WHO/EIP/OSD/2003.3
English only

International nurse mobility

Trends and policy implications

World Health Organization International Council of Nurses Royal College of Nursing

WHO/EIP/OSD/2003.3
English only

International nurse mobility

Trends and policy implications

James Buchan
Queen Margaret University College
Edinburgh, United Kingdom
jbuchan@qmuc.ac.uk

Tina Parkin
Queen Margaret University College
Edinburgh, United Kingdom

Julie Sochalski
Center for Health Outcomes and Policy Research
University of Pennsylvania
Philadelphia, Pennsylvania, United States of America

World Health Organization
Geneva
2003

Acknowledgements

The report is based on research funded by the World Health Organization, the International Council of Nurses and the Royal College of Nursing.

International nurse mobility: trends and policy implications could not have been prepared without the active contribution of many individuals and organizations in many countries. These include: Australian Nursing Council, Australian Nursing Federation, Royal College of Nursing, Australia and the State registration authorities in Australia, Michele Rumsey; An Bord Altranais, Higher Services Employers Agency, Irish Nurses Organization, the Department of Health and Children (Ireland), Michael Shannon; Democratic Nursing Organization of South Africa, Ghana Registered Nurses Association; Per Kristensen, Nina Hernes, Lawrence Malto, Norwegian Nursing Association, Nordic Nurse Federation, Norwegian Public Employment Service (AETAT), Norwegian Registration Authority for Health Personnel (SAFH); Nursing and Midwifery Council (United Kingdom), Department of Health (England), Royal College of Nursing (United Kingdom); American Nurses Association, Council of Graduates of Foreign Nursing Schools; F. Marilyn Lorenzo; Philippines Nurses Association; European Union; and the International Organization for Migration.

International nurse mobility: trends and policy implications

© World Health Organization 2003

All rights reserved. Publications of the World Health Organization can be obtained from Marketing and Dissemination, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 2476; fax: +41 22 791 4857; email: bookorders@who.int). Requests for permission to reproduce or translate WHO publications—whether for sale or for noncommercial distribution—should be addressed to Publications, at the above address (fax: +41 22 791 4806; email: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

The named authors alone are responsible for the presentation, analysis and interpretation of information in the report.

Contents

Acknowledgements

Overview ... 1
- Trends in nurse mobility ... 1
- "Push" and "pull" factors ... 2
- Policy issues in source countries ... 2
- Policy issues in destination countries ... 3
- Policy conclusions ... 4
- Improving the evidence base ... 5

Chapter 1. Introduction ... 6

Chapter 2. Trends in international mobility of nurses ... 8

2.1 General trends in migration ... 8
- Positive impact on source countries ... 10
- Negative impact on source countries ... 11
- Positive impact on destination countries ... 11
- Negative impact on destination countries ... 11
- Summary of trends in migration ... 12

2.2 International recruitment and migration of nurses ... 12
- Trends in flows of nurses ... 13

2.3 Australia ... 15

2.4 Ireland ... 20

2.5 Norway ... 21

2.6 United Kingdom ... 23

2.7 United States of America ... 26

2.8 The Caribbean ... 29

2.9 Ghana ... 30

2.10 The Philippines ... 30

2.11 South Africa ... 31

2.12. Country analysis ... 32

Chapter 3. "Push" and "pull" factors ... 37

3.1 Push factors ... 37

3.2 Pull factors ... 39

3.3 The experience of moving ... 42
- Temporary or permanent migration ... 43
- Moving between industrialized countries ... 44
- Moving from developing to industrialized countries ... 46
- Moving between developing countries ... 48
- The role of recruitment agencies ... 48

Chapter 4. The policy context 50
4.1 General issues 50
4.2 Policy issues: international recruitment and migration of nurses 51
4.3 Policy issues: source countries 52
4.4 Policy issues: destination countries 54
4.5 Policy issues: international agencies 56
4.6 Summary 59

Bibliography 61

Appendix 1. Recommendations on a country-level minimum database to monitor the international flow of nurses 68

Appendix 2. Methods used in this study 70

Table 1 Destination countries: total number of nurses and main recent sources of international recruitment 14
Table 2 Source countries: main recent destinations 14
Table 3 Outflow of professional nurses from the Philippines, 2001 31
Table 4 Verifications issued by the South African Nursing Council, 1991–2000 32
Table 5 Key indicators of international recruitment 35
Table 6 Examples of recent initiatives to facilitate international recruitment of nurses 36
Table 7 Main push and pull factors in international nursing recruitment 42
Table 8 Internationally recruited nurses in the United Kingdom: a typology 43
Table 9 Models of recruitment agency involvement in the international movement of nurses 49
Table 10 Framework for policy responses to nursing shortages 54
Fig. 1 Australia: assessments completed and nurses found suitable for migration by Australian Nursing Council (ANC), 1999-2002 15
Fig. 2 Australia: new registrants to Nurse Register, Nurses Board of Victoria, 1990-2001 17
Fig. 3 Australia: first-time UK registrants to Nurses Registration Board, New South Wales, 1987-2001 17
Fig. 4 Australia: total registrants and overseas registrants to South Australia Nursing Board, 1988-2002 18
Fig. 5 Ireland: origin of new qualifications registered with An Bord Altranais, 1990-2001 20
Fig. 6 Norway: international nurse registrants as recorded by SAFH,a 1996-2002b 21

Fig. 7 United Kingdom: admissionsa to the UKCC Register (initial registrations) from EU and non-EU sources, 1993-2002 24

Fig. 8 United Kingdom: international and UK sources as a percentage of total admissions to the UKCC/NMC Register (initial registrations), 1989-2002 25

Fig. 9 USA: distribution of foreign-trained registered nurses receiving their first US RN licences in 1990–1999 by the number of years since graduating from their basic RN education programme 28

Fig. 10 USA: foreign-trained first-time candidates or US licensure examination, 1995-2001 28

Fig. 11 The Philippines: outflow of professional nurses, 1996-2001 30

Fig. 12 Flows of nurses between Ireland and the United Kingdom, as measured by number of requests for verification, 1994-2002 45

Fig. 13 Trends in flows of nurses between the UK and Australia, as measured by the UK Registration Body, 1997-2002 45

Fig. 14 Inflow of international nurses to UK, Norway, Ireland and Victoria State, Australia, from source countries according to World Bank classification 46

Fig. 15 New registrants on UK nursing register from selected sub-Saharan African countries, 1998-2002 47

Box 1 International nurses in Australia 39

Box 2 International nurses in Ireland 40

Box 3 International nurses in Norway 41

Box 4 International nurse mobility: policy questions and subsidiary research questions 51

Overview

International nurse mobility: trends and policy implications examines the trends and policy issues relating to the international mobility of one key group of "knowledge workers" — nurses. The increase in knowledge worker migration, which is partly a result of industrialized countries attempting to solve skill shortages by recruiting from developing countries, is a key component of current international migration patterns.

Trends in nurse mobility

This report examines trends in international recruitment and migration of nurses. It uses data from professional registers and censuses to examine the scale of the movement of nurses. Core data from a selection of five "destination countries" are used to track trends from source countries. The five destination countries are Australia, Ireland, Norway, the United Kingdom and the United States of America. Information is also assessed from four "source" areas — the Caribbean, Ghana, the Philippines, and the Republic of South Africa. These were selected as they are closely linked by language and, in some cases, culture, and because their review provides the opportunity to examine different types of flows. Some of the key findings in the destination countries are summarized below.

- ***Australia.*** There are different entry routes for temporary and permanent migrants. Federal and state-level data suggest that some states have reported an increase in inflows of nurses from other countries in recent years, the main sources being the United Kingdom and New Zealand. The Australian Nursing Council and the federal registration authority both have policy statements on ethical recruitment.
- ***Ireland.*** There is a single point of entry via the national-level registration authority. Registration data highlight rapid growth in inflow of nurses in recent years, with the Philippines, the United Kingdom, Australia, South Africa and India being main sources. The Irish government has published guidelines on international recruitment.
- ***Norway.*** There is a single point of entry for nurses from other countries, via registration. The main inflow of nurses has been from other Scandinavian countries. There has been some recent recruitment from the Philippines and Poland; this is controlled by the state recruitment agency, with a cap on numbers. The Norwegian Nursing Association has a strong policy statement on ethics of international recruitment.
- ***United Kingdom.*** There is a single point of entry, via registration. There has been a strong upward trend in inflow of nurses from other countries in recent years: the Philippines have become very prominent, and also Australia, South Africa and India. In contrast there has been no upward trend in flow from countries of the European Union. The Department of Health, England, has a code of practice on international recruitment; this only covers the public sector. The Royal College of Nursing has a position statement on international recruitment.

- ***United States***. Applications for licensure data suggest growth in applications from nurses in other countries in recent years, but to a level no higher than in the mid-1990s. The Philippines and Canada are the two main sources of applicants. The National Nurses Association has a position statement on international recruitment.

In summary, there has been a significant upward trend in inflow of nurses to some, but not all, of the five selected destination countries. More detailed analysis reveals that the composition of inflow to these countries also varies, in terms of the mix of source countries and their level of development. It is oversimplistic to suggest that the flow of nurses is only from developing to industrialized countries. Some countries, such as the United Kingdom, have reported significant increases in nurse registrants from developing countries, but others, such as Norway, have been recruiting mainly from other industrialized countries. In the case of Norway, this has been the result of a policy decision by the government.

Reports from the Caribbean, Ghana, the Philippines and South Africa highlight that there are perceived to be a number of major negative impacts caused by outflow of nurses, which are linked to the effect on remaining staff, reductions in the level and quality of services, and loss of specialist skills.

"Push" and "pull" factors

There is continued debate about the various potential positive and negative effects of migration of nurses and other key staff, particularly from developing countries. The main push factors stimulating workers to cross national borders include relatively low pay and poor employment conditions in source countries, with an additional pull factor in terms of facilitated in-migration and active recruitment by some industrialized countries.

To a certain extent there is a mirror image of push and pull factors, related to the relative level of pay, career prospects, working conditions and working environment available in the source country and in the destination country. Where the relative gap (or perceived gap) is significant, then the pull of the destination country will be felt. However, there are other factors that are acting as push factors in some countries, such as the impact of HIV/AIDS on health system workers, concerns about personal security in areas of conflict, and economic instability. Other pull factors, such as the opportunity to travel or to assist in aid work, will also be a factor for some individual nurses.

Policy issues in source countries

Some national governments and government agencies (for example, in the Philippines) are attempting to encourage outflow of nurses from their country. This may have a financial imperative, to encourage the generation of remittance income; it may be a response to labour market oversupply; or it may be an attempt to develop a long-term improvement in the skills base of the nursing workforce by encouraging short-term outflow to other countries where training is available.

For most source countries, however, outflow of nurses is a problem rather than a policy initiative. Some countries have initiated or examined various policy responses to attempt to reduce outflow — including bonding nurses to home employment for a specified period of time after completion of training, or attempting to negotiate a fee in compensation from the departing nurses or the destination country. This may not be effective if compliance is not monitored or if there is scope to buy out of the bond. The scope for compensation claims continues to be raised in international forums, but there is little evidence that such schemes have been effective in the past.

Preventing nurses from leaving through the use of monetary or regulatory barriers is one policy response, but it does nothing to respond to the push factors that have stimulated the nurses' desire to leave and is also contrary to notions of free mobility of individuals. Other policy responses to reducing outflow would relate to a more direct attempt to reduce the push factors, by tackling poor pay and career prospects, poor working conditions, and high workloads; responding to concerns about security; and improving educational opportunities. Clearly there is a financial cost involved in such initiatives, but national governments must be confident that nurses are receiving fair and equitable treatment within existing financial constraints and that they are not being disadvantaged because nursing work is undervalued relative to other professions.

Another policy response is to recognize that outflow cannot be halted where principles of individual freedom are to be upheld, but then to work at ensuring that such outflow that does occur is managed and moderated. The "managed migration" initiative being undertaken in the Caribbean is one example of coordinated intervention to attempt to minimize the negative impacts of outflow while seeking to secure at least some benefit from the process.

Policy issues in destination countries

A central concern for destination countries is to assess the relative contribution of international recruitment compared with other key interventions — such as home-based recruitment, improved retention, and return of non-practising nurses — in order to identify the most effective balance of interventions.

Home-based solutions, such as improving staff retention through provision of flexible working hours or improved working conditions and attracting returners through part-time career opportunities, may be more cost-effective than international recruitment. Any nurse leaving an organization will incur costs to the organization in terms of replacement and lost productivity. At the aggregate level, this can have a significant impact on direct costs to an organization and can also disrupt continuity of care.

The second policy challenge for destination countries can be characterized 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 include improving the regulatory or certification process to enable these nurses to obtain registration more easily; fast tracking their visa or work permit applications; developing coordinated, multi-employer approaches to recruitment; developing multi-agency approaches to coordinated placement and (where necessary) providing initial periods of supervised practice or adaptation as well as language training, cultural orientation and social support. There can be a

tension between the pressure to accelerate inflow of these nurses and the need to maintain regulatory processes and standards. Countries that are currently heavily reliant on inflow of international nurses have seen policy attempts to speed up the process of inflow; in some cases, these attempts have been opposed by stakeholders who fear a potentially negative impact on standards and patient safety.

The third policy challenge of destination countries is the "ethical" challenge. Is it justifiable, on moral and ethical grounds, to recruit nurses from developing countries? The simple response is that it should not be justifiable to contribute to brain drain from other countries, but a detailed examination of the issue reveals a more complex and blurred picture. "Active" recruitment by employers or a national government in the destination country has to be contrasted with individual decisions, as the nurses themselves may have taken the initiative to move across a national border. Currently, it is not possible to quantify the relevant flow related to active recruitment as a proportion of total recruitment, but some countries have put in place mechanisms to support active recruitment of large numbers of nurses. Temporary migration, related to a temporary oversupply in one country or to a managed exchange of staff, has to be differentiated from planned, permanent migration attributable to pull factors in the destination country.

Some countries have developed a policy response to attempt to manage the balance between ethics and efficiency. England and Ireland have initiated ethical guidelines for employers recruiting nurses from other countries. However, in practice, these guidelines tend to focus more on the practicalities of recruitment than on any moral considerations. A different approach has been adopted by Norway, which has announced an annual restriction on the number of nurses that can be recruited by its governmental agency, and this recruitment is based on government to government agreements. The capping of the number of recruits limits the impact of active recruitment. The impact of the ethical guidelines is difficult to assess, because they have been in place only a short period of time. The initial guidelines from England (which cover only NHS employers) did have a short-term impact in reducing inflow from named developing countries, but overall the inflow has since increased. The Norwegian approach of setting a state recruitment target is more effective in limiting the impact on other countries.

Policy conclusions

The message from this report is that the main driver for the current high level of active international recruitment activity is nursing shortages in some industrialized countries. These destination countries have failed to "grow their own" and "keep their own" nurses in sufficient numbers and have used the quick fix of international recruitment, exploiting the existence of push factors by exerting a pull of better salaries and conditions of employment. Nurse migration can be a symptom of deeper problems in nurse workforce planning, in either source or destination countries — or both.

Inadequate policy responses by country governments to the fundamental causes of nursing shortages have been the drivers of the dynamics of international recruitment. Free trade blocs or agreements may facilitate flows, but these only happen when there is a pull–push imbalance, with the importing country pull being paramount.

If national governments and international agencies wish to engage actively in changing these dynamics they have three basic options. One option is to support improvements in pay, working conditions, and the prestige of nurses in their countries. In many cases, it is likely that nurses would prefer to stay in their home country if their quality of life were at least adequate. Secondly, they could encourage and facilitate bilateral, country-to-country managed or regulated flows of nurses. Thirdly, they could institute some arrangement whereby compensation flows from the recruiting country back to the source country. This could be direct or indirect financial compensation, as part of a donor package, or in the form of a return flow of better-trained staff. (A fourth possible intervention, to constrain the mobility of nurses, would be unethical.)

Policy interventions that support country governments to reach mutually beneficial (managed) models of international recruitment have some potential for a win-win situation. However, it is clear that the flow of nurses, partly as a result of active recruitment by industrialized countries, is a symptom of deep seated problems in these countries that have failed to plan for, and retain, sufficient nurses from their own sources. International recruitment of nurses is a symptom of global shortages of nurses, but the underlying problems can only be solved by local-level and country-level improvements in the status of nursing and in the planning and management of the nursing workforce.

Improving the evidence base

One of the most notable aspects of the current debate on the impact of nurse migration and mobility is the limited availability of information and data on which to base policy analysis. Many quoted sources in reports and articles on nurse mobility have been drawn from media coverage or are anecdotal, and are often misleading or inaccurate.

The ability to monitor trends in inflow, in terms of numbers and sources, is vital if any country is to be able to integrate this information into its planning process. Equally important is an understanding of why shortages are occurring: because of poor planning, unattractive pay or career opportunities, early retirements, etc. An initial assessment into the contributing factors for the nursing shortages in any country needs to be undertaken and those factors carefully considered. This will include nurse "wastage" to other sectors or regions within the country.

Many countries are hampered in the process of tracking outflow and inflow of nurses by the relative paucity of data to enable monitoring. Reliance on incomplete data or incompatible data from different sources (such as work permits, visas, registration/certification, labour statistics, or census) often means that it is not possible to have an accurate picture of the trend in outflow, let alone any assessment of its impact on the health services.

Ensuring that the available data are verified, collated and monitored for trends should be the first objective; methods to achieve improvement in data availability should be investigated collectively by stakeholders (government, employers, nurses' associations, etc.). It is important that the information base enables policy-makers to assess the relative loss from outflow to other countries in comparison to 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. International outflow may be a very visible but relatively small numerical loss of nurses compared with flows of nurses leaving the public sector for other sources of employment within the country.

Chapter 1. Introduction

International nurse mobility: trends and policy implications draws from research supported by the World Health Organization (WHO), the International Council of Nurses (ICN) and the Royal College of Nursing (RCN). The main objectives of the report are to identify trends in migration of nurses, to highlight different push and pull factors and to assess the policy options and interventions. It is complemented by another report examining the scope for modelling trends in nurse migration (Sochalski, Ross & Polsky, 2003).

Nursing shortages are reported to be an increasing challenge in many industrialized and developing countries alike (e.g., Buchan, 2002a). In 2001, the Fifty-fourth World Health Assembly noted its concern about "global shortages of nurses and midwives" (WHO, 2001). The International Council of Nurses Workforce Forum in 2002 reported that most industrialized countries are or will be facing nursing shortages (ICN, 2002), caused by increasing demands for health care combined with a diminishing supply of nurses in some countries. These shortages have led to some countries increasing their recruitment activity in international nursing labour markets.

The report analyses data on international migration of nurses and examines the growing trend of active international recruitment of nurses by some industrialized countries. This trend is highlighted in the report as the main driver of increased migration of nurses. "Push" factors relating to poor pay, limited career and educational opportunities, and concern about safety and security can all act to make a nurse wish to move from her home country. However, without an active "pull" from countries experiencing shortages and offering better pay and prospects, the flows would not be of the current magnitude.

