Issue 5

International migration of nurses: trends and policy implications

ISBN: 92-95040-25-2

Issue paper

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Acknowledgements

This report is based on data and information from a range of sources and informants.
The authors alone are responsible for the content of this report.

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Executive Summary

This report focuses primarily on the policy implications of the international migration of nurses, and highlights recent trends. International recruitment and migration of nurses has been a growing feature of the global health agenda since the late 1990s. Nurses have always taken the opportunity to move across national borders in pursuit of new opportunities and better career prospects, but in the last few years nurse migration appears to have grown significantly, with the potential to undermine attempts to achieve health system improvement in some developing countries.

Whilst the issue of international migration of nurses is sometimes presented as a one-way linear "brain drain", the dynamics of international mobility, migration and recruitment are complex, covering individual rights and choice; motivations and attitudes of nurses to career development; the relative status of nurses (and women) in different systems; the differing approaches of country governments to managing, facilitating or attempting to limit outflow or inflow of nurses; and the role of recruitment agencies as intermediaries in the process. This report provides an overview of this dynamic situation.

Country-level data are used to examine trends in nurse migration. Both "source" and "destination" countries are used to provide comprehensive background information. As there are no common or "standard" data or methods of tracking trends in migration of nurses, there can be no universal assessment of flows between countries. Any analysis of trends in migration of nurses is therefore constrained by data limitations and gaps.

The report emphasises that, in order to undertake an accurate assessment of the impact and policy implications of migration of nurses, it is necessary to assess the level of migration within the broader context of trends and dynamics in the national nursing workforce. For example, it is important that any examination of out-migration of nurses relates the numbers leaving the country to the overall numbers leaving the nursing workforce – many nurses may actually remain in the country, but leave nursing. Out-migration may be the most obvious and media-worthy aspect of outflow of nurses, but it will not necessarily be the biggest flow of nurses from the system.

It is also important to note that migration is not just about a one-way flow from "source" to "destination" – nurses may leave one country to work in a second, and then either return to their home country, or move onto a third. They may even live in one country and cross a national border on a regular basis to work in another. Improvements in travel and communication, combined with availability of employment, can encourage this circulation.

The increases in flows of nurses across national boundaries create a series of policy questions for national governments and international agencies. The report assesses the main policy issues, and also discusses where the current knowledge gaps are most critical in preventing a full assessment and understanding of the dynamics of nurse migration. The main gaps, and recommendations for policy action, are summarised below:

- One crucial gap is the absence of accurate data on the flows of international nurses; this is a constraint on any effective monitoring, and also limits the ability to assess impact. *Stakeholders at national level, and international agencies, need to collaborate to agree and implement improved systems to monitor international flows of nurses and other health workers.*

- The position of many developing countries, which are sources of international nurse workers, is weakened by inadequate workforce data and planning capacity, and it is difficult to assess how much of a "problem" outflow to other countries is in comparison to the numbers of underemployed or unemployed nurses in the country. *These countries must assess and improve their planning systems, and give more policy attention to encouraging and supporting non-practising nurses to return to nursing employment.*

- The overall impact of out-migration of nurses on source countries, in terms of its effect on health systems and on remaining staff, requires more systematic assessment. *More research and evaluation are required to inform national stakeholders and international agencies of the true costs (and/ or benefits) and impact of nurse migration.*

- Relatively little is know about the experiences of international nurses now working in destination countries, in terms of their profile and future career plans (including likelihood of return to source countries or onward movement to other countries), and equality of treatment. *Research and evaluation are required to highlight good practice and expose poor practice in the treatment of migrant nurses.*

- The gender issue in relation to the migration of nurses is an important factor; there is a need for donors to support strengthened professional nurses associations in source countries, so that the position of nurses in society can be promoted by stronger advocacy. *Donors need to focus attention on supporting the strengthening of representative organisations for nurses.*

- The issue of how – or if – to "manage" migration is important, and requires more considered investigation, with systematic assessment of the various models of managed migration. *The various policies and models of managed migration, bilateral agreement, ethical codes, return migrant schemes and possible models of "training for export" require examination and evaluation to support a more effective approach to international recruitment of nurses at national and international levels.*

Introduction

"The loss of human resources through migration of professional health staff to developed countries usually results in a loss of capacity of health systems in developing countries to deliver health care equitably. Migration of health workers also undermines the ability of countries to meet global, regional and national commitments, such as the health-related United Nations Millennium Development Goals, and even their own development. Data on the extent and the impact of such migration are patchy and often anecdotal and fail to shed light on the causes, such as high unemployment rates, poor working conditions and low salaries."
(WHO 2004a:1).

This report focuses primarily on the policy implications of the international migration of nurses, and highlights recent trends. It is one of a series of papers prepared in a programme of work on the global nursing workforce. The programme is led by the International Council of Nurses (ICN) and supported by the Burdett Trust for Nursing. These papers provide the background material to inform a meeting of experts and a global summit on the nursing workforce, to be held in 2005.

International recruitment and migration of nurses has been a growing feature of the global health agenda since the late 1990s.[1] Nurses have always taken the opportunity to move across national borders in pursuit of new opportunities and better career prospects,[2] but in the last few years nurse migration appears to have grown significantly, with the potential to undermine attempts to achieve health system improvement in some developing countries.

Whilst the issue of international migration of nurses is sometimes presented as a one-way linear "brain drain", the dynamics of international mobility, migration and recruitment are complex, covering individual rights and choice; motivations and attitudes of nurses to career development; the relative status of nurses (and women) in different systems; the differing approaches of country governments to managing, facilitating or attempting to limit outflow or inflow of nurses; and the role of recruitment agencies as intermediaries in the process. This report provides an overview of this dynamic situation.

It is important to note that it is not just nurse migration that appears to be on the increase. The migration of other skilled occupations is also growing, facilitated by globalisation, easier transport and communications, and active recruitment by some developed countries that are facing skills shortages. Nurses are one of the occupational groups whose skills are in short supply in both developing and developed countries, to the extent that there now exists a global market for their skills (Findlay 2002).

[1]See e.g. Kingma (2001), Buchan (2001), OECD (2002), Stilwell et al. (2003), Buchan et al. (2003), Bach (2003), Padarath et al. (2003), Stilwell et al. (2004), Oulton (2004), Global Equity Initiative (2004).

[2]See e.g. Mejia et al. (1979).

General trends in migration

It should also be noted that there are different reasons why individuals migrate, and different types of migration – some temporary, some permanent. The available data make it difficult to identify and delineate different types of migrants. The different types of migration are summarised below by Stilwell et al. (2003).

Typology of different types of migrants

- **Permanent settlers** are legally admitted immigrants who are expected to settle in the country, including persons admitted to reunite families.
- **Documented labour migrants** include both temporary contract workers and temporary professional transients:

  Temporary migrant workers are skilled, semiskilled or untrained workers who remain in the receiving country for finite periods as set out in an individual work contract or service contract made with an agency.

  Temporary professional transients are professional or skilled workers who move from one country to another, often with international firms.
- **Undocumented labour migrants** are those who do not have a legal status in the receiving country because of illegal entry or overstay.
- **Asylum seekers** are those who appeal for refugee status because they fear persecution in their country of origin.
- **Recognised refugees** are those deemed at risk of persecution if they return to their own country. Decisions on asylum status and refugee status are based on the United Nations Convention Relating to the Status of Refugees, 1951.
- **Externally displaced persons** are those not recognised as refugees but who have valid reasons for fleeing their country of origin (such as famine or war).

Source: Stilwell et al. (2003).

Recent research findings indicate five main trends in general migration:

- The numbers of international migrants is increasing (Organisation for Economic Cooperation and Development, OECD, 2004). In terms of actual figures, the number of persons migrating has more than doubled from 75 million in 1965 to an estimated 175 million in 2003 (United Nations data, quoted in International Organization for Migration, IOM, 2003) when international migrants are defined as "those who reside in countries other than those of their birth for more than one year". The International Labour Organization (2004) estimates that there are approximately 81 million migrant workers worldwide (excluding refugees) – 2.5 million in Latin America and the Caribbean, 3 million in Oceania, 5 million in Africa, 21 million in North America, 22 million in Asia, and 28 million in Europe.
- There has been a growth in the migration of skilled and qualified workers (OECD 2004a).
- Migration flows are becoming more diverse and complex for a range of reasons: for example, communications improvements facilitate greater information exchange; easier transport links (Stalker 2000); international trade agreements; and immigration policies that have at times supported the entry of foreign workers needed to fill national or local skill shortages.
- Previously distinct categories of migrants have begun to blur (Stalker 1997). There has been an increasing mix of temporary/permanent migrants (Timur 2000), including a recent reported growth in temporary migration (Findlay and Lowell 2002).
- Female migrants have accounted for a high and increasing proportion of all migrants over the last 40 years, and growth has been particularly marked in labour migration flows to developed countries (Zlotnik 2003). Increasing numbers of females are now reported to be migrating independently of partners or families (Timur 2000).

