from China and other parts of the world. Many of the doctors had studied medicine in the Dominican Republic, and most all of them remained in the community and really became a part of the Virgin Islands. But they, too, are now retiring and, fortunately, and not quite by accident, as this has been happening though, we have improved our healthcare system. There are more opportunities for specialists and better support for those specialties, and we've become to attract some of our own Virgin Islanders back

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to the Virgin Islands, but we still have to recruit others to fill our complete need.

But nursing is always where the rubber hits the road, and our nursing pattern also closely parallels that of the US and the global picture. Even our own local School of Nursing has not been able to completely fill the void, and for the same reasons that keep us from being able to increase the indigenous health workforce in many inner city and minority communities, a poor K-12 experience, a poor K-12 preparation. I can remember times when we brought in groups of nurses from Spain who couldn't speak a word of English and other times from the Philippines. But as with our own, the Virgin Islands is often a gateway to the better-paying positions and to upward mobility in the states that are north. So a few stayed, but most of them left. So we struggle, like many communities, to keep our nurse/patient ratios within the requirements of the Center for Medicare and Medicaid Services for JCAHO. We do so even if we have to reduce beds to keep that ratio intact. I'm sure we're not alone, but that only means that the patients then wait for days in the emergency room until a bed becomes available. It buys us time, but it's not really a solution as you all know.

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In microcosm, we're really one of the phases of this problem; we're at one time a source and, at the same time, a recipient country or territory, and we bear the scars of both. Like our recipient country counterparts, we have faced major barriers of language and culture, not to mention substandard training, and in many cases, the gap has been very, very severe. We probably would not have overcome them, but we were lucky in the doctors that came. They were basically goodhearted and they worked hard and they tried very hard. But in the end, our healthcare system did suffer from the language barriers, from the educational barriers, and we were not able to give our residents in the Virgin Islands the care that they needed and deserved.

Today in the United States Virgin Islands, as in the industrialized countries, physicians are not the major shortage in health professions. In fact, here in the United States, I understand that it's being reported that the demand for residents outstrips the number of students in our pipeline, driving institutions to seek students from other foreign countries. Many will stay I'm sure and, although they'll be somewhat acculturated during their training, as long as we continue to import workers in such a

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unique profession as healthcare and ignore the potential pool of providers in our own neighborhoods, the system will not do full justice to those who remain among the underserved.

While doctors remain a big part of the problem, it's nurses and allied health professionals that present the greatest dilemma before us. Approximately 22-percent of physicians and 12-percent of nurses in the United States are foreign born, with 70-percent coming from developing countries such as Africa, the Caribbean, and Southeast Asia. In total, 30-percent of the US health workforce comes from other undeveloped nations. The migration of healthcare workers, physicians, nurses, pharmacists, and other allied health professionals from developing countries that are wealthier countries such as the United States, Australia, Canada and the United Kingdom has a devastating impact upon developing countries, which are politically and economically fragile, often destabilizing the healthcare infrastructure of those countries. And the brain drain hurts those countries with the greatest need. It limits the number of people who receive care, as well as decreases the quality of care in developing countries, because the recruiters take the cream-of-the-crop, often leaving less

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qualified healthcare workers to provide health services, creating lower provider/patient ratios and creating sometimes hazardous and sometimes unsanitary working environments that make not only those countries, but the entire world a less safe and healthy place. It leaves a void in the poorest of nations for many reasons, but among them a lack of trained health professionals are, to date, fighting a losing battle against epidemics such as HIV and AIDS, malaria, and tuberculosis.

The impact of the migration of healthcare workers has been most evident in Sub Sahara and Africa. There are only approximately 600,000 doctors, nurses, and midwives to care for 600 million people who reside in that region. Therefor, those who are sick, ill and dying often do not have someone who can provide them with the needed medical care. It is estimated that the African countries need at least one million additional workers in order to offer basic healthcare services in that region. The Caribbean, which not accidentally, is also second to Sub Sahara and Africa in rates of HIV and AIDS is the next most adversely impacted region.

Some may point to the remittances, and those always come up, of these healthcare workers who migrate and send money back to their home countries. But when

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you really look at the bigger picture, the money that does contribute to the economic base of those countries does not make up for the loss of intellectual, economic, infrastructure, and human capital that occur. Also, some health professionals do return to their native country later in life and they contribute then, but those years may be too short to make up in a significant way for the loss of their most productive years, unless a concerted effort is made to maximize their contribution when they do return.

As I think you heard this morning, in 2020 the nurse shortage is expected to balloon to 800,000. I remember doing an information technology crisis a few years ago when groups were pressing for easier visas meet the need, and they are doing it again to meet the nursing crisis. This is clearly not the most effective way to address this need in such a personal, sensitive, and critical area as healthcare.

