

**Health In Foreign Policy Forum
Policy Debate with Public and Private Sector Leaders
February 8, 2006**

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POLLY BEDNASH, Ph.D.: ...We are going to begin the second part of our program if you can believe it. I know it's almost the end of the day and you must be tired but this is actually the most interesting part. This is the part where we're going to try and generate a conversation among different stakeholders, key leaders, and representatives from important organizations that influence policy both in the private sector and in the public sector. The first panel, of course, is on the private sector. I did want to reiterate that the Power points that were not included in your notebook will be available on our web site and that web site for this conference, as you may know, is www.academyhealth.org/nhpc, which is the national health policy conference slash foreign policy and there will be a link on that web site as well to the Kaiser web cast, which will have a full written transcript of the entire conference as well and we'll have the Power points that you've seen today so I did want to mention that. It's a great pleasure to now have Susan Dentzer here with us to moderate the next 2 panels. As you know, Susan's a correspondent for the News Hour with Jim Lehrer where she leads the unit that specializes in coverage of health policy. Susan.

SUSAN DENTZER: Thank you very much, Polly. It is a great pleasure to be here with you. I, believe it or not, just came back from New Orleans, speaking of a place with a

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healthcare workforce issue. Only 1/3 of the health providers being left in the city. So I had to get a quick summary on what you've discussed already so that we don't duplicate it in the panel this afternoon. So let me put it this way, sources have told the News Hour, or at least me, that you had some wide ranging discussions today on obviously the topic at hand but specifically, you've spent a lot of time on some various points—a lot of dialogue on what kind of health professionals are needed here in the United States as, of course, overseas. How do we figure out what our demand is going to be in the areas of health professions if we can't even agree on which profession should be delivering that care. Not to mention what is care going to look like in the future. A lot of disagreement as I understand it that recruitment alone is going to solve the problem. The U.S. is not going to solve its issue about healthcare workforce on the backs of other nations. A lot of agreement, as I understand it also, sources have told me that education is a lot of the reason for the bottleneck and so hence we'll be talking a good deal about that today and finally, near universal agreement that a major problem here is that the United States needs a policy on this. So that is a good segue way into what we're going to talk about now. The two panels that we have ahead today are indeed going to focus on solutions. We're going to minimize our ongoing discussion of the problems as we all see it and really attempt to focus on solutions and we've split this up into 2 separate phases—one

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oriented around private sector solutions, viewpoints, as we put it, from the expanded provider community from hospitals, from medical schools, medical colleges, colleges of nursing and indeed even from recruiters who are focused on bringing health professionals into the United States. Even though we'll be hearing from many of these folks that solutions must be undertaken outside their individual control that is to say at the federal level or the state level, we're going to try to also focus on what these institutions and enterprises may do themselves in the interim. Our second panel is going to focus very much on the federal state and international solution level and so we'll have a separate cast coming up to do that. We are going to try to keep this as interactive as possible. I have been told that there's a great desire to forge ahead to solutions. Many of you have many aspects of these problems figured out already anyway so we'll be hoping to involve you in the discussion as actively as we possibly can. So with that, let me introduce our distinguished first panel and let me just get everybody in order here. Immediately to my right is Polly Bednash who's Executive Director of the American Association of Colleges of Nursing. You'll see with Polly as with all the other participants, extensive bios in your notebook so I'll keep these introductions brief. Polly has many, many activities to her credit—not the least of which is working to secure federal support for nursing education and research and she also co-authored the association's landmark study of the financial

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costs of students in pursuing nursing degrees so we're delighted to have her with us as well. Next to her is Edward Salsberg who's Director for the Center of Workforce Studies at the Association of American Medical Colleges. The center's a national leader in the field of physician workforce studies and, of course, AAMC has recently called on the nation's medical schools to increase enrollment to accommodate the nation's future needs so we're delighted to have him as well. Catherine Crowley—give us the old Queen Elizabeth wave Catherine—is Vice President of the Maryland Hospital Association, leads the association's statewide workforce development activities. Her work includes developing strategies to interest young people in health careers and meeting the long-term staffing needs of Maryland hospitals and as we'll hear, the organization has been actively engaged in thinking about lobbying for more visas for health professionals coming into the United States as a piece of the solution for all this. Finally with us are both—is pardon me, is Patrick Page—I shouldn't say finally—semi-finally with us is Patrick Page, Chief Executive Officer and President of Saint John's Health Network, which offers full recruitment and immigration management of foreign born health professionals for U.S. employers. Overall, about 1,000 foreign born nurses working in the U.S. have had their entry managed by his company and he's especially focused on practices that promote transparency and accountability for recruits and for prospective employers. Now

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truly finally, we have with us on this panel William Plested, III, MD who is President Elect of the American Medical Association. He's a thoracic and cardiovascular surgeon in Santa Monica, California and will be speaking to us about what my friends at organized medicine constantly tell—disabuse me of thinking of organized medicine, right, Dr. Plested? Anyway, we're delighted to have him here on the panel as well. He may have to scoot out a bit early so we'll try to get to questions that address that perspective as quickly as we possibly can. So with that, let me toss out the first question to you, Polly Bednash. As you heard, a lot of the discussion today was on the bottleneck in education, the fact that more nurses apply for positions at nursing schools than we're currently able to accommodate and we know all kinds of reasons for that, not the least of them being the adequacy of the teaching ranks now and in the future at the nation's nursing schools. So, quickly—any additional [inaudible] pieces of that puzzle that you think are relevant but, more important, what can the nation's nursing schools do about this? I know we're going to get to federal policy sooner or later but to the degree we can keep it on what can be done proactively by nursing schools—we'd be grateful.

POLLY BEDNASH, Ph.D.: Well, first of all, I'd like to say that I think the issues have been covered quite adequately today regarding the issues of the access of the programs, the inability to accept qualified applicants because of the infrastructure, the lack of faculty, the lack of clinical

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placements. All those have been very well covered and I think to point to the schools of nursing and say what can schools of nursing do may be a limited perspective on what has to happen here to try and address the issue of bringing more people in. I personally believe from the work that we do that nursing schools are doing just about everything they possibly can do with the resources they have, with the infrastructure, with the faculty and I will say that our colleagues in the hospital associations and in the hospitals themselves have been working very hard with clinical partners to try and expand capacity. Annually, we report what's happening in enrollments and in graduations and for about 5 years now, we've reported increase in enrollments in the undergraduate, entry level and graduate level masters and doctorate programs and that's amazing to me that year after year, we continue to see the enrollment increases but the enrollment increases have begun to decline themselves. They're not increasing at the same pace because we're reaching maximum capacity to expand based on the partnerships that we have. I get very worried about the partnerships because the partnerships are that kind of soft money that can come and go depending on how much pain the hospitals are feeling. I do know situations—the Ohio State University, for instance, in the last shortage, they were promised lots of money by the Ohio State University Health System to expand their enrollment. By the time the students got to the junior year, the hospital was feeling other pain and

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said I'm sorry but we don't have the money. Students had been admitted, faculty needed to be hired and resources were not available. So that kind of tenuous stream of support, I think, is very, very difficult in terms of the increases and how it's liable to disappear. So what needs to happen in schools of nursing? One thing schools of nursing need to do and the profession needs to do is to move more quickly to move people along to graduate education and this is where other public kinds of policies have to come into play. We have a very perverse conversation going on right now that doesn't take into account what Linda Aiken has said and that is that education makes a difference about the quality of care and the kind of workforce you need and all that we're talking about right now is the end of nurses in the country instead of the kinds of nurses and what we're seeing is public policies that are mitigating the increase of baccalaureate programs and preferentially supporting the associate degree programs that Dr. Aiken was exactly correct about are no longer 3 years in length. These are the people who are least likely to become the faculty in the future. They're not the people who go on for additional education. They are not going to have the same kind of career path that's going to create a workforce. If you think nurses in general are old, you should see the faculty. They would scare you to death. The average age of a full professor is 55. They look more like me than the rest of the workforce so we need to be very concerned about bringing together these

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issues about having a stable source of funding for the schools of nursing so they don't have to worry about this tenuous stream of support that can come and go depending on the pain felt by the employers. We also need to have, in profession, more rapid movement towards graduate degrees and we need to focus on the population of people who are going to do that. They will give better care. They will be the people who will be the faculty of the future that are going to fix this situation more permanently and in the discipline, we have to stop telling new graduates that they need to go out and work before they continue their education. That then means that by the time they come back to get their doctoral degree, they're in their mid-40s, they have a truncated career pattern and they go to school on the 15-year plan because they are married, they have a kid or 2. They have a house, they have a car payment and a house payment and they need healthcare benefits and they get done with their doctoral degree in their early 50s and a truncated career so we need to get them right out of school. My good friend, Carol Anderson says you need to get them when they're a new baccalaureate graduate. They're poor but they're used to being poor and so they don't mind keep going to school. Some bright lining there. I'm going to skip over, just a moment, to Catherine Crowley because since a lot of your efforts have been focused on the nursing supply, I'd like you to speak right to some of the issues that Polly raised but more broadly, what can the hospital sector do to support these kinds of efforts she's

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been talking about?