Cross-border mobility of nurses may be a symptom of deeper workforce problems in the source and/or destination country (internal migration, particularly from rural to urban areas in developing countries, is not examined in this report but can be another significant factor). In assessing the policy implications of this mobility, the report adopts the principle that any policy response should be based on the recognition that all individuals should have the right and the freedom to move, in order to improve their lives and increase the contribution they can make to other lives.

The report draws from country case study information and from focus groups of recently recruited international nurses. Additional information was also obtained from international bodies including the European Union, International Organization for Migration, the Commonwealth and the International Council of Nurses. Country data are reported from five "importer" countries — Australia, Ireland, Norway, the United Kingdom and the United States. Information from "exporters" — the Caribbean, Ghana, the Philippines, and the Republic of South Africa — is also reported. Some exporter developing countries also actively recruit nurses from other developing countries.

International recruitment, mobility and migration of nurses have been the focus of increasing attention in recent years. However, many publications on the subject have relied on anecdotal information or media reports, which can lead to a misleading or fragmented assessment of trends and implications. In order to focus on evidence rather than assertion, this report is based primarily on country-specific data, where possible independently verified and supported by the results of focus group surveys and information provided by key informants.

In the report that follows, Chapter 2 examines current trends in the international mobility of nurses; Chapter 3 reports push and pull factors on the attitudes, experiences and motivations of mobile nurses; and Chapter 4 discusses policy considerations, including the impact of free trade blocs, the use of national or international ethical guidelines, and the scope for policy interventions to manage or moderate international mobility. Appendix 1 contains recommendations for a minimum database at country level to track international flows of nurses, and Appendix 2 explains how the data were collected for the preparation of this report.

Chapter 2. Trends in international mobility of nurses

The issue of migration of health professionals has been at the forefront of international health policy debate since the late 1990s (e.g., Buchan, 2000; Chanda, 2002; Martineau, Decker & Bundred, 2002; OECD, 2002a; WHO, 2002). Health care is labour intensive, and the availability of sufficient well-qualified and motivated staff is a key determinant of effective health service delivery. Staff shortages and geographical maldistribution are being reported in many countries. This has particularly been the case in industrialized countries since the mid-1990s. After a period of retrenchment in health systems in the first half of the decade, which led to reduced requirements for nurses and fewer new nurses being trained, many industrialized countries are now facing nurse shortages. These shortages relate to increased demand for health care, the ageing of the nursing population in these countries, and difficulties experienced in some countries in recruiting home-based new entrants to nursing in the face of increased competition from other career opportunities (Buchan, 2002a). International recruitment has increasingly become a "solution" to the nursing skill shortage in some of these countries, which has included large-scale active recruitment of nurses, doctors and other professionals in addition to the natural migration flows of individuals moving across borders for a range of personal reasons.

Just as international recruitment can be a solution to the staff shortages in some countries, it can create additional problems of shortages in others. There have been increasing reports in national and international media about the negative impact of international recruitment on some of the main exporter countries, particularly developing countries in Africa and the Caribbean, and some in South-East Asia. Countries that lose scarce skilled staff suffer a negative impact on the effectiveness of their health systems. The policy implications of these matters will be considered in more detail in Chapter 4. The primary objective in this chapter is to assess trends in the recruitment of nurses, the motivations for migration and its implications.

2.1 General trends in migration

Before examining the mobility and migration of nurses (section 2.2), this section examines recent overall trends in migration, to place the situation of nurses in context. Recent research findings indicate five main trends in general migration that are currently evident.

- The rate of international migration is increasing (OECD, 2000; Castles, 2000). In terms of actual figures, the number of persons migrating has doubled from 75 million in 1965 to an estimated 150 million in 2000 (IOM, 2000) 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 (2001) reports that, of these, about 80–97 million were migrant workers and members of their families.
- There has been recent growth in migration of skilled and qualified workers (OECD, 2000; OECD 2002b).
- Migration flows are becoming more diverse and complex for a range of reasons: for example, the advancement of telecommunication facilitates greater information exchange and global awareness (Stalker, 2000) and transportation links are easier (Castells, 1996, cited in Castles,

2000). Between 1970 and 1990, the numbers of countries that qualified as major receivers of migrant workers rose from 39 to 67 and those that qualified as major senders rose from 29 to 55 (ILO, 2000).

- Previously distinct categories of migrant, e.g. planned migration for employment or asylum seekers, have begun to blur (Stalker, 1997). There has been an increasing mix of temporary/permanent migrants and legal/illegal immigrants (Timur, 2000) and a recent reported switch from permanent to temporary migration (Findlay & Lowell, 2002a).
- Increasing percentages of females are now migrating independently of partners or families (Timur, 2000).

Many studies report difficulties of assessing current migration flows and trends. This is in part attributable to the incomplete recording of necessary data (Baptiste-Meyer, 2001; Findlay & Lowell, 2002a). Where information is documented, it is often inaccurate and inconsistent. There also appears to be little international standardization of documentation, making comparison between countries even more complicated (Findlay, 2002; Auriol & Sexton, 2001). There is also a lack of profession-specific data in relation to nursing; this problem includes differences in categories and definitions in different countries.

According to Stalker (2000), migration will continue as long as there is developmental imbalance between countries. Workers in developing countries are often subject to low pay, poor working conditions, poor career structure and limited employment opportunities (OECD, 2002b). These are common "push" factors which stimulate migration from source countries and can at least partly explain why natural migration flows exist. More recently, as the education syllabus in an increasing number of countries becomes of international standard, more people become dissatisfied with domestic employment opportunities (Commonwealth Secretariat, 2001). They may therefore be encouraged to work abroad to utilize the skills they have learnt.

The role of "pull" factors in receiving countries is also influential in determining migration flows and trends. Expectations of improved wage rates have long been established as a pull factor (ILO, 2000) — indeed, Stalker (2000) argues that the prime reason people are emigrating today is to seek skilled employment and better pay. Another influential factor is evident in countries where demand for suitably qualified staff exceeds the available supply, resulting in temporary or prolonged skill shortages across a range of professions. Active, targeted, international recruitment drives by receiving countries for workers with particular skills have become an increasingly strong pull factor (Commander, Kangarsniemi & Winters, 2002).

There are a number of barriers to the migration process. Language competency, for example, can be one. Lack of recognition of qualifications can also potentially restrict the countries to which migrants are able to move (Research and Development Statistics Directorate, 2001). The Audit Commission (2000) reported both these factors as contributing to what can be "cumulative barriers to employment for potential migrant workers". In contrast, mutual recognition of qualifications can facilitate the migration process.

International recruitment can be perceived positively as a means of "brain exchange" (Stalker, 2000). However, there has been increasing concern that benefits to receiving countries, particularly industrialized countries, far outweigh the benefits to source countries, especially if these are developing countries (Department for International Development, 2000). The impact of migration

will be influenced by whether workers are migrating from a developing country or industrialized country and by which sector the workers leave or are recruited from (RDS, 2001). This highlights the need to analyse the issue of migration country by country. For example, if some countries have a surplus of skilled staff from professions that are in shortage in other countries, the adverse effects of migration of these workers are likely to be less significant. However, if workers are being recruited from a profession that is already understaffed in the source country, the effect will be more significant (RDS, 2001). In addition, policies linked to migration in sending and receiving countries are likely to affect migration and contribute to whether its effects are positive or negative (Guellec & Cervantes, 2001).

Positive impact on source countries

There is some evidence to indicate that migration can have a positive impact in some circumstances in three key areas: the return of migrant workers; remittance of income earned abroad; and links between migrants and their source country being established and maintained through networks. Evidence suggests that these factors can at least partially dilute initial negative impact on developing countries (OECD, 2002b).

If migrants return to their country of origin with new skills, knowledge and experience, these can be utilized to educate others and to develop and improve local services (Oulton, 1998; Stalker, 2000), therefore potentially enhancing economic development. In some countries, substantial migration of workers has actually served to alleviate unemployment pressures, thus if all migrant workers were to return home there may not be enough employment opportunities to cater for this huge influx (Stalker, 2000). In light of this consideration, some governments may not only agree to, but in fact facilitate, the active recruitment of their workers by overseas employers; for example, the Philippines Overseas Employment Association (POEA) actively assists its nationals to apply for overseas work.

Another potential advantage of migration for source countries is income from remittances. As defined by the ILO, remittances are monies that are sent back home by migrant workers, usually to family or friends. Findlay & Lowell (2002a) report that both receiving and source countries have a role to play in encouraging productive utilization of remittances. This income can boost the local economy and can accrue more value than the physical return of the individual to the labour force. Ascertaining the exact values of remittance income is difficult as a large proportion of remittances are transferred informally and therefore not recorded (van Doorn, 2000; Puri & Ritzema, 1999). One example is Jamaica, which experienced an increase in remittances from 4.1% to 9.8 % of the GDP between 1991 and 1997 (cited in Stalker, 1997). Estimated figures cited in Castles (2000) indicate that the total income from global remittances has risen from less than US$ 2 billion in 1970 to US$ 70 billion in 1995.

The international networks created through migration can forge links between source and destination countries. This facilitates exchange of information and expertise between migrant workers, their international employers, and relevant organizations and professionals in the country of origin (Baptiste-Meyer, 2001). These may be informal networks or formal organizations such as South Africa Network of Skills Abroad (SANSA) and can potentially have a positive impact on economic growth in the source country.

Negative impact on source countries

Stalker (2000) argues that there is a watershed point up to which economic development in the source country is facilitated by migration of skilled workers. Excessive loss of domestic labour, however, can contribute to a brain drain of young, highly skilled labour. The departure of migrant workers may leave their own country with a depleted workforce and a severe reduction in the availability and quality of services. Findlay (2002) argues that the increase in recruitment of highly skilled workers in particular can add to the loss experienced by the source country. Fewer workers also mean that productivity in the source country is likely to be reduced, which could restrict economic development (Findlay & Lowell, 2002a). Furthermore, a diminishing supply of workers in the source country may push wages up, putting added pressure on the economy (Baptiste-Meyer, 2001).

Positive impact on destination countries

It has largely been considered that receiving countries are the main beneficiaries of international recruitment. Guellec & Cervantes (2001) reported "stimulation of innovation capacity, an increase in stock of available labour and the international dissemination of knowledge" as just some of the positive effects for receiving countries. Also, a number of industrialized countries have an ageing population that is contributing to and exacerbating existing labour shortage problems. Influx of migrant workers can serve to rejuvenate the labour force (Tacoli & Okali, 2001) and contribute to the viability of pension funds responding to increased demands from an ageing population.

Negative impact on destination countries

An issue highlighted by some commentators is that if overseas workers are employed to meet demands of employers, wage rates will be suppressed. Another concern is that a large increase in employment of migrant workers reduces the number of jobs available to the native population. However, research has indicated that in periods where migration flows are highest this has not been coupled with higher unemployment in the native population (Stalker, 2000); migrant workers tend to fill positions at the very top (highly specialized skills) and the very bottom (unskilled work) of the employment ladder.

International recruitment may only be a "quick fix" to labour and skill shortages, but long-term sustainable measures need to be considered to overcome prolonged problems. Findlay (2002) argues that focus on international recruitment as a solution can detract energy and investment away from enhancing domestic retention strategies that will encourage existing staff to stay. They also argue that the "true long-term detrimental effects of migration can be unique to particular countries where the situation compounds the fundamental problems that led to the skilled emigration in the first place". Little is known about the return of migrants to their native country and there are no well-calibrated measures to ascertain accurately whether brain exchange or brain drain is in operation and to what extent (Findlay, 2002).

Summary of trends in migration

This section has highlighted the general background context of trends in international migration. The increase in "knowledge worker" migration — partially as a result of industrialized countries attempting to solve skill shortages by recruiting from developing countries — was reported, as was the increase in migration of women. The continued debate about the various potential positive and negative effects of migration was also summarized. The main push factors were reported to be relatively low pay and employment conditions in source countries, and an additional "pull" factor in terms of facilitated in-migration by some industrialized countries was also noted. In the next section, the trends in nurse migration will be examined within this broader context.

2.2 International recruitment and migration of nurses

In the previous section it was noted that incomplete data place limitations on the assessment of trends in migration. This general limitation applies also to the examination of nurse migration. Only one detailed multicountry report on nurse migration has been published, on work conducted in the 1970s (Mejia, Pizurki & Royston, 1979). The situation has changed markedly since then, with significant growth in migration of knowledge workers, easier travel and communications, and cultural change — in some countries at least — in the role of women at work. The gender issue in nursing is sometimes overlooked, but it has often been a factor in explaining the relative underinvestment in the profession in some countries. It may also be a factor contributing to the migration patterns of nurses.

This section examines more recent trends in international recruitment and migration of nurses. Data from professional registers and from employment records and censuses are used to examine the scale of the movement of nurses. One core source of data is information from five destination countries (Australia, Ireland, Norway, the United Kingdom and the United States), which is used to track trends from the source countries. Information from four source areas is also examined: from the Caribbean, Ghana, the Philippines, and South Africa. These sources were selected as they are closely linked by language, and in some cases culture, and because the opportunity arises to examine different types of flows.

There are limitations in the use of any type of data to assess migration. Registration data, where the international nurse is registered to practise in the destination country, have four limitations.

- Registration signifies the intent to practise in the destination country, rather than the actuality of working.
- Registration may not record some inflow where nurses have arrived in the destination country without the intention (at least for the time being) of practising.
- A nurse may apply to enter the register of more than one country.
- In federated or decentralized countries, there may be multiple separate registers and it may not be possible to aggregate to a complete national overview.

A more general issue relates to variations in the definition of nurse. The registration process, as configured in the importer countries examined below, attempts to assess that the nurse from the source country has an acceptable level of skills and/or qualifications to practise in the destination country. As such, it serves as a bridging process, but one in which there is a check on skills and qualifications.

Registration data are a key source — year-to-year trends give an indicator of the number of registrants from home sources and from international sources. This information enables an assessment of the relative importance of international flows. The fact that it registers intent to leave one country to move to another, even if the move does not happen, is also significant. Achieving registration is normally a time-consuming process, often with cost implications. It provides a good measure of potential inflow or outflow.

This chapter assesses what could be termed "developed to developed" country flow, where nurses move from one industrialized country to another, and the flow of nurses from "developing to developed" countries. The latter, in particular, has been the recent focus of much policy attention, but the former is also a significant feature of the current dynamics of international nursing labour markets; "developing to developing" country migration is also reported to be a significant factor in some countries, for example in sub-Saharan Africa, but its magnitude is not easily assessed with publicly available data.

Some of the recent policy documents and reports on international migration of health professionals have highlighted the need to improve monitoring of cross-border flows. There are two basic problems with the current data availability: the information is, at best, incomplete for any one country, and it is not compatible between countries. This situation constrains any attempt to develop a clear international or global picture of overall flows of health workers. However, what can be achieved by taking a national focus is to use available data to fix any one country within the international dynamic and also to assess the connections with other countries in terms of the flows of nurses. The data sources and types vary in different countries, but it is possible to assess trends in flows of nurses and to cross-check bilateral flows using data from source and destination countries, where such information exists.

Trends in flows of nurses

The current "stock" of nurses in each of the destination countries and current main source countries for nurse recruits are summarized in Table 1; the main reported destinations of nurses from source countries are shown in Table 2.

The main issues highlighted in the tables are: the prominence of the Philippines as a source of recruits for most of the countries examined; the extent to which there are cross-flows of nurses between the countries being examined — for example, between the United Kingdom and Australia — and the current prominence of the United Kingdom as a destination country.

Table 1. Destination countries: total number of nurses and main recent sources of international recruitment

Country	No. of nurses[a]	Main sources of international recruitment
Australia	149 202	United Kingdom New Zealand
Ireland	61 629	United Kingdom Philippines South Africa
Norway	45 133	Other Scandinavian countries Germany Philippines
United Kingdom	640 000 (580 000)	Philippines South Africa Australia
United States	2 238 800	Philippines Canada Africa (mainly South Africa and Nigeria)

[a] Data from *OECD Health data* CD-ROM (OECD, 2001b), reported as full-time equivalent (FTE) practising nurses; for some countries this figure appears to be the number of nurses on the register, some of whom will be inactive. OECD data for the United Kingdom are known to be incorrect, so the figure in brackets is the actual number of registrants in the United Kingdom (source: Buchan, 2003).

Table 2. Source countries: main recent destinations

Origin	Reported destinations
Caribbean	United Kingdom United States Canada
Ghana	United Kingdom United States
South Africa	United Kingdom Saudi Arabia New Zealand
Philippines	United Kingdom Saudi Arabia Ireland

An examination of the flow patterns to or from these countries gives more details of trends and highlights the extent to which the destination countries are reliant on specific source countries, as shown in the following sections.

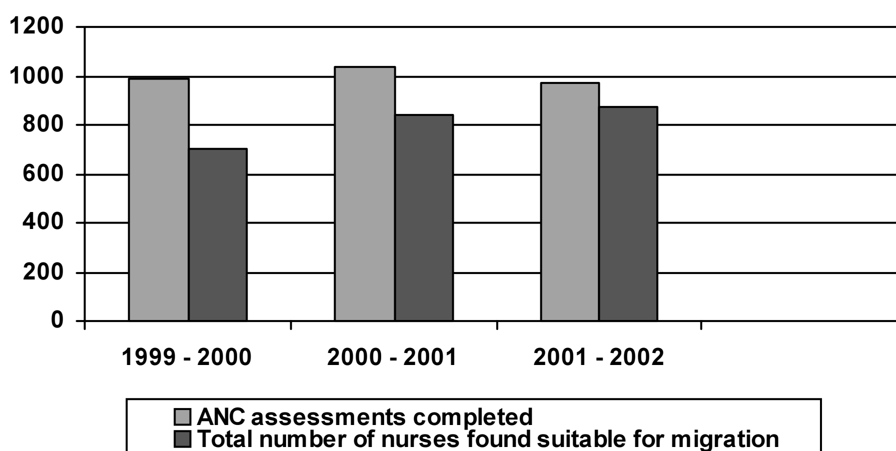
2.3 Australia

Registration of nurses in Australia is at the state level but, in addition, many nurses applying for migration will first have to be approved by the Australian Nursing Council (ANC) which screens applications from source countries. Nurses from other countries (Canada, Hong Kong Special Administrative Region of China, Ireland, Singapore, South Africa, United Kingdom, United States, Zimbabwe, or those who hold Higher Education Qualifications (HBO) from the Netherlands) have mutually recognized qualifications and therefore "meet the requirements for registration without having to undertake a competency based assessment programme" (ANC 2001–02). These nurses do not have to apply to the ANC, but can apply directly to the relevant state nursing registration authority. Nurses and other health professionals from New Zealand are covered by the Trans-Tasman Mutual Recognition Act (1997), which facilitates flows between Australia and New Zealand.

There are, therefore, different entry routes for nurses to Australia, of which application for permanent residence through migration is one. A second route is long-term temporary migration, with visas granted for one to four years, and a third is working holiday visas for shorter time periods (for a maximum of one year).

