

# ETHICAL CONCERNS IN NURSE MIGRATION

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International nurse migration is natural and to be expected. Recently, however, those who have fostered nurse migration believe that it will solve nursing shortages in developed countries and offer nurse migrants better working conditions and an improved quality of life. Whether natural or manipulated, migration flow patterns largely occur from developing to developed countries. In this article, nurse migration is examined using primary health care (PHC) as an ethical framework. The unmanaged flow of nurse migrants from developing to developed countries is inconsistent with “health for all” principles. Removing key health personnel from countries experiencing resource shortages is contrary to PHC equity. Often, nurse migrants are placed in vulnerable, inequitable work roles, and employing nurse migrants fails to address basic causes of nurse shortages in developed countries, such as dissatisfaction with work conditions and decreased funding for academic settings. Nurse migration policies and procedures can be developed to satisfy PHC ethics criteria if they (1) leave developing countries enhanced rather than depleted, (2) contribute to country health outcomes consistent with essential care for all people, (3) are based on community participation, (4) address common nursing labor issues, and (5) involve equitable and clear financial arrangements. (Index words: Nurse; Migration; Primary health care; Ethics) *J Prof Nurs* 22:226–35, 2006. © 2006 Elsevier Inc. All rights reserved.

THE PHENOMENON OF unmanaged nurse migration is of growing concern. Promoting unmanaged nurse migration to solve a nursing shortage masks serious workforce issues in source and recipient countries and perpetuates inequity in global health care. Even if the effects of nurse migration are beneficial for recipient countries, given the global shortage of nurses, the effects are detrimental to source countries because they destabilize health systems. The source countries that have invested in educating health care professionals do not receive a return on their investment when excessive nurse migration occurs. For example, approximately 50% of students graduating from two excellent nursing colleges in India migrate out of the country (Solheim & Marks, 2005). This is occurring as

India faces having the largest number of people affected by HIV/AIDS in the world (Solomon, Chakraborty, & Yepthomi, 2004). Although nurse migration can be financially beneficial for some individual nurses and countries, the overall value to the economy and health system is uncertain.

Achieving equitable health systems requires constructive, corrective measures about nurse migration. In this article, we examine nurse migration as an issue in realizing ethical primary health care (PHC) delivery systems. We urge that policymakers, educators, clinicians, and researchers examine nurse migration, paying particular attention to the governmental and individual influences that result in policies that lessen community participation and equity in health care.

## Background

International migration has doubled since 1965, and almost half of the migrants are female. The movement of health workers is expected to intensify (Bach, 2003; Buchan, Parkin, & Sochalski, 2003; Gwatkin, 2000; Hochschild, 2002). Nurse migration flow patterns largely move from developing countries to developed countries. Further, the migration of nurses is a complex

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NIH, NINR Grant #NR07079 PHC Research Training (K.S. and M.A.C.).

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issue, influenced by international factors such as trade agreements, national strategies to export or import health care providers, profit motives, and individual factors (Bach, 2003). Nurse leaders are increasingly asked to become involved in activities to train foreign nurses for export to the United States or to support legislative changes to facilitate nurse migration practice. Hospital administrators and politicians, often without participation of nurse leadership, make recruitment trips to source countries to devise ways to solve local issues by importing human resources. In fact, U.S. employers have used foreign nurses as a strategy to deal with nurse shortages for at least the past 50 years (Brush, Sochalski, & Berger, 2004; Choy, 2003). Foreign nurses comprise approximately 5% of the U.S. nurse labor force, and the percentage of newly licensed U.S. RNs who are foreign educated has been increasing since 1998, reaching more than 14% in 2003 (Brush, Sochalski, & Berger, 2004).

### PHC Framework

PHC, as defined at Alma-Ata, Kazakhstan, in 1978 and ratified by the 134 World Health Organization (WHO) member countries, including the United States, continues to be an important framework for understanding global health (Braveman & Tarimo, 2002; Chowdhury & Rowson, 2000; Gwatkin, 2000; McElmurry & Keeney, 1999). Considering PHC as an ethic, a philosophy, and a strategy for implementing health care is useful in international, national, and local settings (McElmurry & Keeney, 1999; Tejada de Rivero, 2003). Here, PHC is used as a philosophy with ethical underpinnings to examine the ethics of nurse migration (Table 1). "Health for all" is a desired outcome of PHC systems and encompasses essential basic health services that foster socially and economically productive lives. The word "primary" in the PHC phrase means that health for all is a principal, first-order issue (Tejada de Rivero, 2003). Health is not only key to individuals but is integral to the development of countries (Sen, 1999). Achieving health in one country benefits other countries (Tejada de Rivero, 2003).