CATHERINE CROWLEY: All right. To respond somewhat directly to some things Polly said, in Maryland, 50% of our graduates come from associate degree programs and we've recently had tremendous success in getting them to on to baccalaureate programs and we did that by bringing the baccalaureate program to them instead of having them travel 2 hours to the baccalaureate program. We have any number of hospitals now, I think it's 18 or 20 out of 50, that have baccalaureate courses being taught on the hospital campus at times when the nurses can participate in them. We have a transition program for associate degree nurses that allows them to use their 3-year associate program and with 1 more year of the baccalaureate work complete their 4-year degree. So we're very proud of that and I think it can serve as a model for the nation. I would not, for a minute, say that we need anything—I would never disagree with the idea that we need more baccalaureate nurses but the reality is that a large portion of this country is rural and for nurses to get to 4-year colleges or to have access to the nursing students is in some respects difficult. So I think one of the things that hospitals can do, which is what we've done is to support our nurses and make it something that is desirable from the employer's point of view and feasible from the employee's point of view to complete that degree and so that's...

SUSAN DENTZER: That degree—you're talking about the

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baccalaureate?

CATHERINE CROWLEY: The B.A.

SUSAN DENTZER: The B.A., all right.

CATHERINE CROWLEY: The second thing that has to...

SUSAN DENTZER: Excuse me, the B.S., right.

CATHERINE CROWLEY: Yes. The second thing that hospitals can do is to help with faculty support. We have a number of programs where the faculty—the hospitals are loaning masters-prepared clinical experts to the schools and those people are serving as classroom educators as well as clinical instructors and the hospital and the school are sharing the funding for that position. The nurse is being paid at a hospital rate of pay. One of the things that didn't come up today in the faculty shortage issue is the large discrepancy in pay—particularly between an acute care nurse and even a nurse at the doctoral—full professor level in a university system—the gradient can be \$20-30,000 difference a year with the hospital nurse making more and that certainly is discouraging for the professor. I understand that but the—so we're trying to help mix and match those things.

SUSAN DENTZER: What do you believe is the dedication within the hospital sector to pursue these kinds of policies?

CATHERINE CROWLEY: I think it's very high. I think that there's not much question that the gap between supply and demand is real that we're going to see a change in our demographics of nurses. Polly's point about the age of the

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professors, the nurses are almost as old and gray quickly, the staff nurses that is. We also have to look at the other side though. What work needs to be done and one place that I think that hospitals and schools or any employers and schools can work more closely together is to define the work. We've got all kinds of roles that we're preparing people for in the universities but we don't necessarily have a job for that particular role in acute care and so we need to work more closely on that. I would say--this might be heretic to hospital people so plug your ears, it might be a time to look very much more closely at differentiating practice. What's the difference in the work that a graduate nurse does with an associate degree and a baccalaureate degree? There's clearly a difference in some of the ways that those nurses work but there's not necessarily a difference in the jobs that they do and so we have to get better at that.

SUSAN DENTZER: All right. Again, to stay on nursing for a moment, I do want to skip over to you Patrick. You heard the sentiment earlier today that presumably the recruitment is not going to be the solution for the United States but I think probably everybody would acknowledge that recruitment will be with us for a long, long time given the magnitude of the problem so let's talk specifically about what you have been trying to do in terms of getting your industry to focus on transparency and accountability to improve the recruitment that is going on and at least do it in a way that is perhaps more

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ethical or whatever compared to recent practice.

PATRICK PAGE: Sure. Well, I think anybody who spends any amount of time in the foreign recruitment context knows very well that this will not be the solution for American healthcare. I don't think anybody is putting that position forward so the idea that anybody's advocating that is just plain wrong. What I noticed earlier today was a bit of disinformation about the volume of activity that is actually represented by foreign nurse recruitment and I would just ask for a show of hands—how many people think greater than 10,000 nurses come to the United States every year. How many think greater than 20,000 come to the United States every year? Okay. I'm searching for the number here. 30,000? Nobody wants to raise hands on any of these questions? Okay. So...

SUSAN DENTZER: It's an audience of people who don't want to be wrong.

PATRICK PAGE: Okay. My point is the presentations earlier today indicated that anywhere between 14 to 30,000 nurses come to the United States. It's just not accurate information. According to the Office of Immigration Statistics from the Department of Homeland Security, in 2004 through the permanent residence program, which is the primary vehicle by which nurses come to the United States, is 6,625. If you look at the statistics from CGF&S, their numbers are also in line with that in that every nurse who comes here who comes through an employment option other than say refugees—we have a

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tremendous number of Eastern Europeans in this country who came as family members' refugees from when the Wall fell and they're foreign educated healthcare professionals. They fit in to some of those numbers that we saw earlier today so some of those numbers, I don't think, are an accurate reflection of the reality. So the reality is foreign healthcare recruitment contributes somewhere between 7 to 10,000 nurses per year and the reason I give a number higher than the one I quoted a moment ago is to take consideration for the TN visas from Canada. Now, so obviously it can't solve the problem so then the question is what is the proper role for it. The profile of most of my clients, I've represented more than 37 clients in 25 states—the profile of most of my clients are that this is one component of a larger plan to deal with their nursing problem. A typical client has a high vacancy rate, very high vacancy rate so they're losing money because of diversions and any of you in hospital services—anyone here who's providing direct healthcare services know the cost of diversions. Second thing is they're dealing with high overtime costs as well as traveling nurse costs. So a lot of these organizations are too cash strapped because of their immediate situation to implement long-term solutions. What most of my clients have done is they've used the foreign nurse recruitment piece as a stepping stone towards a larger goal. So they bring in a group of nurses to alleviate the immediate crush that they're feeling from traveling nurse expenses, losses in revenue due to diversions

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and they take those resources and they invest them in the local nursing supply chain that Catherine was referring to. Several of my clients pay outright scholarships to nurses to go to local hospitals and their scholarship programs, over the years, grow to a point where they no longer need the foreign nurse component. With most of those clients, what they do then is they ratchet down their foreign nurse component to save 10% of the original amount that they used to do with an idea that we want to keep a lifeline alive. We want to have some level of presence, some level of activity so that if this crisis really blows up, they have an option in the future. I'm sorry if I'm thinking too [inaudible] about that. So what we're doing is we're taking a look at the reality of this market worldwide. We're looking at example of say the U.K. and South Africa, which is a very unhealthy relationship. Personally, I think that the U.K. is abusing its position in the world market. They take twice as many nurses from the world market as say the United States does...

SUSAN DENTZER: In actual numbers?

PATRICK PAGE: Yeah.

SUSAN DENTZER: Yeah?

PATRICK PAGE: Yeah. So we're looking at the backlash caused by that kind of behavior and, incidentally, I know very few recruitment groups that work in Africa exactly for the reasons that were expressed here today, which is at least I'll say American groups that work in Africa. In fact, that's

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supported—by saying that’s supported by - if you look at the information from ICHP, they identify the top 5 countries from which nurses come from, the fifth is South Korea with a total of 489 per year. The top one is the Philippines, which has—these are visa—these are just visa screened applications—so they are not issuances. Forgive me, I should have found you a better stat than that. I guess my point is you have a very, very shallow pyramid. A couple countries at the top provide 95% of the nurses. The rest of the countries of the world produce the last 5% in the international nurse context. What we’re doing though is we’re taking the lessons of say the U.K. and South Africa and we’re saying let’s make sure that in our activity; we don’t repeat those same mistakes. If the United States has a 20-year problem and there is an appropriate role for foreign nurse recruitment as I described it, we then need to provide to our clients a 20-year solution. A 20-year solution can only happen with a healthy relationship between the source country and our own.

SUSAN DENTZER: Which, at the risk of asking you a little bit longer, what do you mean by that? What’s a healthy relationship?

PATRICK PAGE: What I mean by that is for a long period of time, we had advocated with our clients to establish deeper relationships because some of their actions just as—I’m sorry—Polly had indicated, hospitals are somewhat soft with their money. They’re committed today but tomorrow they change their

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mind. Okay? A lot of the hospitals have sat on the fence the past several years so we decided unilaterally we won't ask their permission for it anymore, we will do it on our own. So for every nurse we bring into the United States, we commit about \$1,000 back to the local healthcare economy where we pay for things like cleft palate repairs, cataract surgery, and that sort of thing. We do that to start forging relationships between schools, hospitals—open dialogue about if this activity is going to happen anyway—and you know it will—then the question is how does the activity take place in an ethical manner. We've got a relationship with Central Escalar [misspelled?] University who you saw from Dr. Tan's information that the number of nursing schools in the Philippines has more than doubled. It went from 190 to 470. Now the quality of some of those nursing schools is very poor but even the solid schools say Central Escalar [misspelled?] has grown from less than 1,000 nursing students to greater than 3,000 nursing students in a 4-year period because of our presence, because of our activity, it's made the profession more attractive, more people are going into it. Their concern for sustaining the education system—the concern expressed to me by their dean was that in order for us to sustain this education system, we need to make sure these people get jobs and the capacity issues that were touched on by Dr. Tan in the Philippines cannot absorb that total number of nurses. If you shut down and I'm sure Dr.—Ms. Navarro could support what I'm saying here, if you shut

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down the foreign flow of the nurses from the Philippines to the Middle East, to the U.K., to Canada, to Australia, to New Zealand, to the United States, of which the United States is a big player—those nurses would not find employment in the Philippines. It's common in the Philippines for a nurse after graduation from college to serve 1 to 2 years without pay to get experience.