Data from ANC are shown in Fig. 1. These data only record applications for migration requiring ANC approval, and show little significant change over the last three years, in terms of overall number of assessments or number of nurses found suitable to migrate to Australia. It should be noted that not all of these nurses will actually have emigrated to Australia. Furthermore, information from ANC highlights that nurses applying for migrant status represent only a small proportion of the total "inflow" of intended nurses to Australia.

Fig. 1. Australia: assessments completed and nurses found suitable for migration by Australian Nursing Council (ANC), 1999-2002



Note: ANC only deals with applicants for migration from some countries (those that do not have an agreement with Australia).
Source: Australian Nursing Council, 2002.

The ANC's 10th Annual Report, for the year ended 30 June 2002, suggests that the decrease in that year of the number of applicants from overseas for assessment of their qualifications "could be attributed to an increased number of nurses entering Australia on visas that do not require skills assessment by ANC. This includes working holiday visas and employer sponsorships." (ANC, 2002).

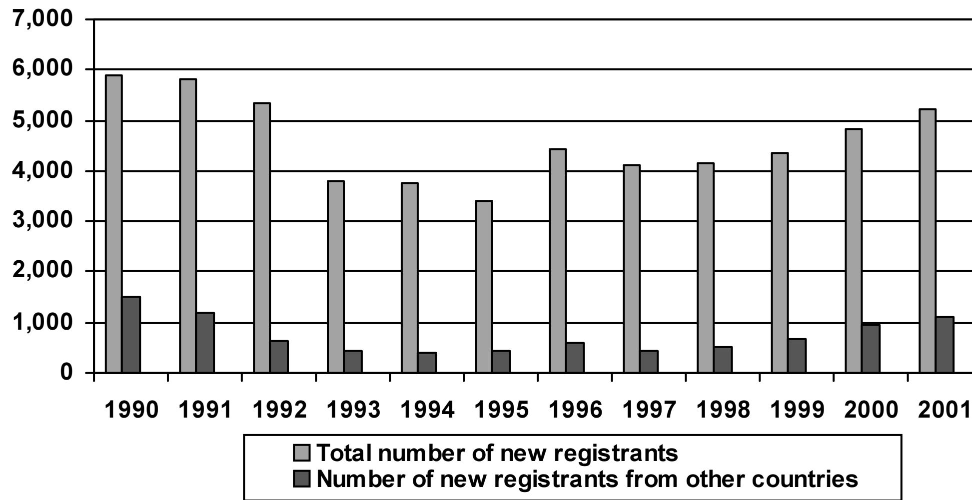
A second entry route for nurses is long-term temporary visas. According to figures from the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) in 2002, over 1000 long-term temporary visas have been granted to nurses each year for the past two years. For the period 2001–02, nursing was the "2nd ranked occupation in this visa class, compared with 4th ranked the previous year". Overseas nurses must meet the requirements of nursing registration in order to be eligible for this visa.

A third route is the working holiday visa. It has a 12-month duration and can only be granted once. Eligibility for this visa is restricted to applicants between 18 and 30 years of age. They must also be a citizen of one of the following countries: Canada, Denmark, Finland, Germany, Hong Kong Special Administrative Region of China, Ireland, Japan, Malta, the Netherlands, Norway, the Republic of Cyprus, Sweden, the Republic of Korea, or the United Kingdom. Applicants must be either single or married without children and need to demonstrate sufficient funds to purchase a return ticket and to support themselves until they find work. Holders of this type of visa must show that their main reason for coming to Australia is for a holiday and that they intend to leave Australia at the end of their authorized stay. Holders are permitted to work but they must not remain working for the same employer for longer than three months. Requirements for nursing registration must also be met in order to be eligible to work as a nurse under this temporary visa. Figures from DIMIA indicate that 3200 working holiday visas were granted to overseas nurses in 2000–01 to enter Australia.

In total, this information suggests that in recent years between 4000 and 5000 nurses annually would have been eligible to enter Australia through these different routes. However, because many would have entered as working holiday-makers, they would have been eligible to work for relatively short periods of time. As such, the registration data will overstate actual availability. More detail of trends can be ascertained by examining data from the individual state nursing boards. However, this information cannot be aggregated to provide an nationwide picture because data are collected differently in the different states and there may be data duplication. For example, if an overseas nurse is assessed and registered in one state but then registers with another, this may be recorded as a home-based applicant. However, state-level examination does provide scope for assessment of trends. For illustrative purposes, information from three of the larger states is discussed in this section.

Fig. 2 illustrates the trend in the total number of new registrants at the Nurses Board of Victoria, and the number of registrants who had come from other countries.

Fig. 2. Australia: new registrants to Nurse Register, Nurses Board of Victoria, 1990-2001

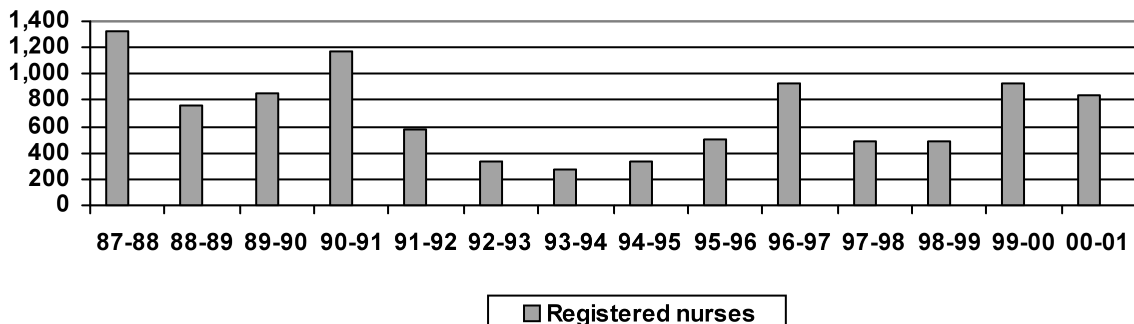


Source: Nurses Board of Victoria Annual Statistics

There has been a rising trend in the number of registrants to Victoria from other countries in the late 1990s, after a marked reduction in the mid-1990s, mainly from the United Kingdom, Ireland, New Zealand, the Philippines and Canada. In 2001, overseas registrants accounted for one in five of total initial registrants.

A similar overall trend is reported from the Nurses Registration Board of New South Wales, in relation to registration of nurses from the United Kingdom, with a decline in the mid-1990s and some upward trend in the latter part of the decade, but with significant year-to-year fluctuation (see Fig. 3).

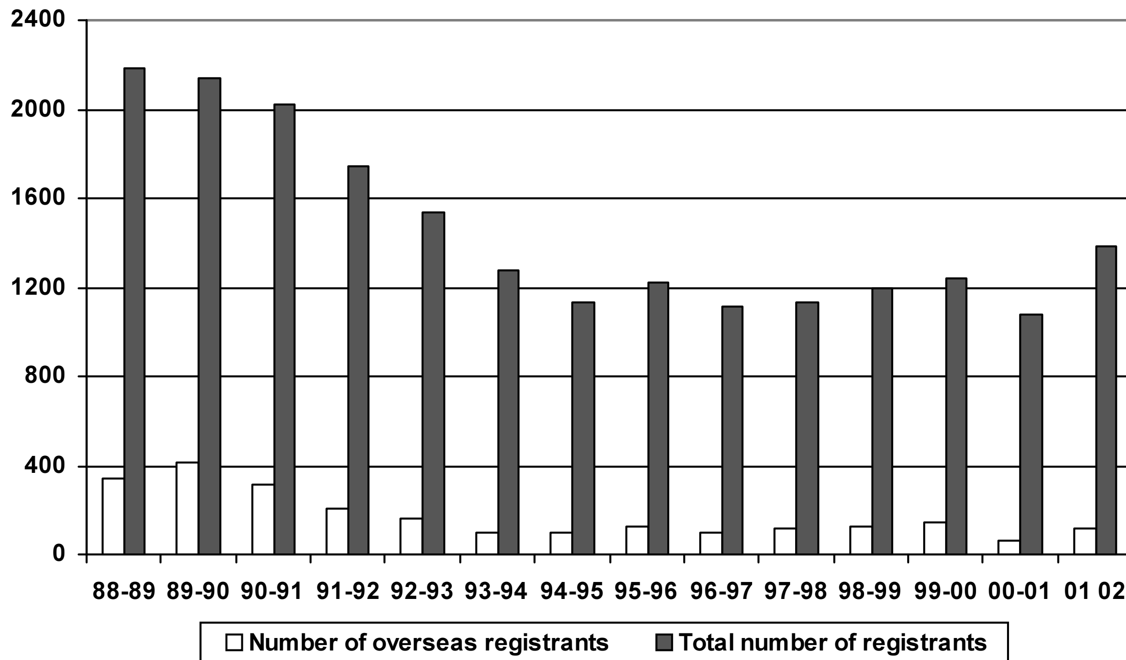
Fig. 3. Australia: first-time UK registrants to Nurses Registration Board, New South Wales, 1987-2001



Source: Nurses Registration Board of New South Wales.

The long-term trend in registration to the South Australia Nurses Board is shown in Fig. 4. While the overall number of annual registrants reduced markedly in the early 1990s and picked up slightly at the end of the decade, the annual number of overseas registrants has not varied significantly in recent years, the three main sources being the United Kingdom, Norway and South Africa. In 2001–02, the number of overseas registrants was 118, 9% of a total new registration of 1384.

Fig. 4. Australia: total registrants and overseas registrants to South Australia Nursing Board, 1988-2002



Source: South Australia Nursing Board *Annual statistics*.

The registration data reviewed from Australia indicate that the overall trend in inflow of nurses to Australia has been upwards in recent years, but with significant variation between states. There also appears to be a current heavy reliance on recruitment from the United Kingdom and New Zealand, with many of these nurses travelling to Australia as temporary migrants, particularly as working holiday-makers.

The ANC has published a position statement on ethical recruitment, the main points of which are that the Australian Nursing Council recognizes the rights of all people to receive nursing care of the highest professional standard and confirms this by:

- supporting nursing workforce planning that meets the needs of the Australian community, taking into consideration the diversity that exists within different cultural groups;
- supporting the ICN position statement on ethical recruitment;
- supporting the Draft Commonwealth Code of Practice for International Recruitment of Health Workers;

- recognizing the rights of individual nurses to migrate and acknowledging the opportunities and benefits such as career development for both individual nurses and the host country when nurses return;
- condemning unethical recruitment practices that exploit or mislead nurses;
- supporting recruitment processes based on ethical principles that guide informed decision-making and reinforce sound employment policies on the part of the governments, employers and nurses, thus supporting fair and cost-effective recruitment and retention practices.

The key principles outlined by the ICN in the position statement Ethical Nurse Recruitment and those contained in the Commonwealth Code of Practice for International Recruitment of Health Workers are embedded in the ANC role in ethical recruitment. The key principles include:

- transparency;
- fairness;
- mutuality of benefits for the countries involved;
- credible nursing regulation;
- effective human resources planning and development;
- access to full employment;
- good faith contracting;
- equal pay for work of equal value;
- access to grievance procedures;
- safe work environment;
- effective orientation/mentoring/supervision;
- freedom of movement.

The main professional union for nurses, the Australian Nursing Federation, has also developed a position statement on the recruitment of overseas nurses. This clearly states that although "migration is an international phenomenon … immigration is neither an effective or desirable instrument to overcome labour market deficiency" and stipulates that international recruitment should only be used if a specific need has been identified for nurses and that other avenues of employing appropriate nursing staff from within Australia have been tried first. If nurses are recruited from overseas, it states that these employees should be offered "identical employment conditions" to their counterparts from Australia. The statement also indicates that all overseas applications should be assessed equitably and that decisions should be based on "English language proficiency, acknowledging clinical competence, experience and formal qualifications" (Australian Nursing Federation, 1998).

Australia summary

There are different entry routes for temporary and permanent migrants. Federal and state-level data suggest that some states have reported an increase in inflows of nurses from other countries in recent years, the main sources being the United Kingdom and New Zealand. The ANC and the federal registration authority both have policy statements on ethical recruitment.

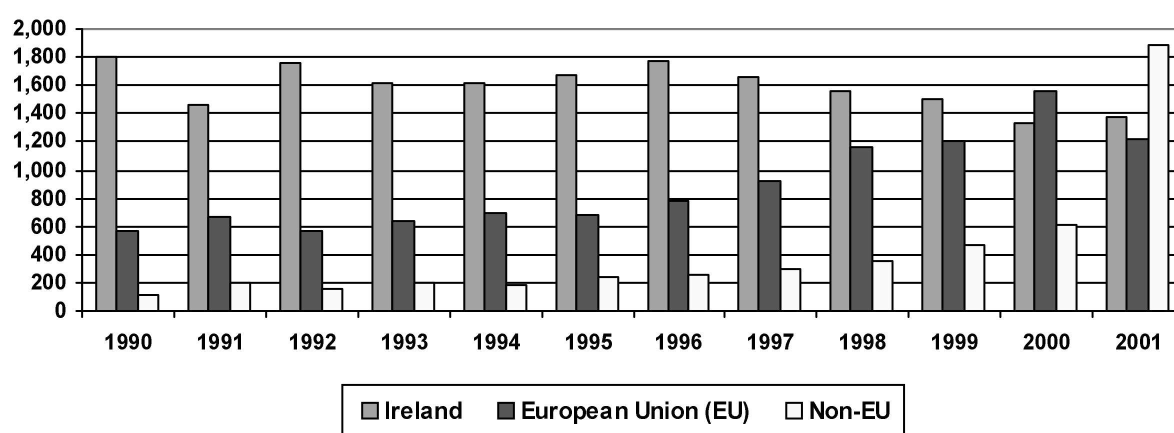
2.4 Ireland

Ireland traditionally has been an exporter of skilled labour, including nurses, primarily to other English-speaking countries. However, in recent years nursing shortages have become apparent in the Irish health system, while the Irish economy has improved significantly. This has led to Ireland becoming a very active recruiter of nurses from other countries.

All nurses practising in Ireland are registered with An Bord Altranais, the nursing registration authority. It is therefore possible to obtain a relatively complete picture of trends in inflow of nurses from other countries. Fig. 5 shows the origin of new registrants since 1990.

Under European Union directives, nurses from other EU/EEA countries are eligible for registration by An Bord Altranais. Nurses from other countries have their applications considered by An Bord Altranais. Applicants from countries other than Australia, Canada, New Zealand and the United States may be required to work a period of "supervised clinical practice, orientation and assessment" at a site approved by An Bord Altranais. National coordination of supervised clinical practice placements for non-EU/EEA nurses is provided by the Health Service Employers Agency (HSEA).

Fig. 5. Ireland: origin of new qualifications registered with An Bord Altranais, 1990-2001



Source: An Bord Altranais.

There has been significant growth in the annual number of new registrants from other EU countries and from non-EU countries, to the extent that Ireland was much more reliant on other countries for new recruits than on its own training sources — about two-thirds of new registrants in 2001 had come from other countries. The main source countries for registered nurses were the Philippines, the United Kingdom, Australia, South Africa and India.

The Irish Department of Health and Children published guidelines on international recruitment of nurses in 2001. The guidelines concentrate primarily on setting out efficient and equitable recruitment practices, but note: "some developing countries are experiencing nursing and

midwifery skills shortages of their own. It is recommended that Irish employers only actively recruit in countries where the national government supports the process. This approach is consistent with the concept of ethical recruitment” (Nursing Policy Division, Department of Health and Children, 2001, para 1.3).

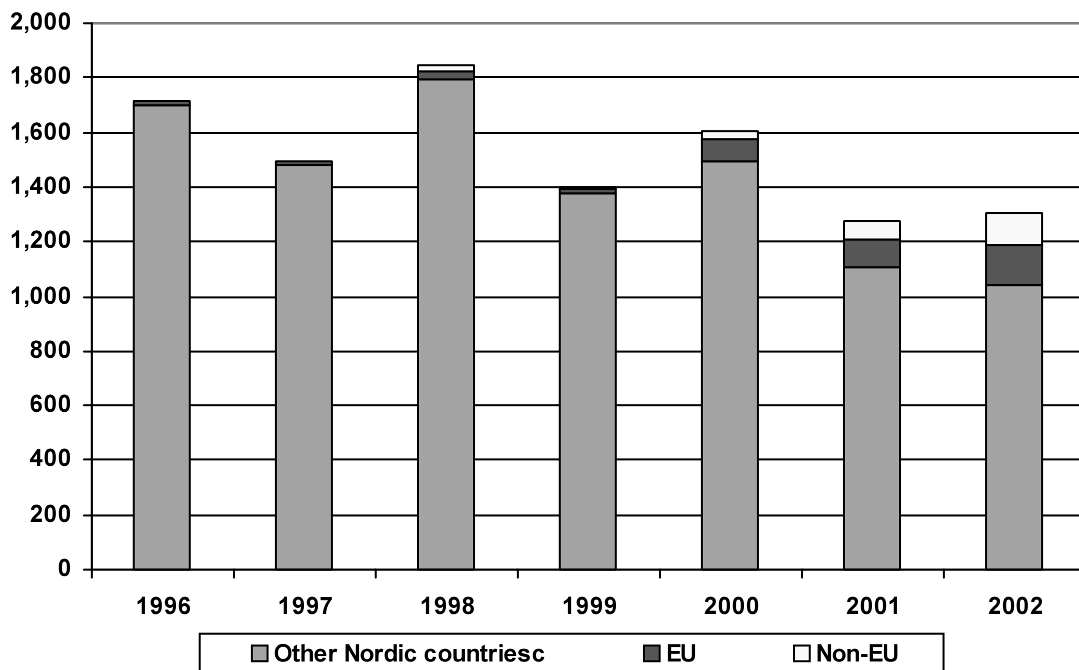
Ireland summary

There is a single point of entry via the national-level registration authority. Registration data highlight rapid growth in inflow of nurses in recent years, with the Philippines, the United Kingdom, Australia, South Africa and India being main sources. The Irish government has published guidelines on international recruitment.

2.5 Norway

Norway is not a member of the European Union but has close ties to other Scandinavian countries. There has been an agreement for free movement of nurses within the Nordic countries for about 20 years. Nurses from other countries applying to work in Norway are recorded by the Norwegian Registration Authority for Health Personnel (SAFH). Fig. 6 illustrates the recent trend in the number of nurses registered by SAFH.

Fig. 6. Norway: international nurse registrants as recorded by SAFH,a 1996-2002b



[a]Norwegian Registration Authority for Health Personnel.
[b]2002 data are provisional (to 6 December).
[c]Other Nordic countries = Denmark, Finland and Sweden.
Source: SAFH *statistics on overseas recruitment.*

There appears to have been a broadening of source countries for recruitment in recent years, with fewer nurses being recruited from other Nordic countries and more coming from other European countries and elsewhere. Data for 2002 indicate that Sweden, Denmark, Finland, Germany and the Philippines were the five main sources of recruits.