PHC is based on the assumption that health is determined by economic, social, and political circumstances (Tejada de Rivero, 2003). Although it is understood that economic gains improve citizens' health, economic growth is not necessarily accompanied by benefits to the citizenry (Braveman & Tarimo, 2002). Rather, health improvements depend on how economic resources are allocated. The positive relationship between gross national product per capita and longevity occurs if resources are allocated to poverty reduction and health expenditures (Sen, 1999). Economic growth supports health when there is conscious commitment of resources to achieve health objectives. Some very poor countries such as Sri Lanka have achieved better health outcomes than have richer countries such as South Africa because of skillful support of health, education, and other social programs. Health supports economic development in that healthy citizens are able to earn income, seek health care, and have adequate nutrition (Sen, 1999). Focusing on health promotion in PHC areas is associated with cost savings because health inequity is expensive and potentially affects all social groups (Braveman & Tarimo, 2002).

Close ties among health, economic, and political processes underscore Tejada de Rivero's (2003) statement that the framework of PHC goes well beyond being a bureaucratic blueprint for technical programming for impoverished people. In fact, PHC cannot be accomplished in an isolated health institution but rather entails multisectoral decision making and reorientation of health policy at national and local levels (McElmurry & Keeney, 1999; Tejada de Rivero, 2003). In other words, enacting PHC often requires social and political change.

Participation, a significant tenet of PHC, requires individual, community, and national engagement, as well as international dialogue (McElmurry & Keeney, 1999; Tejada de Rivero, 2003). When discussing health and development, Sen (1999) states that perhaps nothing is as important for health care resource allocation as informed public discussion and a democratic process whereby peoples' understanding of

**Table 1.** PHC Defined

PHC definition	Basic principles
<p>"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community and through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of continuing health care process."</p>	<p>Equitable distribution and accessibility of health services to the population.            Focus on prevention of disease and health promotion.            Use of appropriate, socially acceptable, and sustainable technology and local resources.            Multisectoral approach to health programs that integrate social and economic development.            Community involvement in defining and addressing problems is essential.</p>

NOTE. Adapted from McElmurry and Keeney (1998), pp. 457–458.

**Table 2.** UN's MDGs

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. Reduce child mortality.
5. Improve maternal health.
6. Combat HIV/AIDS, malaria, and other diseases.
7. Ensure environmental sustainability.
8. Develop a global partnership for development.

NOTE. Source: UNDP (2003).

choices can be incorporated. The social allocation of resources cannot be separated from participatory politics. Participation is a right and an obligation involving horizontal, symmetrical, integral relationships among many societal sectors and stakeholders (McElmurry & Keeney, 1999; Tejada de Rivero, 2003).

Equity is another key ethical concept in PHC. In fact, the original WHO vision of PHC grew out of awareness of intolerable levels of health inequity (McElmurry & Keeney, 1999; Tejada de Rivero, 2003). Inequity refers to health differences that are unfair and unjust (Gwatkin, 2000). Pursuing equity means reducing unfair, unnecessary, and avoidable gaps in physical and psychological well-being, which are systematically observed between groups with different social privileges (Gwatkin, 2000).

The effects of globalization can create inequities, widening the gap between the rich and the poor (Braveman & Tarimo, 2002; Ehrenreich & Hochschild, 2002; Gwatkin, 2000; McElmurry, Kim, & Al Gasseer,

2000). The income of the poorest 20% of the world's citizens declined from 2.3% to 1.4% in the last 30 years (Braveman & Tarimo, 2002). At the same time, the income of the richest 20% increased from 70% to 85%. Sixty countries were worse off economically in 1999 than they were in 1980 (Hochschild, 2002). Particular differences between nurse source and recipient countries, based on indicators that reflect the Millennium Development Goals (MDGs), are shown in Table 2. Further, remarkable economic inequities exist between source and recipient countries. In 2001, the per capita gross domestic product (GDP) in international dollars ranged from \$12,000 to \$35,000 in the recipient countries and roughly \$1,000 to \$15,000 in the source countries.