SUSAN DENTZER: Unfortunately, we should probably move on...

PATRICK PAGE: Yeah.

SUSAN DENTZER: ...Because Dr. Plested's time is pressed but thank you very much. That was a very thorough explanation. Let's move to the physicians' sector if we could now and Ed Salsberg—AAMC has called for this increase in enrollment in medical schools, extremely controversial. A lot of people think part of the problem the U.S. healthcare [inaudible] system is maybe too many doctors in the wrong places but let's talk about that. Why did AAMC reach this conclusion? What supports it? And more important, what are you going to do about it?

PATRICK PAGE: I think there is a growing consensus that we will need more physicians in the future and that it's appropriate policy to support the expansion of medical school enrollment. Last year, COGNI [misspelled?] issued its report calling for a 15% increase. AAMC issued its report also calling for the 15% increase in and the AMA issued a statement calling for an increase. So I think there is a growing consensus. I

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think you have to be worried about how we're going to meet our future needs—the recommendations that the AAMC made were really focused on the needs in 2015 to 2020. It's come out somewhat in the discussion today, it takes a very long time and it's very difficult to change the physician workforce, the physician supply as we begin to talk about medical school expansion, it takes several years before you actually can accept additional students or build a new school—4 years of medical school, 3 to 8 years of training so we're really trying to look at what are the needs going to be in 2015 and 2020 and I don't think there's any way to deny that the demand will be exceeding the supply. AAMC is now, in the next few months, considering further policy change, which would recommend an increase of 30% in U.S. medical school production. The cause of the recommendation last year and this year really focused on the growth of the population in the aging of the population of the changing practice patterns of physicians. There is also concern about the large number of international medical school graduates that we continue to bring in. In medicine, the numbers are smaller than in nursing but the 6,000 international graduates that are coming in each year represent about 25% of the new physician workforce. Many of us think that is high. That's not good global responsible policy and that we need to increase our medical education capacity so that we can reduce the pull of and the attraction of any opportunities in America for foreign trained physicians but I think it's really critical

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to point out how long and difficult it will be to increase the supply of physicians and even if we increase 15 to 30% over the next few years, we're only going to have a marginal impact on the number of physicians that are available to practice in 2015 to 2020. The recommendation for the 3,000, which is about 15%, increase if we phase that in over the next few years, we'll only have about 30,000 additional physicians in 2020 and that's about 2% more than we would otherwise have. So if we're concerned about the global health implications of our recruitment, we have to realize that even if we increase 30% over the next decade, we're not going to suddenly have a number of new physicians that would allow us to reduce international migration and as I sit here today and listen to these discussions, clearly a sense of urgency around the world in less developed countries - clearly a great need for additional health professionals and what we're doing, I think, begins to move in a direction that reduces our draw but clearly is not going to be the short-term solution to increasing the availability of physicians in less developed parts of the world. We also are considering a recommendation that the AAMC get more involved in-around the world and providing technical assistance wherever we can to medical groups, associations, and medical schools about the role of an association to get more involved through our members that are opening up programs or partnerships in around the world and we think that our medical schools and teaching hospitals can make a contribution in

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developing and improving medical education around the world but again, these are not short-term solutions to the problems of the lack of physicians in less developed parts of the world.

SUSAN DENTZER: Good and Dr. Plested, from the standpoint of AMA?

WILLIAM PLESTED, III, M.D. First, before I say something about the doctors, I do want to make a comment about the nurses. You introduce Polly as an expert on the cost of nursing education in the United States, I kind of wanted to add that to my list of qualifications [misspelled?] as I'm the father of a nursing student of Duke right now and I know that first hand.

SUSAN DENTZER: And where does she go?

WILLIAM PLESTED, III, M.D.: Duke.

SUSAN DENTZER: Oh, Duke.

WILLIAM PLESTED, III, M.D.: Well, if there is such a thing as an inexact science, it's guessing what kind of personnel we're going to need in medicine in the future and there have been studies for as far back as I can remember, all of which have been wrong but there is the imperative to look at facts and look at what's happening today and try to make a reasonable guess and a lot of things—the fact that a lot of physicians are retiring earlier, they're leaving practice, they're [inaudible] doing other types of jobs. We have decreased applicants. We have horrendous problems with the distribution of states because of medical liability problems,

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which are discouraging what our most highly trained doctors, which find that they are high risk specialists and we need to look at all of these incentives and disincentives as important things in going into medicine and I think what we're really talking about is not necessarily do we need a policy that's going to tell us exactly what we need but the real question, the elephant in the room is money. It's how do we finance this and should this be a government imperative? Is this like education in our country? Is a government imperative—should we recognize that education of a healthcare workforce is a government imperative? I do not know what the funding is for all these nursing schools in the Philippines but maybe there is a reason why these can schools turn out so many people that comes to do how it's funded—I'm not sure of that but that's the debate that we need to have in this country, Judy, is where we're going to finance all of this education.

SUSAN DENTZER: We're going to open this up to questions in a moment in the interest of getting to that dialogue but—and let me ask those of you who have questions again, to come to the mic and introduce yourself by name and affiliation but let me ask an important question here, or I think—I'll brag that I think it's possibly an important question. Polly said we're talking about the "n," the number. We're not talking about the quality or the level of the training and I want to ask Ed and Dr. Plested here, is there an analogous issue on the physician side? There is a school of thought that says a lot of care

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that's delivered by doctors in this country could be delivered by nurses or nurse practitioners and maybe what doctors ought to be focusing on as we continue to crack the code of the human genome is a much more scientific aspect of medicine than they've ever been practicing in the past and therefore, perhaps we're not just talking about training more MDs, we're talking about training more MD, Ph.D.s who will really advance the science not necessarily exclusively focusing on delivery of the care and just quickly, perhaps, Ed, Dr. Plested, you have some comments on that.

EDWARD SALSBERG: I think that you raise an excellent point and certainly the answer for meeting our increasing needs and demands is not just more physicians and I really think there's been a silent revolution over the past 20 years in America. People don't appreciate that we have more than 160,000 nurse practitioners and PAs working with physicians and we wouldn't be meeting the needs of Americans today if we weren't using other health professionals more so I think in the future, you're absolutely right, given the limited number of physicians, we want to make sure we're using them for what only physicians are qualified to do. On the quality issue, I feel you going a different direction though about U.S. graduates and international graduates and on that one, I think we're relatively comfortable with the systems that we've put in place to assure the quality of international graduates. We have had far more concerns with the offshore medical schools that have

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tended to be responding to a set of [misspelled]

entrepreneurial reasons and we have some concerns with quality there but with the other international graduates, it seems as though the U.S. is, in fact, recruiting among the best and the brightest of physicians from other countries.

WILLIAM PLESTED, III, M.D.: You're absolutely right.

That's happening today more and more. Nurses and PAs and others are performing the tasks of physicians, which brings up a problem in itself and I personally don't think the problem is quality. I think we can get excellent quality from well trained people. The problem is this exacerbates the need for nurses in our hospitals doing the things that we were told earlier lead to much better patient survival and patient outcomes when you have highly trained nurses when, again, I'm becoming an expert at this. My daughter's already being pushed to do these types of specialized things while her mom says I'm a nurse and I worked at the bedside and you've got to learn how to do that. So it is complex but I would get back to my earlier statement is I think that we must look at the funding of this educational system and make a decision—is this a national imperative that this be funded.

SUSAN DENTZER: Well, congratulations on confronting national health policy in your own family. It must be quite an experience. Questions from those of you or solutions perhaps that many of you want to put on the table as we continue our private sector solutions panel?

