International Migration of Nurses: Introduction

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The migration of highly skilled workers from less-developed nations to industrialized nations is an inevitable part of the process of globalization and has positive and negative aspects. Those potentially advantaged often include the individuals who move and the source, or home, country that receives capital in the form of remittances from those who have moved. At the same time, major disadvantages are incurred if departures impair a country's ability to deliver vital services in local communities.

While nurse migration affects different countries in different ways, there is a troubling pattern of growing disparity in which poor nations with the fewest nurses are losing them to wealthy countries with the most nurses. As numerous reports have noted, developing nations often publicly fund nurse education, making the loss of nurses to wealthy countries in effect a massive public subsidy from the poorest to the richest areas of the world.¹

This special issue includes a set of case studies for countries that represent a spectrum of different situations in relation to nursing shortages and migration. The case studies were commissioned by AcademyHealth (AH) and originally presented at a conference in Bellagio, Italy.^{2,3,4} These include the United States, the United Kingdom, Canada, China, Philippines, and India. Each country case study describes the nurse educational system, presents data on the current stock of nurses and the inflow and outflow from the profession, and reviews trends in migration. The final section of the papers describes the policy debates taking place within each country. In addition, AH commissioned two reviews for regions in which several country case studies had already been carried out: the Caribbean and sub-Saharan Africa.

Two additional papers are included in this special issue. Mirielle Kigma presents an overview of what is known about nurse migration at a global level.

Patricia Riley and colleagues report on an innovative program in Kenya to strengthen the country's capacity to monitor nurse production, deployment, and attrition, in order to assess the impact of migration.

Despite severe data deficiencies in most source countries, what emerged from this exercise was a continuum of situations that debunk the simple duality of source and destination countries. There is a spectrum of types of nurse shortages and policy reactions to the phenomenon of nurse shortages and migration. Several key variables define the diversity of situations, including nurse vacancy and unemployment rates, causes of the shortages, the level of education of the nurses who leave the country, nursing education capacity and, of course, the political will to retain and produce more nurses, and the policy reactions to migration itself. In reviewing these case studies, we see at least five different scenarios.

Sub-Saharan Africa represents the most dire scenario. There, health systems are historically poorly developed and now, due in part to nurse shortages, some are in a state of crisis. Dovlo reports in this issue that there is a double burden experienced by these countries: already weak health systems tend to exacerbate the rate of migration leading to a surge in vacancy rates (Dovlo 2007). In Zambia, the nurse to population ratio is 0.22 to 1,000, a figure that is more than 40 times less than that of the United States (WHO 2006). Destination countries for African nurses are not limited to the wealthiest nations; there is considerable migration within the region, in particular to South Africa, as nurses seek better lives. But across this region, governments are indignant when recruiters from wealthier nations capitalize on the crisis. They argue that there is an urgent need and obligation for wealthy governments to reorient foreign aid to help improve work conditions and retain health professionals in source countries.

The English-speaking Caribbean nations comprise a second scenario. Most of these countries have fairly well-developed U.K.-style national health systems and historically have reported nurse to population ratios relatively higher than many other developing nations. The region's ties to the United States, Canada, and the United Kingdom, however, have made these

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countries natural destinations for Caribbean nurses seeking further education and for recruiters seeking English-speaking nurses. Current nurse to population ratios range from 1.65 in Jamaica to 4.7 in Bahamas per 1,000 population (WHO 2006). Salmon et al. (2007) report in this issue that vacancy rates for budgeted nurse positions have reached almost 59 percent in Jamaica and 53 percent in Trinidad. The governments of Caribbean countries have responded to the nurse brain drain with innovative strategies to increase the status of nursing in the region, and to manage migration through agreements with recruiters.

A third scenario is comprised of low and middle income nations that have embraced global markets with fervor and tend to view human capital as a legitimate export. Such is the case of China, India, and the Philippines, each reviewed in this issue. These countries have weak health systems with low levels of funded nursing positions. Their nurse to population ratios have historically been extremely low, with all three just over one nurse per 1,000 population (WHO 2006). Demand for nurse education as a "ticket" out of the country, and the prospect of recruiting businesses profiting from emigration, has led to a surge in the number of private nursing schools, many of which are viewed locally as less academically rigorous than the major public universities. International recruiters find these "nurse exporting" nations of special interest because of the official support for migration and because they are perceived to be more ethical sources for recruitment of nurses than countries opposed to the migration of their nurses.