The Norwegian Public Employment Service (AETAT) has been recruiting nurses from other countries on behalf of Norwegian employers since 1998 — conducting interviews, screening applications, arranging language training, etc. AETAT targets specific countries for the active recruitment of nurses. Initially the focus of activity was in the EU, and Finland and Germany were the two main cooperating countries, where there was a signed agreement between AETAT and a country counterpart. More recently, this recruitment activity has spread to other countries such as the Philippines and Poland. Though AETAT is the main state-sponsored source, private sector recruitment agencies may also recruit nurses on behalf of Norwegian employers.

AETAT is set an annual limit for the number of recruits: 228 in 2001 and 260 in 2002. For 2003, it is reported that the recruitment budget will be reduced. The target-setting by AETAT means that overseas recruitment to Norway is more regulated than in some of the other destination countries examined in this report. Norway also has the additional problem of having to provide language training to virtually all nurses coming from other countries. The significant trend in inward recruitment has been the shift from reliance on recruitment from other Nordic countries (where entry is easy and language differences are less pronounced) towards recruitment from a broader range of countries.

The main nurses' professional union, the Norwegian Nurses Association (NNA), is a constituent of the Northern Nurses Federation (NNF). The NNF has a position statement on recruitment of nurses from other countries (NNF, 2001). It notes: "Nurses form a key group in the health service all over the world. This gives the occupation a unique and positive opportunity for the development of professional skills through periods of work and study visits in other countries. Through cooperation at a regional level, some nations (such as those within the Nordic area and in Europe) have also laid the foundation for individual migration through the establishment of a free labour market extending across country borders. This gives nurses freedom and offers them the opportunity for exchange of experience — a beneficial situation which must be maintained."

This position statement also affirms: "that the shortage of nurses is an increasing problem worldwide; that the countries affected by this shortage have difficulty in maintaining and developing a health service of acceptable quality for their people; that this situation creates a difficult and stressful work situation for employed nurses and other health personnel; that some countries, including the Nordic countries and Europe, compensate for their shortage of nurses by active recruitment from other countries and short-term appointments. Also, that a long-term problem can never be solved through short-term action. The countries suffering from a shortage of nurses must therefore mainly counteract this by finding solutions on a national level. Such solutions must also allow for an increasing tendency to individual mobility within the occupational group."

The NNF does not oppose international recruitment in principle, but argues for checks and guidelines. "In cases where recruitment of foreign nurses can be regarded as appropriate, NNF requests the authorities and employers in Nordic countries to pay special attention to the following:

the candidates' language skills and cultural understanding; the candidates' professional skills — to safeguard quality and safety in the treatment of patients; a good working environment; the integration of the recruited nurses, both at work and socially; consideration for countries which are building up the nursing facilities they can offer to their own people. NNF is in no doubt that priority must be given to employing permanent personnel — with emphasis on acceptable conditions of pay and work and on providing a suitable and stable workforce situation which will form the basis for the proper and acceptable performance of work and for professional development opportunities — in order to solve the shortage situation in the long-term. Such prioritising will also have a favourable financial effect."

Norway summary

There is a single point of entry for nurses from other countries, via registration. The main inflow of nurses has been from other Scandinavian countries. There has been some recent recruitment from the Philippines and Poland; this is controlled by the state recruitment agency, with a cap on numbers. The Norwegian Nursing Association (NNA) has a strong policy statement on ethics of international recruitment.

2.6 United Kingdom

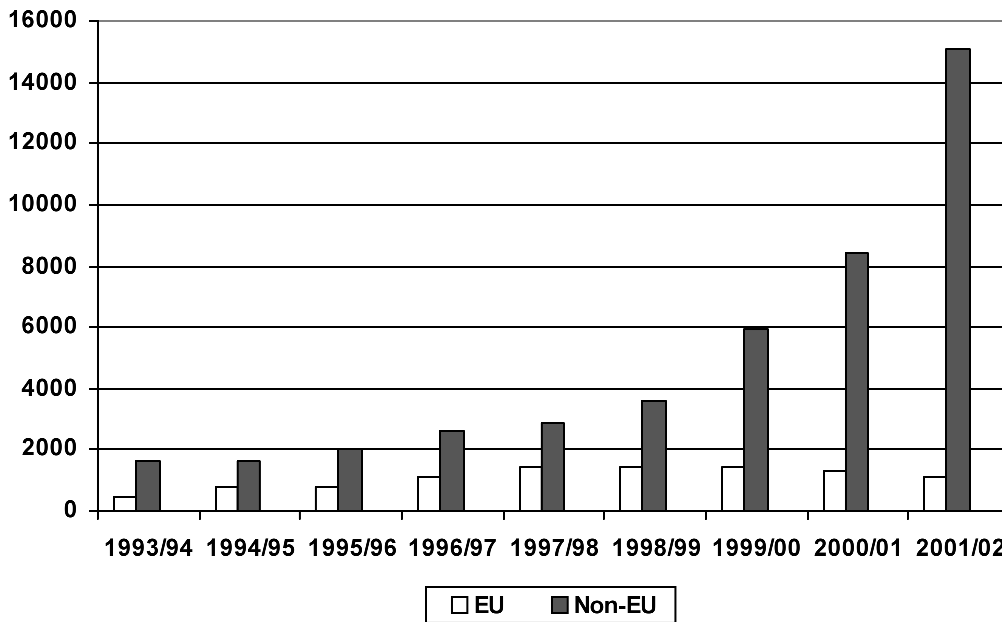
The United Kingdom, particularly England, has experienced significant nursing shortages in recent years. In England, the Department of Health has set nurse staffing increase targets — initially of 20 000 additional nurses by the year 2004 (a target which has already been met) and subsequently of 35 000 more nurses by 2008 (Department of Health, 2002). This recruitment activity has included intergovernment agreements to recruit actively in some countries (for example, Spain, India and the Philippines), but many other countries are currently sources of nurses for the United Kingdom, and individual employers and recruitment agencies continue to be active. Most nurses in the United Kingdom work in the National Health Service (NHS) but there is also a private sector.

Any nurse who wishes to practise in the United Kingdom must be registered with the professional regulatory authority, the Nursing and Midwifery Council (NMC). Applicants with general nursing qualifications from the other countries of the EU/EEA have the right to practise in the United Kingdom because of mutual recognition of qualifications across EU countries: they can register with the NMC via the European Community Directives. Nurses from all countries outside the EU have to apply to the NMC for verification of their qualifications in order to be admitted to the Register. Most nurses from outside the EU will also have to apply for, and be granted, a work permit to take up paid employment in the United Kingdom. As holders of such permits, their employment in the United Kingdom may be time limited.

Registration data only record the fact that a nurse has been registered, they do not show when a nurse actually enters the United Kingdom or indicate what the nurse is doing. Even so, registration data are a strong indicator of trends in applications to practise in the United Kingdom.

Fig. 7 highlights the strong upward growth in the numbers of new overseas nurse registrants. In 2001–02, 15 064 new non-EU entrants and 1091 from the EU/EEA were recorded, giving total overseas admissions for the year of over 16 000.

Fig. 7. United Kingdom: admissions to the UKCC Register (initial registrations) from EU and non-EU sources, 1993-2002

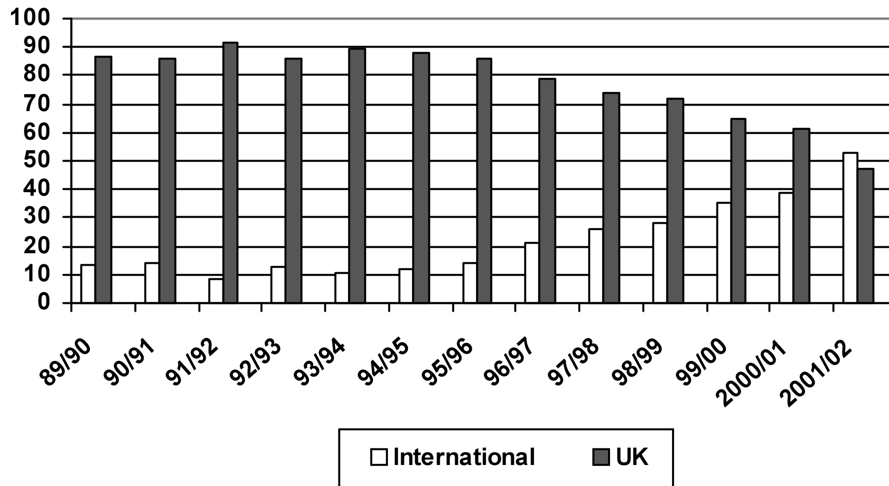


[a] includes a small number of midwives.
Source: United Kingdom Central Council for Nursing Midwifery and Health Visiting/NMC.

The main non-EU source countries for registrations in 2001–02 were the Philippines (7235), South Africa (2114) and Australia (1342), but entrants from other countries, such as India and Zimbabwe, have also significantly increased over the last three years. In the previous year (2000–01), when a total of 9694 entrants were recorded, the three main source countries were the same.

Fig. 8 shows the comparative importance of non-United Kingdom source countries, in relation to the annual total number of all new nurses on the United Kingdom register, including those from United Kingdom sources. In the early and mid-1990s, about one in ten new entrants was from a non-United Kingdom source; by 2000–01 the proportion had risen to almost four in ten of total initial registrations; and in 2001–02, for the first time ever, there were more overseas additions to the register than there were home country registrants.

Fig. 8. United Kingdom: international and UK sources as a percentage of total admissions to the UKCC/NMC Register (initial registrations), 1989-2002



Source: UKCC/NMC.

It should also be noted that, at any one time, thousands more international nurses are in the process of applying to practise in the United Kingdom, or are already in the United Kingdom for a period of adaptation in order that they can be registered and can practise.

The Department of Health in England first issued ethical guidance on international recruitment of nurses in 1999 (DoH, 1999), and published a Code of practice in 2001 (DoH, 2001). The 1999 guidelines required NHS employers to avoid recruiting in the West Indies and South Africa (it did not cover non-NHS employers). This appeared to have only a short-term impact in reducing the numbers of nurses coming from these specified countries, but recruitment from other developing countries grew more rapidly — perhaps because it had been displaced from the West Indies and South Africa (Buchan, 2002b). After this short-term decline, the level of recruitment of nurses from South Africa increased again in 2001–02.

The revised 2001 Code was extended to cover recruitment agencies working on behalf of NHS employers. However, there has been recent criticism by one Member of Parliament that the recruitment aspect of the Code is a sham, with only 30 out of 92 recruitment agencies reportedly complying with the Code, no formal mechanism in place for the Department to check on compliance (Mulholland, 2002), and no specification of source countries that are either banned or approved. There was also media coverage of some private sector employers providing misleading information to nurses about their terms and conditions of employment, or paying them at a lower level than they had originally been offered.

The United Kingdom has increased rapidly its international recruitment activity. This has been driven by the pull factor of shortages and government targets for NHS staffing growth. Recruitment has also broadened out to cover more countries, with current reliance being primarily on English-speaking countries outside Europe.

The Royal College of Nursing (RCN), the largest professional association for nurses in the United Kingdom, has produced good practice guidelines on international recruitment, covering issues such as working with commercial agencies, immigration and work permit requirements, developing and implementing supervised practice, adaptation and general induction programmes, and professional and career development. “The guidance sets out the key considerations and the RCN principles for ensuring both ethical recruitment and employment of internationally recruited nurses” (RCN, 2002).

The RCN notes: “Nurse migration can be mutually beneficial. Internationally recruited nurses (IRNs) broaden their professional and social experience, and they in turn enrich the professional nursing practice of the host countries and enhance the quality of patient care. But if these mutual benefits are to be realized, it is important that heath care employers give careful consideration to a number of issues before deciding to recruit from overseas.” The RCN argues that “targeted, international nurse recruitment can only be a short-term solution to domestic shortages”. It notes: “the key to developing healthy, domestic, nursing labour markets must be medium and long-term strategies. These will ensure that the profession is capable of attracting and retaining adequate numbers of nursing recruits by improving workforce planning and standards of human resource management practices. The actions of individual employers are paramount in ensuring the success of these strategies and should include: fair pay, good terms and conditions of employment, career development opportunities, healthy and safe working environments.” The RCN has also recently established a database of international nurses in the United Kingdom — including refugee health workers.

United Kingdom summary

There is a single point of entry, via registration. There has been a strong upward trend in inflow of nurses from other countries in recent years: the Philippines have become very prominent, and also Australia, South Africa and India. In contrast there has been no upward trend in flow from countries of the European Union. The Department of Health, England, has a code of practice on international recruitment; this only covers the public sector. The Royal College of Nursing has a position statement on international recruitment.

2.7 United States of America

A significant nursing shortage in the United States is prompting a wide variety of responses, including increased interest in foreign recruitment. According to a recent report from the National Center for Health Workforce Analysis in the US Department of Health and Human Services (2002), there was a shortfall of nearly 111 000 registered nurses (RNs) in the United States in 2000, and this number is projected to grow to over 800 000 by 2020 if current trends continue. The shortfall is the result of a 40% increase in demand for RNs and only a 6% increase in supply over the period. Furthermore, the Center for Health Workforce Studies at the University of Albany (2002) projects the growth of over one million jobs for nurses in the period 2000–2010: 561 000 new jobs to meet the growing demand and 443 000 job vacancies that will need to be filled because of retirement and other factors.

Though the United States has selectively used foreign recruitment to fill gaps in nursing personnel and has in the past been active in recruiting nurses from other countries, there is as yet no sign of a recent significant upward trend in recruitment of nurses. However, US-based employers are lobbying for an easing of immigration requirements in order to facilitate recruitment of nurses and other health workers.

There is a two-step process for obtaining a RN licence in the United States, separate from the process necessary for obtaining a work visa. The Commission on Graduates of Foreign Nursing Schools (CGFNS) pre-screens foreign-educated nurses wishing to practise in the United States. Pre-screening involves: a review of a nurse's education; licensure in the home country; English language proficiency testing; and a predictor exam that provides an indicator of the nurse's ability to pass the US National Licensure Exam (NCLEX). In the United States, every nurse must meet additional requirements as established by the State Board of Nursing in the state where the nurse intends to practise and take the NCLEX. Each state has its own board of nursing: some will accept the Canadian Nurses Association Testing Service (CNATS) or the Canadian Registered Nurses Examination (CRNE); there are also a few that will directly endorse foreign-educated nurses who have never taken the NCLEX.

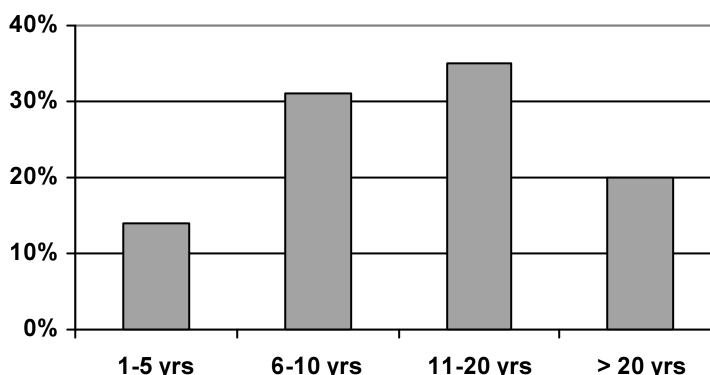
Registration and licensing of individual nurses is the responsibility of the state-level nurse registration board. Each one operates independently and, with more than 50 states or territories, it is very difficult to obtain a complete accounting of foreign nurses registered in the United States. This accounting is further complicated by the fact that up to 15% of nurses have multiple registration across different states. There is one national data source: a sample survey of RNs conducted every four years on behalf of the US Department of Health and Human Services. In 2000, the survey reported that there were nearly 100 000 foreign-trained, US-licensed RNs working in the United States (n = 99 456). Among them, 86% (n = 85 696) were working in nursing and 3% were working in other fields, over half of which were health-related occupations. The mean age of foreign-trained nurses — 45.4 years for all RNs and 43.8 years for those working in nursing — was comparable to those who were US-trained. There were more men among foreign-trained nurses compared with nurses from US schools — 6.4% for all registered nurses and 6.8% for those working in nursing, compared with 5.4% and 5.8%, respectively, for US-trained nurses.

The dominance of recruitment efforts by hospitals for foreign-trained nurses is reflected in their distribution across practice settings: 72% reported working in hospitals (compared with 59% of US-trained registered nurses), followed by 9% in nursing homes and 8% in public health.

Among foreign-trained RNs working in nursing, 43% received their first US licence in the last 10 years (1990–1999). In that group, only 14% are recent graduates from their basic nursing education programme, and just under half of them graduated in the last 10 years. The recent graduates were more likely to come from Canada, while earlier graduates were more often from the Philippines.

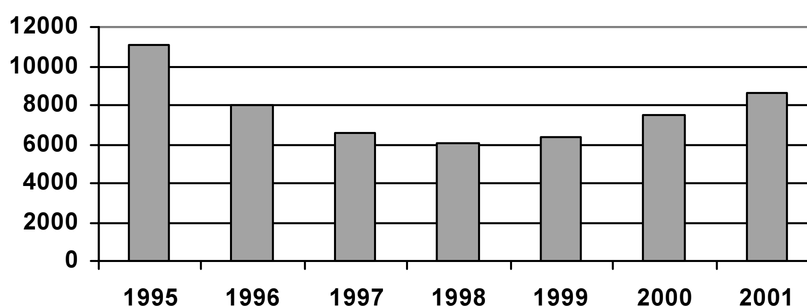
In terms of inflow from other countries, the main indicator is the annual number of nurses applying for the RN licensure examination in the United States. This fell in the latter half of the 1990s and then began to increase again by the end of the decade. Similarly, examination pass rates fell until 1998 (from 63% to 45%) and then began to rise slowly.

Fig. 9. USA: distribution of foreign-trained registered nurses receiving their first US RN licences in 1990–1999 by the number of years since graduating from their basic RN education programme



Source: *National sample of registered nurses*, Health Resources and Services Administration, US Department of Health and Human Services (2000).

Fig. 10. USA: foreign-trained first-time candidates for US licensure examination, 1995-2001



Source: National Council of State Boards of Nursing. These data are available from reports on their web site: www.ncsbn.org

Of the 26 506 nurses applying for US RN licensure in the last half of the 1990s (1997–2000), 11 countries or areas represent 86% of the applicants, as follows:

Philippines	32.6%
Canada	22.0%
Africa	7.4% (mainly Nigeria and South Africa)
Republic of Korea	7.1%
India	5.8%
United Kingdom	4.4%
Russian Federation	2.2%
Australia	1.3%
People's Republic of China	1.3%
Poland	1.0%
Jamaica	0.7%

Over this period, the annual number of applicants from Canada gradually fell by nearly half, while applicants from the Philippines virtually doubled.

The data from the United States suggest that there has been an upturn in applications from nurses to enter the country to work in recent years, but that the annual number is no higher than it was in the mid-1990s. However, projections for future demand point to the likelihood of further increases, particularly if current immigration restrictions are eased.