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BRIAN FOLEY: I'm Brian Foley. I'm from Northern Virginia Community College but I'm not here wearing my Northern Virginia Community College hat. I'm here wearing the Northern Virginia health force hat to give you an example of the regional alliance to address the healthcare workforce shortage. The alliance is a group of healthcare organizations, educational organizations, business organizations, and economic development authorities—bottom line, upfront is the healthcare workforce shortage needs to be addressed by alignment of healthcare education, economic development, and social agencies. The other thing is that the business community has to realize this is not a healthcare problem. This is their problem. It affects their quality of life and the bottom line in the quality of care. We used Price Waterhouse Coopers to do a study and we used Price Waterhouse Coopers to do the study because business community recognizes Price Waterhouse Coopers. I know there's somewhere from Price Waterhouse Coopers here so no extra charge for the commercial but we used them so when the business community saw the data, they say Price Waterhouse Coopers. Just in Northern Virginia, we found that by 2020, we will have—between nursing and allied health, 16,000 vacancies in nursing and allied health professions. Lots of people do studies. Then, after we did the study, we brought together 8-week work groups of over 100 people, stakeholders, from education, healthcare, the middle schools, the high schools and to address what should be done. We came up with 14 solutions—

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this is on the web site addressing capacity, pipeline, and innovation. In the capacity, what we did is we actually brought together, thanks to Jerry Hoffler [misspelled?] who's sitting back there, the program manager for the first time—all of the hospitals in Northern Virginia and all of the universities in northern Virginia—Community [misspelled?] College, George Mason University, the Old Dominion Marymount University, so forth—had the presidents of the universities and the hospitals sit down and talk about solutions, focal solutions [inaudible] having faculty, creating pipeline for bedside nurse to go to their masters to go into the faculty. How do we address the focal training sites? How do we use simulation to address the focal training site requirements?

SUSAN DENTZER: Suggesting a lot of latitude for involvement at the community level, as you said.

BRIAN FOLEY: This was not just the community college. This was George Mason University, this was the hospitals—the teaching point is you have to align the universities, the healthcare organizations social [misspelled], pipeline, how do we address the students? We found out that when we talked to—the parents need to be the targets. They're the ones that influence the students. We found out that the education guidance counselor in the high school—what they knew about healthcare is what they saw on Marcus Welby. They had no idea what the professions were. We found out too...

SUSAN DENTZER: We've got quite a line in back of you so

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let's...

BRIAN FOLEY: Okay. Sorry. So what we did then is we went on and we divided the upper mobility for the associate degree to the bachelor and master's degree and the innovation—we're looking at health information technology. So in summary, what you need to look at is aligning all your organizations—not try to approach it as a hospital and education but as a community problem. Thank you.

SUSAN DENTZER: And I venture to say you'll get no disagreement from this panel on that holistic perspective.

LINDA AIKEN, Ph.D.: Linda Aiken, University of Pennsylvania. I just wanted to make sure that Maryland's very innovative program came up and I'd be interested, Catherine in your response. We're talking about finding solutions and having policy and Maryland is an example of a state that set a policy and funded it and the policy is to try to solve the nursing shortage and they're using, as the vehicle, their hospital rate commission and by increasing the hospital reimbursement rates by a fraction of 1%, they're generating \$10 million dollars a year for 10 years—total of \$100 million dollars for the funding of a policy, which is to basically create the faculty capacity in Maryland nursing schools to allow them to expand providing the funding for all the initiatives that you suggested—the collaboration between hospitals and nursing schools to better exploit the graduate prepared nurses in hospitals, to fast track the education of faculty, and one that you didn't

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mentioned, which is to try to support innovative ways to fully use the community college to educate nurses but to ensure that they come out of that with a baccalaureate degree to be, as Polly said, a feeder, for the creation of faculty in the future and one of the reasons why I think the Maryland program is so important is that if it's successful, it's a way that it really points the way for a potential role for Medicare because about 15% then propping down of GME funding goes to nursing and other health professions and it doesn't really go for any purpose that is contributing to the nursing shortage. It's the largest amount of money that exists, potentially, for nursing education, something on the order of \$200 million dollars a year, so it could be fashioned in exactly the same way that the Maryland Rate Commission has fashioned its program. So I'd be interested, Catherine, in what you think of that from a hospital perspective.

CATHERINE CROWLEY: I'm delighted with it from a hospital perspective. It's a very elegant solution. For those of you who don't know, Maryland has the only rate setting state commission in the 50 states and that gives us a latitude that are very fortunate to have. By increasing hospital rates by 1/10 of 1%, the rate setting commission then has said hospitals, you will pass that rate through to another partner, the Maryland Higher Education Commission that will administer it for the types of programs that Linda mentioned and I would also like to acknowledge that Linda has been instrumental in

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setting that program up and we're delighted to have her as an advisor to it. The exciting thing about it is it's going to be available state-wide and it's going to be available for a faculty of many different types and so we can do those things setting up the pipeline...

SUSAN DENTZER: And just quickly, how do the payer community go along with that? The businesses that...

CATHERINE CROWLEY: Well, the payer community is very important and it goes to Bill's point. The payers and the businesses that pay for health insurance are really who's paying for it. The question that Polly raised is how serious are hospitals about this in the long run? Well hospitals' money is all soft. We're taking money from the community, from the payers, from the clients and patients that we have and that's all the money that we have. So to the extent that the community wants that care, we have the funding to pay for it. The other side of it is, though, this is a tremendous worry for me, we can educate all the faculty we want but if the universities do not elect to put money in the budget for positions for those faculty people and to pay them at a salary that's attractive, we're going to have all kinds of people prepared to teach who are not going to be ready, willing, to go into these jobs and that's a major concern.

SUSAN DENTZER: Okay. It is a major concern but one of the issues that's going to solve that is not the Dean of Nursing going to her president and saying I need to have more

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resources for my faculty. It's going to be the business community, the hospital community, other providers coming to the university and saying they've got to be held accountable for addressing these issues.

CATHERINE CROWLEY: The faculty's salaries are abominable. They're about 60% of what an individual can get on the open market working in your community and if the reality is people have to live.

SUSAN DENTZER: And they make choices.

CATHERINE CROWLEY: And we see that as an important part of our partnership—the hospitals and the hospital association advocating for those kinds of responses for sustainability so it's—everybody's involved.

SUSAN DENTZER: Great. Let's take the next question please.

MONICA LATHAM: Hi. My name is Monica Latham from the American Public Health Association representing over 50,000 public health professionals and I'd like to thank you for your provocative discussion thus far and also acknowledge that APHA has a policy on this particular issue but my question is—and this is to the entire panel as well as you Susan—what you feel the effective strategies would be to actually develop policy solutions, engage the media as well as non-traditional stakeholders.

SUSAN DENTZER: I'm sorry—engaging media, did you say? Okay. I'm going to punt on that one for the moment because I

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want to hear what these folks say and actually if I could hold your question over, I want to make it the concluding question for this panel. So if you don't mind, let's skip that for the moment. We're going to come right exactly back to that. Let's take the next question and then we'll come back.

WILLIAM SANDLER: Hi. William Sandler. I think some of the most fascinating things that we heard today relate to international trade and we see that there are distortions and externalities [misspelled?] that have been caused by trade and there have been winners and losers. One of the things that I think that we all must admit is that we're not going to stop trade. Trade will continue to grow and it will continue to grow in services and if and when the GATS, the General Agreement on Trade and Services gets negotiated in a future WTO round then I think we could see trade and services in a similar way that we see trade in merchandise today. So it's very possible that there are tariff classifications that refer to service workers and they're traded as if they're ones and zeros. SO I think that if we're going to be forward-looking, what we're going to need to do is to think about how we can leverage the international trading system to solve the supply problem and it seems—I don't want to say obvious—but if we look back in history, we can see that customs' duties, countervailing duties, dumping duties, and other things, other devices that were used as part of the trade laws helped balance distortions and helped move resources to and from where they were needed

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and in the context of nursing, if each and every country of the world had a population to nurse ratio, let's call it 1 nurse to every 100 people in the population, if a nurse were to go from 1 country then have a lower ratio to a country that has a higher ratio, you can simply apply a customs duty. The money would go into a fund and that would be used to train nurses in that country that has a lower ratio.

SUSAN DENTZER: This is a very terrific and interesting subject of discussion and it sounds like there's a Ph.D. thesis in here so at the risk of having you write it today, why don't you turn it into a question for the panelists and we'll...

WILLIAM SANDLER: Okay. Just in order for innovative, forward thinking ideas to be able to take grasp, I think we're going to need to approach scope of practice reform. Right now, scope of practice rules under each individual state within the United State and around the world are a mess. What physicians are allowed to do, what nurses are allowed to do, what they're not allowed to do and under what circumstance is confusing and is divorced from actual competency.

SUSAN DENTZER: Okay and that's great and let's carry that over because our next panel, as you know, is federal, state, et cetera, solutions and that's a perfect segue way to that panel because the scope of work laws really are, in fact, an issue that probably needs to be dealt with in that context. Okay, I promise that we will get back to that previous question, which are what are the most effective strategies and

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just to quickly take on the news media end of it. The way to engage the news media is to keep beating us over the head and pointing out that this is a major story that we need to cover. Frankly, it's just that simple and we do try but we you can't do enough, all of you, in terms of outreach to us to point to the specific cost of not grappling with these problems. So, that being said let me give this panel an opportunity to hit it out of the park. For 15 seconds or 30 seconds, I'm in television after all, if we could only do one thing immediately, in your context, each of you, that is solution-oriented and I recognize now we're going to start to get into state, federal, and local policy issues and that's okay now because we're at the end of this panel. What would it be? What needs to be done? What's the first most important priority and let me toss that out to you first Polly.

