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Research Paper

Nursing Shortage in Developing Countries: Understanding the Context and Emerging Strategies in Post-COVID 19 Pandemic Situation

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ABSTRACT

The contribution of the healthcare workers in the society was highlighted on several occasion in public and with emphasis especially since the onset of COVID-19 pandemic. Simultaneously, questions have been raised in terms of the inability of the countries to live up to the standard doctor and nurse ratios as per population. The significant nursing shortage in developed countries while have been met with migrant professionals from developing countries, the condition of the latter became more serious. Although the decision of international migration by health professionals play an important role in this, fallacy in the structural arrangement of healthcare services is an inescapable issue. The current article, therefore, endeavours to discuss the complexity of the said situation and investigate the pledges and steps taken in post-pandemic context to remedy the shortage of healthcare workers, especially nurses.

Keywords: *International Migration, Healthcare Worker Migration, Healthcare Worker Shortage, Pandemic*

The stigma from association with patient's bodily impurities as well as the low payment in private hospitals, do not inhibit the aspirations of individuals pursuing nursing in India (Gill, 2011). Instead, the global shortage and thus, demand for nurses creates scope for relatively higher income from employment in developed countries (Gill, 2011; Percot & Rajan, 2007). This act as determinant to the still growing popularity of nursing courses across India. However, nursing as an occupation is rarely acknowledged with as much dignity as given to other medical professionals, with the gendered construction of care and undervaluation of it (Wichterich, 2023). The sheer ignorance towards the contributions, sacrifices and basic demands made by nurses during the COVID-19 pandemic, therefore, epitomize the lived experiences of nurses.

Situated in this context, the current article, endeavours to delve into the context and motivations of nursing migration, as well as the pre- and post-pandemic handling of nursing workforce and workload patterns, in health systems of developing countries, especially in

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India. The paper firstly discusses the unequal distribution of the human resources for health (HRH) across countries in relation to globalized labor market. Secondly it illustrates the relation between nursing shortage and the gendered care economy. Finally, the article investigates the experiences of nurses in relation to the healthcare configuration during the COVID-19 pandemic.

GATS and International Migration of Healthcare Workers

As World Trade Organization (WTO) emerged as a regulatory body of international trade, it envisioned free movement of goods and services across the national borders of consenting countries. Additionally, the General Agreement on Trade in Services (GATS) being incorporated within the purview of WTO mandates, seamless migration of human resources as consumers and providers of services, was enabled for the WTO member countries (Woodward, 2005). An inevitable outcome of this was for the concerned nation-states, to agree to the migration of skilled personnel and especially of the human resources for health (HRH).

The post-war stream of migrant workers, thereby, was rejuvenated in the 1990s. Women along with men were now actively seeking employment in developed countries as the global economy was moving towards deskilling. Consequently, popular direction of migration became South to North (S-N) and North-North (N-N) (Kapur, 2010). Individuals looking for higher relative income and families willing to risk a member in search of a better earning source were thus utilizing transnational social networks to migrate abroad (Massey, et al., 1993). Technically this strategy for migration was both individually and structurally profitable in other cases especially for remittance-receiving home countries (Kapur, 2010). However, the loss of healthcare professionals in this process, was detrimental to the healthcare system of the major HRH exporters, the developing countries (Gill, 2011; Woodward, 2005).

In case of nursing especially, the World Health Organization (WHO) recommends for 3 nurses per 1000 population, but this requirement is met differently by different countries amidst the global nursing shortage. The first world countries generally meet this criterion by importing migrant nurses trained as per international standards and proficient in foreign language. While this saves the temporal and monetary investments in training of nurses, the solution only meets short-term goals. However, the case is different for developing countries. Some countries lack the overall set-up of advanced medical training and research (Shoman, Karafillakis, & Rawaf, 2017). On the other hand, countries like the Philippines and India, facilitate highly standardized nursing training[4] with English medium instruction to fellow students, who, later migrate and contribute to the foreign health systems (Thompson & Walton-Roberts, 2019). Therefore, GATS which facilitates, rather mandates the free movement of humans can also be identified as one of the contributing factors, resulting in a unidirectional movement of nurses from developing to developed countries and thus, contributing to the nursing shortage in developing countries.