Migration of nurses and other health workers is also likely to be affected by the General Agreement on Trade in Services (GATS).[3] Mode 4 of GATS concerns the movement of natural persons and, in relation to trade in health services, it focuses particularly on the provision of health services by individuals from another country, on a temporary basis (Stilwell et al. 2004). It is not yet clear what the overall impact of GATS Mode 4 on nurse migration will be, but it is likely to stimulate further growth, perhaps through bilateral agreements between countries, and will also encourage further cross national harmonisation of nursing qualifications.[4]

Against this backdrop of increased migration of skilled workers and increased numbers of women who are migrating, this report focuses on the migration of nurses. It is divided into two further sections:

- Section One examines trends in the migration of nurses in selected "source" and "destination" countries.
- Section Two discusses the dynamics of nurse migration in relation to the international policy context, identifies current knowledge gaps, and highlights key policy considerations.

[3]See e.g. Chanda (2002) and Bach (2003).

[4]See e.g. ICN (2003); Padarath et al. (2003).

Section One: Trends in Nurse Migration

This section uses country level data to examine trends in nurse migration. Data from both "source" and "destination" countries are used. Country case studies are utilised because there are no common or standard data or methods of tracking trends in migration of nurses, and therefore there can be no universal assessment of flows between countries.

A recent review by World Health Organization (WHO) noted that most data on the migration of nurses and other health workers is "neither complete nor fully comparable, and they are often underused, limited…and not as timely as required" (Diallo 2004:601). A recent study of migration of health personnel in Africa (Padarath et al. 2003:14) noted, "The precise directions and volumes of health personnel movement within each of the southern Africa countries, their impact on equity and performance of health services, the factors influencing these flows and the extent to which they are linked with wider between- and out-of-country flows is not well documented". Any analysis of trends in migration of nurses is therefore constrained by data limitations and gaps.

There are two main indicators of the relative importance of international migration of nurses to a country – the "inflow" of nurses into the country from other source countries (or "outflow" to other countries), and the actual "stock" of international nurses (as compared to the home-educated nurses) in the country at a point in time. To undertake an accurate assessment of the impact and policy implications of migration of nurses, it is necessary to assess the level of migration within the broader context of trends and dynamics in the national nursing workforce.

For example, it is important that any examination of out-migration of nurses relates the numbers leaving the country to the overall numbers leaving the nursing workforce – many nurses may actually remain in the country, but leave nursing. Out-migration may be the most obvious and media worthy aspect of outflow of nurses, but it will not necessarily be the biggest flow of nurses from the system. Data are often more difficult to collect in private employment settings, and this can lead to an incomplete or distorted statistical overview of the nursing workforce.

It is also important to note that migration is not just about a one-way flow from "source" to "destination" – nurses may leave one country to work in a second, and then either return to their home country, or move onto a third. They may even live in one country and cross a national border on a regular basis to work in another. Improvements in travel and communication, combined with availability of employment, can encourage this circulation; examples include Indian nurses being actively recruited from the Middle East to work in Scotland and Filipino nurses being actively recruited from Ireland to Australia (Marino 2002).

Another contextual issue that is of importance is national-level regulation of the nursing profession, in terms of the requirement to be able to practice in that country. The existence of any international agreements that facilitate cross-border movement of nurses through mutual recognition of qualifications, or by automatic registration in the destination country, will increasingly influence migration flows.

The issues of regulation of nursing are examined in greater detail in a companion paper, but it should be recognised that the standards, competencies and qualifications required to practice as a nurse vary in different countries. This variation may be a barrier to migration of individual nurses, if they do not meet the criteria to practice in the destination country. These criteria could include language proficiency as well as qualifications in nursing (Hawthorne 2001). Some countries, such as Ireland and the United Kingdom (UK), may require nurses from other countries to work a period of time under supervision, or undertake additional training or education in order to practice independently.

An example of a bilateral mutual recognition is the Trans-Tasman agreement, which enables nurses from Australia and New Zealand to practice in either country. An example of a multilateral agreement is the Directives in the European Union (EU), which mean that a registered nurse qualified in one country of the EU should be able to move to and work in another EU country. The entry of 10 new countries into the EU in May 2004 has made it easier for suitably qualified nurses in these countries to migrate to Western Europe, provided their qualifications meet minimum EU training standards.

Changes in the regulatory and legal framework at national or international level may have a significant impact on migration of nurses – either making it more difficult or easier to move between countries to work as a nurse. Recently, for example, changes in visa requirements in the United States of America (USA) meant that Canadian nurses were required to apply for a visa (they had previously been exempt from the need to have a visa or take the licensing exam under the North Atlantic Free Trade Agreement (NAFTA) [ICN SEW News 2004].

"Source" countries

This section looks first at data from some source countries to illustrate trends in the level of international out-migration of nurses. As noted above, the limited data available for many countries restricts the focus of analysis. Five "source" countries are illustrated in this section: Ghana, Swaziland, Barbados, the Philippines and South Africa.

Ghana

Ghana is a mid-sized sub-Saharan country, which has been impacted by the outflow of nurses to the UK and to other English speaking countries. Approximately 6,500 nurses were re-employed in the public sector in Ghana in 2002 (Table 1) and nurse vacancy rates are estimated to have increased significantly over the period between 1998 and 2002 (Table 2).

Table 1: Nurses in Ghana

Cadre 2002	Total	Public	Private	NGO
Registered Nurses/Midwives	10,265	6,481	3,784	not known

Source: Buchan and Dovlo (2004).

Table 2: Estimated vacancy levels in Ghana, Ministry of Health 1998, 2002

	1998	2002
Registered Nurses Vacancy	25.5%	57.0%

Source: Buchan and Dovlo (2004).

There are different sources of data on outflow of nurses from Ghana to other countries. As in many countries, these different data sources are not always in alignment. Buchan and Dovlo (2004) cited Ghanain data estimating that in 2001, 2,972 nurses left Ghana compared to 387 in 1999; mainly, in this case to the UK, USA and Canada, whilst the General Secretary of the Ghana Registered Nurses Association (GRNA) reported that membership had reduced from over 12,000 in 1998 to under 9,000 in 2003. Verification data from the Nurses and Midwives Council for Ghana show an upward trend in verifications issued to other countries to the year 2001, a dip in 2002, and apparent increase in 2003 (data for the first five months only of this year). The UK is the main source of verification requests, accounting for three quarters of the total.

Table 3: Ghana nurses verification: Country of destination and year

Country of Destination	Number and Year of Seeking Verification						
	1998	1999	2000	2001	2002	2003*	Total
USA	50	42	44	129	81	80	**426**
UK	97	265	646	738	405	317	**2,468**
Canada	12	13	26	46	33	10	**140**
South Africa	9	4	3	2	6	-	**24**
Other	4	4	8	8	5	-	**29**
Total:	**172**	**328**	**727**	**923**	**530**	**407**	**3,087**

*Jan-May, 2003 only

Source: Ghana Nurses and Midwives Council/ Buchan and Dovlo (2004).

Buchan and Dovlo (2004) report that Ghanain nurses prefer the UK as a destination because it does not require the nurse to sit pre-entry examinations and only requires an adaptation once registration and qualification in Ghana have been verified and accepted. For Ghanain nurses, the need to write examinations and other higher costs (exam fees, air ticket costs, etc.) makes the USA less attractive *(Note: in 2005, the US NCLEX examination will be available for the first time in three non-USA locations: South Korea, Hong Kong and the UK).*

Focus groups' discussions with nurses and doctors in Ghana conducted for Buchan and Dovlo (2004) highlighted various key reasons for outflow to other countries, which may be grouped into the following key areas:

Table 4: Reasons for considering migration: Focus groups, Ghana, 2004

- Low salary and remuneration.
- Limited career prospects.
- Feelings of lack of respect/value placed in health workers by country/system.
- Concern about poor governance and management of the health system.
- Concern about poor retirement benefits and prospects.

Source: Buchan and Dovlo (2004).

Focus group respondents told of problems with "handing-over" at the end of shifts because qualified nurses were unavailable, and of extremely low staffing levels – a single professional nurse required to oversee a full ward of some 30-40 beds with only small numbers of enrolled nurses or untrained attendants. Buchan and Dovlo (2004) also reported that the Nurses Council (also responsible for nurse education) estimates that they have lost 20-30% of tutors over the past few years, predicted to severely limit the country's capacity to educate future generations of nurses.

Swaziland

A report conducted on behalf of WHO (Dlamini, undated, but 2003 or more recent) examined nurse migration from Swaziland, a small sub-Saharan African country. The report noted that 3,200 nurses were registered in the country. A small survey of nurses who had left Swaziland (n = 20) reported that half (50%) were working in South Africa (highlighting the significant intra-regional migration flows), and 40% were working in the UK. Main reasons for leaving Swaziland were reported to be relatively low salaries and benefits, poor working conditions and lack of career opportunities.