POLLY BEDNASH, Ph.D.: I'll go back to my earlier statement and that's change the conversation about the end of workforce. Start thinking about who we need in the workforce. We are working around the notion of making more and more people to maintain the current system. The current system isn't working. We have tremendous problems in them. The conversation that's occurred here to some extent is if nurses would just go back to do what they used to do, we wouldn't have a nursing shortage. That came from several people today. There are new ways of delivering care and new ways that well-educated people in medicine, other health professions and nursing can try to

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address this so that we can craft different kinds of solutions rather than just thinking that we need to pump out more and more and more of the same and that needs to be...

SUSAN DENTZER: I gather that [inaudible] you to endorse the notion of looking at scope of the work loss.

POLLY BEDNASH, Ph.D.: Looking at scope of work, looking at creating different kinds of people to do the work and thinking about organizing the work quite differently. The fact that nurses aren't at the bedside anymore isn't because they've left healthcare. It's because the skills they have meant that they were important in other places and they are meeting very important needs as Ed has suggested.

SUSAN DENTZER: Ed, your first step?

EDWARD SALSBERG: I think it's to be clear that we really have a very serious problem coming up over the next 20 years—sort of a perfect storm—a very aging population. The baby boom generation reaching 65—beginning—hitting 70 in 2016 just when our physician population ratio will be declining. If we don't get underway soon to expand the medical education system, we're going to have a serious shortage in the future and I feel we're going to turn, even more, to international sources of physicians as the short-term stop gap measure. People are going to say why didn't you realize it in 2005 that we were going to have a problem in 2015? So the message today is it's time to get moving and in ways, stop the debate about whether we're going to need more and start looking at how do we expand

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capacity.

SUSAN DENTZER: Catherine?

CATHERINE CROWLEY: I would take a look at the way we do things and I would follow on Polly's point. I would look first at the qualifications for our educators in our schools of nursing and I would say that we have a vast number of highly qualified masters-prepared nurses working today who do not have masters in nursing and therefore, cannot teach. I would look at some kind of a post-graduate certificate course for nurses in that situation who are available and willing to teach on short order and to get them going and to increase capacity that way quickly and then I would continue to do the work that we're talking about for masters and doctoral programs.

SUSAN DENTZER: Patrick?

PATRICK PAGE: The first thing that needs to be improved in the segment of this question that I deal with is better information available to the employers, the decision makers who are involved in the process. Second more establish long-term relationship between American direct healthcare providers and foreign direct healthcare providers where the fate of the American healthcare provider is staked to and tied to the success of the foreign healthcare provider. That's what we're seeking to do.

SUSAN DENTZER: Okay and Bill Plested.

WILLIAM PLESTED, III, M.D.: I think we need to establish a national imperative that the healthcare of our

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population is of equal importance to something like putting a man on the moon and we need to just do it and it's interesting to note that today, I'm sure that you all read that in Michigan the number one economic engine in the state of Michigan with GM and Ford and others is healthcare and in the new millennium, the opportunities for growth and economic stability in healthcare outweigh any other predictable type of etcetera of our economy so it isn't just to make people feel better that we need to look at healthcare and I think it takes a national imperative to do this.

SUSAN DENTZER: Okay. You heard it here, national imperative. I think, again, no disagreement but perhaps something that cannot be said often enough. Let me thank this panel. We're going to adjourn very, very briefly. Please don't leave the room because we're going to move directly into our next panel to carry on the discussion about federal, state, and other solutions, international solutions. Thank you very much...

Come up and join me please. All right, if you would take your seats, I'm going to introduce the next panel. Again, our effort now is to look at the perspectives of those involved in thinking about solutions at the federal, state, and international level, again, carrying forward some of our discussion from the previous panel, no doubt but focusing on the perspectives at hand. Let me introduce, immediately to my right, Lynden Melmed, who's council to the Senate Subcommittee on Immigration Border Security and Citizenship. He's on detail

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from the Department of Homeland Security where he handles a wide range of immigration issues in the Office of the General Council.

Next to him is Kathleen White who is Associate Professor at the Johns Hopkins University School of Nursing. She has many credentials to her credit as you see in the book and as you will see for all of these folks. She's authored a number of articles on the nursing shortage and is actively involved in nursing and health policy issues. She's going to tell us today about what the state is doing, the state of Maryland is doing and the limits of states' strategies, again, carrying forward from some of the discussion that we had on the earlier panel.

Next to her is Marko Vujicic who's a labor economist specializing in issues related to healthcare for the World Bank. Among his special areas of interest are provider responses to incentives, migration of health professionals, labor market dynamics in the health sector and fiscal implications of human resources for health strategies.

Next to him is Peter Scherer who is head of the health division of the Organization for Economic Co-operation and Development in Paris. He previously was counselor to the Director of Employment and Social Affairs Directorate at the OECD and has published extensively in labor economics, industrial relations, comparative social expenditures, and social policy trends.

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And finally, also with us is Estelle Quain, who's the Senior Development Advisor in the Office of HIV/AIDS at the USAID where she's responsible for overseeing USAID's development activities for the HIV/AIDS programs under the President's emergency plan for AIDS relief, known as PEPFAR. So thanks to all of you. Again, focusing on solutions as this group very much wanted to do, let me start by asking you—from each of your individual perspectives, again drawing from our conversation on the previous panel but moving it forward. Lynden, as we think about this, as we think about these immigration issues, as we think about them obviously now in the context of national security as well, what is the current thinking that you can discern from the Congress, from the federal government about how to approach this going forward and how do we mesh what will be at least some ongoing recruitment needs as we heard from the previous panel with these other considerations that we now have on our plate?

LYNDEN MELMED: I think you stated very delicately what is really a difficult situation on the Hill right now and the immigration debate, I work on the judiciary committee and I handle many divisive from Supreme Court nominations to the recent surveillance issues and immigration is about as tough as it gets on the Hill right now and there is a very strong focus on the security concerns, on the border concerns, and where there is not consensus is the role that immigration reform and the number of visas that are available in all categories—from

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unskilled workers to healthcare workers to high-skilled workers and students, there's not a consensus within the Senate or within the House on the extent to which the existing visa structure and visa availability needs to be changed to help address the border security concerns. So it's very difficult to look into any sort of crystal ball. The Senate was able to pass a bill in the fall that would have increased the number of green cards as well as the number of temporary visas and that would have had a [inaudible] effect on healthcare workers but the House rejected it and the House did an enforcement only bill and now the ball is back in the Senate's court and we'll probably be taking it up in the next few months.

SUSAN DENTZER: Would your guess be, in the long run I recognize it is only a guess—I was once told you should never trust anybody who tells you what Congress is going to do because that person will surely lie to you about other things as well. So with that as the backdrop, recognizing that is only a guess, would you guess that there will be more stalemate in the near-term on this issue such that we're not going to necessarily see any increases in visa numbers anytime soon and perhaps as we heard from the earlier panel, that's not going to be that big a deal because there are not that many coming in now as it is at least in the healthcare sector.

LYNDEN MELMED: I have learned that much not to make any predictions about Senate activity or House activity. I do think an immigration bill will go through. I think we're at the point

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where Congress, the worst thing that they can do is nothing and then the optimist, in terms of dealing with some of the reform aspects, the optimist in me looks back and sees that in the real ID provision and rack [misspelled?] supplemental where you had enforcement provisions that the House was able to accept increased visas for scheduling nurses in that setting and so if an enforcement bill does go through, it tends to change the discussion a little bit between the chambers.

SUSAN DENTZER: Do you think that the needs where at least the perceived need to expand the healthcare workforce by immigration is a loud voice that is being heard in this debate? Is it a driver of the debate or is it just one of many?

LYNDEN MELMED: I can safely say it's one of many and certainly not the loudest voice at all. When you look at the debate over comprehensive immigration reform, it is certainly being driven primarily by unskilled workers, which of course, have the fewest number of visas and the highest demand right now and then I would group together healthcare workers, agricultural workers, and for no better term—high-skilled workers as other groups who are lumped into the broader debate but also somewhat weary of being included in that debate because you have the issues of amnesty and enforcement and if a broad comprehensive bill doesn't go through, then I think everyone's lining up to try and move something on a different vehicle.

SUSAN DENTZER: Okay. Thank you. Kathleen, let's talk

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about state initiatives. We heard a lot about the Maryland initiative earlier. Perhaps you will have some things to add about that. We also heard that Maryland's is a rather unique situation because of this rate setting mechanism that it gives you a very handy dandy vehicle to tack these increases on to and so regulation and rate setting has gone out of style in 49 other states, it perhaps, is not the vehicle of choice for those states but give us a sense—what do you think might be replicable out of the Maryland experience for other states.