[4]In an increasingly privatized industry of nursing education, the individuals enrolled in expensive private nursing courses get trapped in debt and look for better-paying jobs, which further the need for migration as well as shortage of nurses in the home countries (Walton-Roberts & Rajan, 2013; Wichterich, 2023).

Gendered Care Economy and Nursing Shortage in Developing Countries

With this being established that nursing education and training as available in certain developing countries are of international standards and these courses are popular among young individuals, a question emerges organically- why is nursing job in these countries so popular among migrants and not domestic nurses. The reasoning behind this, however, needs to be traced in gendered care economy.

Both the domestic and global shortage of nursing at the level of developed and developing countries, emanate from one persisting problem and that is patriarchal conceptualization of care. The stereotypical presumption of nursing as unskilled care work natural to women, has justified its gross undervaluation at the level of culture as well as global political economy (Wichterich, 2023). Therefore, the low remuneration for nurses and private care workers as per the domestic job market, leads to disenchantment of individuals from developed countries towards the job (given the time and amount they are supposed to invest in training and gaining experiences for the job). This void is filled by the migrant nurses from developing countries who again gives up on job in own national economy for relatively higher financial incentives in developed countries. And to compensate for the explicit shortage of nursing stuff in the latter countries, adjustments are made at the institutional level to create more private nursing schools, more seats while compromising the quality of training (Thompson & Walton-Roberts, 2019).

Henceforth, the current global nursing workforce despite the persisting shortage has been functioning with makeshift temporary solutions. The surrogate workforce of migrant nurses may be cheaper alternative for the needs of the developed countries. Also lowering institutional standard requirements to produce more nursing graduates as a reserve army of labour may be a consolation reward for the developing countries. But the shortage of nurses remains a constant issue to the point, where post-pandemic, immigration restrictions are proposed to be revoked to guarantee uninterrupted flow of new care professionals in countries like UK and US. Similarly, the average retirement age of nurse in Asian and African countries are proposed to be raised to have more experienced nurses at workstations (Zhu, Liu, & Zeng, 2023).

Crisis Response Mechanism and the Efficiency of Healthcare System: An Evaluation of Supply and Workload of the Nursing Workforce in pre- and post-Pandemic Context

According to the State of the World's Nursing 2020 Report, global nursing stock of 28 million as of 2018. There is a global shortage of 5.9 million nurses and this shortage is concentrated in low and lower-middle income countries. On top of this, 1 out of 6 nurses are expected to retire in next 10 years and so along with need for new nurses to cover the already existing shortage, more nurses are required to replace the ageing nursing population, as per 2018 data.

On the other hand, in this global nursing shortage scenario, some countries are leaning to maintaining their healthcare system with migrant nurses. As per SOWN 2020 report, globally 1 in 8 nurses (13%) was born or trained in a country different from the one in which they currently provide service. However, in high income countries reportedly 15.2% of the nurses were documented to have been born or trained in other countries. Furthermore, around 80% of world's nurses work in three regions (Americas, Europe and the Western Pacific), which account for 51% of the world population.

The contribution of migrant healthcare professionals has in fact been recognised in OECD reports too, which identify 16% of nurses in the OECD countries to be foreign-born[5] (Scarpetta, Dumont, & Socha-Dietrich, 2020). As per this report which draws from data in pre-pandemic period (around 2015-18 period), around 35% of nurses in Australia are foreign born while the number remains at 24% for Canada, 21.9% for UK and 16.4% for US. New Zealand too reports of 26.2% nurses of being foreign trained.