Barbados

Migration is a widely accepted social phenomenon and part of the social and economic fabric of Caribbean life. As a relatively small country, with well-educated English speaking health professionals, Barbados, like other Caribbean islands, can be vulnerable to the effects of out-migration. The vulnerability of the Caribbean to the possible negative effects of out-migration of health professionals is exacerbated by its geographical proximity to North America and by its long established migratory paths both to North America and the UK (Thomas Hope 2002). In 2003, the draft nursing strategy for Barbados noted, "Records show that between 2000 and 2001 approximately 10% of nurses have left the nursing sector, with a significant percentage seeking employment overseas" (Ministry of Health, Barbados 2003: 11).

Research conducted in 2003 (Buchan and Dovlo 2004) estimated the annual number of general nurses resigning from the Queen Elizabeth Hospital (QEH) (the only general hospital on the island), reportedly to migrate, over the period 2000-2003 (see Table 5).

Table 5: Annual number of nurses resigning to emigrate, QEH, Barbados

2000	**2001**	**2002**	**2003** (partial)
26	16	18	14

Source: Buchan and Dovlo (2004).

Measured against a working 'stock' of approximately 500 nurses employed in the hospital, this represents an average outflow due to migration of approximately 4% per annum in recent years. These nurses were reported to have gone to the UK, US, Canada and other Caribbean Islands (e.g. Bahamas).

It should be noted that these data relate only to nurses who are known to have migrated. Some nurses do not resign prior to having emigrated – they may take holiday or sick leave, and then travel abroad, only actually "resigning" at a later date. In some individual cases it will be unclear if the nurse has actually left the country, or just left the hospital. The Caribbean is known for its circular migration patterns (back and forth flow), and these statistics do not show how many nurses returned to their homeland after a temporary period of employment abroad.

The Caribbean office of the Pan American Health Organisation (PAHO) audited the nursing workforce and migration factors as part of its work on managed migration. Focus group interviews of nurses were conducted in different countries across the Caribbean. The PAHO assessment identified the following key factors influencing nurses' decisions to stay or leave employment in the Caribbean:

Table 6: "Push" factors encouraging Caribbean nurses to emigrate

- Financial.
- Poor working conditions.
- Lack of professional development opportunities.
- Lack of promotion opportunities.
- Non-involvement in decision-making.
- Lack of support from supervisors.

Source: PAHO (2001).

Focus groups of nurses in Barbados revealed that some of the participants were critical of the current career and development opportunities available to them in Barbados; several alluded to the fact that promotion was based on seniority rather than merit and that it was extremely difficult to achieve flexible working hours because of the rigid management (similar findings have been reported from Trinidad and Tobago, Schmidt 2003). The focus group participants also identified the main factors facilitating migration:

Table 7: Main factors enabling out-migration of nurses, Barbados, 2003

- Tradition of migration, with Barbadian communities/relatives in destination countries.
- Recruitment visits to Barbados by agencies (mainly USA).
- Recruitment facilitated by Barbados-based agencies.
- Personal contacts with Barbadian health professionals in destination country.
- Internet search/web-based recruitment by agencies.

Source: Buchan and Dovlo (2004).

The opportunities to connect with well-established communities in destination countries, and the role of the Internet in facilitating the identification of career opportunities in other countries, have also been noted as factors in general trends of skilled worker migration from the Caribbean (Thomas Hope 2002).

South Africa

As one of the largest countries in sub-Saharan Africa, and also one of the most developed, South Africa has experienced both in-migration and out-migration of nurses. DENOSA, the national nursing association and professional union in South Africa, commissioned a report on nurse emigration, which was published in 2001 (Xaba and Philips 2001). The report authors cautioned about differences in emigration data collected by different institutions in South Africa. They report that it was not possible to determine the actual number of nurses leaving South Africa, or to which countries they had moved. This limitation has also been noted in relation to broader based examinations of skilled worker migration from South Africa; one recent report suggested that official data underestimates actual outflow from the country (Bhorat et al. 2002).[5]

The DENOSA report assessed verification data held by the South African Nursing Council (SANC) (see Table 8). This showed applications to work as a nurse in another country, but did not necessarily mean that the nurse actually left (it could also include double counting). There was a clear upward trend in verifications issued, until the year 2000. *(Note: whilst not commented on by the authors, the reduction in verifications in the year 2000 may be linked to the reduced 'outflow' from South Africa to the UK in 2000 as a result of the introduction of 'ethical' recruitment guidelines in England in November 1999, although a completely unrelated dip in numbers is also seen in 1994 and 1995.)*

Table 8: Verifications issued by the South African Nursing Council, 1991-2000

Year	No. of applications for verifications of qualifications	Percentage change year on year
1991	455	–
1992	578	27.0%
1993	595	2.9%
1994	547	- 8.1%
1995	511	- 6.6%
1996	957	87.3%
1997	1,359	42.0%
1998	1,746	28.5%
1999	3,672	110.3%
2000	2,543	- 30.7%

Source: Xaba and Phillips, SANC (2001).

The report also examined data on actual outflow reported by other governmental agencies – Statistics South Africa and the Department of Home Affairs. It noted that the data from these other sources is 'likely to release inaccurate figures' and is contradictory. The UK, Saudi Arabia, New Zealand and Australia were reported to be the most common destinations for emigrating nurses, on the basis of the incomplete data that was available.

The main impacts of nurse emigration were reported to be:

- Frustration/de-motivation of nurses remaining in South Africa.
- Loss of skills (and of quality of service).
- Increased staff shortages (60% of institutions surveyed reported it was difficult to replace nurses who have left).

[5]See also Padarath et al. (2003).

DENOSA conducted a workshop to consider the implications of emigration. Noting that 'migration is a non-negotiable right of the nurse embedded in the Constitution', it raised concerns about shortages, poor working conditions and 'exploitation' within and outside South African borders. It argued that remuneration and service conditions of nurses in South Africa must be improved. The main 'push' factors identified by the report commissioned by DENOSA included:

Table 9: Main push factors encouraging nurses to leave South Africa

- Lack of competitive incentives in the public sector.
- Work pressures – long hours, poor resources and high ratios of patients per nurse.
- Few opportunities for career development.
- Escalating crime and the rise of HIV/AIDS in South Africa.

Source: Xaba and Philips (2001).

The report also noted that South Africa had recruited unspecified numbers of foreign nurses, who were working in South Africa. The small survey of nurses who had migrated from Swaziland (Dlamini, reported above) indicated that some were working in South Africa; another report highlighted a "brain drain" of nurses from Lesotho to South Africa (Bhorat et al. 2002) and a third reported on movement to South Africa from other countries in Africa and from Cuba (Padarath et al. 2003).

The South African Department of Health, which finances public sector nursing education, estimates the cost of training a nurse at 10 times the GDP per capita, and training a physician at 23 times the GDP per capita (OECD 2002). Based on South African migration statistics, the Department estimates that the cost impact of migration of nurses and doctors is equivalent to total foregone investment of around US$1 billion, equivalent to 17 percent of national public health expenditures in 2000.

The Philippines

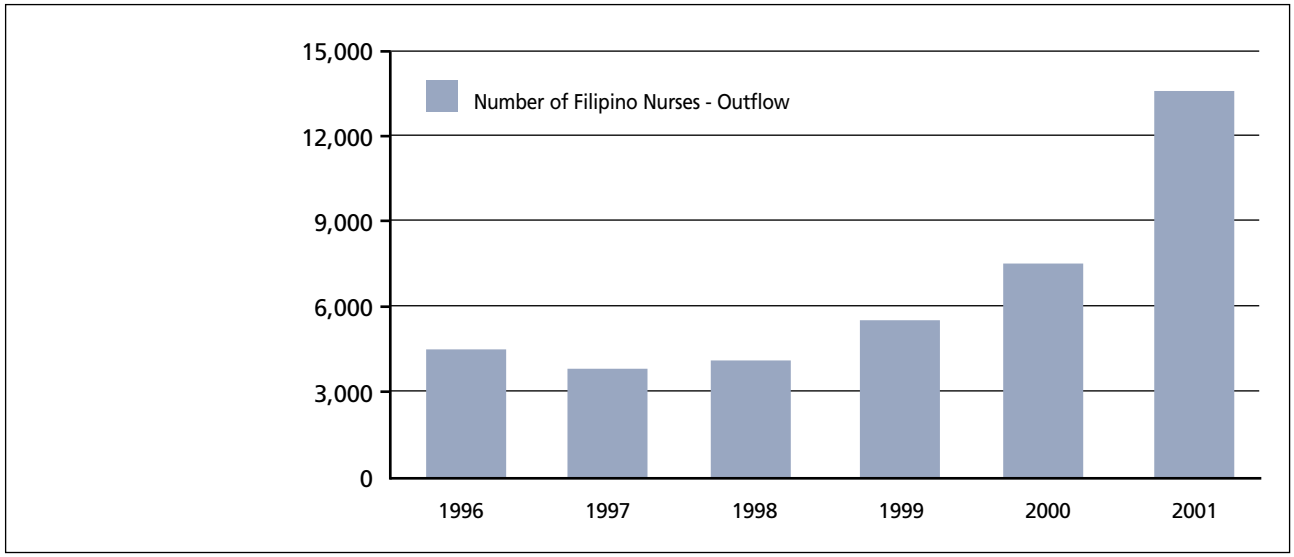
The Philippines is well known as a source country for nurse migrants, and other types of migrant worker. While there is no explicit policy that encourages migration, there are a number of government agencies established to facilitate the deployment and the protection of its citizens abroad: the Philippine Overseas Employment Authority (POEA) and the Office of Workers Welfare Administration (OWWA). These have been cited as "good practice" in handling the needs of workers deployed overseas. These organisations also facilitate worker migration.