In addition, great inequities in overall health conditions exist between source countries such as the Philippines and recipient countries like the United States (see Tables 3 and 4). Recipient countries generally have a mean mortality rate for children of about 10 per 1,000 live births, and source countries such as Nigeria had a much higher rate of 183 per 1,000 live births in 2001. Maternal mortality ratios and life span averages also show similar trends for source and recipient countries.

Even with vast disparities in health care availability, overall health conditions improve as the number of health professionals increase. WHO estimates have indicated that most recipient countries had more than 800 nurses per 100,000 population per year, whereas four out of six source countries had fewer than 150 nurses per 100,000 population per year. Rates of

**Table 3.** Health, Economic, and Social Differences Between Nurse Recipient and Source Countries

Countries	Health condition			Availability	Economy		Education
	Maternal mortality ratio per 100,000 live births (2000)*	<5 Mortality rate (per 1,000 live births) (2001)†	Life expectancy at birth (years) (2002)‡	Births attended by skilled health personnel (%) (2002)‡	Per capita GDP in international dollars (\$) (2001)‡	Poverty (% of population below \$2 per day consumption) (1990–2001)†	Education Index (2001)†
<b>Recipient</b>							
United States	17	8	77.3	99	35,182	–	0.97
UK	13	7	78.2	99	26,273	–	0.99
Canada	6	7	79.8	98	29,235	–	0.97
Australia	8	6	80.4	100	27,614	–	0.99
Saudi Arabia	23	28	70.8	91	12,877	–	0.71
Ireland	5	6	77.1	100	30,004	–	0.96
<b>Source</b>							
Philippines	200	38	68.3	58	5,166	46.4	0.90
Korea	20	5	75.5	100	15,905	–	0.96
India	540	93	61.0	43	1,560	79.9	0.57
Nigeria	800	183	48.8	42	915	90.8	0.59
South Africa	230	71	50.7	84	7,538	14.5	0.83
Ghana	540	100	57.6	44	1,272	78.5	0.64
Zimbabwe	1100	123	37.9	73	2,271	36.0 (64.2)	0.79

\*United Nations Statistics Division: <http://millenniumindicators.un.org/unsd/>.

†Human Development Indicators 2003: [http://hdr.undp.org/reports/global/2003/indicator/indic\\_6\\_1\\_1.html](http://hdr.undp.org/reports/global/2003/indicator/indic_6_1_1.html).

‡WHO Core Health Indicators by country: <http://www3.who.int/whosis/country/indicators.cfm>.

**Table 4.** Definition of Health Indicators

Indicators	Definitions
Maternal mortality ratio per 100,000 live births	The International Classification of Diseases, Tenth Revision defines a maternal death as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.*
<5 Mortality rate per 1,000 live births	The probability of dying between birth and exactly 5 years of age, expressed per 1,000 live births.†
Life expectancy at birth (years)	Life expectancy is the average number of years of life persons can expect to live if they experience the current mortality rate of the population at each age.‡
Proportion of births attended by skilled health personnel	Percentage of births attended by skilled health personnel (UNICEF estimates).§
Per capita GDP in international dollars	GDP per capita is the per capita market value of the total final output of goods and services produced in a country over a specific period. The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. Figures expressed in international dollars are calculated using purchasing power parities (PPPs), which are rates of currency conversion constructed to account for differences in price level between countries.‡
Population living below \$2 a day (%)	The percentage of the population living below the specified poverty line: \$2 a day—at 1985 international prices (equivalent to \$2.15 at 1993 international prices), adjusted for PPP. National poverty line—the poverty line deemed appropriate for a country by its authorities. National estimates are based on population-weighted subgroup estimates from household surveys.†
Education Index	One of the three indices on which the human development index is built. It is based on the adult literacy rate and the combined primary, secondary, and tertiary gross enrollment ratio. Net enrollment ratio is the number of enrolled children compared to the total population of that age.†

\*World Health Organization. International Statistical Classification of Diseases and Related Health Problems. Tenth Revision. Geneva, WHO, 1992. Maternal mortality in 2000: Estimates developed by WHO, UNICEF and UNFPA at [http://www.who.int/reproductive-health/publications/maternal\\_mortality\\_2000/index.html](http://www.who.int/reproductive-health/publications/maternal_mortality_2000/index.html).