The main nurses' professional union, the American Nurses Association (ANA) "believes that the US health care industry has failed to maintain a work environment that is conducive to safe, quality nursing practice and that retains experienced US nurses within patient care. ANA supports continuation of the current certification process to apply to all foreign-educated health care workers regardless of their visa or other entry status. ANA opposes efforts to exempt foreign-educated nurses from current H-1B visa program requirements." The ANA position is that "the practice of changing immigration law to facilitate the use of foreign-educated nurses is a short-term solution that serves only the interests of the hospital industry, not the interests of patients, domestic nurses or foreign-educated nurses". It condemns the practice of recruiting nurses from countries with their own nursing shortage, and argues: "the cause of instability in the nursing workforce must be addressed. Over-reliance on foreign-educated nurses serves only to postpone efforts required to address the needs of the US nursing workforce. Foreign-educated nurses brought into the United States tend to be placed in jobs with unacceptable working conditions with the expectation that these nurses, as temporary residents and foreigners, would not be in a position to complain." (American Nursing Association, 2003).

United States summary

Applications for licensure data suggest growth in applications from nurses in other countries in recent years, but to a level no higher than in the mid-1990s. The Philippines and Canada are the two main sources of applicants. The National Nurses Association has a position statement on international recruitment.

2.8 The Caribbean

There has been a long history of emigration of nurses from the countries of the English-speaking Caribbean to the United Kingdom, Canada and the United States. A review of nurse migration in the Caribbean was conducted as background to the development of a collective approach to managed migration, which noted that there were flows of nurses within the Caribbean as well as outflow from the Caribbean, mainly to the United States, the United Kingdom and Canada (PAHO, 2001). The review estimated that the economic effect of the outflow of nurses was a human resources dividend to the destination countries of approximately US$ 16 million; the main implications for the Caribbean countries were summarized as follows:

- not enough nurses to support delivery of essential health care;
- decreased capacity to deliver health services;

- increased costs of recruitment and retention;
- possible compromises in quality of care;
- low consumer and staff morale.

2.9 Ghana

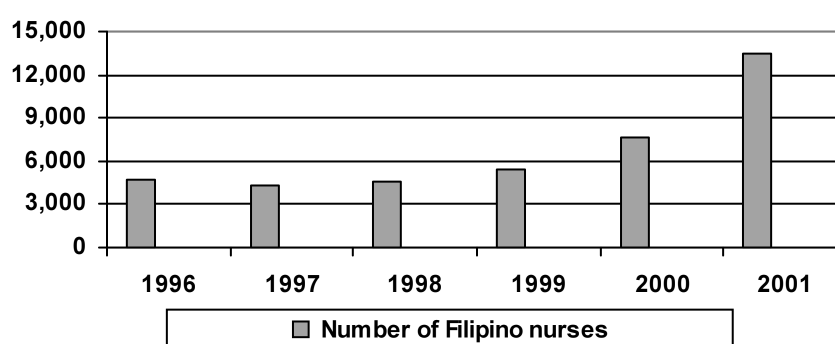
Information provided by the Ghana Registered Nurses Association (GRNA) highlights that it is very difficult to have the actual number of nurses who leave Ghana each year. This is because no single agency compiles a complete list of data, some nurses leave immediately after training, and aggregation of local and regional data takes a long time (GRNA, personal communication).

The GRNA estimates that 2972 nurses left the country in 2001 and 3534 in 2002, mainly to the United Kingdom and the United States. (Statistics from the Nursing and Midwifery Council indicate that 195 Ghanaian nurses were registered in the United Kingdom in March 2001–2002.)

2.10 The Philippines

The Philippines has figured prominently as a developing country source of nurses. There has been a deliberate policy to encourage outflow of nurses and inflow of remittances from these nurses. 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 because of a reduction in demand from destination countries, particularly the United States, annual outflow in recent years appears to have increased (see Fig. 11).

Fig. 11. The Philippines: outflow of professional nurses, 1996-2001



Note: Filipino sources suggest these figures may be underestimates.
Source: POEA/Lorenzo.

In 2001, the United Kingdom, Saudi Arabia, Ireland and Singapore were the four most important destinations for Filipino nurses (see Table 3)

Table 3. Outflow of professional nurses from the Philippines, 2001

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

Source: POEA/Lorenzo.

The Philippines is relatively unusual in that it stimulates high levels of recruitment from industrialized destination countries. For most other developing countries, outflow is the result of individual responses to push and pull factors rather than an active policy.

2.11 South Africa

The Democratic Nurses Organisation of South Africa (DENOSA) commissioned a report on nurse emigration that was published in 2001 (Xaba & Philips, 2001). The report analysed statistics on nurse emigration, surveyed health care institutions, and interviewed emigrating nurses. The authors planned to survey 100 institutions (29 responded), to analyse questionnaires provided to 100 nurses considering emigration (10 responded), and to interview 20 nurses who were emigrating (16 responded). The authors caution about variations 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.

The report assessed verification data held by the South African Nursing Council (SANC) (see Table 4). Applications to work as a nurse in another country were recorded, which did not necessarily mean that the nurse left South Africa and could also include double counting. There was a clear upward trend in verifications issued until the year 2000. Though not commented on by the authors of the report, the reduction in 2000 may be linked to the temporarily reduced flow of nurses from South Africa to the United Kingdom in 2000 as a result of the introduction of ethical recruitment guidelines in England in November 1999.

Table 4. Verifications issued by the South African Nursing Council, 1991–2000

Year	No. of applications for verification of qualifications	Percentage change per 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 & Phillips (2001)/SANC.

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 these other sources are "likely to release inaccurate figures" and that the data are contradictory. The United Kingdom, 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 were available.

The main impacts of nurse emigrations were reported to be:

- frustration and demotivation 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 had left).

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" (DENOSA, 2001). It argued that remuneration and service conditions of nurses in South Africa must be improved. It also noted that unspecified numbers of foreign nurses were working in South Africa.

2.12. Country analysis

Trends in cross-border flows of nurses are shown by the above analysis of registration data. It is evident that there appears to have been a significant upward trend in inflow to some, but not all, of the destination countries. More detailed scrutiny reveals that the composition of inflow to these countries also varies, in terms of the mix of source countries and their level of development.

It is over-simplistic to suggest that the flow of nurses is only from developing to industrialized countries. Some countries, such as the United Kingdom, have reported significant increases in nurse registrants from developing countries, but others, such as Norway, have been recruiting almost exclusively from other industrialized countries. In the case of Norway, this has been the result of a policy decision by the government.

The trend data from source developing countries examined in this chapter support the contention that there has been an upswing in outflow from some countries since the mid-1990s (South Africa appears to have dropped back in 2000). While there are data limitations for some countries, the upward trend is confirmed by inflow registration data from destination countries. However, though the trends match the data rarely do — because of differences in methods of calculation, but also because of different levels of data accuracy and completeness. Data limitations, highlighted as a difficulty in assessing general levels of migration, are also a problem in evaluating flows of nurses.

If trend data from the Philippines are accurate, there was a relatively static period of outflow of nurses in the early and mid-1990s. This was a time when the United States, the traditional destination of these nurses, was in the process of significant retrenchment in the nursing workforce as a result of funding constraints and health system restructuring. The more recent rapid increase in outflow of nurses from the Philippines has been to new English-speaking destinations: Ireland and the United Kingdom. In 1998–99, the United Kingdom reported registering only 52 nurses from the Philippines; three years later it reported registering 7235. Outflow from the Philippines has therefore switched to new destinations, as a result of job opportunities underpinned by active recruitment practices. This situation highlights the dynamic nature of these flows of nurses — they may rise or fall or change direction in response to the level of opportunity in different destination countries or to the incidence of push factors in the source country.

In terms of assessing the impact of outflow of nurses, the Philippines is atypical because of the active encouragement and development of nurse migration as a means of ensuring remittance monies being returned to the country. The Caribbean, Ghana and South Africa are examples of countries that have been considering the negative impact of out-migration of nurses. Information from these countries points to a direct negative impact on remaining staff and on the quality of care provided. This may become a cause, as well as a symptom, of migration. There is little evidence from these countries of some of the potential positive effects of migration noted earlier in this report.

Another issue to note is the stance taken by regulatory authorities and professional associations in the destination countries. Most of them have drafted policy statements emphasizing the freedom to move but also highlighting concern about the potential negative effects of active recruitment from developing countries. While professional associations may be open to accusations of protectionism if their concerns are related to the possible dampening effect on nurses' pay levels if there is a large influx of nurses from other countries, this may be less of a direct issue in countries such as Ireland and the United Kingdom, where pay rates are set nationally.

The information from the countries highlights some key trends and significant variations between countries. What becomes very evident in analysing country level data is that it is not possible to generalize. Two importer countries (Ireland and the United Kingdom) report significant upward

trends in international recruitment. Australia, at state level, reports more moderate growth, while there does not appear to have been significant recent growth in Norway or the United States (though there has been a switch to new non-Scandinavian source countries in Norway). One common trend is a broadening out of recruitment activity to a wider range of source countries.

Table 5 summarizes some of the key indicators. Even though the data are incomplete for source countries, there are two key indicators to examine. First, how significant are international nurses as a percentage of the total "stock" of nurses in the country? Second, how significant is the current inflow of international nurses as a percentage of total new inflow to the stock? The latter indicator is particularly important in highlighting the current level of reliance of the country on international recruitment of nurses.

The data in the table must be interpreted with caution, as different countries collate information in different ways. In particular, comparison between countries using the table should only be at the broadest level. It is apparent, however, that the United Kingdom and Ireland are much more reliant on new inflow of international nurses than the other countries that were examined.

International recruitment and migration are dynamic features of nursing labour markets. Table 5 attempts a point in time snapshot but also serves to highlight another important factor: it is the contribution of international nurses to overall new inflow or outflow that is the key policy feature for both source and destination countries. Merely identifying the number of international nurses as the percentage of the stock of all nurses in a country is not sufficient. Many may have arrived years or decades ago (this will be the case in Australia, the United Kingdom and the United States, all of which relied on immigration in the postwar decades). As a measure of active engagement in international nursing labour markets as a source or destination country (or both), it is the size and contribution of international nurses to inflow (or outflow) that is the key factor.

A secondary indicator is the current inflow or outflow of international nurses as a percentage of total stock. Brain drain is in essence an issue both of actual size of outflow and also of the relative size of this outflow in relation to the total stock of nurses in the country.

A further issue to consider is the relative size of the source and destination countries, in terms of the total stock of nurses in each country. A large country such as the United States, with more than two million nurses, will have an annual replacement need (to replace nurses retiring or leaving work) far in excess of the total stock of nurses in some countries in the West Indies or Africa. In Zimbabwe, the yearly number of new graduated nurses for the years 1998–2000 is around 340, whereas the number of annual nurse registrations for Zimbabwean nurses in the United Kingdom amounted to 382 in 2001. Assuming that there is no surplus of nurses in Zimbabwe, these figures clearly show the potential negative impact of migration on the renewal of human resources for health for Zimbabwe (WHO, 2002).

It should be highlighted that a focus on the quantitative aspects of inflow and outflow gives an overview, but not a complete picture. It is not just the numbers of nurses leaving a country that matter — it is the loss of skills and potential future contribution. These factors are not easy to assess but, given that mobile nurses are likely to be younger, if their outflow is permanent the real damage to the health system may be long term if it loses the next generation of potential leaders.

Table 5. Key indicators of international recruitment[a]

Country	Total current stock of nurses	International nurses in country	International nurses as percentage of current stock	Recent total annual flow to stock from all sources	International inflow	International nurses as percentage of recent annual flow	Major source countries
Australia: Victoria		?	-	5 000	1 100	28%	United Kingdom New Zealand
Australia: South Australia		?	-	1 384	118	9%	United Kingdom New Zealand
Ireland[b]	61 629		-	4 400	3 050	69%	United Kingdom Philippines South Africa
Norway	45 133		-	4 650	1 300	28%	Other Scandinavian countries Germany Philippines
United Kingdom[c]	580 000	42 000	7%	30 600 (2001–02)	16 000	52%	Philippines South Africa Australia
United States[d]	2 000 000 +	100 000	5%			3–4%	Philippines Canada Africa (mainly South Africa and Nigeria)

[a]Estimates based on country data; should be treated with caution.
[b]Ireland stock is all nurses on the register (source: An Bord Altranais).
[c]United Kingdom stock is United Kingdom-based nurses on the UK register (source: NMC/Buchan, 2003).
[d]US data are derived from different sources and may not be directly comparable with the other four countries.
Sources: Flow information from country correspondents; relates to registrations (apart from United States, see text).
Stock information from OECD unless stated otherwise.

A final key issue for consideration is the extent to which industrialized countries actively stimulate inflow or rely on individual nurses in developing countries to offer their services. In other words, whether destination countries are marketing their pull factors or whether they are relying on the push from source countries.

While it is not possible to assess in detail the relative importance of active and passive recruitment, there are a number of examples of policy and practice initiatives in industrialized countries which suggest that active recruitment, often on a large scale — batches of 20, 50 or 100 nurses at a time — is increasingly a feature of the dynamic. Some examples of initiatives are given in Table 6.

The next chapter of this report will examine in more detail the "push" and "pull" dynamics that stimulate nurses to consider moving across national boundaries.

Table 6. Examples of recent initiatives to facilitate international recruitment of nurses

Country	Initiative
England	Regional coordination of international recruitment for National Health Service, by government agency
Ireland	National coordination of clinical placements for overseas nurses
Norway	Provision of language skills training
United States	Relaxation of immigration requirements and opportunity to sit licensing examination in home country

Chapter 3. "Push" and "pull" factors

This chapter reports on the attitudes and motivations for mobility. Previous research on nurse mobility (Mejia, Pizurki & Royston, 1979; Connell, 2001; Buchan, 2002a) highlights the importance of push and pull factors, leading nurses to leave one country and look for employment opportunities in another.

3.1 Push factors

It has to be recognized that many health workers in many health systems are working in situations where they are underpaid, have inadequate resources to perform their functions, are struggling with heavy workloads, and, in some cases, have to cope with the threat of violence. This may be particularly the case in developing countries where health systems are under-resourced (Mutizwa-Mangiza, 1998; Bennett & Franco, 1998). In this situation, some workers will leave to go to other sectors, to other parts of the country or abroad, thus creating bigger challenges for those who remain.

Dovlo (1999), in his 1998 survey of seven African countries, found vacancy levels in the public health sector to range between 7.6% (for doctors in Lesotho) and 72.9% (for specialists in Ghana); Malawi reported a 52.9% vacancy level for nurses. Those who attempt to stay in a demanding and stressful situation have to adopt coping strategies (Ferrinho & Van Lerberghe, 2000), but others will make use of the possibilities of internal or external migration. Some of the analyses conducted in developing countries have assessed the impact of push factors in these countries, stimulating nurses to leave (see Xaba & Phillips, 2001; PAHO, 2001). The sections below summarize information from focus groups and interviews conducted in the Caribbean, the Philippines and South Africa.

The Caribbean. The review conducted to inform managed migration (PAHO, 2001) summarized the main push factors encouraging nurses to consider leaving the Caribbean as follows:

- poor pay;
- poor working conditions, including concerns about security in some workplaces;
- limited opportunities for professional development;
- lack of job tenure;
- lack of involvement in decision-making;
- lack of support from supervisors;
- unstable economic conditions.

The Philippines. Focus groups with nurses, conducted by Lorenzo (2002), reported the following factors contributing to nurse supply/demand imbalances in the Philippines, and the subsequent stimulus to migrate.

- Economic factors:
  - high general unemployment rate in the country;
  - overproduction of nurses not addressed adequately;
  - decreased demand in the international market (Note: refers to downturn in mid-1990s) with no or very little increase in domestic demand.

- Social factors:
  - values attached to nursing by the family;
  - preference for urban and city life.

- Political factors:
  - non-enforcement of existing laws that control and monitor nursing supply and demand;
  - absence of comprehensive human resource planning in health;
  - inadequate networking and collaboration among institutions and agencies responsible for production and utilization of nursing human resources.

- Professional factors:
  - lack of emphasis on independent nursing practice;
  - perceived weakness of nursing leadership to advocate for nurses;
  - inability to influence decision-making and policy-making bodies;
  - inadequate networking and collaboration between nurses involved in production and utilization of nurses;
  - failure to shift from traditional roles to innovative and entrepreneurial roles.

Lorenzo noted that the pull factor of demand from various industrialized countries had varied markedly over time, with huge outflow to the United States and the Middle East in the 1980s but lower demand from these countries in the 1990s. Recently, this has been replaced by heavy recruitment from the United Kingdom and Ireland.

South Africa. The main push factors identified by the report commissioned by DENOSA (Xaba & Philips, 2001), using focus group interviews with nurses based in South Africa, included:

- 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 rates in the country;
- rise of HIV/AIDS in South Africa.

3.2 Pull factors

To explore the motivations of individual international nurses who had actually moved, focus groups were conducted for this study with international nurses in Australia, Ireland and Norway. Information from these focus groups was complemented by data from a larger survey of international nurses in the United Kingdom who were members of the Royal College of Nursing: an analysis of 1119 responses, representing a 35% response rate (RCN, 2002).

The key points identified in the focus groups are reported in Boxes 1–3. These highlight common themes relating to recruitment practices, but also reveal the different reasons why nurses have moved from one country to another. Even from these small groups, it is apparent that there is

Box 1. International nurses in Australia:

9 respondents: 7 from the United Kingdom, 1 from Canada and 1 from New Zealand.

Demographic details
All respondents were female. The age range was 26–40 years. The number of years in nursing ranged from 4 to 22. Most had RGN or RN qualifications; 7 had trained in the United Kingdom. Four had previous international experience, e.g. in New Zealand, the United States, West Africa, Sweden, and Bosnia.

Coming to Australia
All had been recruited through recruitment agencies. Some reported very good experiences with one agency. Others using different agencies reported that they had had problems and had continued the application process themselves once initial contact with the hospital had been made. Telephone interviews were held with hospital management prior to being offered the job. None of the nurses paid a fee to their recruitment agency but they paid their own travel costs. Verification for United Kingdom registrants was provided by the NMC; there was a fee for this information.

Arriving in Australia
Apart from those who used the 'good' agency (who reported that they continued to receive support), most others reported that support from their agency stopped once employment commenced. Ward-based educators were provided, but length and quality of orientation reportedly varied. The nurses felt that the information necessary for application and registration could be made clearer: this was because of the range of organizations that had to be contacted for various reasons and the number of health checks, all of which varied in cost. The majority of nurses experienced no problems since arriving in Australia, though some reported initial difficulties with the tax system. Basic accommodation was supplied to all respondents at a minimal rate for the first 13 weeks of their employment. The majority reportedly intended to stay for 1–4 years before returning home or moving on.

Nursing in Australia
The nurses reported differences in care delivery, which included medication being checked more thoroughly; different medication measurements; and limited opportunity for autonomy as wards were protocol-driven and every activity (e.g. hanging a blood bag) was assessed according to the protocols. Staffing ratios were reportedly better than "at home", as was the working relationship between doctors and nurses. Less technology in wards was reported.