Filipino overseas migration reflects the issues of Philippine socio-political and economic life. Overseas migration results in the loss of millions of skilled and unskilled Filipino workers to first world countries due to the limited employment opportunities and relatively low wages in the country.

With persistent but fluctuating 10-year trends of health worker migration since the 1950s, it has been shown that the country has become dependent on health human resource out-migration to address surpluses and other employment related issues. Over the years, health worker migration patterns have largely been driven by economic and career development opportunities overseas.

The Department of Foreign Affairs in the Philippines reports that there are approximately 7.2 million Filipino migrants all over the world. A recent estimate is that 85% of employed Filipino nurses are working internationally – over 150,000 nurses (Lorenzo 2002). After stagnating in the mid 1990s, (due to a reduction in demand from destination countries, particularly the USA) annual outflow of nurses in recent years appears to have increased (see Figure 1).

Figure 1: Outflow of professional nurses from the Philippines



Note: Filipino sources suggest these data may be underestimated.

Source: POEA/Lorenzo (2002).

The top three countries of destination for Filipino nurses for the last decade include Saudi Arabia, the USA, and the UK. Other preferred destinations include Libya, United Arab Emirates, Ireland, Singapore, Kuwait, Qatar and Brunei (POEA 2003). In recent years, Saudi Arabia has been the main destination of nurses. The USA market was dominant in the early 1990s, but after 1995, nurse deployment in the USA declined significantly, dropping to a low of 0.1 percent of all nurse deployment in 1998. The UK has increased in prominence since 2001 – being the "top" destination in 2001 when deployment to the UK accounted for a high of 40% of all Filipino nurse deployment.

In 2001, the UK, Saudi Arabia, Ireland and Singapore were the four most important destinations for Filipino nurses (see Table 10).

Table 10: Outflow of professional nurses from the Philippines 2001

Destination Country	Male	Female	Total
UK	1,152	4,231	5,383
Saudi Arabia	483	4,562	5,045
Ireland	311	1,218	1,529
Singapore	45	368	413
USA	56	248	304
United Arab Emirates	79	164	243
Other	143	476	619
TOTAL	**2,269**	**11,267**	**13,536**

Source: POEA/Lorenzo (2002).

Lorenzo (2002) noted that the 'pull' factor of demand for Filipino nurses from other countries had varied markedly over time, with huge outflow to the USA and Middle East in the 1980s, but lower demand from these countries in the 1990s. Recently, this has been replaced by heavy recruitment from the UK and Ireland.

The Philippines is relatively unusual in the extent to which agencies and organisations in the country facilitate a high level of active recruitment from 'destination' developed countries. One factor is the opportunity to encourage remittances – regular transfer of significant amounts of foreign currency being returned from Filipino nationals working abroad. Remittance income can represent a significant source of "hard" currency for developing countries (IOM 2004), and nurses from the Philippines, the Caribbean and other source countries are important generators of funds back to their home countries. Recent research on Tongan and Samoan nurses working in Australia suggests they make a major contribution to the economies of their home countries, which far surpasses the initial financial investment of educating the nurses (Connell and Brown 2004).

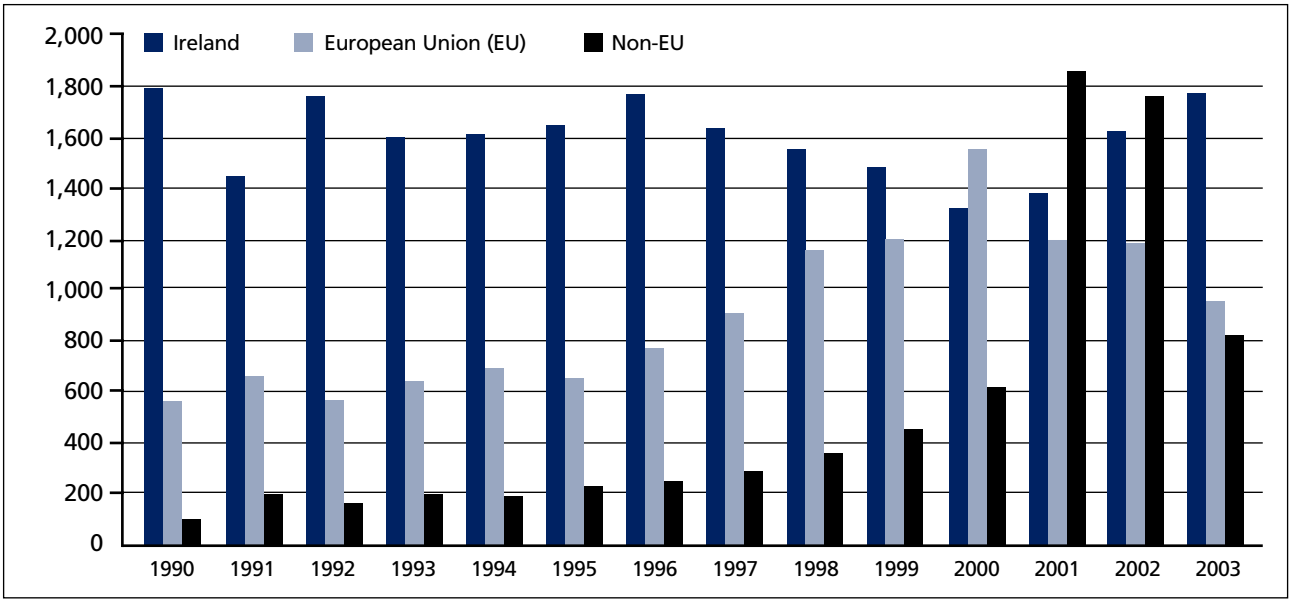
With the exception of the Philippines, and, to an extent India and Cuba, in most developing countries, outflow of nurses is the result of the individual decisions of nurses and their responses to push and pull factors rather than being policy led. However, it is reported that several other countries in the Caribbean, Africa and Asia are now considering developing the capacity to "train for export" of nurses.

"Destination" countries

In a recent report on health systems, the OECD (2004b) highlighted that "there are increasing concerns about nursing shortages in many OECD countries". There appears to be an upward trend in inflow of nurses to some developed countries, as a response to these nursing shortages. Recent research (Buchan, Parkin and Sochalski 2003) used registration data from five destination countries – Australia, Ireland, Norway, the UK and the USA – to examine the international flows of nurses.

Analysis of registration data found that the inflow of nurses from developing countries to these destination countries has risen in recent years, in some case quite substantially, in terms both of actual numbers and as a proportion of all "new" nurses becoming eligible to practice. Ireland and the UK are two countries where the increase in inflow of international nurses was most pronounced. Figures 2 and 3 show the registration of domestic and international nurses in these two countries in recent years.

Figure 2: Source of newly registered nurse registration, Ireland

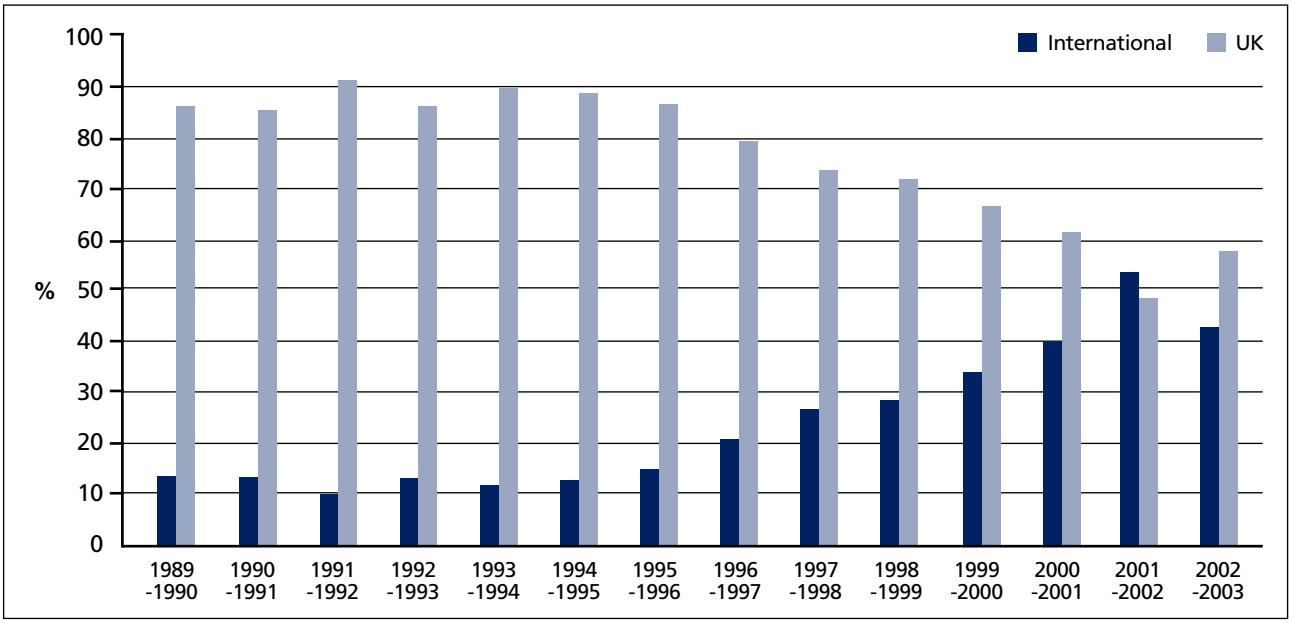


Source: An Bord Altranais, Dublin, Ireland (Various years).

