NURSES: VITAL SIGNS

FACT SHEET
2003–4

More Nurses Needed

- Registered nursing was among the fastest growing occupations in the 1990s. Employed RNs increased by 26.9% from 1992–2002, when 2,273,000 RNs were working.[1]
- The need for RNs is predicted to continue to grow rapidly, rising by 25.6% from 2000–2010, compared to 15.2% for all occupations. More than one million openings for RNs are projected by 2010 due to growth and replacements.[2]
- There were 376,000 licensed practical or vocational nurses working in 2002 and their job prospects are expected to increase by 20.3% from 2000–2010.[3,4]

Demographic Changes

- The vast majority of nurses are women, although the percentage of men in the field increased slightly from 1992–2002: male RNs increased from 5.7%–7.1%, and the percentage of male LPN/LVNs fell slightly from 5.2%–5.1%.[5]
- Most nurses are white, although the percentage of minorities among nurses is increasing. From 1992–2002:
  - Blacks' share of RN positions increased from 8.5%–10.3%. The proportion of black LPN/LVNs also increased from 17.2%–21.1%. Blacks made up 11.3% of the total labor force in 2002.[6]
  - The percentage of Hispanic RNs increased only slightly from 2.9%–3.2% from 1992–2002. Hispanics' share of LPN/LVN positions increased from 3.1%–4.7%, while they made up 11.1% of the labor force in 2002.[7]
- The nurse population is aging since fewer people are entering the profession. The average age of RNs increased from 36 in 1980 to 45 in 2000. Over two-thirds of RNs are 40 or older. In 1992, 24% of RNs were between 25 and 34; by 2000, less than 16% of RNs were in that age group.[8]

A Nursing Crisis

The U.S. is experiencing a severe nursing crisis that will intensify as baby boomers age and the need for health care grows.

- The Health Resources and Services Administration estimated nurse shortages in 30 states in 2000 and projects the problem to expand to 44 states and the District of Columbia by 2020.[9] Another study predicts a shortfall of 400,000 RNs by 2020.[10]

Factors involved in the shortage include declining nursing school enrollments, an aging nurse population, and widespread burnout among nurses due to understaffing.

- Declining Nursing School Enrollment: Enrollments in entry-level RN baccalaureate programs began declining in 1995 and continued until 2001, when new enrollments increased slightly over the previous year. While the number of students entering 4-year programs jumped nearly 9% in 2002, it was still 9% lower than in 1995. Enrollment of RNs with associate's degrees or nursing diplomas in baccalaureate programs also continued to decline.[11] The decline in entrants to the profession contributes to the increase in average nurse age.

- Understaffing: There are not enough nurses to do what needs to be done on any given shift and the nurses who are on duty are exhausted and stressed. Calling the nursing shortage "a prescription for danger", a 2002 report by the Joint Commission on Accreditation of Healthcare Organizations found that the lack of nurses contributed to nearly a quarter of the unanticipated problems that result in death or injury to hospital patients.[12]

- High Patient:Nurse Ratios: With managed care restructuring the health care industry in the 1990s, hospitals reduced staffing levels to lower costs. Nurses care for more patients and patients who are more acutely ill due to shorter hospital stays. One study of hospital staffing found that decreases in the number of LPN/LVNs added to RNs' patient load.[13] Studies have linked high patient-to-nurse ratios to medical errors and to poorer patient outcomes, as well as to nurses leaving patient care. A 2002 study by Linda Aiken, et al., found that for each additional patient over four in an RN's workload, the risk of death increases by 7% for hospital patients. Patients in hospitals with eight patients per nurse have a 31% higher risk of dying than those in hospitals with four patients per nurse.[14]

- Nurse Burnout: The Aiken study also found higher emotional exhaustion and greater job dissatisfaction in nurses were strongly associated with higher nurse to patient ratios: each additional patient per nurse corresponds to a 23% increased risk of burnout, as well as a 15% increase in the risk of job dissatisfaction. Forty-three percent of nurses reporting job burnout and dissatisfaction intend to leave their current position within the next 12 months; only 11% of nurses satisfied with their positions intend to leave within 12 months.[15]

- A study by Peter Hart & Associates found 50% of currently employed RNs had considered leaving patient care within the past two years for reasons other than retirement, and 21% of them said they expect to quit within five years.[16] Nurses who are considering leaving patient care and those who have quit consistently cite better staffing levels and more time with patients as key to persuading them to stay or return to patient care.[17]

- Some nurses have left hospitals to work in less stressful environments. The proportion of RNs who work in hospitals fell from 66.5% in 1992 to 59% in 2000.[18]

- It is likely that health care employers will increasingly recruit more nurses from overseas which would allow them to avoid making fundamental changes to improve the quality of care, retain nurses and make nursing an attractive career. Extensive use of temporary visa programs frequently depresses wages and guest workers themselves are particularly open to exploitation. Overseas recruitment also drains health care personnel from countries with more limited resources and health care personnel, and jeopardizes the well-being of their citizens.