KATHLEEN WHITE, Ph.D., R.N.: Well, Maryland definitely is a state that has a lot of mandates and regulations—always has and I don't know—we have our first republican governor since Spiro Agnew but I'm not sure things are really changing there but I think though one that Catherine didn't talk about that is something that can be replicated is a legislative mandate that the state of Maryland had back in 2000 to establish a commission on the crisis in nursing and this—it was something that was brought up in the legislature that year. We also have a very unique situation in Maryland where the Maryland Nurses Association and our Maryland Board of Nursing actually have a very good relationship and not, unfortunately, not all states have that particular kind of good thing in place and when we have a nursing issue in Maryland, the more MNA and the Maryland Board of Nursing can work together. It seems like the better we do. So this commission legislation was passed and within a month and ½, a summit was held, had over 600 nurses

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together. They identified 4 taskforce areas—education, recruitment, retention, and workforce—or workplace, excuse me, and subcommittees went to work. This legislation was funded for 5 years. The director of our department of health and mental hygiene, Dr. Georges Benjamin [misspelled?] came to the taskforce meetings, the subcommittee meetings. He was very visible in the process and a lot of really good things have happened. Now they've been [misspelled?] including what you—I think, the Health Services Cost Review Commission supporting the efforts, as you've heard in the past but several documents have been written and the schools of nursing have really risen to meet some of the challenges. In 1998, I believe, 6 or 7 schools of nursing in Maryland were at capacity out of the 24. Now, all 24 are at capacity. We turned away over 2,000 qualified applicants this particular year in the fall and when I say qualified, I'm talking about people that have 3.0s up to 3.5 GPAs coming out of either a previous college experience or a high school experience so these are tremendously qualified people and we're—at Hopkins, since I went there to work, we had 90 students in our undergraduate—I'm sorry, 90 in our accelerated program, 70 in our undergraduate program—both of those programs are 160 students each so we have almost doubled the number of undergraduate baccalaureate prepared students that we're producing and we are at capacity. We're getting ready to build a new building in the next 3 years and we don't have the faculty facing the same issues. Salaries have risen a

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little bit in Maryland schools of nursing and we've got a lot of those partnership relationships that you heard about in the past but there's still a lot of work to be done. The commission's sun setted in the summer and the Maryland Board of Nursing has taken on the work itself because it believes in what has been happening in Maryland, is now funding it. It has a new name, it's called the Maryland Nursing Workforce Commission but the work continues. The one thing that no one really has talked about that after the legislation was passed in 2000 was the identification of technology as an important adjunct to the work of nursing and, in fact, a fifth subcommittee began to meet to look at technology and its relationship to help the nurse in direct patient care and in other ways and so the new commission has technology as one of its main subcommittees and that work continues. They're looking at ways to decrease documentation needs for nurses, ways that technology can increase efficiency and productivity and so I think as a model, and many other states have developed commissions or centers that are looking at workforce but a lot of them are data collecting commissions. You've got to really have that implementation or those groups that are meeting and talking and trying to come up with ideas and solutions that you can test out. They're not all going to work but at least they're talking and the groups are communicating.

SUSAN DENTZER: Are there other states that come to mind that have moved beyond the data collection phase?

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KATHLEEN WHITE, Ph.D., R.N.: Oh, yes. I think New Jersey has some really good work going on. I think Michigan has some good work going on. North Carolina is one that has been pointed to many times so there are other states that are doing things. We heard an example in Virginia; I'm not sure how involved the nursing community is in that formally, I'm sure they are.

SUSAN DENTZER: Great. All right, we're going to hear next from Marko and Peter from the international perspective, both of you, and Marko—I want to start by just asking follow up from one of the earlier panels when the health minister from Zambia mentioned that for better or for worse, some of the IMF World Bank policies, in fact, militate against the training and payment of healthcare workforces in some of the poorer countries because they are public sector workers and we're not going to hold you responsible here today for 40 years of constantly wrongheaded IMF policy here ...

MARKO VUJICIC: That's okay.

SUSAN DENTZER: But you're the only one we have here to beat up today. So here you are but nonetheless, is there thought among the international financial institutions about these kind of perverse consequences of those kinds of things and, more broadly, from the international perspective, we had one solution that was advanced earlier essentially viewing this as trade and services and thinking of a way to address all of these things via duties. Is any kind of thinking about a

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formulistic approach like that going on at the institution or financial-international financial institution level and feeling [misspelled?] that, what is going on in terms of thinking through these issues at the World Bank?

MARKO VUJICIC: Okay. Thank you. I'll come to the Zambia and the weight ceilings issue in a second but just something that we tend to keep in mind in a development institution like the World Bank is that this migration issue really needs to be viewed in a broader labor market context. So we've talked a lot about the global labor market, the pulls from the developed countries but even domestically, I think a lot of people overlook the fact that there's simply not enough financing in a lot of these countries to support an expanded workforce, even though we know we need an expanded workforce to deliver services. Now these are the economic realities of the countries we work in. A couple of statistics, I mean in Malawi [misspelled?], there are clearly—I don't know the statistics or the level of the health workforce but clearly there are shortages compared to what the government envisions, yet, there are 1,200 nurses that are unemployed. In South Africa, there's 30,000 nurses that are unemployed. So there are people there and a lot of times, they simply, you know, we talk about shortages but really, I would ask also the colleagues that spoke earlier in the Philippines—are there positions that are funded—that are funded long-term and not being filled? That's a very different question than do we need more health workers. So

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basically that kind of lends to the issue that this is really, to us, a financing issue and it's about strengthening the healthcare systems by getting more money into the system and spending that money more efficiently and one the first one, getting more money into the system, absolutely—in terms of the domestic side, you need to have strong economic growth. You need institutions for taxation. In terms of national health insurance, these are all avenues where we can generate more resources and then in terms of the international community's role—definitely, this is an issue that keeps coming up in terms of—there are articles, the bank is killing people because they won't let countries hire more health workers and the IMF is doing the same thing. These are definitely issues that we're being forced to deal with and at the higher levels up to President Wolfam [misspelled?]. It's hard to address this issue at a very high level forum from the Minister of Health from Kenya.

SUSAN DENTZER: And what is the upshot?

MARKO VUJICIC: The upshot is that basically we're recognizing that—a—there's a lot of misinformation about who affects policies, so who sets policy in their countries—at the ministries of finances [misspelled?] at the World Bank. The issue in Zambia, I think what's important to note is that in the preceding 10-year period, the expenditure on the civil service relative to GDP went from something like 3% up to 10%. So there was a large increase in the government's spending on

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civil service salaries and that clearly was an indicator that hey, this is not sustainable. Now I don't know if it's a right or wrong issue to bring it down to 8% or 9% but clearly I don't know the situation well enough to know but there is some sort of dialogue going on now and just in terms of the—we recently asked the IMF—or the IMF also needed to respond to this—to do a review of the actual programs in their countries and they looked at 30 countries and of those 30 countries where IMF programs are active, there's 14 that have some sort of agreement on the level of growth on the public sector wage bill and actually in only one, there's what they call an adjustor, which under certain circumstances, will make the program be much more flexible. Now this also was very important information and now is starting to look at what kind of things need to be written into these agreements. So if you do get sustainable financing—like for example, in Malawi [misspelled?], the British Aid Agency guaranteed money for 6 years to go towards health workers' salaries and in this case, the IMF was like okay, if this is long-term, it's sustainable—clearly, there's no problem but the issue is can you take money from the Global Fund, money from Gates that's promised for 2 years and hire someone onto the civil service where they're guaranteed a job, in a lot of cases, for their entire lifetime. So there are a lot of issues here and specifically on this issue, we're looking at what's country experiences with short-term hiring, with contracting—are there ways to get money into

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the system that's much more flexible and let's get the donors around the table to agree. Stop with one country promising 2 years, the World Bank having a 5-year loan, somebody else having a 3-year loan. If you're serious about the issue, get all the donors together, promise money for 20 years and not for 2 years and make this consistent with the countries' economic programs. So, in short, this is the dialogue we're having internally but I'm happy to take questions.

SUSAN DENTZER: Okay. Thank you. Peter, from your perspective over the OECD and particularly, it would be useful if you would bring Europe in particular into this discussion because we heard on the earlier panel, in effect, a statement made to the degree that the U.S. is not particularly the biggest actor in here in terms of importation, if you will, of healthcare workers—that the U.K. is far and away a bigger force in this arena than the United States. How does this play out from the OECD perspective and what is viewed as—really what is viewed as the problem and what is viewed as the solution?