In Ireland, the relative importance of non-Irish, non-EU sources rose rapidly to the extent that, in 2001, about two thirds of new entrants to the Irish nursing register were from other EU and international sources. The principal contributors were the UK, the Philippines, Australia, South Africa and India. The number of international nurses first registering in Ireland has since dropped back, but has remained at a level above that noted in the middle of the last decade.

Figure 3 shows the comparative importance of non-UK source countries, in relation to the annual total number of all new nurses entering the UK register.

Figure 3: International and UK sources as a % of total new nurses admitted to the UK Register, 1989/90-2002/03 (Initial Registrations)



Source: UKCC/NMC data (Various years).

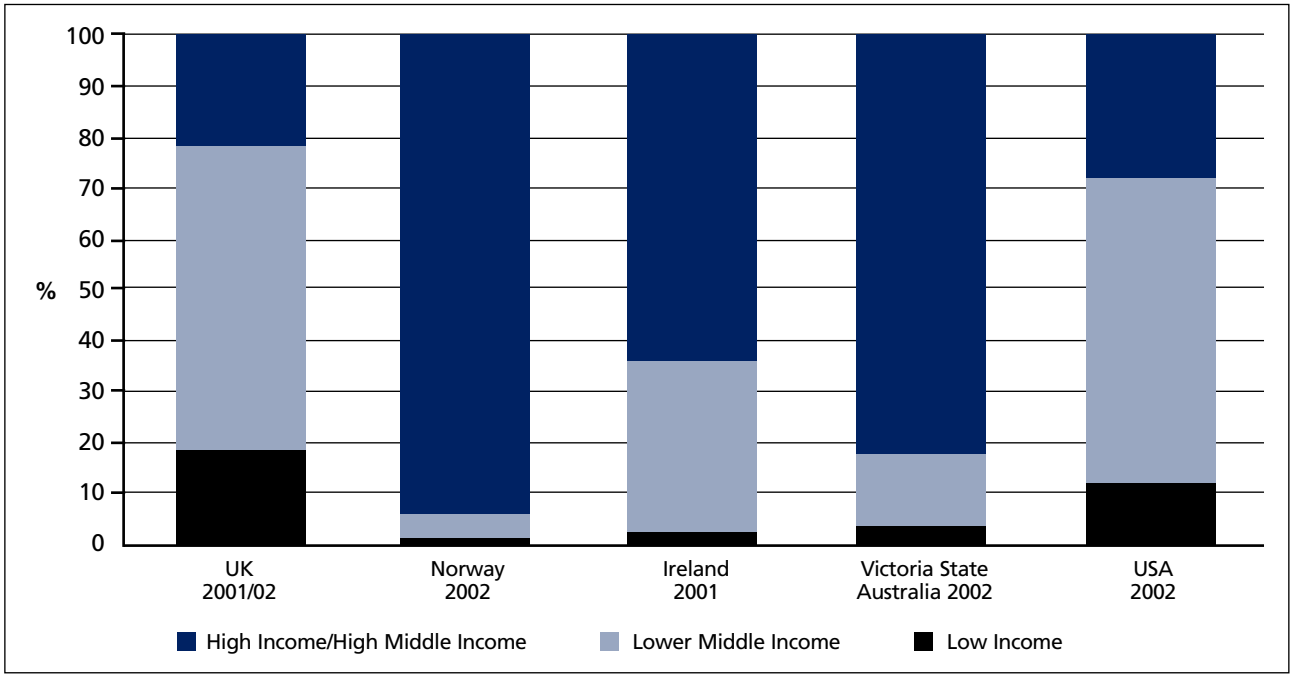
This relative importance of non-UK sources has increased year on year since the mid 1990s, peaking in 2001-2, when more than half the new entrants to the register were from abroad. (Note: the apparent drop back to 43% of the total in 2002-3 may be related to the registration backlog in that year). The main source countries for international nurses have been the Philippines, Australia, South Africa and India.

These examples of Ireland and the UK highlight that some developed countries have become much more active in international recruitment of nurses. Similar patterns of growth are predicted in other developed countries such as the USA (Brush, Sochalski and Berger 2004), and the Netherlands (de Pasch 2002). Whilst some recruitment is from one developed country to another (e.g. Canada to USA, Australia to the UK, UK to Ireland), the increase of nurse recruitment from the developing world to the developed is more significant. For example, in countries, such as the UK, growth in recruitment from other developed countries (e.g. Scandinavian or EU countries) has remained static or has fallen, whilst there appear to be increased flows of nurses from developing countries.

Some countries in the Middle East and elsewhere have also traditionally relied on recruiting nurses from other countries. In 2000, two thirds of staff nurses working in Oman were non-Omanis. The country is currently pursuing a policy of "Omanization" of its workforce to reduce reliance on recruits from other countries (Ministry of Health, Oman 2000). Another example is Singapore, which recruits from China, the Philippines and Malaysia. One fifth (20%) of the nurses on the Singapore register in 2003 were "non-resident", and a further 10% were resident non-Singapore nationals (Singapore Nursing Board 2003).

The extent to which different destination countries rely on recruiting from different "mixes" of source countries is highlighted in Figure 4 below. Data for Australia (Victoria State), Ireland, Norway, the UK and the USA are used to illustrate the source countries, by level of development, as measured by the World Bank. The UK, the USA and, to a lesser extent, Ireland are recruiting significant proportions of international nurses from lower middle income and low-income countries, as defined by the World Bank. In contrast, Norway and Victoria State are primarily registering nurses from other high income or high middle-income countries.

Figure 4: Inflow of international nurses to UK, Norway, Ireland, Victoria State (Australia) and USA with source countries defined by World Bank classifications



Source: Buchan and Sochalski (2004).

The growth in active recruitment by some developed countries, as they attempt to address nursing shortages, is a key driver in the current growth in nurse migration. The number of source countries, the target for international nurse recruitment, has steadily increased over the years. In the UK, the number of countries sending recruits has increased from 71 in 1990 to 95 countries in 2001 (Buchan and Sochalski 2004).

Some countries, such as the UK, have made international recruitment an explicit national policy (i.e. it is government led); in others, such as the USA, it is primarily driven by individual employers. One significant element in the dynamic of international recruitment is the role of recruitment agencies, who act as intermediaries in the process. Some are based in the source countries; others are located in destination countries but work internationally. These agencies act on behalf of employers, charging fees to employers (and in some cases to nurses) to recruit and transport the nurses to the destination countries. They often also act on the nurses' behalf in obtaining the necessary work permits and registration.

Agencies thus both stimulate and ease the process of migration for individual nurses. There have been reports of some agencies providing misleading information to nurses about conditions in destination countries, or charging nurses unnecessary or inflated fees for travel. Concern about "unethical" behaviour from some recruitment agencies led the Department of Health in England to establish a list of "preferred provider" agencies that agreed to abide by a Code of Practice (Department of Health 2001). The ICN, in its Position Statement on Ethical Nurse Recruitment, calls for a regulated recruitment process based on ethical principles that guide informed decision-making and reinforce sound employment policies.

There are also international instruments (conventions) which provide some protection to nurses and other migrant workers: the 1990 UN Convention and the two International Labour Office (ILO) migrant worker Conventions (C.97 and C.143). These Conventions provide international good practices for ensuring protection to migrant workers. Several European countries have ratified one or both of these ILO Conventions. The majority of the signatories, however, are from the developing world, also their citizens being most directly implicated and in need of protection against exploitation or abuse. There are other ILO Conventions on nursing, which are relevant to improving working conditions and retention.

Section Two: Nurse Migration – Policy Implications and Knowledge Gaps

The previous section has highlighted a trend of growth in migration of nurses from some developing countries, stimulated by poor working conditions, poor pay and career prospects, and facilitated by active recruitment in some developed countries. Given data limitations and incompatibility, it is not possible to develop a detailed overview of all flows of nurses between countries. There are also aspects of the dynamics of nurse migration that are little understood, because of current knowledge gaps.