†Human Development Indicators 2003: [http://hdr.undp.org/reports/global/2003/indicator/indic\\_6\\_1\\_1.html](http://hdr.undp.org/reports/global/2003/indicator/indic_6_1_1.html).

‡WHO Core Health Indicators by country: <http://www3.who.int/whosis/country/indicators.cfm>.

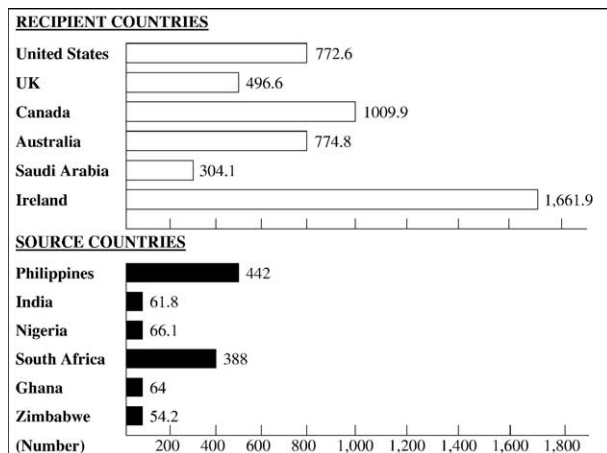
§United Nations Statistics Division: <http://millenniumindicators.un.org/unsd/>.

births attended by skilled health personnel who can manage normal deliveries are an important indicator of disparities that affect perinatal health conditions for the general public in a given country (WHO, 2005). Skilled personnel attended almost all childbirths in the recipient countries, whereas more than half of the childbirths were unattended in source countries such as Nigeria, India, and Ghana in 2002.

Educational differences also exist between the recipient and source countries. The Education Index (EI) in 2001, a Human Development Indicator calculated from the adult literacy rate and the combined primary, secondary, and tertiary enrollment ratio, shows a 0.97 EI in the United States and a 0.57 EI in India, the third-ranking country importing nurses to the United States.

Thus, source countries lose precious investments in education through nurse migration.

Health-related indicators such as health care availability, economic conditions, and education have improved within the last 12 years in all countries, yet health conditions in some source countries are rapidly deteriorating (United Nations Development Program [UNDP], 2003). For example, the under Age 5 mortality rate in South Africa grew from 60 in 1990 to 85 in 2002. Some interesting exceptions occur when source and recipient countries are compared. For example, although a source country for the United States, Korea resembles a developed country in terms of the above indicators, and Korean nurses migrate for reasons other than economic conditions. Conversely, Saudi Arabia is an economically



**Figure 1.** Numbers of Nurses per 100,000 persons (2004)  
Source: WHO Human Resources for Health, <http://www.who.int/GlobalAtlas/DataQuery/ViewData.asp>.

developed country that has historically employed migrant workers for basic service industries such as health care. Although middle-eastern countries might be economically advantaged, they often have underdeveloped health care systems, especially concerning public health services.

Much like PHC, the UN's MDGs tie health, social, and economic issues together in a global effort to promote development and sustain the environment. The MDGs shown in Table 2 depict a global value for health as well as an agenda for health. The MDGs indicate priority areas for comparing health goals and indices in source and recipient countries.

### Current Patterns of Nurse Migration

Analysis of current patterns and trends in nurse migration are hampered by insufficient quantitative documentation. For convenience, we use the terms "source" and "recipient countries" when describing what is known about nurse migration. Most source countries are developing countries; most recipient countries are developed countries (see Figure 1). Source countries for the United States are the Philippines (52% of foreign National Council Licensure Examination [NCLEX]-RN candidates in 2001), Canada (12%), Korea (6%), India (4.5%), the UK (3%), and Nigeria (2%), according to NCLEX-RN licensure candidate statistics (Crawford, Marks, Gawel, & White, 2002). The National Council of State Boards of Nursing data are consistent with the rates of the Commission on Graduates of Foreign Nursing Schools (CGFNS) Certification Program. The Philippines, India, and Nigeria are also top source countries (CGFNS, 2005). In all data for the United States, the Philippines has traditionally been a major source country for more than 40 years. Other major source countries include South Africa, Ghana, and Zimbabwe (Kline, 2003).