Why did respondents want to work in Australia?
The majority reported travel to be their main motivator, with standard of living and pay also of significance. Two respondents reported family reasons. Other factors were also reported: more job opportunities, English speaking, nursing more respected, sun, and access to other countries (e.g. trans-Tasman agreement to work in New Zealand).

usually one main factor that has stimulated the nurse to move, but that there are often secondary factors too. For example, the Filipino nurses in Norway reported better pay as the primary pull factor, but some also reported opportunities for additional training; the United Kingdom and New Zealand nurses in Australia reported travel as the main factor. The RCN survey highlighted that international nurses reported professional development and better salary as the two best features of working in the United Kingdom.

Box 2. International nurses in Ireland

12 respondents: Filipino.

Demographic details
There were 11 female respondents and 1 male. The age range was 25–45 years. The number of years in nursing ranged from 4 to 12. The majority had BSc in Nursing and/or RN qualifications. All had trained in the Philippines and the majority had no previous international experience. The one male respondent (also the oldest) had worked in Saudi Arabia, Bahrain, Libya and Canada.

Coming to Ireland
Their recruitment has been coordinated by one recruitment agency on behalf of the employer. The majority reported that they had received considerable information from the agency about many aspects of Ireland and its culture and also their employment. One had received information from friends already working in Ireland. There was a split between why the nurses chose to go to Ireland: some had specifically chosen Ireland because it was a peaceful and stable country with better working conditions, while others reported that recruitment agencies were hiring for Ireland at the time. The majority reported that their travel expenses had been paid by the employer or agency. The majority also reported that the agency was very helpful in processing their registration information, but that a fee was charged which they had to pay themselves. All reported that they had to have a number of interviews with the agency and employers and that documents were thoroughly checked.

Arriving in Ireland
All reported the agency as being very supportive in orienting them to Ireland, assisting with accommodation and arranging adaptation seminars. One also noted that the hospital and colleagues were very helpful. All were given free accommodation for one month on arrival, organized through the agency, and most were offered assistance in finding permanent accommodation following this period. Some mentioned experiencing racial discrimination, but on the whole the main difficulties appeared to be with general adaptation to the culture and understanding the Irish accent. The minimum length of time that the nurses reported they wanted to stay in Ireland was two years. Others wanted to stay beyond this. All but one nurse wanted to renew their work permits if given the opportunity.

Nursing in Ireland
The majority reported few differences between nursing in Ireland and in the Philippines, though some mentioned procedures in the Philippines that were not permitted to be conducted by nurses in Ireland. Some emphasized that, unlike in Ireland, relatives (rather than health professionals) are generally responsible for care of the elderly in the Philippines. Most reported positive, supportive attitudes from other staff but some also mentioned that some Irish staff made it clear they did not think Filipino nurses belonged there.

Why did respondents want to work in Ireland?
The majority reported that a range of factors influenced their move to Ireland, e.g. enhanced career opportunities and acquisition of new skills to take back to their home country. However, all reported that the overriding factors were better pay and improved standard of living.

Box 3. International nurses in Norway

9 respondents – Filipino.

Demographic details
The majority (7) were female. The age range was 25–51 years. The number of years spent in nursing ranged from 4 (the most frequent) to 10. All nurses had either BSc in Nursing (BSN) or RN qualifications. All had trained in the Philippines and one had also done some training in Norway. Two had previous international experience, both having worked in Saudi Arabia, and one had also worked in Dubai.

Coming to Norway
The majority had received information from friends and relatives about Norway which partly influenced their decision to move. One nurse had a sister who was there already and another's grandmother lived there. In terms of travel costs, five had paid for the cost of travel to Norway themselves, four had costs paid for by their employer. Some had been recruited directly by the government agency (AETAT), while others had been involved via recruitment agencies. Most reported that there had been checks on their qualifications, by employer and by AETAT.

Arriving in Norway
There was variation between respondents regarding information and assistance they received on arriving in Norway. Those who had family there relied on them for support and/or accommodation. Most said they were given guidance on getting a licence to work. Some said they were oriented to the culture and given advice on housing by their employer, and most had been given some housing support. One nurse highlighted that they (and others) had been assigned a Norwegian nurse to help them settle in and make sure they had the necessary skills and training to do their work. The main problem reported by the majority of the Filipino nurses was the language. Concern was expressed about language barriers preventing them from integrating fully with colleagues, but also inhibiting their ability to express themselves. Other problems mentioned were low pay, housing support and attitudes of coworkers. When asked how long they intended to stay in Norway, two said "indefinitely", one said "for ever" and one said "until I get my pension". The majority were planning to extend their permits and one reported wanting to apply for residency.

Nursing in Norway
Some respondents highlighted differences in the nursing education curriculum between Norway and the Philippines. Several were working in nursing homes and acknowledged that this was very different for them as there was little emphasis on this type of nursing in the Philippines, where relatives generally care for the elderly. Some mentioned differences in technology and nursing practice between the two countries. Five of the nine mentioned sometimes being discriminated against in Norway; this was often linked to not knowing the language.

Why did respondents want to work in Norway?
All reported that better pay and living conditions were the most important factors in making the move to Norway. Five also rated enhanced career opportunities as very important (two did not rate this as important at all).

To summarize the main push and pull factors, Table 7 lists the key factors reported in previous work and those highlighted in the focus groups undertaken for this study.

To a certain extent, the push and pull factors present a mirror image — on the issues of relative pay, career prospects, working conditions and environment available in the source and destination countries. Where the relative gap (or perceived gap) is significant, the pull of the destination country will be felt.

However, there are other factors that may also act as significant push factors in specific countries at specific times, such as the impact of HIV/AIDS on health system workers, concerns about personal security in areas of conflict, and economic instability. Other pull factors, such as the opportunity to travel or to assist in aid work, will also be a consideration for some individual nurses.

Table 7. Main push and pull factors in international nursing recruitment

Push factors	Pull factors
Low pay (absolute and/or relative)	Higher pay (and opportunities for remittances)
Poor working conditions	Better working conditions
Lack of resources to work effectively	Better resourced health systems
Limited career opportunities	Career opportunities
Limited educational opportunities	Provision of post-basic education
Impact of HIV/AIDS	Political stability
Unstable/dangerous work environment	Travel opportunities
Economic instability	Aid work

One relevant issue which is virtually unreported in terms of motivating nurses to move is their family circumstances. The extent to which those who have partners and/or children decide to move with or without their families is unknown (the entry visa requirements to some countries may prevent this from happening even if the nurses wish to move with their families).

3.3 The experience of moving

The focus groups conducted for this study also highlight some of the negative experiences of moving from one country to another, including racism (from other staff or from patients), undervaluing of their qualifications (one-third of international nurses in the RCN survey reported this) and varying experiences with recruitment agencies. The RCN survey reported that one in three international nurses had paid a recruitment agency in order to move to work in the United Kingdom.

A major distinction has to be drawn between international nurses anticipating a permanent move from source to destination country and those planning only a temporary move. Most Filipino nurses in Ireland and Norway reported their intention of staying on if possible. Half the international nurses in the RCN survey reported plans to stay long term in the United Kingdom. There are also issues of professional and cultural adaptation to be considered, which are under-researched (but see Yi & Jezewski, 2000; Daniel, Chamberlin & Gordon, 2001; Watson et al., 2003).

Taking into account push and pull factors and individual circumstances, a typology of different categories of international overseas nurses has previously been developed (Buchan, Seccombe & Thomas, 1997) and is updated in Table 8.

Table 8. Internationally recruited nurses in the United Kingdom: a typology

Permanent move	
The economic migrant	attracted by better standard of living
The career move	attracted by enhanced career opportunities
The migrant partner	unplanned move, as a result of a spouse or partner moving nursing qualification used to "finance" travel
Temporary move	
The working holiday	acquisition of new knowledge and techniques, for use in home country
The study tour	acquisition of postbasic qualifications, for use in home country
The student	employed on fixed term contract; often awaiting
The contract worker	improved job prospects in home country

This typology helps to delineate different push and pull factors. It is clear that the opportunity for personal development can be a major incentive for many nurses considering a temporary move. For example, nurses entering the United Kingdom from Australia, or entering Australia from the United Kingdom, are more likely to conform to the "working holiday" types. An unpublished survey of 41 nurses recruited from Australia to the United Kingdom in 1999 found that 61% had chosen the United Kingdom for travel reasons, or to visit friends or relatives, and that 27% had moved for career development reasons (Buchan, 2002b). In contrast, many of the flows from developing to industrialized countries are likely to be economic migrants or contract workers.

Temporary or permanent migration

The other main issue that cannot be answered by looking only at inflow data is the extent to which it represents a temporary or permanent inflow — have nurses moved from source to destination country for only a period of time, or do they regard the move as permanent migration?

WHO (2002) notes that the following typology of international migration is widely accepted.

- **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.
- **Recognized 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 recognized as refugees but who have valid reasons for fleeing their country of origin (such as famine or war).

It is not possible to type flows of nurses, or to assess the balance between temporary and permanent migrants with the available data. There are also other considerations. Firstly, nurses' situations will change over time and some temporary moves will become permanent, while some planned permanent moves will be short lived. Secondly, some countries place time restrictions on entry to some categories of nurses — the provision of one-year or two-year work permits in the United Kingdom, for example, suggests a temporary flow, but it is likely that these permits will be extended.

At aggregate level, it is likely that moves will be planned as temporary if there is a pull factor which is regarded by the nurse as only temporary, or if there is an expectation by the nurse that push factors in the source country may disappear within a short period of time, or that the gap between positive pull factors and negative push factors will narrow significantly.

The recruitment of Finnish nurses to the United Kingdom, for example, was a significant feature for a few years in the late 1990s as a result of temporary oversupply of nurses in Finland. When nursing jobs became available in Finland, the outflow to the United Kingdom dropped and many of the Finnish nurses working in the United Kingdom returned home.

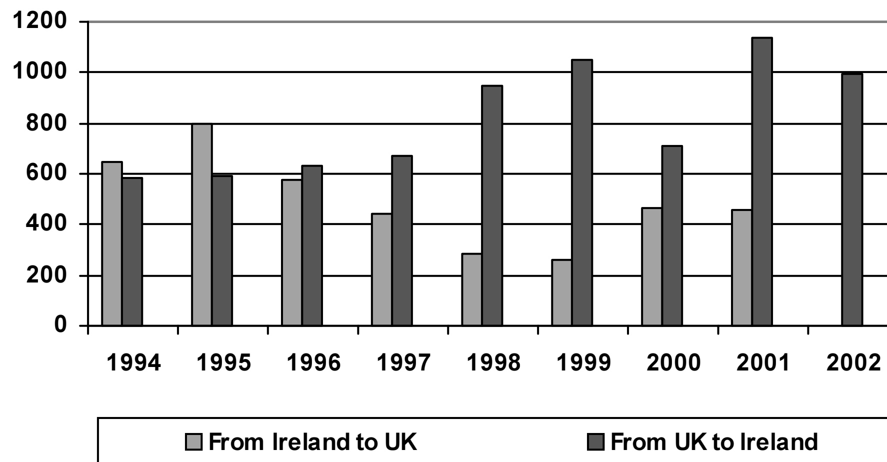
If there is not the expectation by the nurse of a relative improvement in the situation in the home country, it is more likely that outflow will be planned by the nurse to be long term or permanent.

Moving between industrialized countries

The study by Mejia et al. in the 1970s highlighted the main importer and exporter countries and reported that nurse migration, compared with physician migration, was less likely to be permanent and more likely to be over a shorter geographical distance. Mejia et al. also noted that some countries were both major importers and exporters of doctors and nurses. In general, this was a feature of countries such as the United Kingdom or Ireland, which "lost" staff to the United States and Canada and recruited from other countries. Though it is tempting to characterize this feature in terms of a hierarchy or league table of countries with those at the top having the most desirable pull factors, the situation is more complex and can shift over time.

As an illustration, Fig. 12 shows the flows of nurses between the United Kingdom and Ireland, as indicated by data from the relevant nurse registration authorities. The upward trend in the number of nurses based in the United Kingdom entering the Irish register and the relative reduction in the number of Ireland-based nurses entering the United Kingdom register are illustrated.

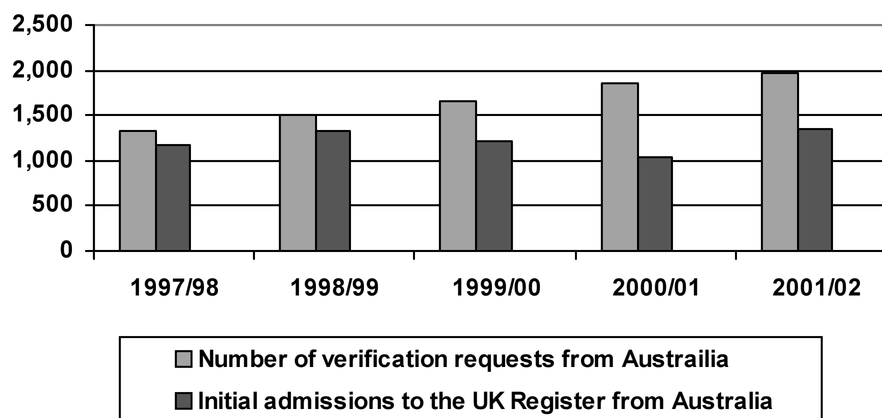
Fig. 12. Flows of nurses between Ireland and the United Kingdom, as measured by number of requests for verification, 1994-2002



Note: United Kingdom data on Ireland only indicates those practitioners who are under the EU directive.
Source: An Bord Altranais/NMC *Annual Reports*.

Fig. 13 shows data from the United Kingdom registration body on flows of nurses to and from Australia. The figure shows a consistent upward trend in the flow from the United Kingdom to Australia, as measured by verification requests, while the number of Australian nurses entering the United Kingdom register (inflow) has not matched this rise — remaining at around 1200 per annum over the last five years. Many of these flows in both directions will be temporary — as young United Kingdom and Australian nurses become working holiday-makers in the other country for a year or two.

Fig. 13. Trends in flows of nurses between the UK and Australia, as measured by the UK Registration Body, 1997-2002



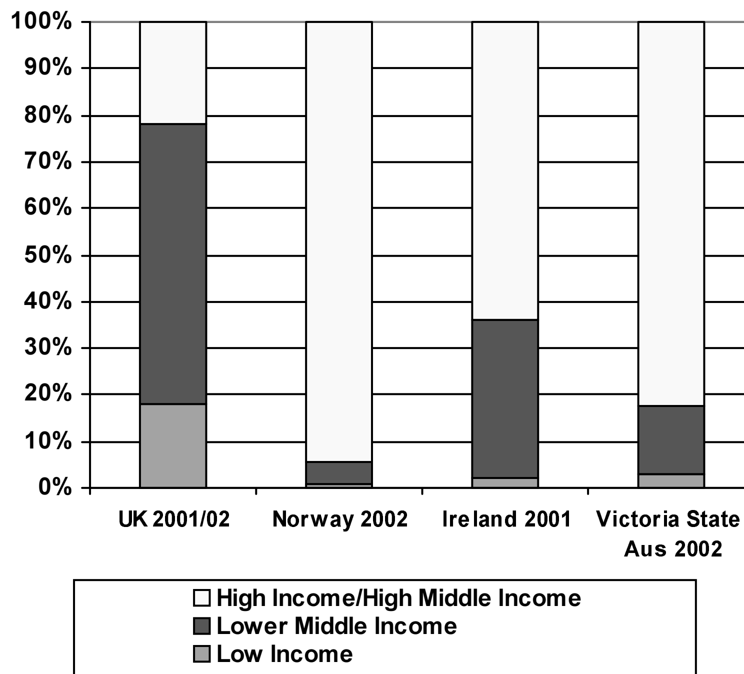
Note: Initial admissions data are not disaggregated before 1997–98.
Source: NMC *Annual Reports*.

Moving from developing to industrialized countries

The outflow (brain drain) of nurses from developing to industrialized countries has the highest profile and is the most controversial aspect of the current dynamics.

The data analysed earlier have illustrated the extent to which some destination countries have become increasingly reliant on recruiting nurses from developing countries. Fig. 14 shows an estimate of the current proportion of recent inflow of international nurses with source countries defined by World Bank income level (e.g. Lower Middle Income (LMI), Lower Income (LI), etc).

Fig. 14. Inflow of international nurses to UK, Norway, Ireland and Victoria State, Australia, from source countries according to World Bank classification

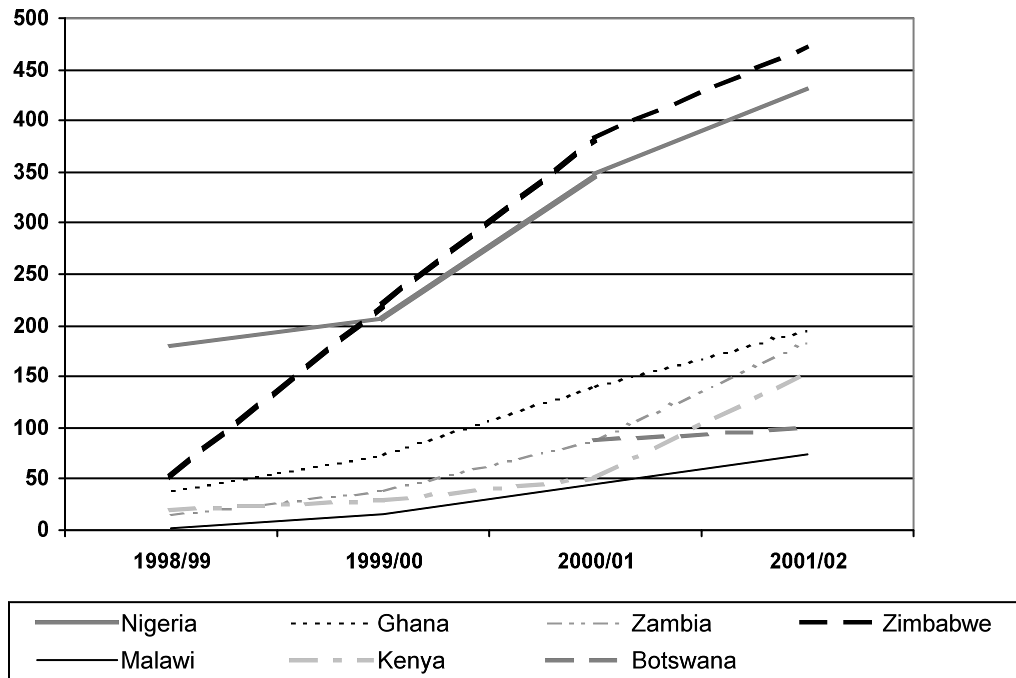


Note: For purposes of analysis, data from all Caribbean countries have been incorporated into the Lower Middle Income category.
Sources: World Development Indicators Database, World Bank; NMC Annual Reports; Statistics as required by the study of nursing and midwifery resource, An Bord Altranais; Personal Communication from SAFH, Norway (2002); National Board of Victoria Annual Report.