The Congressional Black Caucus, from whom I bring greetings to all of you, and our other minority Caucus partners, as you can imagine, agree with you and agree with me that this is not the most appropriate or the best solution, not when our children are left behind in K-12 and left out in college and university enrollment. Not when we suffer the highest and most

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intractable unemployment numbers. And not when we continue to be victims of discrimination in both the private and public healthcare system, if we're fortunate enough to access it. And not when we know that having healthcare providers of our same racial, ethnic, and certainly linguistic backgrounds has the potential to greatly contribute to the elimination of health disparities, the health disparities which kill us disproportionately, avoidably, and prematurely. The need, the challenges, and the adverse potential if migration of healthcare professionals continues unaddressed is global, adversely impacting both source and recipient countries, and it has global implications. It therefore requires global attention and remedies.

It begins with an understanding that globalization needs to be more than just eliminating tariffs and opening up duty-free trade, but it has to recognize the need for special and differential treatment of those smaller countries, so as not to destroy them. In other words, a need for fair trade, not just free trade. And it must recognize also the other barriers that are already present, like those of terror and disease, and it must acknowledge our interdependence. There are some responsible,

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thoughtful, and compassionate institutions, agencies, and organizations, many of them represented in this room, that have put some very worthy recommendations forward. And in those recommendations is where we find a nexus to the Congressional Black Caucus and our Tri-Caucus agenda.

With the exception of Native Americans, we were all at one point either willing or unwilling immigrants. And because we in the Congressional Black Caucus and the other minority caucuses in this instance, again excluding Native Americans who do share our fate nonetheless, but because we come from some of those poor or less industrialized countries, which are considered developing, we have never seen ourselves as being apart from our brothers and sisters of our mother countries. So we know that we are one, and our agendas reflect that. We are very clear though that those who elect us are our primary constituency, but that we also know that we have a responsibility to all of our sisters and brothers here and to the people of African descent and all who are disadvantaged everywhere. So many, if not all, of your recommendations as I've read from Harvard, from the Physicians for Human Rights, from AcademyHealth, resonate with us and are, to a greater or lesser extent, already a part of our Tri-

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Caucus agenda. Unfortunately though, our agenda is largely marginalized, ignored, and unrealized. So this meeting and your discussions and recommendations are like water to the thirsty. They re-energize our efforts on the hill, and they revive our hope that we will succeed in realizing them.

Long before I ever thought about coming to Congress, members like Lou Stokes worked to increase the number of disadvantaged students in this country entering not just health professions, but science and math careers, and those in Foreign Service. The fruit of that effort has begun to wither on the vine in this bitter season of narrow, conservative ideology, anti-affirmative action policies, and increased corporate welfare and ownership society values. As an example, health professions and graduate training funds have had to be fought for every year, and this year a proposed \$136 million cut is being proposed on top of the \$155 million cut that we experienced last year, or in this fiscal year that we're in currently.

Reality has given way to delusions of a colorblind society where even presidents of major institutions can speak of SATs being the great equalizer of opportunity for all students. Not only is the deck stacked against Americans of color at the

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door, in too many cases we can't even make it there because our children continue to be left behind no matter what the White House and the leadership in Congress call that pet program, which remains underfunded, the No Child Left Behind program, and in the proposed 2007 budget, it's underfunded to the tune of 15.4 billion dollars.

Health and education cannot be separated. Improving the situation and giving the people of this country a chance to be a part of healing this nation brings together two pillars of this Congressional Black Caucus agenda. It's also central to yours. Addressing this need is an important part of our Healthcare Equality and Accountability Act; it's something we call the Heal America Act, because that's what it would do. To pass it, we need your support; we need to be working together.

Our country's currently misguided foreign policy agenda is creating enemies, not building friendships. It does not even recognize the strong bonds of friendship and history that bind us to our closest neighbors in my region of the Caribbean. In Africa, it does not see the cause of justice that Bono stoke to us about when he was here last week, only opportunity and advantage. And in Asia and the Middle

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East, as we increase our dependency on those areas and yet invade a sensitive and dangerous territory, we don't seem to have a clue. The Congressional Black Caucus's work is for a level playing field for all people here in this country and for the countries of the world, and we do not accept that it cannot be done. We, the CBC, and you are both for a justice agenda here in this country and abroad; for debt relief; for a major investment now to control HIV and AIDS and all of the other killer diseases; a support for strong health and educational sectors, especially in the current source countries, for health professionals; indigenous economic development and the creation of an environment where good governments, peace, and wellness can exist and thrive. This responds to both of our agendas, and it responds to the needs of the people in these needy parts of the world, and again, we ought to be working together.

I've had a chance to look at the recommendations that have come from Harvard, Physicians for Human Rights, from AcademyHealth and others as I said earlier. Within them is a clear and strong matrix from which we can work, and I look forward to the reports coming out of this meeting, which I hope will

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provide us a blueprint and a strategy for how we move forward from here, together.