The United States is a major recipient country of nurse migration. The UK, Canada, Australia, Saudi

Arabia, and Ireland are also recipient countries (Kline, 2003). Overall, 1,145 foreign registered nurses entered the United States with H1A visas in the 2002 fiscal year (Homeland Security, 2003). The UK has also historically relied on foreign nurses from developing countries, and about half of their new nurses come from non-UK sources (BBC News, 2004). Experts expect that migrating from developing to developed countries will continue and increase (Bach, 2003).

## Issues Influencing Nurse Migration

### Global Issues

Understanding some of the economic, political, and social issues that influence nurse migration and promoting equitable resource allocation to achieve health for all is important. Economic policies to promote free and equitable trade among nations are a powerful theme in the migration of nurses (Bach, 2003). The World Trade Organization (WTO), with 147 member nations, operates on a global level to liberalize trade among nations, negotiate trade agreements, and settle trade disputes (WTO, 2004). Although improving a country's economy through liberalized trade and ensuring equitable access to quality health services can be compatible, the benefits of trade in international health services often comes at the expense of equitable health services (Timmermans, 2004).

Certain global economic initiatives by the World Bank and International Monetary Fund, intended to help poorer countries become more competitive in global markets, actually deplete health and social welfare resources by shifting resources away from those sectors and by devaluing currency (Bach, 2003; Ehrenreich & Hochschild, 2002; Sassen, 2002). Thus, health services and medications are less available and staff members are unsupervised and unpaid (Bach, 2003; Braveman & Tarimo, 2002; Ehrenreich & Hochschild, 2002; Sassen, 2002; Zaremka, 2002). As a result, nurses seek work in parts of the world with more resources.

Other factors in global nurse migration are private recruiters. For example, one Midwest-based nurse recruitment agency founded by a physician has placed 145 nurses in local settings (Brush et al., 2004). This recruiter receives up to \$10,000 per nurse from hospitals and anticipated profits of more than \$5 million in 2004. One third of the Filipino nurses migrating to the UK were required to pay up to \$3,600 in commissions to recruiters after obtaining employment (Royal College of Nursing [RCN], 2002). Nurse recruiters are also active in Nigeria where there are an estimated 66 nurses per 100,000 persons, as compared with 773 nurses per 100,000 persons in the United States (WHO, 2003).

Migration is also influenced by grassroots activity (Hochschild, 2002). Migration pathways and social networks, once started between countries, stimulate further migration (Bach, 2003). Similar ethnic communities,



especially those including family members, friends, and nursing associations composed of nurses from the same country, strengthen the network and build a sense of professional community.

National policies (such as Norway's) and organizational statements (such as those of the RCN and International Council of Nurses [ICN]) identify controls to guard against depleting poorer nations of their nurses (Bach, 2003). Brain drain and the effects of dislocation, such as the suffering related to mother-child and family separation, are among the detrimental effects of migration (Bach, 2003; Hochschild, 2002).

Dissatisfaction with work hours, lack of rewarding work, lack of control over such conditions as mandatory overtime, increased patient acuity, responsibilities for being legally responsible for the work of unlicensed caregivers, lack of respect from physicians and administrators, and poor wages and benefits are other factors commonly cited as reasons for the global nursing shortage (Bach, 2003; Brush, 1999; Jacox, 2003; Janiszewski-Goodin, 2003; Scherzer, 2003; Sochalski, 2002; Stanton, 2003).

#### Source Country Issues

Wage compression is an issue in many source countries where the civilian workforce grew faster than the economic structure, resulting in many poorly educated, unskilled health care workers competing with skilled workers for available dollars (United States Agency for International Development [USAID], 2004). Limited professional or career options in the source country can include poor working conditions, insufficient resources to provide efficient and effective care, and low morale. Personal reasons for migrating include the desire to achieve higher levels of education and a better lifestyle for children (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Brush et al., 2004; Kingma, 2001; Padarath et al., 2004; Stilwell et al., 2004). If morale and job satisfaction are high, the likelihood of migration is less.

#### Recipient Country Issues

In recipient countries, nurse migration is often cited as a strategy to relieve current nursing shortages. We contend that the nursing shortage in the United States and abroad reflects long-standing problems that cannot be solved by importing nurses. Long-standing issues include changing demographic patterns, issues related to nursing practice and management, questions of discrimination, and resources for nursing education.