The figure highlights the variations in the mix of source countries. The United Kingdom and, to a lesser extent, Ireland are recruiting significant proportions of international nurses from lower middle income and low income countries. In contrast, Norway and Victoria State are primarily registering nurses from other high income or high middle income countries. In Norway, this reflects the flow of nurses from other Scandinavian countries and the policy of the state recruitment agency (AETAT) in recruiting only from certain countries.

An example of outflow is illustrated by the trend in the annual number of new registrations in the United Kingdom from selected sub-Saharan African countries, shown in Fig. 15. The upward trend is evident, most notably from Zimbabwe where the political and economic situation may have been a particular push factor.

Fig. 15. New registrants on UK nursing register from selected sub-Saharan African countries, 1998-2002



Note: 1999–00 data not available for Botswana.
Source: Nursing and Midwifery Council, London.

The marked upward trend in outflow from sub-Saharan Africa to the United Kingdom is evident, despite the introduction of ethical guidelines by the Department of Health in November 1999. These guidelines did not cover private sector employers, and it is not possible to differentiate between outflow caused by active recruitment and that resulting from decisions made by individual nurses.

Examining these trends in terms of numerical flows gives only part of the picture. For a deeper understanding of the policy implications it is also necessary to assess the impact of the loss to the source country in terms of skills and the size of the outflow in relation to the total size of the nursing workforce.

Two examples illustrate these issues. The first is that of a local nurse in an African country, who was recruited and trained by an international aid organization to coordinate a national quality assurance programme. Soon after, the nurse was recruited to work as a staff nurse in England. The flow statistic shows only a net gain of one nurse for England and a net loss of one nurse for the African country. However, the relative impact in each country is highly disproportionate. England has added only one more staff nurse to the 320 000 already in employment — an insignificant addition. In contrast, the African country has lost a key skilled worker, who will be difficult to replace from a declining pool of available nurses.

A second example shows the aggregate impact. An English-speaking industrialized country such as the United Kingdom, Ireland or the United States may recruit annually approximately 100 nurses from a sub-Saharan African country such as Botswana, Ghana or Malawi. This inflow represents an insignificant proportion of total stocks in the destination country, but a very significant proportion of the stock in the source country: as high as 10% or more in some of the smaller sub-Saharan countries.

However, presenting the "developing to developed" dynamic only as a brain drain is over-simplistic. As noted earlier, governments in some countries, such as the Philippines, actively encourage nurses to move to other countries in order to generate remittance income back to their home country. Other governments are in dialogue to develop temporary flows of nurses, with the objective of training these nurses so that they will return to their home country with new skills (for example, England–China). A third scenario is where there is a formal process for one country to solve its nursing undersupply situation by agreeing to recruit from a country with a reported current oversupply (for example, England–Spain). In the last example, however, there may be disagreement among different stakeholders in the source country as to the actual extent of any reported oversupply.

Moving between developing countries

There are also examples of significant flows of nurses from one developing country to another. These moves tend to be less well documented. They may be the result of push factors — such as civil unrest — displacing nurses from one country to an adjoining country or pull factors, as a relatively well-resourced developing country attempts to compensate for nurse losses to the industrialized world. In other cases the moves are the result of active recruitment: some countries, such as Botswana or South Africa, have attempted to make good their staffing shortfall by recruiting elsewhere in Africa. The PAHO report on emigration of nurses from the Caribbean (PAHO, 2001) noted that some Caribbean countries were net gainers from migration of nurses within the Caribbean, while others lost nurses both to countries within the Caribbean and to countries farther away.

The role of recruitment agencies

One final issue to note in consideration of push and pull factors is the role of recruitment agencies as stimulators or active intermediaries in the process of international recruitment. Some agencies in some countries have been criticized for providing misleading information to nurses about the

conditions of employment in the destination country, and some importer countries (for example, England) have attempted to regulate the role of agencies or to establish “preferred provider” lists of agencies that comply with ethical criteria. The Department of Health, England, places a list of approved recruitment agencies on its web site, along with the names of NHS employers who can be contacted for references.

Recruitment agencies are of different types (international; single country focusing on assisting outflow; single country focusing on assisting inflow) and also function in different ways (see Table 9). In some cases, the agency is the instigator of the movement of the nurse; in others, it fulfils a facilitative or supporting role.

Table 9. Models of recruitment agency involvement in the international movement of nurses

Recruitment model	Main features
Agency provided	Agency actively recruits nurses on their own behalf for placement in other countries.
Agency led	Employer appoints an agency to identify a source country. Agency takes lead on recruitment, selection and placement, with some input from employer.
Agency facilitated	Employer works in active partnership with agency to identify a source country. Employer is directly involved in selection process, which is facilitated by agency.
Employer led	Employer uses its own resources to identify a source country, select, recruit and place nurses, and deal with registration and permit issues, etc.

In countries with unregulated agencies, their role may be difficult to delineate or control. There have been reports in some countries that some agencies have exploited nurses, by providing misleading information about pay and conditions in destination countries, or by charging large fees to enable nurses to move from one country to another (see, for example, Fritsch 2001; Buchan, 2002b).

Chapter 4. The policy context

4.1 General issues

The main policy issues at national and international levels relate to monitoring, intervening in, managing or regulating international migration: for example, actively encouraging recruitment or by developing ethical guidelines for international recruitment. An associated issue is the development of effective retention strategies in both source and destination countries.

According to Stalker (2000), "international migration makes business sense" in purely economic terms. International recruitment is currently being prominently used, especially by industrialized countries, as a solution to skill shortages. Concerns have arisen as to whether this is appropriate in view of the potential negative impact on source countries. The United Kingdom government (Department for International Development, 2000) highlights that "industrialized countries need to be more sensitive to the impact that active recruitment of skilled workers from developing countries may have on local growth and development".

"Managed migration" schemes have been introduced in some countries, which aim to facilitate the recruitment of labour (temporarily at least) while limiting adverse effects, so as to protect the domestic labour market (Stalker, 2000). For example, CARICOM has proposed a scheme to train people for export on a rotational basis in an attempt to regulate the export of labour and subsequently to limit the effects currently being experienced in a number of Caribbean countries (La Rose, 2002). Other schemes aim to facilitate access for highly skilled migrant workers in response to specific skill shortages, for example in Australia, the United Kingdom and the United States (MPI, 2002a; MPI, 2002b), Ireland and Norway (McLaughlan & Salt, 2002). In Canada, the Seasonal Agricultural Worker Programme regulates recruitment of low-skilled migrant workers (Greenhill, 2000). Many of these initiatives are offered on a temporary work visa, encouraging the return of migrants to their country of origin; thus the potential for brain exchange is maximized.

International recruitment alone, however, is unlikely to solve the problem of skill shortages as it does not focus on the core issues that generate the problem (RDS, 2001). Improvements to human resources development plans are crucial for comprehensive, accurate, long-term workforce planning (Commonwealth Secretariat, 2001). Once in place, these plans could be used to predict potential staff shortages and prevent them from arising (WHO, 2002). Lack of a systematic plan for human resources, or inadequate implementation of one, is "a significant downfall in a number of developing and developed countries" (Commonwealth Secretariat, 2001). Some countries that are attempting to deal with core recruitment and retention problems in the health service are reportedly experiencing a reverse brain-drain effect (Pang, Lansang & Haines, 2002).

The current magnitude and diversity of migration relating to international recruitment, with demands for labour being met predominantly by workers from developing countries, accentuates the need to devise ways to restrict the detrimental effects of brain drain and to maximize the potential benefits of migration (Findlay & Lowell, 2002a). The World Trade Organization and General Agreement on Trade and Services also have a role to play in the broader implications of international recruitment.

4.2 Policy issues: international recruitment and migration of nurses

The increases in flows of nurses across national boundaries — partly as a result of the growth of active recruitment by some industrialized countries — creates a series of policy questions for national governments and international agencies. These are summarized in Box 4.

Box 4. International nurse mobility: policy questions and subsidiary research questions

Source countries
Policy

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?

Research

What are the destination countries for outflow?

How much outflow is permanent or temporary (short or long term)?

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?

How should flows be monitored?

Destination countries
Policy

Is inflow sustainable?

Is inflow a cost-effective way of solving skills shortages?

Is inflow ethically justifiable?

Should recruitment agencies be regulated?

Research

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?

International agencies

How should international flows of nurses be monitored?

In the context of the working relationship with the country government, what is the appropriate role and response of the agency to the issue of international nurse mobility?

Should the agency intervene in the process (for example, develop an ethical framework, support government-to-government contracts, introduce regulatory compliance)?

These issues are examined in greater detail in this section of the report, which also highlights potential policy interventions.

4.3 Policy issues: source countries

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.

Many countries are hampered in this process by the relative paucity of data to enable monitoring. Reliance on incomplete data or incompatible data from different sources (for example work permits, visas, registration/certification, labour statistics, or census) often means that it is not possible even to have an accurate picture of the trend in outflow, let alone any assessment of the impact of this outflow on the health services.

Ensuring that the available data are verified, collated and monitored for trends should be the first objective; methods to achieve improvement in data availability should be investigated collectively by stakeholders (government, employers, nurses' associations, etc.). It is important that the 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. International outflow may be a very visible but relatively small numerical loss of nurses compared with flows of nurses leaving the public sector for other sources of employment within the country.

Some national governments and government agencies are attempting to encourage outflow of nurses from their country. This may have a financial imperative, to encourage the generation of remittance income; it may be a response to labour market oversupply; or it may be an attempt to develop a long-term improvement in the skills base of the nursing workforce by encouraging short-term outflow to other countries where training is available.

The main policy question to be answered in this scenario is: does the country actually have an oversupply of nurses? National-level stakeholders (government, employers, and nurses' associations) are best placed to determine the answer. Where there is agreement that outflow should be encouraged, there is the potential for government agencies, professional associations and regulatory authorities to be involved in the process to facilitate it and ensure that individual nurses are not exploited.

Facilitated outflow is much less common than the unmanaged outflow of nurses in response to push factors at home and/or pull factors in destination countries. Unmanaged outflow may damage the health system or erode the current and future skills base. Some countries have initiated or examined various policy responses, including bonding nurses to home employment for a specified period of time after completion of training or attempting to negotiate a fee in compensation — from the departing nurses or the destination country — but this may not be effective if compliance is not monitored or if there is scope to buy out of the bond (e.g. Miller, 1992). The scope for compensation claims continues to be raised in international forums, but there is little evidence that such schemes have been effective in the past.

Preventing nurses from leaving through the use of monetary or regulatory barriers is one policy response, but it does nothing to alleviate the push factors that stimulated the nurses' desire to

leave and 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.

Clearly there is a financial cost involved, but national governments must be confident that nurses are receiving fair and equitable treatment, within existing financial constraints, and are not being disadvantaged because nursing work is undervalued in relation to other professions.

Another policy response is to recognize that outflow cannot be halted where principles of individual freedom are to be upheld, but then to work at ensuring that such outflow is managed and moderated. The “managed migration” initiative being undertaken in the Caribbean is an example of a coordinated intervention that attempts to minimize the negative impacts of outflow while hoping to secure at least some benefit from the process.

The Caribbean approach to managed migration of nurses was developed after a meeting in 2001, when nursing leaders, national professional nursing associations, training institutions, government agencies and regional institutions gathered to examine the nature, scope and causes of migration and the shortage of nurses. Goals for the meeting were to determine the impact of migration on health programmes and the ability of governments to deliver health care and to agree on effective national and regional strategies. The strategies developed at the meeting covered six main areas:

- terms and conditions of work recruitment;
- education and training;
- value of nursing;
- utilization and deployment;
- good governance;
- policy and health sector reform.

It was recognized that implementation would require successful partnership of multiple stakeholders at the national, regional and global levels. A key aspect of the strategy was a request to Ministers of Health in the region to:

- acknowledge the critical nature of the problem and its impact on the delivery of quality health care;
- endorse the managed migration programme advanced by the nurses;
- provide necessary support for its implementation;
- mobilize resources to support programme activities.

In April 2002, the regional nursing body forwarded the proposal to the Human and Social Development Ministers attending the Caribbean Community (CARICOM) meeting. The Health Ministers supported, endorsed and approved the proposal. In addition, they agreed to expand the programme to include all health professionals and supported the involvement of more key players such as the Regional Negotiating Machinery of CARICOM (Yan, 2002).

4.4 Policy issues: destination countries

In some ways, the policy challenges for destination countries mirror those of source countries. The first concerns monitoring and assessment, as the ability to monitor trends in inflow (in terms of numbers and sources) is vital if the country is to be able to integrate this information into its planning process. In countries with a relatively centralized approach to regulation and planning and with mainly public sector employment of nurses (such as Ireland, Norway and the United Kingdom), such monitoring may be more readily achieved than in federated or decentralized countries (for example, Australia) or ones where there are multiple private sector employers (as in the United States). However, even in countries such as the United Kingdom and Ireland there are constraints and limitations on what can be assumed using available data.

Equally important is an understanding of why shortages are occurring — because of poor planning, unattractive pay or career opportunities, early retirements, etc. An initial assessment of the contributing factors for the nursing shortages in any country needs to be undertaken and those factors taken into account. This assessment will include nurse "wastage" to other sectors or regions within the country.

It is crucial to assess the relative contribution of international recruitment compared with other key interventions (such as home-based recruitment, improved retention, and return of non-practising nurses) in order to identify the most effective balance of interventions. This assessment has to be embedded in an overall framework of policy responses to nursing workforce issues if it is to be relevant. Table 10 sets out the main components of this framework.

Table 10. Framework for policy responses to nursing shortages

- Increase new supply — from pre-registration/training
- Improve retention of current staff
- Improve utilization of nurses' skills and mix with other staff
- Encourage return of nurses currently not practising
- Examine scope for ethical international recruitment

Source: adapted from Buchan, 2000.

Home-based solutions, such as improving staff retention through provision of flexible or improved working conditions and attracting returners through part-time career opportunities, may be more cost-effective than international recruitment. Any nurse leaving an organization will incur costs to the organization in terms of replacement and lost productivity. At the aggregate level, this can have a significant impact on direct costs to an organization and can also disrupt continuity of care.

The second policy challenge for destination countries can be characterized 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 include improving the regulatory or certification process to enable these nurses to obtain registration more easily: fast tracking their visa or work permit applications; developing coordinated, multi-employer approaches to recruitment; developing multi-agency approaches to coordinated placement and (where necessary) providing initial periods of supervised practice or adaptation as well as language training, cultural orientation and social support. There can be a tension between the pressure to accelerate inflow of these nurses and the need to maintain regulatory processes and standards.

Countries that are currently heavily reliant on inflow of international nurses have seen policy attempts to speed up the process of inflow; in some cases, these attempts have been opposed by some stakeholders who fear a as potentially negative impact on standards and patient safety. The pressure to ease inflow can run counter to regulatory requirements; in the United Kingdom, the huge growth in entry applications from nurses has overwhelmed the capacity of the regulatory authority to process them, leading to a reported backlog at one time of 7000 applications.

The third policy challenge of destination countries concerns ethics. Is it justifiable, on moral and ethical grounds, to recruit nurses from developing countries? The simple response is 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.

The question also needs to be posed, why does international recruitment appear to be a major issue concerning nurses and health workers but not in other professions? (One reason may be that health workers are relatively scarce, and also that they are usually trained in the public sector.) Why do policies focus on health worker migration and not general skilled worker migration? There appear to be relatively few countries that have intervened in the recruitment process; those that have issued ethical guidelines, such as Ireland and England, have done so only for health workers.

Active recruitment by employers or national government in the destination country has to be contrasted with a situation in which nurses themselves have taken the initiative to move across a national border. Currently, it is not possible to quantify the relevant flow related to active recruitment, but many countries have put in place mechanisms to support active recruitment of large numbers of nurses. Temporary migration, related to a temporary oversupply in one country or to a managed exchange of staff, has to be differentiated from planned permanent migration attributable to pull factors in the destination country.

What can be summarized from country information is that active intervention in the recruitment process by employers and/or government has become a more significant feature in recent years in four of the five source countries examined in detail. This can leave these countries open to criticism that they have subordinated ethical concerns to a drive to solve their own staffing shortages.

Some countries have developed a policy response to attempt to manage the ethics–efficiency balance. England and Ireland have initiated ethical guidelines for employers recruiting nurses from other countries. However, in practice, these guidelines tend to focus more on the practicalities of recruitment than on any moral considerations. A different approach has been adopted by Norway, which has announced an annual target of the number of nurses that can be recruited by

its governmental agency, and this recruitment is based on government-to-government agreements. This capping of the number of recruits sets a limit to the impact of active recruitment.

The impact of the ethical guidelines is difficult to assess, because they have been in place for only a short period of time. The initial guidelines from England (which cover only NHS employers) did have a short-term impact in reducing inflow from named developing countries, but overall the inflow has since increased. The Norwegian approach of setting a state recruitment target is more effective in limiting the impact on other countries.

Another aspect for ethical consideration is the role of recruitment agencies. England has an established list of preferred provider agencies who have undertaken to comply with a code of practice (Department of Health, 2001).

4.5 Policy issues: international agencies

Many international agencies have a stakeholder interest in the issues of international recruitment and migration of nurses. These include international professional associations (for example, ICN); UN agencies (in particular, WHO, ILO, International Organization for Migration, and World Trade Organization); trade blocs (for example, NAFTA); and multi-country organizations (European Union and the Commonwealth). The donor agencies of donor countries (for example, USAID, DFID, NORAD) will also have an interest in assessing if their activities in developing countries are being compromised by outflow of nurses.

The current role of international agencies can be summarized as having two main elements. Firstly, by examining trends in cross-border flows and by commissioning research to assess the dynamics and impact of these flows, these agencies can contribute to developing a more complete, accurate picture of trends and impacts. Secondly, by promoting position statements and policy guidelines, these agencies can contribute to establishing an international benchmark for effective and ethical practice in international recruitment. If they have the capacity to monitor performance of countries that are significant importers or exporters of nurses, international agencies — by combining these two elements— can identify any that are not complying with good practice.

International Council of Nurses

ICN, as the lead organization for nurses' associations throughout the world, has established an international position statement on nurse mobility. The main points are as follows.

- ICN and its member associations firmly believe that quality health care is directly dependent on an adequate supply of qualified and committed nursing personnel, and ICN supports the evidence that links good working conditions with quality service provision.
- ICN recognizes the right of individual nurses to migrate, and confirms the potential beneficial outcomes of multicultural practice and learning opportunities supported by migration. The Council acknowledges the adverse effect that international migration may have on health care quality in countries seriously depleted of their nursing workforce.

- ICN condemns the practice of recruiting nurses to countries where authorities have failed to implement sound human resource planning and to deal seriously with problems that cause nurses to leave the profession and discourage them from returning to nursing.
- ICN denounces unethical recruitment practices that exploit nurses or mislead them into accepting job responsibilities and working conditions that are incompatible with their qualifications, skills and experience.
- ICN and its member national nurses' associations call for a regulated recruitment process based on ethical principles that guide informed decision-making and reinforce sound employment policies on the part of governments, employers and nurses, thus supporting fair and cost-effective recruitment and retention practices.