Besides reading your work, I've come across at least one other encouraging report in this country, and I think it has the potential to meet our need and maybe provide an example for some of the other source countries to follow, and that is in the development and rapid increases in enrollment in health science programs at US colleges and universities. *The New York Times* reported last Sunday that 70-percent of these students are minorities, and the vast majority of them move into further education, training, or into jobs as providers of healthcare. In both your agenda and our agenda, we know what needs to be done; what's lacking has always been the political will. Together and reaching out to others who share our vision for a future of fairness, equality, and justice, I know we forge the will of our country and our leaders to do the right thing. And that begins with something that's right on the front burner. It begins with working to build opposition and to defeat the extension of the President's tax cut; tax cuts which would be made permanent and paid to the rich on the backs of the poor. It will be before Congress in the coming weeks.

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I come to you today particularly moved by the funeral for Coretta Scott King in Atlanta yesterday, and that of Rosa Parks a few months before. In the latter we were reminded that she sat down so that we could stand up, and yesterday that despite her grief, she, Coretta Scott King, immediately took up the cause and fought steadfastly and courageously to pursue the dream, the seed, that was planted by her husband, the Reverend Dr. Martin Luther King, Jr. Yours and ours is, without question, a part of that dream; your cause and ours is, without question, a part of that dream. Most of all, I think that by yesterday and the funeral before, we were reminded that there is still so much to be done, and that the key to achieving our goals and realizing the dream is that we come together and work together.

So, on behalf of the Congressional Black Caucus, and I would say all of the minority caucuses, the Congressional Hispanic Caucus and the Congressional Asian Pacific Caucus, we look forward to working with all of you to do our part to realize that dream and to create Martin's beloved community here and across the world. Thank you. [Applause]

We have time for questions or comments or recommendations. Are there any questions or comments?

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FEMALE SPEAKER: [Inaudible] I would like to make a comment that there was an article that was printed by a [inaudible] in India, and he was talking about migrational nurses, and he was talking about the AIDS problem in Africa. He spoke of the irony, he said, that the developed countries, though making money for AIDS, at the same time they are also taking away the healthcare workers who could provide aid for this group of patients. So he actually said that he would [inaudible].

HONORABLE DONNA CHRISTENSEN: Right, and the aid that we're giving does not make up in any way for what we're taking out of that country at the same time. It's not something that is consciously in the minds of the policy makers, and we need to make sure that we remind them of that, that they're knowledgeable about that so that that can be taking into account as they do budgeting and create policies, but it's going to take persistence on all of our part to make sure that that's not lost sight of. Yes?

FEMALE SPEAKER: 99-percent of my students in Laredo are Spanish, and they have come from the poor educational systems that you've talked about, and most of the courses are on the web, so I get a lot of communications from them. And just yesterday, there were communications from so many of these students who are

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single mothers with children that are saying that their Medicaid funding is being cut, their food stamps are being cut, the school loans are being cut; how are we going to prepare people to care for us and themselves?

HONORABLE DONNA CHRISTENSEN: In my remarks, and in reading some of the articles that probably some of you have written, one of the things that are talked about is the interdependence of countries, but there's interdependence of legislation. Sometimes we who are in healthcare focus on just the healthcare legislation, and that's probably a little too late. We need to start looking at the budget. We just passed, on a partisan vote, some Republicans coming with Democrats and opposition, the Budget Reconciliation, which cut all of those programs that you just mentioned. And there are further proposals in the budget that we received this week to cut them even further. And that's why I brought up the issue of the Tax Reconciliation Bill. If that money, the trillions of dollars that that would take over the next 10 years, go to the Tax Reconciliation, we will have no money to put back into food stamps, to Pell Grants, into No Child Left Behind, and all of the educational programs that are needed, so we have to start very early and we have to be very vigilant. We have to make sure that we watch

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the budgets and we watch where the tax cut money is going, because between that and the war, unless we stand up and insist that the funding that is needed to invest in this country and invest in our students and our education and healthcare is there, it won't be there. Yes?

FEMALE SPEAKER: One of our great challenges in this field, where we're trying to both deal with domestic shortages and interface with the global workforce, is that health policy is made in the Department of Health and Human Services and in some health committees of the Congress, and then the State Department and other committees of Congress are dealing with international affairs. The problem that we're discussing at this meeting can't really be solved unless there's an interface between the two. Do you have any suggestions to us or strategies to help that goal of some kind of an interface?

HONORABLE DONNA CHRISTENSEN: Did you have anyone from HHS or the State Department here? Sometimes it's good to bring them to your meetings and let them participate. I spent a fair amount of time looking into your issues just in preparation for coming here, so I got an education and, as I said, I'm sold. It is part of our agenda in many ways already, but now I'll pay more attention to it. I think you need to

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invite them in and let them hear. We can incorporate that into our agenda as we move forward from here as well, because we have the opportunity to interface with both, but it's going to take you doing your part while we do our part of make it happen. And Britt is saying yes, so I guess that I'm on the right track.

Thank you again for inviting me. Please keep in touch with our office. I have my senior health policy analyst here, Britt Weinstock. If you can't get me, you can always get her. Thanks again. [Applause]

[END RECORDING]