PETER SCHERER: Well, I was reflecting on what was being discussed just earlier. I remembered my daughter, she was born in the United States but is an Australian citizen and she was in the middle of the application process for medical school entry and then was offered a place at Sydney University so she left, depleting the pool of potential medical practitioners in the United States. In other words, this is really a global marker and you have to understand, from that point of view, in

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Europe you have significant [inaudible], for example, from Germany to Switzerland to Norway to Austria. France is consistently recruiting and frankly often not well creating medical practitioners from Algeria. They've tried to recruit nurses but they have the same linguistic problems that were mentioned earlier. Spanish wasn't as close to French as they thought. Spain and Germany are increasingly exporting medical practitioners to the United Kingdom. So the idea that there is something illegitimate about international movement of health professionals is frankly is silly as the idea is there's something illegitimate about the movement of goods across borders. Having said that, it is clear as people have been discussing that there are features of the health sector labor market, which mean that the usual assumptions that you make in trade discussions—that the market will certainly always give you the right signals are clearly wrong. Look at what is being said today about the obvious restrictions in entry into both the medical school and nursing schools in the United States. In principle, in a free market, the situation—places should be found; capitals should be raised because there are opportunities. The places should open up and the market will eventually equilibrate but it won't if you have these sorts of restrictions so any discussion of the way this topic should be addressed needs to start with a proper understanding of where these restrictions and inefficiencies in the market lay and policy needs to be based on an adjustment for those. One of the

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ideas that is often put forward and was discussed in the previous panel is that well, perhaps you can compensate for these problems by having codes of practice to guide recruitment. Well, the United Kingdom does have a memorandum of understanding with South Africa and I'd actually [misspelled?] [inaudible] with the Philippines so I may be wrong. Certainly, it is over the last 4 years, which reduced its rate of recruitment of nurses from those 4 countries, but it's compensated this by increasing net recruitment from India so that the actual number of nurses it's been recruiting from outside the European area has remained at the same level. There has been an attempt in the commonwealth to agree on a code of practice but the only developed countries that's actually signed up to this is New Zealand because the issue of whether countries from which health professionals are recruited should be compensated for the training costs, has led to stalemate. You can address that issue of cost by requiring people who've received training to repay the cost of their training if they take jobs elsewhere but there are actually very few countries, which finance their tertiary education system in this way. The United Kingdom is starting to. Australia does but actually you can avoid the Australian restrictions if you leave the country. So the question then really becomes really—and it's quite interesting, Australia for example, has just had a—carried out a very comprehensive review of its own national workforce strategy and they decided that actually it is no longer really

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sensible to say that one of the features of their strategy, which has been in principle—their policy for some years to be self-sufficient and rather they feel that for the reasons that we've been discussing here that they have to move towards a—to not be unsustainably reliant on health workers trained in other countries and clearly the sorts of pathological situations, which we will describe, for example, in the Philippines where you have a massive training but nonetheless inability to fund the domestic needs. That's an unsustainable situation so there clearly needs to be much better dialogue between countries where—in which this sort of training and services is taking place and to be fair, this is taking place at an increasing rate. We're doing work now jointly with the WHO on the issue—countries in the Asian Pacific region are getting together to discuss the problem but it does need to be looked at from the point of view as being a natural part of the way this type of workforce will develop and not some anomaly.

SUSAN DENTZER: Great. Thank you and Estelle, let's turn to you and ask you from your perspective looking at the workforce development going on in the context of PEPFAR. We heard a bit earlier about the efforts to develop the workforce at the local level. Expand on that. How does that fit into this equation that we've been talking about?

ESTELLE QUAIN: Well, I think that USAID—I think first everyone here should realize that USAID is a partner under PEPFAR as is other U.S. government agencies including the

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Centers for Disease Control. USAID's interventions deal largely with technical assistance interventions to help build the workforce and I particularly liked what Linda Aiken was saying this morning about improving the productivity and retention of healthcare workers. I think that this is a key area that we need to look at instead of trying to maybe looking at broader economic context, I think it's really important to see what we can do in certain areas being number one, human resource management—I think that that's a topic that was talked about somewhat today but possibly not enough. Better human resource management can do a tremendous amount to help retain healthcare providers because we're looking at the people that do the personnel policies, that do issues related to recruitment and career development paths, all of this falls under the area of human resource management, which is sometimes not as strong as it really should be in many of the countries in which we work. I think another area that we need to pay more attention to is the needs of healthcare providers. What are their needs regarding their own safety on the job and their own well being on the job particularly when we look in the context of HIV/AIDS. As Lincoln Chen was saying this morning, healthcare workers are under a tremendous amount of pressure because of the AIDS epidemic and we need to look at what their needs are so that maybe they won't be so inclined to leave their jobs and then finally I think also what Lincoln mentioned about the knowledge base being very weak in this area is something that

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we can do a lot more about looking at which retention schemes work, what is it that will keep healthcare providers on the job? What are the issues in workplace climate and workplace environment that we could be paying more attention to that would help to retain healthcare providers and make them more productive so I think that besides looking at some of the broader issues, if we focus in more uniquely on the healthcare worker, him or herself, I think we're liable to come up with some answers to some of the tough questions.

SUSAN DENTZER: Other than serving in the technical advisory role to countries and [inaudible] systems on that, what is the role for government in that equation?

ESTELLE QUAIN: The role for U.S. government or the role...

SUSAN DENTZER: U.S. government or governments generally because it sounds like—most of where the rubber hits the road is going to be in the systems themselves to put in place those human resource management issues and by systems, I mean not just the national health systems but obviously the healthcare systems themselves. What would government do?

ESTELLE QUAIN: I think the U.S. government plays a large role in bringing donors together and play a role in working with other donors. To help local governments come to terms with some of these issues and providing some of the tools that can help them to address, for example, developing a national human resource strategy that can be implemented.

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SUSAN DENTZER: And has that, in fact, happened in some of the countries that you've been working in?

ESTELLE QUAIN: I think it's happening in some places. I think that Simon talked about some of the efforts that are being made in Zambia where the U.S. government is a large player along with other donors. I think we have a long way to go in this area but I think that as we realize that more and more donors need to coordinate efforts and national governments also need to take a large part of the responsibility. There's a huge amount of work that needs to be done, I think as was mentioned today in advocacy and policy development for human resources for health.

SUSAN DENTZER: Great. All right, once again, we are going to open this up to questions and discussion among all of you so let me remind you again to use the mic and identify yourself by name and affiliation. Let's go ahead.

VICTORIA NAVARRO: Yes, this is Vicki Navarro. I was the alternate for Dr. Galveston [misspelled?] and I would like to thank Miss. Quain for actually alluding to what he also said in his talk about the human resource—health human resource development and we are always going to see things very differently. The countries who recruit nurses versus the countries who provide the nurses and I think Dr. Galveston [misspelled?]-and with all due respect to Mr. Patrick Page—he's looking for it in a very, very global way and just as a comment, his statistics are quite credible.

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SUSAN DENTZER: Are quite?

VICTORIA NAVARRO: Credible.

SUSAN DENTZER: Credible?

VICTORIA NAVARRO: Yes, and he's not here today so I feel like I'm responsible for at least talking about his presentation and there was some allusion to the fact that there may be some question about the information or the statistics that were presented today so in fairness to him and to give credit to him, I would like to say to this forum that his statistics are quite credible. As an FYI, one small community hospital in one state already recruited 300 nurses from the Philippines and also a comment on if the nurses were not recruited overseas that they will be unemployed—that is a whole big problem that if you have the supply—there is a demand, there is going to be a response of providing that demand so it's a whole issue related to economics, to policies, and it's not just one simple thing that you look at at the domestic level. It's a whole country's—in a way of how to survive and how to develop a country.

SUSAN DENTZER: Marko, do you want to make a comment on that?

MARKO VUJICIC: I agree with that.

SUSAN DENTZER: Okay. Easy enough.

STEVE SHANNON: Steve Shannon, American Association of Colleges of Osteopathic Medicine—an observation based upon what I've been hearing and reading about recently about workforce is

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that—and I think it's pretty obvious—is that we don't really have a system by which we can do planning that's going to really take into effect what's happening 15-20 years from now in this country and the way we're letting play it out is one that's going to increase disparity of access in this country as well as internationally. So my question actually, I guess, is targeted to Mr. Melmed and Dr. White would be, where is the possibility of policy coordination in the United States on this issue?

SUSAN DENTZER: And let me build on that, many in this room are familiar with the work of Uva Reinhart [misspelled?] on this issue, who has basically systematically shown that our ability to accurately forecast future healthcare workforce demands is nil that I think, as Dr. Plested said earlier, we get it wrong every time we try to guess what future workforce needs are going to be. So let me ask the economists on the as well, if that is, in fact, the case and a fairly good summary of the state of the art and prognostication in this vein, what do we do about that given our struggles to address current needs? How do we begin to think through it all how we put in place meaningful policies that whatever the future looks like, at least won't make the future worst? Nobody wants to take that. Peter, why don't you start and then let's come back and answer the question more directly.