International recruitment of nurses creates challenges for "source" and "destination" countries, and for individual nurses themselves. Some of the key issues for country governments and nurses are summarised in Table 11. It also highlights some of the potential opportunities created when nurses are, or can be, internationally mobile.

Table 11: International recruitment of nurses: Possible opportunities and challenges

	Opportunities	Challenges
Destination countries	Solve skills/ staff shortages. "Quick fix".	How to be efficient, and ethical in recruitment.
Source countries	Remittances. Upskilled returners (if they return). Lower unemployment in certain cases.	Outflow may cause shortages; negative impact on delivery of care. Costs of "lost" education. Increased costs of recruitment of replacements. "Manage" migration?
Internationally mobile nurses	Improved pay, career opportunities, education.	Achieving equal treatment in destination country.
Static nurses	Improved job and career opportunities (if worker oversupply).	Increased workload as other nurses leave. Lower morale.

Policy issues

The increases in flows of nurses across national boundaries create a series of policy questions for national governments and international agencies. This section assesses some of these main policy issues, and also discusses where the current knowledge gaps are most critical in preventing a full assessment and understanding of the dynamics of nurse migration.[6]

[6]See also e.g. Stilwell et al. 2003; Bach 2003; Padarath et al. 2003.

"Source" countries

Source countries: Policy questions and likely knowledge gaps

Policy questions (in source countries)

- Should outflow be supported or encouraged (to stimulate remittance income or to end oversupply)?
- Should outflow be constrained or reduced (to reduce brain drain)? If so, how (what is effective and ethical)?
- Should recruitment agencies be regulated?

Knowledge gaps (in many countries)

- What are the destination countries for outflow?
- How much outflow is permanent or temporary (short or long term)? If temporary, how can "returners" be encouraged?
- How much outflow is going to health sector-related employment and education in other countries? What proportion is going to non-health-related destinations?
- What is the size of outflow to other countries compared with outflow to other sectors within the country?
- What is the impact of outflow?
- Why are nurses leaving?
- What retention measures are required to address the need to migrate?
- What measures encourage and facilitate return migration?
- How should flows be monitored?

Source: adapted from Buchan, Parkin and Sochalski (2003).

Countries that are experiencing a net outflow of nurses need to be able to assess why this is happening and evaluate what impact it is having on the provision of health care in the country. Reliance on incomplete data or incompatible data from different sources often means that it is not possible even to have an accurate picture of the trend in outflow of nurses, let alone any assessment of the impact of this outflow on the health services.

It is important that the available information base enables policy-makers to assess the relative loss from outflow to other countries in comparison with other internal flows, such as nurses leaving the public sector to work in the private sector or leaving the profession to take up other forms of employment. For example, nurses working in the private sector in Zimbabwe reportedly earn about 40% more than those in the public sector (Padarath et al. 2003). International outflow may be a very visible but relatively small numerical loss of workers compared with flows of nurses leaving the public sector for other sources of employment within the country.

Unmanaged outflow of nurses may damage the health system or erode the current and future skills base. Various countries (e.g. Ghana) have initiated policy responses, including bonding nurses to home employment for a specified period of time after completion of training. This does not appear to have been effective – with compliance not being effectively monitored, and with scope to buy out of the bond.[7] Preventing nurses from leaving through the use of monetary or regulatory barriers is likely to be an ineffective policy response, and

[7] See also South Africa: Padarath et al. (2003); and Malawi: Muula et al. (2003).

does nothing to alleviate the push factors that stimulated the nurse's desire to leave; it also cuts across notions of free mobility of individuals.

Other policy responses to reducing outflow relate to a more direct attempt to reduce the push factors: by dealing with matters concerning poor pay and career prospects, poor working conditions and high workloads, responding to concerns about security, and improving educational opportunities, etc. The managed migration initiative in the Caribbean (see box below) is a broader based attempt to take a more proactive stance on migration – recognising that it is not possible to stop it where there are severe push/ pull imbalances.

Managed migration of nurses in the Caribbean

The "Managed Migration" project was initiated by the Caribbean Nurses Organization (CNO) and the Caribbean office of the Pan American Health Organization (PAHO). CNO and PAHO have joined with other organisations including the Regional Nursing Board (the umbrella body for the chief nurses from Caribbean countries) to develop a framework, which is intended to provide a regional strategy for retaining sufficient nurses in the Caribbean whilst also respecting the individual nurse's right to choose where they work and live. There is a six-part framework to the initiative:

1. Recruitment and Retention	Recruitment video/TV advertising. "Year of the Caribbean Nurse" Mentorship programme.
2. Education and Training	Study to evaluate current training capacity. Development of distance learning, base nursing degree at University of West Indies (UWI).
3. Utilisation and Deployment	Introduction and evaluation of workload measurement tool.
4. Terms and Conditions of Employment	Healthy Workplace Initiative. Promotion of ILO resolutions on nursing.
5. Management Practices	"Magnet Hospital" Programme. Leadership for Change Programme. Nursing/HR database.
6. Policy Development	Evaluation/ country "report card".

Sources: Yan (2001); Buchan and Dovlo (2004).

Events in the Caribbean highlight another policy response based on the recognition that outflow cannot be halted where principles of individual freedom are to be upheld, but that interventions can be developed to ensure that such outflow is managed and moderated.

The scope to encourage "returners" – temporary migrants who may be in a position to return to the source country – should also be examined (Wickramasekara 2003). This issue requires more consideration, as there may be possibilities of harnessing the skills and contribution of "diaspora" of health professionals who have migrated.[8]

Source countries: Knowledge gaps

The ability to determine the actual impact of out-migration in many developing countries is limited by the lack of complete data on the size of outflow, trends and destination countries.[9] There is a need to "place" the level and impact of international out-migration of nurses in a broader labour market context. For example, in many countries, there is a need for a more detailed assessment of the actual impact of outflow of health workers to other countries, in comparison to that caused by outflow from the health sector, but remaining in-country.

The other main issue, which is under-explored, is a more detailed evaluation of the various attempts to constrain outflow, or encourage returners. Case study research would provide more evidence on "what works" (and is appropriate); such research could be linked to broader based studies, which look at all interventions to improve the recruitment and retention of health workers in the country.[10] This, in turn, is related to issues of capacity, governance and planning within the country.

Another important associated issue is gender within nursing and the broader health care workforce. There may be differing patterns of migration and migration experiences, for male and female health workers. For example, the multi-country study of migration of health workers in the 1970s, by Mejia et al (1979), suggested that, at that time, nurses (predominantly female) were likely to migrate over shorter geographic distances than doctors (mainly male). There may also be an issue of whether particular occupations or professions receive differential treatment because they are perceived to be gender specific. In particular the undervaluing of nursing as "women's work" in some countries may be both a direct driver for internationally mobile nurses to leave that country, and an indirect reason why interventions to reduce outflow may be ineffective.

As well as being the focus of policy research studies, these topics could also be the focus of regional workshops, bringing together the Ministry of Health and human resource planners, health sector employers, national nurses associations, NGOs and representatives of civil society to share knowledge and develop a better understanding of which policy interventions can assist in ameliorating the negative impacts of outflow of nurses. International organisations such as ICN, ILO, WHO and the Commonwealth Secretariat have already been instrumental in raising awareness of these issues by sponsoring research and by supporting stakeholder meetings and conferences.

[8]See e.g. Padarath et al. (2003); Saravia and Miranda (2004).

[9]See e.g. Buchan et al. (2003); Padarath et al. (2003).

[10]See e.g. EQUINET/ Health Systems Trust (2004).

"Destination" countries

The policy challenges for destination countries mirror those of source countries. The first concern is monitoring and assessment, as the ability to monitor trends in inflow of nurses (in terms of numbers and sources) is vital if the country is to integrate this information into its planning process. Equally important is an understanding of why nursing shortages are occurring – is it because of poor planning, unattractive pay or career opportunities, early retirements, etc.?

Destination countries: Policy questions and likely knowledge gaps

Policy questions (in destination countries)

- Why is an inflow of nurses necessary?
- Is inflow sustainable?
- Is inflow a cost-effective way of solving skills shortages?
- Is inflow ethically justifiable?
- Should/ how can recruitment agencies be regulated?

Knowledge gaps (in many countries)

- What are the source countries for inflow?
- How much inflow is permanent or temporary?
- How much inflow is going to health sector-related employment and education in the country? What proportion is going to non-health-related destinations?
- Is inflow effectively managed?
- Why are nurses coming?
- How should flows be monitored?
- What measures are in place to protect migrant nurses from abuse and exploitation?
- Do migrant nurses require specific support to be effective health care providers?

Source: adapted from Buchan, Parkin and Sochalski (2003).

An initial assessment of the contributing factors for the staffing shortages in any country needs to be undertaken and those factors taken into account. This assessment would include that of nurse "wastage" to other sectors or regions within the country. In most countries, both developed and developing, there are "pools" of individuals with nursing qualifications who are not currently working in nursing (some may be retired), e.g. in the USA, there are over two million nurses fully registered, but several hundred thousand are not in the health sector.