Therefore, as per pre-pandemic records, two statements can be made with conviction. Firstly, there is a global shortage in nursing which is more concentrated in countries with low-income status. Secondly, the 2030 SDGs to become self-independent in terms of obtaining target number of doctor and nurse ratio, is reached by higher income countries[6] more effortlessly given that they keep actively engaging in bilateral agreements and sponsored training programs for nurses abroad along with producing more nursing graduates and creating better working atmosphere in own countries, for example the case of Germany (SOWN report, 2020). This available workforce from foreign countries were rejuvenated especially in pandemic context as HRH with job offer from abroad were exempted from travel ban. Even in UK, medical professionals got their visas extended up to 1 year so that they could provide necessary service in the host country uninterruptedly (Scarpetta, Dumont, & Socha-Dietrich, 2020). The nurses in training were included in apprenticeship programs under experienced nurses amidst ongoing pandemic and stuff-shortage in Idaho while in California, nursing students were engaged as supplement stuff (Chan, et al., 2021).

Contradictorily, despite their migrant status, as part of their occupational responsibilities nurses remain crucial characters as 'first responders' as per the SOWN report (2020 September). However, the nurses confronting epidemic challenges in real time may not always be the ones with specific training for epidemic management and also may not be equipped with all the protection gears at the onset level of such cases. Simultaneously, with 9 out of 10 nurses being female globally, the intersection of race and gender, expose female migrant nurses to harsher work conditions, following the same report. Thereby, not only nurses remain overworked and stressed due to their short-stuffing and gendered workplace situation but also are in high risk of getting perished themselves, as was recorded throughout the COVID-19 pandemic (especially due to lack of PPE kits and increased contact with infected patients).

In the American context, as reported by *The Guardian*, in March 2020-2021 period, approximately 3600 health workers died while placed in frontline, of whom 32% were nurses. In fact, based on the information they had, around 11.5% of the deceased health-workers were from Philippines while 1.32% were from Nigeria and 1.01% from India (The Guardian, 2021). Similarly, around 21.46% and 16.82% of the affected HRH were of Black and Asian/Pacific Islander origin, although non-Hispanic Americans consist 60% of the total US population.

[5]Of this Philippines and India respectively are the first and second biggest suppliers of foreign-born and foreign-trained nurses.

[6]As per the WHO Global Code of Practice on the International Recruitment of Health Personnel, both the shortage condition and negative effects of nursing migration have been acknowledged. It has also provided suggestions to form agreements on mutual benefits between source and receiving countries in terms of nurse migration, to handle situation. But ultimately this option to come into consensus remains voluntary which obviously puts high-income countries in upper hand situation. The exporter countries thus, must choose between remittance or health worker maintenance in own country.

There have already been reports of nurses experiencing depressive symptoms and crushing stress and leaving jobs in US (Chan, et al., 2021). Parallelly SOWN reports have confirmed even in pre-pandemic times of migrant nurses having more physical and mental burdens for their intersectional experiences of discrimination at work. Therefore, in global shortage and nurse exporting condition in developed countries, not only were the nurses worst hit by the pandemic but also a large share of the deceased and affected nurses is likely to be of migrant foreign origin.

However, unlike the acknowledgements made on role of migrant doctors and nurses in pandemic response and post-pandemic tackling of health of host country people, there have been less steps taken at a policy level. Medical professionals after pandemic, are being one of the highly sought after migrants for developed countries.

CONCLUSION

Women from developed countries opt out of nursing due while the global nursing scene is instead almost monopolized by Filipina, Indian, Nepalese, Ghanaian and Asian and African nurses. The answer to this contradictory situation is not global nursing shortage itself and rather the macro structural arrangements leading to the shortage, which is the mandated free market and gendered care economy. Thus, decisions made at the policy level to arbitrarily address the 'problem' of nursing migration and shortage, does not officially acknowledge the hardships and income inequalities met by nurses transnationally.

This article, therefore, attempts to prepare the ground to ask more empirical questions around the lived experiences of nurses in service. How the nurses worked and negotiated at work during pandemic and whether they see any changed at the hospital management level or at the level of nursing unions- are to be explored further in upcoming works.

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Conflict of Interest

The author(s) declared no conflict of interest.

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