PETER SCHERER: I think that this is, in general, most countries have abandoned the idea of manpower planning in

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general. Unfortunately, in this area, you're condemned to plan. You do it implicitly even if you're not doing it explicitly because the way, in fact, in all countries including this one medical education is funded and governed. There are implicit decisions made about at least how many people will go into the pipeline and by [inaudible], how many will come out a few years later. That's why one of—there's no doubt—one of the ways in which adjustments can take place is through exchanges between countries. Hopefully, areas will be compensating. Some people will overestimate and some will underestimate but there is, because of the cost involved, in having said that, because of the costs involved in training medical practitioners, although this also applies to nurses, there's a natural tendency to under train. There's a natural tendency to say well, we'll rely on the rest of the world to deal with any problems, which arise and, of course, if everyone does that, it doesn't add up. That's why there does need to be more of a dialogue than there has been between countries about the way they're going about this and while we do need to, I think, look more carefully at what it is about this market, which makes the signals unreliable and what we can do to correct those.

SUSAN DENTZER: Go ahead Kathleen, please.

KATHLEEN WHITE, Ph.D., R.N.: Well, I was really hoping that on this panel Carrie Nessler [misspelled?] would be here from the Health Resources Services Administration of Peer [misspelled?] and Professions because we can just, in the

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states—as I mentioned, a lot of the commissions and centers that have developed on workforce are data collecting and it's funny, I have a midpoint evaluation from ours and they wrote it out—projections - 2003 shortage and then they had optimistic—1990, pessimistic—3622 and they have those projections for 2003, 2008, and 2012 so we can do all the projecting and data collection in the states but unless there is some kind of an overall comprehensive coordinated national look at that and the Bureau of Health Professions just released the executive summary for the 2004 National Sample Survey for Registered Nurses and somewhat, the picture's a little better but I think in some respects, it's not as good as we might have hoped with all the efforts that have been going on across the country to deal with the nursing shortage in the last 5 years and so I would have looked to her actually for some real pearls of how maybe the division of nursing could be doing a little better job at projecting that and providing for national scholarships because we're limited in what we can do, I think, on the state levels.

SUSAN DENTZER: And maybe speak the fact that there doesn't appear to be as much of a federal policy response in that arena as there might have been. Marko?

MARKO VUJICIC: I just want to add I don't necessarily think countries like the U.S. are doing a bad job. I mean this is an incredibly difficult thing to forecast. You have public sector involvement on the provision side, on the training side.

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I mean the lags in terms of training physicians and doctors are huge so I think you need to segment it into short-term solutions, which are using migrants, try to mobilize people that are outside the sector but trained, medium-term things and long-term things like training but I don't necessarily—I think we're doing the best we could and, thankfully, there's an international market that is there to fill the gaps. Now what I...

SUSAN DENTZER: Just quickly, Lynden, would Congress say yeah, there's a global market, let's take off the constraints and let it flow given what you just talked about?

LYNDEN MELMED: Well I think, in some respects, it does work that way that the pressure builds up to a certain point and when you look at the immigration laws and the quotas, the last time the immigrant numbers were adjusted was back in 1990 and then since that time what you see is individual needs being adjusted as the pressure in specific industries builds up and so I do think there's an international market and what we see as well in immigration scene is when those quotas do not meet reality then people are able to go to other countries and so that's always what we hear on the Hill is that it is part of the global economy and it's just a matter of no one can agree because there is difficulty predicting what it will be 10-20 years from now and we can really only look a year or 2 ahead.

SUSAN DENTZER: All right. Let's take one last question please.

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DAVE WILLIAMS: My name is Dave Williams. I'm the Director of Continuing Education and Workforce for Northern Virginia Community College. My comment is really that—and a recommendation that next year you include someone with information technology background to be members of your panel. We use, for our retention and for our productivity for our staff—we train about 65,000 people a year, we use television, it's a concept and we use computers, video streaming, distance learning, and I think part of the movement of people might be slowed down if you moved the electrons, if you have a library or a school where you train several hundreds or thousands of people and then the quality of life improves with their continuing education and I agree with the World Bank comment. It's a long-term 20-year thing or a 10-year thing or a 5-year thing but it needs to be, as we are in our community colleges, it's a long-term thing and we are community-centered and I think that's part of your challenge. Over time, it becomes their solution, their problem and distance learning can help. One of the things that we can do in the United States is export those electrons whether it's from Harvard or Stanford or somewhere in between, that might be a contribution to the immigration problem.

SUSAN DENTZER: Comments from anyone? All right, I'm going to take the moderator's prerogative of asking the final question, not that it's a summary question but it did occur to me earlier to ask Peter this. We heard on the earlier panel,

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the AAMC, the AMA, and others thinking not just that we need to increase the physician workforce in the U.S. by 15%, but we need to increase education slots by 30%. Now we know we're not the oldest country in terms of share of population of the elderly. We know that Europe got there long before we did and Japan is going to get much higher long before us. We obviously are spending much more on healthcare as a percent of GDP than any other nation but are there other countries out there that think they have the same issue with physician slots or are we alone in this? Do other countries say we need to increase the number of physicians as well?

PETER SCHERER: Oh definitely. I mean the French have done exactly what—even more stringently. They severely cut, 10-20 years ago, the number of people going through medical school and now they've just woken up that they have a very rapidly aging physician workforce. They have more doctors per capita than the United States but they've become used to that and they're really worried now. They have expanded places but the arithmetic is there, no matter how quickly they expand now, they're going to have a real workforce crisis over the course of the next 10 years and the same is true of a number of other countries throughout the OECD area.

SUSAN DENTZER: And they're approaching it from that perspective as opposed to talking about redefining the work, looking at scope of practice, putting more of this care in the hands of advanced practice nurses or the equivalent in other

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countries.

PETER SCHERER: I'd like to say that they're out in front doing that—doing what you said. I'm afraid that many of these countries—it's actually quite difficult for them to adjust their systems because—for the same reasons that you're familiar with here—that you have reimbursement systems, which are based on professional boundaries. You have professional restrictions. We just reviewed the healthcare system in Finland, which is one of the most, in terms of overall costs, one of the best run systems anywhere I think but nonetheless, you still find that nurse practitioners who have a very significant role in the health centers still can't prescribe basic medicines unlike a number of other countries. So, from country to country, you observe these failures to take full advantage of the talents of people throughout the health workforce.

SUSAN DENTZER: Well, nice to know that we're not alone in that. All right, we have heard some very interesting perspectives, obviously, for the last 2 hours and just to take a quick moment to summarize them. We heard a lot of discussion, obviously, on the need to focus not just on the numbers in these professions but on the level of training, on the level of education and that is very closely tied with the notion of having a much more probing discussion on issues around scope of work, redefining the way care is delivered, furthering our understanding of who else can provide the care that we

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anticipate needing to provide in the future. We heard a lot of discussion on the importance of making sure we have an adequate education of workforce as well to educate healthcare providers in the future particularly on the nursing side. We heard the need for or we heard some examples of a very important model in the case of the state of Maryland and some indication that other states are moving forward also whether it's to start first at the level of declaring a crisis and forming a commission or hopefully moving on to actually implementation phase, that that is going on, no doubt needs to go on in more states.

Turning to the second panel, we heard the statement made that this is a global market but it's obviously a global market with a lot of restrictions inherent in both within countries and between countries. We heard about the inherent difficulty of planning for the future, in fact, indeed the impossibility of planning for the future but the inherent imperative to plan for the future because there's no alternative. We have to decide at any given point in time how many nursing school slots there are going to be, how many medical school slots there are going to be, and obviously that has multiple implications or ramifications down the line. We heard also a very important statement though I thought that Peter made, which is that there is this inherent incentive to under train that seems to be international so that that is a very critical piece of this that we need to overcome and

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finally, I think we heard that despite the inability of there to be national planning that fully takes into account a perfect knowledge about the future, it has to go on. It has to go on at the national level and it has to go on as a coordinated effort among countries. As we continue to address it year by year in terms of visa allotments and so on and so forth, that's simply not going to be sufficient but there is going to have to be more coordinated national and international response to this. So with that, let me thank our panel for this terrific discussion and turn it back over to Polly to close out today's session. Thank you very much.

POLLY BEDNASH, Ph.D.: Wow, she has done an amazing job summarizing an incredibly fragmented and complex issue. I really have no words to express the enormous admiration for her ability both in terms of the content and the ability to juggle all of these dimensions and pull something together at the end like this so many thanks Susan for your role. Despite the advice of elders, I know that I have pushed you to the point of exhaustion in this meeting but in truth, I really would not have sacrificed a single presentation, a single question. I think it was a fantastic meeting and I thank all of the speakers and all of the participants for your participation. I also wanted to very quickly thank the staff that worked on this meeting, in particular, Emily Bass who has been running around like a chicken with her head cut off for the last 3 weeks to make this happen and we couldn't have done it without you

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Emily, thank you. A brief commercial, Health Services Research, which is a peer review journal that the academy provides to its is doing a special issue on the topic of nurse migration that will be coming out about this time next year with 14 articles that Linda Aiken and myself and Jim Buckin [misspelled?] have been pulling together with case studies from across the world so I wanted you all to know about that and keep your eyes peeled, it's coming soon. And with that, I would like to adjourn this meeting and look forward to seeing you next year. Thank you.

[END RECORDING]