Solving the nursing shortage by tapping into this "pool" in developed countries would significantly reduce the international labour market demand and, in turn, eliminate many of the challenges of mass nurse migration. The migration push factors found in developing countries are a reflection of the key causes identified for the nursing shortage in developed countries. Both need to be addressed if effective policies are to be applied.

It is crucial to assess the relative contribution of international recruitment of nurses compared with other key interventions (such as home-based recruitment, improved retention, and return of non-practising health professionals) in order to identify the most effective balance of interventions. This assessment has to be embedded in an overall framework of policy responses to health sector workforce issues if it is to be relevant.

The second policy challenge for destination countries can be characterised as the "efficiency" challenge. If there is an inflow of nurses from source countries, how can this inflow be moderated and facilitated so that it makes an effective contribution to the health system? Policy responses have included "fast tracking" of work permit applications; developing coordinated, multi-employer approaches to recruitment; developing multi-agency approaches to coordinated placement; and providing initial periods of supervised practice or adaptation as well as language training, cultural orientation and social support.[11]

The third policy challenge of destination countries concerns ethics. Is it justifiable, on moral and ethical grounds, to recruit nurses from developing countries?[12] The simple response may be that it should not be justifiable to contribute to "brain drain" in other countries, but a detailed examination of the issue reveals a more complex and blurred picture. One fundamental issue is the ability of individual nurses to migrate if they so wish. It can also be argued that countries that do not attempt to address the negative push factors, which make some nurses migrate, could also be behaving in an "unethical" manner.

Account must also be taken of the development of bilateral and multilateral agreements, where source and destination countries reach agreement on the managed flow of nurses or other workers.[13] A few countries, such as England (Department of Health 2001) have introduced "ethical" codes of conduct for public sector employers who are recruiting internationally, whilst other countries such as the Netherlands have adopted an approach where international recruitment is the "last resort", only used if vacancies have not been filled by home based action (de Veer et al. 2004). The Commonwealth has also introduced a multilateral code to underpin the recruitment of health workers within the Commonwealth countries (Commonwealth Secretariat 2003). There has been little independent evaluation of the impact and effectiveness of such approaches. Such evaluation is often constrained by inadequate data,[14] and would require clarity about the content of any such code, detail about coverage (i.e. which sectors/ work locations does it cover?) and also systems to monitor compliance.

Destination countries: Knowledge gaps

As noted above, various types of bilateral and multilateral recruitment agreements are being developed by different recruiting countries. Some of these approaches have an explicit "ethical" dimension, or attempt to focus on encouraging a "win-win" situation for the source as well as the destination country.[15]

Detailed case studies examining the content and actual operation of some of these agreements would highlight the pros and cons of different approaches, and would assist in identifying which appeared to be most effective and appropriate for source countries. Some of the possible interventions for "win-win" situations are summarised in Table 12 on the next page. Some are drawn from initiatives already underway.[16] Few have been tested or evaluated to any extent. Future research on the trends and impact of nurse migration should focus on assessing these current and future interventions.

[11]See e.g. Hawthorne (2001); Buchan et al. (2003); Brush et al. (2004).

[12]See e.g. Muula et al. (2003).

[13]See e.g. ICN (2001); Tjadens (2002).

[14]See e.g. Buchan and Dovlo (2004).

[15]See e.g. IOM (2003); Buchan and Dovlo (2004); Stilwell et al. (2004).

[16]See e.g. Commonwealth (2003); Department of Health (2003); Physicians for Human Rights, PHR (2004) and the Caribbean managed migration project.

Table 12: Examples of potential policy interventions in international recruitment

Level	Characteristics/examples
ORGANISATIONAL	
"Twinning"	Hospitals in "source" and "destination" country develop links, based on staff exchanges, staff support and flow of resources to source country.
Staff exchange	Structured temporary move of staff to other organisations, based on career and personal development opportunities/organisational development.
Educational support	Educators and/or educational resources and/or funding in temporary move from "destination" to "source" organisation.
Bilateral agreement	Employer(s) in "destination" country develop agreement with employer(s) or educator(s) in "source" country to contribute to, or underwrite costs of, training additional staff, or to recruit staff for fixed period, linked to training and development prior to return to "source" country.
NATIONAL	
Government-to-government bilateral agreement	"Destination" country develops agreement with "source" country to underwrite costs of training additional staff, and/ or to recruit staff for fixed period, linked to training and development prior to staff returning to "source" country, or to recruit "surplus" staff in "source" country.
Ethical recruitment code	Destination country introduces Code that places restrictions on employers - in terms of which source countries can be targeted, and/or length of stay. Coverage, content and compliance issues all need to be clear and explicit.
Compensation	Much discussed, but not much evidence in practice - destination country pays compensation - in cash or in form of other resources - to source country. Possibly some type of sliding scale of compensation related to length of stay and/ or cost of training, or cost of employment in destination country; possibly "brokered" via international agency?
Managed migration (can also be regional)	Country (or region) with outflow of staff initiates programme to stem unplanned out-migration, partially by attempting to reduce impact of push factors, partially by supporting other organisational or national interventions that encourage planned migration.
Train for export	[can be a subset of managed migration] Government or private sector makes explicit decision to develop training infrastructure to train health professionals for export market - to generate remittances, or up-front fees.
INTERNATIONAL	
International code	As above, but covering a range of countries, its relevance will depend on content, coverage and compliance. The Commonwealth code is an example.
Multilateral agreements	Similar to bilateral agreements (above), but covering a number of countries (regions). Possibility of brokering/monitoring role by international agency.

Source: Derived from Buchan and Dovlo (2004).

Further research should also include undertaking more detailed cohort studies of international recruits in the destination countries, to develop a better understanding of their career plans, reasons for moving, how long they plan to remain in the destination country, level of remittances sent home, etc. This would enable a better understanding of their experiences, and the extent to which they have received fair and equal treatment in the destination country. Some studies have been conducted (e.g. Yi and Jezewski 2000; Daniel et al. 2001; Royal College of Nursing 2003), but these tend to be small scale or "one off" snapshot surveys, rather than cohort studies tracking nurses over time.

Finally, it is evident that, both for national governments and for international agencies, there is a need to develop a better understanding of the level and dynamics of the flows of nurses. Further research could also be supported in source and destination countries to improve monitoring of flows; this could be undertaken in association with other agencies with an interest in this issue (e.g. ICN, WHO, ILO).

The ILO's Plan of Action 2004 includes ethical recruitment of migrant workers, especially in health and education, as one of the areas for development of guidelines and good practices: "promoting guidelines for ethical recruitment of migrant workers and exploring mutually beneficial approaches to ensure the adequate supply of skilled health and education personnel that serve the needs of both sending and receiving countries, including through bilateral and multilateral agreements" (ILO 2004: 17).

Section Three: Conclusions and Recommendations

Many nurses will continue to be interested in crossing national borders to access "pull" factors – which may be better pay, professional development and improved career opportunities, or the opportunity to experience life and work in a different culture. The demographics in many developed countries – a growing, ageing population and an ageing nursing workforce – make it likely that many of these countries will continue to be active in encouraging inflow of nurses from other countries (Buchan 2002). Given the historically high levels of nurse migration, country governments and international agencies have two policy options: non-intervention; or some level of intervention to attempt to manage the migration process so that it is nearer a "win–win" situation, or at least is not exclusively "win-lose", with the countries that can least afford it being the biggest losers.

The root cause of the current relatively high level of nurse migration is nursing shortages in developed countries, combined with the existence of "push" factors of low pay, poor career prospects, unsafe work environments and instability in some developing countries. Nurse migration is often a symptom of more deep-seated problems in country nursing labour markets. The pattern that is emerging is a trend of increase in inflow of nurses to developed countries from a wider range of developing countries, as these countries become more active in using international recruitment to combat nursing shortages. Shared language, common educational curriculum, and post colonial ties between countries, as well as large diaspora or trans-national communities, tend to be the factors determining which developing countries are being targeted as sources of nurses.

The dynamics of the current pattern of migration can change quickly, but generally reflect a trend towards higher levels of mobility across national boundaries. As the level of migration has increased, so has the debate about its implications and the desirability and scope for policy interventions. Some countries have developed "ethical" elements to their recruitment activities and, at an international level, the International Council of Nurses (ICN 2001) has also set out a position statement arguing for ethics and good employment practice in international recruitment. More recently, the Commonwealth (Commonwealth Secretariat 2003), the World Health Assembly (WHO 2004a), and the Global Equity Initiative have all highlighted the need for better monitoring of, and a more "ethical" approach to, the migration of health workers.

Some developing countries are also intervening to try to add a counter balance. For example, the Caribbean approach to "managed migration" of nurses essentially recognises that out-migration cannot be prevented, but a package is being developed to ameliorate its worst effects, and to seek compensation from importer countries.