Sustainability of the "nurse for export" scenario is being tested in the Philippines, a small country with a limited labor pool. Lorenzo and colleagues report in this issue that health leaders are concerned about distortions in their country's health human resources that have resulted from the massive nurse exodus, including the migration of physicians retrained as nurses. The government is establishing a Health and Human Resources Commission and a number of recommendations have been made to encourage retention of nurses and reinvestment by foreign recruiters in nurse education in the Philippines (Lorenzo et al. 2007). India and China with their very large labor resources may be the dominant countries in the future to export nurses.

Among our case studies, the United Kingdom and Canada represent a fourth scenario. They are developed nations that have histories of relying on nurses from abroad to solve cyclical shortages and they lose nurses who emigrate to the United States and other developed countries. Both countries are experiencing increased demand for nurses and an aging nurse workforce.

Cycles of nurse shortage can be linked to policy decisions influencing the number of budgeted nurse positions as well as fluctuations in investments in nursing education. As Buchan notes in this volume, the United Kingdom experienced a surge in demand for nurses over the past decade in order to expand the National Health System. The demand was met by extensive international nurse recruitment and expansion in domestic nursing education capacity. By some assessments, these interventions seem to have alleviated the shortage and there is considerably less reliance on increased recruitment of foreign trained nurses.

We provide evidence in this volume that the United States is a stand alone case, in that it loses very few nurses to other countries and it has the economic capacity to draw substantially on global nurse resources. As Aiken writes in this issue, the United States is unique in the size of its current nurse workforce and in the size of its projected nurse shortage. The number of new jobs expected to be created for nurses in the United States over the next decade is one of the highest for any occupation. A shortage is forecast of between 400,000 and 800,000 by the year 2020 (HRSA 2002; Auerbach, Buerhaus, and Staiger 2007). The size of the U.S. health care industry, the severity of the nurse shortage, comparatively high nurse salaries, and an active recruiting industry all combine to create a very strong pull on global nurse resources. Moreover, in contrast to many other destination countries, the U.S. government has a weak role in health workforce planning, and little is being done to increase investment in expanding nursing school capacity. As a result, thousands of qualified individuals are being turned away from nursing schools each year.

Visa restrictions and extensive licensure requirements for nurses have served to limit nurse immigration to the United States in the past. However considerable pressure from institutional employers of large numbers of nurses and commercial nurse recruitment stakeholders is likely to result in an increase in nurse migration in the future. Aiken argues that the United States has a large enough domestic labor pool, sufficient interest in nursing, and the economic resources to expand its nursing education capacity to become largely self-sufficient in its nursing human resources in health for the future. Greater domestic self-sufficiency in nurse production by the United States, Aiken argues, is essential for attaining a more equitable distribution of global nurse resources.

Viewed as a set, the papers in this issue reveal major challenges in monitoring international migration of nurses. With the notable exception of the Philippines, much of the data on flows of nurses from source countries has

to be derived from destination countries. The lack of data in many developing nations, the problems of consistencies of definitions of nurses, and of comparability of data sources are apparent. These difficulties point to a need for greater collaboration among nations as they track nurses.

The global shortage of nurses described in the case studies suggests a need for an internationally coordinated policy response. Source countries have a vested interest in identifying and implementing innovations to help retain nurses in their countries, and certainly there are vast untapped opportunities for international donors to assist in that process. Developed nations, however, also bear responsibility for attenuating the pull factors. Given the massive income inequalities between wealthy and the poor nations that drive the desire to migrate, policies to increase domestic production and retention of nurses in wealthy countries are no longer just a national imperative; they are also an international responsibility. Similarly, private sector international recruitment of nurses is an activity with important effects on the migration of nurses. As demonstrated by the English Department of Health's 2004 Code of Practice for the International Recruitment of Healthcare Professionals, various forms of government regulation constitute an additional policy lever that could modulate pull factors in response to international concerns.

Understanding stakeholders' interests and concerns is an essential step toward deepening the policy debate and motivating nations to assume shared responsibility for a global problem. We hope that this special issue of *HSR* will further contribute toward that aim.

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NOTES

1. JLI, WHR, Merchants of Labor.
2. AcademyHealth is grateful for the support provided by the Rockefeller Foundation, the International Development Research Centre, Johnson & Johnson, Robert Wood Johnson Foundation, the Agency for Healthcare Quality and Research, the Canadian Health Services Research Foundation, and the Nuffield Trust.
3. Nigeria and Hungary were also in the original set of case studies. However, severe data limitations in those countries made it impossible to include them in this special issue.
4. See <http://www.academyhealth.org/international/nursemigration/photo.htm>.

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