Patterns in nursing education add to the nursing shortage. Although actual enrollments have increased over the past 4 years, more than 25,000 qualified applicants were turned away from nursing programs in 2004. (American Association of Colleges of Nursing [AACN], 2004). In summary, a variety of social and economic issues affect nursing shortages. Active recruitment of foreign nurses to fill gaps in the U.S. health care system perpetuates global inequities and impedes resolution of long-standing issues behind shortages in

recipient countries. Recruiting foreign nurses from poorer countries to solve national issues is like treating a chronic viral illness with an expensive antibiotic. It is the wrong prescription.

## Effects of Nurse Migration

### Source Countries

Nurses who remain in understaffed facilities often face dismal working conditions. Morale and job satisfaction drop, inefficiencies rise, and safe practices diminish. When no time is allowed for continuing education opportunities, new research findings, techniques, and procedures are neither learned nor implemented, thus perpetuating a cycle of low morale, low job satisfaction, and poor patient outcomes (Aiken et al., 2001; Henderson, 2000). Fatigued nurses are working at a higher risk of contracting diseases like HIV/AIDS (De Graaf, Houweling, & Van Zessen, 1998). Underpaid nurses may work two or more jobs to make ends meet, and in cases where the second job earns them more money, they may leave health care altogether (Stolley, 2003).

According to Buchan et al. (2003), more than 8,000 nurses were recruited from African countries by the UK between 1998 and 2002. Many of these African countries average fewer than 100 nurses per 100,000 population, and some have fewer than 10 nurses per 100,000 (USAID, 2004). According to Castles (2000), countries invest a significant amount of money in raising and educating their citizens. A USAID (2004) report indicated that educating one nurse in Zimbabwe costs the equivalent of US\$8,200, which is subsidized by the Zimbabwean government. At the time of migration, these nurses are in their most productive years and their income is spent in the recipient country, thereby causing a loss of income or return on investments in the source country.

In many countries, the expectation is that migrating nurses will send money to family members who remain in the source country. Families in India received US\$7.6 billion in 1996 (Nielson, 2005); families in the Philippines receive more than US\$800 million in remittances each year (Lindquist, 1993). In addition, many recruiters pay a fee to the government for the nurses who will be leaving. Although the inflow of dollars might help the general economy of the source country, the problem with such remittances is that much of the money is not put back into the health care system.

Serious consequences from nurse migration include the loss of nursing educators and a weakening of nursing schools and the country's health system (Santos, 2002). Without sufficient numbers of care providers, those left behind struggle to meet the needs of patients in understaffed organizations (Stilwell et al., 2004). The mass recruitment of experienced nurses results in care being provided by newly graduated, less experienced nurses. According to Santos (2002), operating rooms in the Philippines are staffed with novice nurses. Health

care staff without nursing education may perform duties beyond the scope of their educational preparation (USAID, 2004; WHO, 2002). The experienced nurses who remain often work double shifts. Patient care suffers as a result. Morbidity and mortality increase when nurses are forced to take on large patient caseloads. In extreme cases, institutions shut down and communities are left without local health care (Padarath et al., 2004), thus creating an environment that contradicts the PHC principles of equity and accessibility.

### Recipient Countries

In recipient countries, migrant nurses might find that they have been promised more by recruiters than they actually receive (Buchan, 2002; Padarath et al., 2004; RCN, 2002; Stilwell et al., 2004). Also, obtaining nursing licensure or registration in the new country might take longer than expected. Unscrupulous recruiters sometimes prey on migrants. Many fail to sufficiently explain the differences in cost of living and the effect it has on the promised salary.

Nurses without a good understanding of the health care system and agencies in the new country are often less effective at negotiating positions and salaries and report more negative experiences (Allan & Larsen, 2003).

The effect of migration on individual nurses includes many negative factors. Culture shock is an initial effect of any kind of migration. Missing family, friends, dietary customs, and other conveniences of the home country are but a few of the challenges to be met. Transition into a culture, language, and professional practice with different values and expectations can also be challenging. Learning new technology and health care terminology might or might not be facilitated by the recruiting health care facility.

Many immigrant nurses experience ethnicity-based discrimination, which is reflected in lower wages or fewer opportunities for career advancement. Thus, immigrant nurses find themselves vulnerable and powerless to implement needed changes in health care settings where patients and staff are at risk. If a health care facility contracts with a foreign nurse for 2 years, the facility is guaranteed 2 years of labor from individuals who are virtually powerless to require the standards of care and safety that are expected by nonimmigrant nurses (Trossman, 2002). This lack of power is particularly evident when immigrant nurses are placed in jobs other than those held by RNs or in settings outside of their practice knowledge. Many migrants have been promised RN positions but work as nursing assistants (Allan & Larsen, 2003). Overall, the working conditions, salaries, and living conditions might be less than what the migrating nurses were led to expect.