Given the underlying demographic, labour market and economic drivers, the current historically high levels of cross border flows of internationally recruited nurses are likely to continue. The problems caused for some developing countries by this migration will continue to be severe. They are losing scarce and relatively expensive to train resources. Levels and quality of care are suffering. Many of the nurse recruits are relatively young, and these countries could also lose out on future leaders in the profession.

At the aggregate level, the challenges are obvious. At the level of the individual, it is less easy to be critical. Who can blame a nurse for claiming freedom of movement, to gain security, better quality of life, or career development? Whilst the debate continues, there is a clear need for the active recruiting countries to examine their own practices, because it is they who are the drivers of the process.

Recruiting internationally may be a quick fix solution for some developed countries, but it is far from clear that it is a cost effective solution in many situations. Importer countries need to ensure that they have developed

their own "home grown" sustainable solutions to achieving greater self-sufficiency, investing in attractive career structures, and improving retention and return of home-based nurses. They should also encourage co-operation at organisational and governmental levels to identify scope for a "win-win" approach to international recruitment, when it is used as a policy instrument.

Recognising that international nurse migration will continue to exist, mechanisms need to be put in place that will safeguard migrants' rights and facilitate their integration into society and their workplace. It is likely that this will need a multi-prong approach incorporating the financial and human resources of stakeholders from both the source and destination countries. Government, professional organisations, trade unions, employers and the for-profit sector (e.g. recruitment agencies) must be held accountable to develop the appropriate structures and procedures.

The recommendations set out in this section are made on the basis of identified key current knowledge gaps. They are also made on the basis that it is unlikely that there will be any slackening in the prominence of international recruitment activity in the next few years. This activity will continue to be stimulated by the significant inter-country imbalances in the pay and career prospects for nurses.[17]

Drawing from the issues and main knowledge gaps highlighted in this report, the key recommendations are:

- One crucial gap is the absence of accurate data on the flows of international nurses; this is a constraint on any effective monitoring, and also limits the ability to assess impact. *Stakeholders at national level and international agencies need to collaborate to agree and implement improved systems to monitor international flows of nurses and other health workers.*
- The position of many developing countries that are sources of international nurse workers is weakened by inadequate workforce data and planning capacity, and it is difficult to assess how much of a "problem" outflow to other countries is in comparison to the numbers of underemployed or unemployed nurses in the country. *These countries must assess and improve their planning systems, and give more policy attention to encouraging and supporting non-practising nurses to return to nursing employment.*
- The overall impact of out-migration of nurses on source countries, in terms of its effect on health systems and on remaining staff, requires more systematic assessment. *More research and evaluation is required to inform national stakeholders and international agencies of the true impact and costs (and/or benefits) of nurse migration.*
- Relatively little is know about the experiences of international nurses now working in destination countries, in terms of their profile and future career plans (including likelihood of return to source countries or onward movement to other countries), and equality of treatment. The structures and services required to protect migrant nurses from exploitation and abuse, while promoting their general well being and integration, need to be further developed and made easily accessible. *Research and evaluation is required to highlight good practice and expose poor practice in the treatment of migrant nurses.*
- The gender issue in relation to the migration of nurses is an important factor; there is a need for donors to support strengthened nurses' professional associations in source countries, so that the position of nurses in society can be promoted by stronger advocacy. *Donors need to focus attention on supporting the strengthening of representative organisations for nurses.*
- The issue of how – or if – to "manage" migration is important, and requires more considered investigation, with systematic assessment of the various models of managed migration. *The various policies and models of managed migration, bilateral agreement, ethical codes, return migrant schemes and possible models of "training for export" require examination and evaluation to support a more effective approach to international recruitment of nurses at national and international level.*

[17] See e.g. Vujicic et al. (2004).

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Abbreviations

3 x 5	Global Initiative Strategic and Operational Framework
AC	Audit Commission
ACETERA	Argentinean Civil Association of Non-University Schools of Nursing in Argentina
ACHIEEN	Chilenean Association of Nursing Education
ACOFAEN	Colombian Association of Schools of Nursing
ADHA	Additional Duty Hour Allowances
AEUERA	Argentinean Association of University Schools of Nursing
AFRO	AFRICA Regional Office
AHRQ	American Health Research and Quality
AHSN	Africa Honour Society for Nurses
ALADEFE	Latin American Association of Faculties and Nursing Schools
ANA	American Nurses Association
APE	Paraguayan Association of Nursing
ARVs	Anti Retroviral drugs
ASEDEFE	Ecuatorian Association of Schools of Nursing
ASOVESE	Association of Schools of Nursing of Venezuela
ASPEFEN	Peruvian Association of Schools of Nursing
AU	Africa Union
AWG	Africa Working Group
CEDU	Uruguay College of Nurses
CHI	Commission for Health Improvement
CHN	Community Health Nurse
CHSRF	Canadian Health Services Research Foundation
CIPD	Chartered Institute of Personnel and Development
CM	Community Midwifery
CN	Community Nursing
CNO	Caribbean Nurses Organization
COFEN	Federal Council of Nursing, Brazil
CREM	Mercosur Regional Council of Nursing
CRHCS	Commonwealth Regional Health Community Secretariat
DENOSA	Democratic Nursing Organization of South Africa
DFID	Department for International Development
DH	Department of Health
DJCC	Directors Joint Consultative Committee
DOT	Directly Observed Treatment
ECN	Enrolled Community Nurse
ECSA	East, Central and Southern Africa
ECSACON	East, Central and Southern Africa College of Nursing
ECSA-HC	East, Central and Southern Africa Health Community
EN	Enrolled Nurse
EPI	Expanded Programme on Immunisation
EU	European Union
FAE	Argentinean Federation of Nursing
FEMAFEN	Mexican Federation of Associations of Schools of Nursing
FEPPEN	Pan American Federation of Nursing Professionals
FIM	Functional Independence Measure
FNHP	Federation of Nurses and Health Professionals (USA)
FP	Family Planning
FTE	Full-Time Equivalents
FUDEN	Nursing Development Foundation (Spain)
GATS	General Agreement on Trade in Services
GAVI	Global Alliance for Vaccines and Immunizations
GDP	Gross Domestic Product
GNP	Gross National Product
GP	General Practitioner
GRNA	Ghana Registered Nurses Association
HC	Healthcare Commission
HIPC	Highly Indebted Poor Countries
HPCA	Health Professionals' Competency Asssurance Act
HPPD	Hours per Patient Day
HR	Human Resource
HHR	Health Human Resource
HRM	Human Resource Management
HSR	Health Sector Reform
ICN	International Council of Nurses
ICNP®	International Classification of Nursing Practice
ICU	Intensive Care Units

IDB	Inter-American Development Bank
IES	Institute for Employment Studies
ILO	International Labour Office
IMR	Infant Mortality Rate
IOM	International Organization for Migration
IOM	Institute of Medicine (USA)
IPC	Infection, Prevention and Control
IUCD	Intra Uterine Contraceptive Device
IWL	'Improving Working Lives'
JLI	Joint Learning Initiative
LPNs	Licensed Practical Nurses
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MSF	Médecins Sans Frontières
MTEF	Medium Term Expenditure Framework
NAFTA	North Atlantic Free Trade Agreement
NCDs	Non Communicable Diseases
NDNQI	National Database of Nursing Quality Indicators
NEPAD	New Partnership for Africa's Development
NGOs	Non-governmental Organisations
NHA	National Health Accounts
NHS	National Health Service
NNAs	National Nurses Associations
OAS	Organization of American States
OCB	Organisational Citizenship Behaviour
OECD	Organization for Economic Co-Operation and Development
OPSNs	Outcomes Potentially Sensitive to Nursing
OWWA	Office of Workers Welfare Administration
PAHO	Pan American Health Organization
PBN	Post Basic Nursing
PDP	Performance Development Plan
PEPFAR	President's Emergency Program for AIDs Relief
PHC	Primary Health Care
POEA	Philippine Overseas Employment Authority
PPP	Purchase Parity Pay
PRODEC	Nursing Development Programme in Central America and the Caribbean
PRSCs	Poverty Reduction Support Credits
PRSP	Poverty Reduction Strategy Papers
QA	Quality Assurance
RBM	Roll Back Malaria
RC	Regional Committee
RCHN	Registered Community Health Nurse
REAL	Latin American Nursing Network
RHMC	Regional Health Ministers Conference
RM	Registered Midwife
RN	Registered Nurse
RPN	Registered Psychiatry Nurse
RSA	Republic of South Africa
SADC	Southern Africa Development Community
SANC	South African Nursing Council
S&T	Science and Technology
SARA-AED	Support for Analysis and Research in Africa - Academy for Educational Development
SEW	Socio-economic Welfare
SSA	Sub-Saharan Africa
TB	Tuberculosis
UAP	Unlicensed Assistive Personnel
UK	United Kingdom
UNAM	Autonomous National University of Mexico
UNESCO	United Nations for Education, Science and Culture Organization
USA	United States of America
UWI	University of West Indies
VCT	Voluntary Counselling and Testing
VF	The Vaccine Fund
WHO	World Health Organization

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