Mandatory Overtime and Floating

Because of the nursing shortage, many hospitals routinely require nurses to work unplanned or mandatory overtime and to "float" to departments outside their expertise.

- On average, RNs work 8.5 weeks of overtime per year according to a recent union survey.[19] RNs working in nursing homes worked 4.1 hours longer than scheduled in 2000, over an hour more than in 1996.[20]
- Mandatory overtime was an issue in several recent strikes and 77% of RNs favor a law banning it except when an emergency is declared.[21]

Health and Safety

Nurses are at high risk of injury or illness due to occupational hazards.

- Registered nursing is one of ten jobs with the highest levels of occupational injury or illness requiring days away from work, with 24,700 cases reported in 2001.[22]
- In 2001, the non-fatal occupational injury and illness rate was 7.2 cases per 100 health care workers, compared to 4.6 per capita cases among workers in the service sector and 5.7 per capita cases in the private sector generally.[23]

In a 2001 survey, the American Nurses Association (ANA) found that 40% of their members had been injured in the previous year, including needle sticks, but many had not reported the injuries.[24]

Wages

Nursing has historically been an undervalued and underpaid profession, considering the high level of education, skills and responsibility required of nurses.

- RNs' wages have stagnated during the past ten years, particularly after 1994 when managed care restructured the health care industry and many nurses were laid off. In spite of the difficulty in retaining experienced nurses, employers have yet to raise nurses' salaries dramatically, as they did in the late 1980s in response to the last nurse shortage.[25] Some employers have offered bonuses as incentives to attract new nurses to their hospitals, but this policy does not benefit experienced nurses or help to retain them.
- RNs' average weekly wages fell by 6.2% from 1992 to 1997, while wages for the total labor market declined by only 1.2% during that period.[26]
- RNs' salaries regained some ground in the last five years, increasing 10.2% from 1997 to 2002, slightly ahead of those for the total labor force. RN wages also rose 4.2% from 2001 to 2002, from $849 in real wages to $877.[27]
- These gains only minimally offset the previous losses, as RNs' wages rose by only 3.3% from 1992 to 2002, while wages for the total labor force rose 6.8%.[28]
- LPN/LVNs' average weekly wages fell by less than 1% from 1992 to 1997. LPN/LVNs gained an 8% wage increase from 1997–2002, with a net result of 7.5% growth for the decade. However, LPN/LVN wages actually fell by 1% from 2001 to 2002, from $576 in real wages to $570.[29]

Benefits

Pension and medical benefits make up a large proportion of total payroll costs for most employers.

- Healthcare employers spend less on benefits than other non-manufacturing employers. Healthcare employers contributed only 1.5% of payroll costs to employees' pensions in 2000, compared to 6.8% spent by all non-manufacturing employers. For medical and medically-related benefits, the health care industry provided 5.1% of payroll, while all non-manufacturing employers spent 9.4%.[30]
- Because the nursing profession is overwhelmingly female, health care employers have justified lower benefits contributions by arguing that women tend to move in and out of the workforce and rely on their husbands' pensions and insurance. However, fewer women can count on a husband's benefits, both because fewer women are married and because more employers are reducing or eliminating coverage for workers and their families.[31]
- Investor-owned hospitals consistently spend nearly 10% less on wages and benefits than nonprofit hospitals.[32]

Unionization

Health care workers have been organizing in greater numbers since the mid 1990s. NLRB elections in the health care industry increased by 77.66% between 1995 and 1999 and unions won in 59.7% of those elections.[33]

In spite of these organizing wins, union membership and the percentage of nurses covered by bargaining contracts did not change significantly between 1990 and 2002.[34]

- Among RNs, union membership decreased slightly from 16.6%–15.6%. Union density fell from 12.0% to 10.9% among LPN/LVNs.[35]
- The percentage of RNs represented by a union declined slightly from 20.8% in 1990 to 17.4% in 2002. For LPN/LVNs, union representation dropped from 13.7% to 12.4%, up from 8.7% in 2001.[36]
- Nurses covered by a union contract in 2002 earned about 11% more per week than non-covered nurses. Union RNs earned $924 per week on average, compared to $823 for nonunion RNs. LPN/LVNs belonging to unions made $625 per week compared to $556 for nonunion LPN/LVNs.[37]

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The Department for Professional Employees, AFL-CIO (DPE) comprises 25 AFL-CIO unions representing four million people working in professional, technical and administrative support occupations. DPE-affiliated unions represent: teachers, college professors, librarians and school administrators; nurses, doctors and other health care professionals; engineers, scientists and IT workers; journalists and writers, broadcast technicians and communications specialists; performing and visual artists; professional athletes; psychologists, social workers and many others. DPE was chartered by the AFL-CIO in 1977 in recognition of the rapidly-growing professional and technical occupations.

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