The UK's target of increasing its workforce in 2004 by 20,000 was achieved only with an increase in overseas nurses (Bach, 2003). Recipient countries can be said to take the "best of the best" from the source countries. Therefore, care received by patients in recipient countries may be superior in quality. In recipient

countries, however, patients' perceptions of foreign nurses can vary greatly. In some Asian cultures, requesting an interpreter is avoided to "save face" (Xu & Davidhizar, 2004). Likewise, when patients have difficulty understanding a care provider, their trust or satisfaction with the care provided will be affected, thus creating undue dissatisfaction with the nursing care.

Although many states have increased their number of foreign nurses (Brush et al., 2004), most foreign nurses work in large cities in New York, Michigan, New Jersey, Illinois, and California (Brush, 1999). Some inner-city hospitals are largely dependent on foreign nurses. Although legislation mandates equitable pay and working conditions, foreign nurses have often been assigned sites, shifts, and days that are unattractive to other nurses (Brush, 1999, Jacox, 2003).

Language proficiency in a health care setting is highly important in providing accurate care. According to CGFNS (2004), some migrant nurses identify face-to-face and telephone conversations as difficult. Legislative efforts to bypass the nursing profession's established requirements (Shusterman, 2001) to expedite the recruitment of foreign nurses may have serious consequences for the delivery of care if errors occur due to misunderstood verbal orders.

Meanwhile, health care facilities continue active recruitment of foreign nurses rather than implementing changes in working conditions. In response to the research-based position of the American Nurses Association (ANA) on foreign nurse recruitment, K. Bruce Stickler, health care labor lawyer with Chicago-based firm Stickler and Nelson, said, "In many cases, foreign nurses have a harder work ethic and put in overtime when they arrive in the U.S. ..." (Reilly, 2003). This ignores the position of the ANA, which uses current research to advocate for patient safety by limiting mandatory overtime and improving nurse staffing ratios and working conditions. Unsafe practices and mandatory overtime are imposed upon newly arrived migrant nurses who are vulnerable because of contractual agreements, language challenges, and fear of retribution if the nurses report problems in the work setting (Felman, McElroy, & Lacour, 2003; Trossman, 2002).

### Recommendations

We propose several strategies to address unmanaged nurse migration, its causes, and its implications based on the following goals. In the spirit of PHC, we recommend that nurses strive for (1) a basic level of health services for people everywhere, especially people experiencing unjust or inequitable social and economic circumstances; (2) the health and well-being of all nations; (3) fair, fulfilling work circumstances for nurses, in which they have a voice, so that their social contract with society can be fulfilled. The following ideas reflect several PHC principles such as participation, equitable resource allocation, and intersectoral involvement. Strategies need to be developed at the national, international, and local levels.

Nurses can play a powerful role through active, informed participation at all levels where decisions about migration are made, holding themselves accountable to professional values and the rights of patients and communities. Nurses must become informed about ethical recruitment codes such as those put forth by ICN and ANA. Further, nurses can educate themselves about other global movements that address migrant workers such as the 1990 UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families. Understanding the vast differences in health services and preparation between source and recipient countries might compel nurse leaders to decide against exporting or importing nurses.

Participatory dialogue with clear decision making must take place among governments, employers, professional leaders, private entrepreneurs, nurses, and community members. Such dialogue could lead to new policies to guide equitable migration strategies between countries or plans to repay source countries for their investment in nurses' education. For example, Thailand has a policy requiring nurses to work in that country for at least 2 years in return for investing in the nurses' initial preparation. Likewise, plans might be devised to offer incentives to nurses to return to their home country. Institutions in source and recipient countries might establish exchange programs whereby nurses from both source and recipient countries have the opportunity to learn about global health issues. Limited clinical facilities are one reason why U.S. nursing programs do not expand. Arranging selected U.S. clinical education experiences in source countries might address this barrier, provide support to nursing in source countries, and support students in acquiring an even richer education. A clinical rotation in a developing country would be consistent with the policies of some European nursing programs.

Continued research, including research on the numbers of nurses migrating and returning to their country of origin and health-related outcomes for patients in both source and recipient countries, is essential to define the scope of migration to have an informed dialogue. An important step toward this goal was announced at the ICN 23rd Quadrennial Congress held in Taipei, Taiwan, in May 2005. ICN and the CGFNS formally announced a collaboration that initiates an International Center for Nurse Migration. This center will play a key role in establishing effective policy and practice related to global nurse migration.

Revising resource allocation between countries and within health care systems is another strategy for addressing unmanaged nurse migration. The Commitment to Development Index ranks the richest countries' performance in aid, trade, investment, migration, security, environment, and technology. The United States, which ranks fifth in the overall score (out of 21 countries), is ranked among the lowest when it comes to quantity and quality of aid as a single measure (Bannon & Roodman, 2004). Investing in developing

nations, especially in health and human resources, could achieve better social circumstances and management of global migration.

Resources must be invested in the nursing profession worldwide. Effective nursing care is cost-effective, good for peoples' health, and a wise health care investment. An array of recent research shows that better nurse staffing levels result in fewer adverse patient outcomes associated with substantial cost increases (Stanton, 2003). Further, although increased RN staffing increases operating expenses by 0.25%, better staffing does not significantly decrease profit margins. Conversely, higher levels of nonnurse staff cause higher operating expenses as well as lower profits.

An increased social value placed on the nursing profession could obviate the need for nurse migrants and improve retention and recruitment to the profession. Allocating additional national and state resources for higher education, in this case nursing, would serve the principle of equity for women and men, open opportunities, and alleviate the need for nurse migration. In the United States, 4.2% of all RNs are African American, 1.6% are Hispanic, and 0.5% are Native American (Minority Nurse.com, 2004). Attrition rates for minority students are high and graduation rates are low (Janiszewski-Goodin, 2003). What would happen if the health care dollar spent by profit-making foreign nurse recruiters were invested in minority students in the United States? What impact might this have on income and health disparities in the U.S. population over the long term?

Working conditions must be improved so that nurses are retained over the long term. To resolve workforce issues, practicing nurses, nurse leaders, other health care organization leaders, and key legislative officials must fully address such issues as job satisfaction, working conditions, preparation levels, educational programs, faculty preparation, and wages. Equitable policies related to these issues, within the constraints of country resources, could enhance recruitment and retention of nurses in developed countries and stem the outflow of nurses from source countries.

We recommend strengthening international nursing relationships through professional associations, collaborating on research, and nurse/faculty and student exchanges to increase pride and professional identity; engendering respect and recognition; empowering nurses; increasing autonomy of the profession; and enabling better understanding of global health issues. In particular, we recommend nurse migration policies and procedures consistent with PHC ethics: (1) leave developing countries enhanced rather than depleted, (2) contribute to national health outcomes consistent with essential care for all, (3) base policies on community awareness and participation, (4) address common nursing labor issues, and (5) ensure equitable and clearly understood financial arrangements.

Respect, recognition, and acknowledgement of nurses for their professional expertise and significant



contributions to health are important aspects of a solution to unmanaged nurse migration. When the workplace offers job satisfaction and good morale, nurses are less likely to migrate (Padarath et al., 2004).

## Conclusion

Recruiting nurses from developing countries has been a long-standing strategy to relieve shortages in recipient countries. Nurse migration is a complex mix of forces affecting health care from personal to global levels. These forces include (1) a free-market system incorporating liberal trade between nations and free-market access and profit for health-care-related businesses, (2) free agency and opportunity for nurse migrants, and (3) health, well-being, and equity for the health of people in source and recipient countries.

Although PHC principles specify bringing health care as close as possible to where people live and work, nurse migration often takes nurses away from where they are needed most (Tejada de Rivero, 2003). Moreover, importing nurses to solve one problem—nursing shortage—often masks other problems in both source and recipient countries. National policies to promote nurse migration are not driven by altruism, equity, distributive justice, or poverty reduction values but more likely by profit motives. The authors of this article believe that health for all is a global issue and does not favor wealthy over poor countries but covers humankind as a whole. Although there is a worldwide shortage of nurses (Bach, 2003), manipulating nurse migration is a poor solution to that problem because it causes complex issues within health and social systems in recipient and source countries.

## Acknowledgments

The authors acknowledge UIC International Doctoral Students Sunanta Thongpat (Thailand) and Annie Lee (Taiwan) for their assistance with the development and critique of tables and references.

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