The key principles of the ICN position include:

- effective human resources planning and development:
- credible nursing regulation;
- access to full employment;
- freedom of movement;
- freedom from discrimination;
- good faith contracting;
- equal pay for work of equal value;
- access to grievance procedures;
- safe work environment;
- effective orientation/mentoring/supervision;
- employment trial periods;
- freedom of association;
- regulation of recruitment.

ICN also notes: "the recruitment and retention of nurses has become an urgent priority and a growing expense. All health sector stakeholders — patients, governments, employers and nurses — will benefit if this ethical recruitment framework is systematically applied." (ICN, 2001).

World Health Organization

As noted earlier, WHO has recognized the significant impact of migration and mobility in relation to health system performance and as a contributory factor in skills shortages in some countries. In view of this recognition, WHO is supporting the improvement of monitoring the flows of nurses and other staff as an integral element in its approach to human resources for health.

"Highly skilled professionals represent an increasingly large component of global migration flows, and this is thought to be costly for developing countries, not only in terms of skill shortages but also in fiscal costs from educational subsidies, when these are available." (WHO, 2002). "It is often the dramatic stories of losses to health systems that get the most publicity, but they provide only a partial picture of health labour markets in developing countries, failing to address those issues that often act as push factors in migration, such as high unemployment rates, poor working conditions and low salaries. In order to develop realistic policy options for managing migration, evidence of the magnitude of the problem and the labour market contexts is needed."

Free trade blocs and multi-country organizations

Free trade blocs, such as the ***European Union*** (EU), the ***North Atlantic Free Trade Agreement*** (NAFTA) and other multilateral or bilateral agreements between countries (for example, the ***Trans-Tasman Agreement*** between Australia and New Zealand) can have an impact on nurse mobility across borders, if mobility is supported by practical interventions such as mutual recognition of professional qualifications or an easing of permit or visa requirements within the free trade zone.

There is little evidence of the impact of free trade zones on nurse recruitment. The European Union is one of the largest free trade blocs and has a long established policy of encouraging mobility of workers. Registered nurses and registered midwives have free movement, but it appears from the information available that flows within Europe have been at a relatively low level and are linked to clusters of countries that share the same language (for example, the United Kingdom and Ireland, Belgium and France, and the Scandinavian countries). The recent significant growth in recruitment of nurses to the United Kingdom has not been sourced by other EU countries. Eastward expansion of the European Union will open up Poland, the Czech Republic and other countries to this free market for mobile nurses. Salaries in these accession states are much lower than in current EU countries, which is likely to lead to an increase in inflow from Eastern to Western Europe but, once again, language will be a moderator of flows.

The issue of language has often been overlooked in other reports on health worker migration but has been repeatedly highlighted in this report as a key facilitator or constraint on nurse mobility. The ability to communicate effectively with patients and other health workers is a crucial element of good nursing care. Though free trade blocs may facilitate nurse mobility, another significant template has to be superimposed on the global labour market for nurses — that of language competency. As such, it is possible to map out English-speaking, Spanish-speaking, French-speaking and Portuguese-speaking zones within which much of the mobility of nurses between source and destination countries exists.

Importer countries excluded by language from these pan-national language-based labour markets (such as Norway) have to put in place additional measures to provide language training for nurses, while potential source countries which are excluded from these broader markets by a relative lack of foreign language capacity (for example, Thailand and Indonesia) may not experience an outflow of clinical nurses to industrialized countries.

The ***Commonwealth*** has commissioned research on migration of health workers (Commonwealth Secretariat, 2001). It has produced guidelines on workforce issues related to the recruitment and retention of nurses (Commonwealth Steering Committee for Nursing and Midwifery, 2001) and is producing guidelines on international recruitment. The intended purpose of the draft code of practice (Commonwealth Secretariat, 2002) is "to discourage the targeted recruitment of health workers from countries which are themselves experiencing shortages" and "seeks to safeguard the rights of recruits, and conditions relating to their profession in the recruiting countries". The key principles of the draft code are: transparency, fairness, and mutuality of benefits.

Mutuality of benefits places emphasis on strategies that target the effects of international recruitment and methods to overcome potential adverse effects (for example, by considering implementation of various compensation schemes). The need for developing advisory guidelines on working with private nurse recruitment agencies and the importance of workforce planning are also considered.

The draft code serves to provide Commonwealth countries with a framework for national and international position statements on ethical nurse recruitment. However, the adoption of the code by countries outside the Commonwealth is also encouraged. This is facilitated by promotion of the code by major international organizations such as ILO and ICN.

4.6 Summary

The message from this report is that the main reason for the current high level of active international recruitment activity is nursing shortages in some industrialized countries. These countries have failed to "grow their own" and "keep their own" nurses and have used the quick fix of international recruitment, exploiting the existence of push factors by exerting a pull of better salaries and conditions of employment.

It is inadequate policy responses by governments to the fundamental causes of nursing shortages in individual countries that have been the drivers of the dynamics of international recruitment. Free trade blocs or agreements may facilitate flows, but these only happen when there is a push–pull imbalance, with the importing country pull being paramount.

If governments and international agencies wish to engage actively in changing these dynamics they have three basic options. One option is to support improvements in pay, working conditions, and the prestige of nurses in their own countries. In many cases, it is likely that nurses would prefer to stay in their home country if their quality of life were at least adequate (Ojo, 1990). As a second option, they could encourage and facilitate bilateral country-to-country managed or regulated flows of nurses. A third option is to institute some arrangement whereby compensation flows from the recruiting country back to the source country. This could be direct or indirect financial compensation, arranged as part of a donor package or in the form of a return flow of better-trained staff. (A fourth possible intervention, to constrain the mobility of nurses, would be unethical.)

Policy interventions that support country governments to reach mutually beneficial (managed) models of international recruitment have some potential for "win-win" situations, to the advantage of all parties. However, it is clear that the flows of nurses, partly as a result of active recruitment by industrialized countries, is a symptom of more deeply seated problems in these countries that have failed to plan for, and retain, sufficient nurses from their own sources. International recruitment of nurses is a symptom of global shortages of nurses, but the underlying problems can only be solved by local-level and country-level improvements in the status of nursing and in the planning and management of the nursing workforce. ■

Bibliography

Anon. *Temporary visa for professionals.* Available at: http://www.liveinaustralia.com (accessed on 13 January 2003).

American Nursing Association (2003). *US licensure requirements*. Available at: http://www.nursingworld.org/ant/inc/license.htm (accessed on 16 January 2003).

An Bord Altranais (2001). *Statistics as required by the study of nursing and midwifery resource*. Dublin, An Bord Altranais (Irish Nursing Board).

Audit Commission (2000). *Implementing dispersal under the Immigration and Asylum Act 1999*. London, Audit Commission.

Auriol L, Sexton J (2001). Human resources in science and technology: measurement issues and international mobility. In: *International mobility of the highly skilled.* Paris, Organisation for Economic Co-operation and Development, 2002:13–39.

Australian Nursing Council (ANC) (1999–2002) *Annual reports.* Dickson, ACT, Australian Nursing Council.

Australian Nursing Council (ANC) (2002) *Position statement on ethical nurse recruitment*. Dickson, ACT, Australian Nursing Council.

Australian Nursing Federation (1998). *Position Statement on Ethical Nurse Recruitment*. Canberra, Australian Nursing Federation.

Baptiste-Meyer J (2001). The ‘brain drain: new aspects of the South/North exodus. *The Courier ACP-EU*, July–August.

Bennett S, Franco LM (1998). *Summary proceedings: Workshop on Health Worker Motivation and Health Sector Reform*. Bethesda, MD, Partnerships for Health Reform, Abt Associates (Major Applied Research 5, Working Paper 2).

Buchan J (2000). Planning for change: developing a policy framework for nursing labour markets. *International Nursing Review*, 47(4):199–206.

Buchan J (2002a). Global nursing shortages. *BMJ*, 324:751–752.

Buchan J (2002b). *International recruitment of nurses: United Kingdom case study. Royal College of Nursing; World Health Organization; International Council of Nurses*. London, Royal College of Nursing.

Buchan J (2003) *Here to stay? International nurses in the United Kingdom.* London, Royal College of Nursing.

Buchan J, Seccombe I, Thomas S (1997). Overseas mobility of United Kingdom-based nurses. *International Journal of Nursing Studies*, 34(1):54–62.

Castells M (1996). Cited in: Castles S (2000). International migration at the beginning of the twenty-first century: global trends and issues. *International Migration*, 165:269–283.

Castles S (2000). International migration at the beginning of the twenty-first century: global trends and issues. *International Migration*, 165:269–283.

Center for Health Workforce Studies (2002). *Health care employment projections: an analysis of Bureau of Labor Statistics and Occupational Projections, 2000-2010.* New York, University of Albany, School of Public Health.

Chanda R (2002). Trade in health services. *Bulletin of the World Health Organization*, 80:158–163.

Commander S, Kangasniemi M, Winters LA (2002). *The brain drain: curse or boon? A survey of the literature*. Available at: http://www.nber.org/books/isit02/commander-et-al-CEPR-site-6-7-02.pdf (accessed on 20 December 2002).

Commonwealth Secretariat (2001). *Migration of health workers from Commonwealth countries: experiences and recommendations for action*. London, Commonwealth Secretariat.

Commonwealth Secretariat (2002). *Commonwealth code of practice for international recruitment of health workers — revised draft*. London, Commonwealth Secretariat.

Commonwealth Steering Committee for Nursing and Midwifery (2001). *Guidance on workforce issues: the global crisis in the recruitment and retention of nurses and midwives*. London, Commonwealth Nurses Federation.

Connell J (2001). *The migration of skilled health personnel in the Western Pacific Region*. Manila, World Health Organization Regional Office for the Western Pacific.

Daniel P, Chamberlain A, Gordon F (2001). Expectations and experiences of newly recruited Filipino nurses*. British Journal of Nursing*, 10(4):254–265.

DENOSA (2001). *Migration of nurses: realities, threats, challenges: the way forward*. Pretoria, Democratic Nurses Organisation of South Africa (DENOSA) (Workshop report, September 2001).

Department for International Development (2000). *Eliminating poverty: making globalisation work for the poor*. London, United Kingdom Department for International Development.

Department of Health (DOH) (1999). *Guidance on international recruitment*. London, Department of Health.

Department of Health (DOH) (2001). *Code of practice for NHS employers involved in international recruitment of health care professionals*. London, Department of Health.

Department of Health (DOH) (2002). *Delivering the NHS plan: next steps on investment, next steps on reform*. London, Department of Health.

Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) (2002). *Annual Statistics.* Belconnen, ACT, Australia.

Dovlo DY (1999). *Report on issues affecting the mobility and retention of health workers in Commonwealth African states*. Arusha, Commonwealth Secretariat (unpublished report).

Ferrinho P, Van Lerberghe W (2000). *Providing health care under adverse conditions: individual coping strategies*. Antwerp, ITG Press (Studies in Health Services Organization and Policy).

Findlay A (2002). *From brain exchange to brain gain: policy implications for the United Kingdom of recent trends in skilled migration from developing countries*. Geneva, International Labour Organization (International Migration Papers, No. 46).

Findlay A, Lowell L (2002a). *Migration of highly skilled persons from developing countries: impact and policy responses*. Geneva, International Labour Organization (International Migration Papers, No. 43).

Fritsch, K (2001). *Health workforce migration — Western Pacific Region*. Atlanta, GA, Emory University (paper presented at Global Nursing Partnerships Conference Enquiry, 19 October 2001).

Gayathri V (2001). Rethinking high-skilled international migration: research and policy issues for India's information economy. In: *International mobility of the highly skilled*. Paris, Organisation for Economic Co-operation and Development, 2002:201-213.

Glover S, et al. (2001). *Migration: an economic and social analysis*. London, Research Development and Statistics Directorate (Occasional Paper No. 67).

Greenhill D (2000). *Managed migration best practices and public policy: the Canadian experience*. Regional Conference on Migration, available at: http://www.rcmvs.org (accessed 6 November 2002).

Guellec D, Cervantes M (2001). International mobility of highly skilled workers: from statistical analysis to policy formation. In: *International mobility of the highly skilled*. Paris, Organisation for Economic Co-operation and Development, 2002:71–99.

International Council of Nurses (ICN) (2001). Position statement on ethical nurse recruitment. Geneva, International Council of Nurses, available at: http://www.icn.ch.psrecruit01.htm (accessed 22 January 2003).

International Council of Nurses (ICN) (2002). *Overview paper prepared by the Icelandic Nurses Association for International Council of Nurses Workforce Forum, Reykjavik, Iceland*. Geneva, International Council of Nurses.

International Labour Organization (ILO) (2000). *Migration: a truly global phenomenon*. Geneva, International Labour Organization (available at: http://www.ilo.org/public accessed 23 September 2002).

International Labour Organization (ILO) (2001). *The asylum – migration nexus: refugee protection and migration perspectives from the ILO*. Paper presented to the UNHCR global consultations on international protection. Geneva, International Labour Organization.

International Organization for Migration (IOM) (2000). *World migration report 2000*. Geneva, International Organization for Migration.

Kaplan D, Meyer JB, Brown M (1999). *Brain drain: new data, new options*. Pretoria, South African Network of Skills Abroad (SANSA). Available at: http://sansa.nrf.ac.za (accessed 18 December 2002).

Kingma M (2001). Nursing migration: global treasure hunt or disaster in the making? *Nursing Inquiry*, 8(4):205–212.

La Rose M (2002). Caribbean Community (CARICOM) Council to draft “Managed migration” plan. Guyana: Land of Six Peoples, available at: http://www.landofsixpeoples.com (accessed 20 January 2003).

Lorenzo F (2002). *Nurse supply and demand in the Philippines*. Manila, University of the Philippines, Institute of Health Policy and Development Studies.

Martineau T, Decker K, Bundred P (2002). *Briefing note on international migration of health professionals: levelling the playing field for developing country health systems*. Liverpool, Liverpool School of Tropical Medicine.

McLaughlan G, Salt J (2002). *Migration policies towards highly skilled foreign workers. Report to the Home Office*. London, Home Office, available at: http://www.homeoffice.gov.United Kingdomk (accessed 18 December 2002).

Mejia A, Pizurki H, Royston E (1979). *Physician and nurse migration: analysis and policy implications. Report on a WHO study*. Geneva, World Health Organization.

Migration Policy Institute (MPI) (2002a). *Australia's transformation*. Washington, DC, Migration Policy Institute, available at: http://www.migrationinformation.org/Profiles/display.cfm?ID=23 (accessed 25 January 2003).

Migration Policy Institute (MPI) (2002b). *A new century: immigration and the US*. Washington, DC, Migration Policy Institute, available at: http://www.migrationinformation.org/Profiles/display.cfm?ID=6 (accessed 25 January 2003).

Migration Policy Institute, Hernandez J (2002). *Immigration, labour, race and the United Kingdom*. Washington, DC, Migration Policy Institute, available at: http://www.migrationinformation.org/Profiles/display.cfm?ID=27 (accessed 25 Januarz 2003).

Miller S (1992), Nurse-midwifery in St Vincent and the Grenadines. *Journal of Nurse-Midwifery*, 37(1):53–60.

MORI (Market and Opinion Research International) (2002). *RCN Internationally Recruited Nurse Members Study: a survey of RCN internationally recruited nurse members. Research study conducted for the Royal College of Nursing.* London, Royal College of Nursing.

Mulholland H (2002). Agencies failing to recruit ethically despite government guidelines. *Nursing Times*, 98(46):3.

Mutizwa-Mangiza D (1998). *The impact of health sector reform on public sector health worker motivation in Zimbabwe*. Bethesda, MD, Abt Associatges; Partnerships for Health Reform (Major Applied Research 5, Working Paper 4).

National Council of State Boards of Nursing. Data are available from reports on the Council's web site at: www.ncsbn.org

New South Wales Nurse Registration Board (1987–2001). *Annual statistics*. Available at: http://www.nursesreg.nsw.gov.au/report (accessed 18 January 2003).

Northern Nurses Federation (NNF) (2001). *Statement on recruitment of nurses from other countries*. Oslo, Northern Nurses Federation.

Norwegian Registration Authority for Health Personnel (SAFH). *Annual statistics on overseas recruitment (1992–2002)*. Oslo, SAFH.

Nurses Board of Victoria (1990–2001). *Annual Statistics.* Available at: http://www.nbv.org.au (accessed 18 January 2003).

Nurses Registration Board of New South Wales (1987–2001). *Annual statistics*. Available at: http://www.nursesreg.nsw.gov.au/report (accessed 18 January 2003).

Nursing and Midwifery Council (NMC) (1989–2002). *NMC annual reports*. London, Nursing and Midwifery Council.

Nursing Policy Division, Department of Health and Children (2002). *Final report of the Steering Group*. Dublin, The Nursing and Midwifery Resource.

Nursing Policy Division, Department of Health and Children (2001). *Guidance for best practice on the recruitment of overseas nurses and midwives*. Dublin, The Nursing Midwifery Resource.

Nyberg-Sorensen N, Van Hear N, Engberg-Pedersen P (2002). *The migration development nexus evidence and policy options — State of the art overview*. Copenhagen, Centre for Development Research.

Ojo, K (1990). International migration of health manpower in sub-Saharan Africa. *Social Science and Medicine*, 31(6):631–637.

OECD (2000). *Trends in international migration*. Paris, Organisation for Economic Co-operation and Development.

OECD (2001). *Trends in international migration*. Paris, Organisation for Economic Co-operation and Development.

OECD (2001b). *OECD Health Data*, CD-ROM.

OECD (2002a). *International migration of physicians and nurses: causes, consequences and health policy implications*. Paris, Organisation for Economic Co-operation and Development.

OECD (2002b). *International mobility of the highly skilled*. OECD, Paris, Organisation for Economic Co-operation and Development.

Oulton JA (1998). International trade and the nursing profession. In: Zarrilli S, Kinnon C, eds. *International trade in health services: a development perspective*. Geneva, United Nations and World Health Organization: 125–132.

PAHO (2001). *Report on Technical Meeting on Managed Migration of Skilled Nursing Personnel.* Bridgetown, Barbados, Pan American Health Organization Caribbean Office.

Pang T, Lansang MA, Haines A (2002). Brain drain and health professionals. *BMJ*, 321:499–500.

Puri S, Ritzema T (1999). *Migrant worker remittances, microfinance and the informal economy: prospects and issues.* Geneva, International Labour Organization (Working Paper No. 21, available at: http://www.ilo.org/public/english/employment/ent/papers/wpap21.htm (accessed 25 November 2002)).

Research and Development Statistics Directorate (RDS) (2001). [pp. 16, 69]

Royal College of Nursing (RCN) (2002). *Internationally recruited nurses: good practice guidelines for health care employers and RCN negotiators*. London, Royal College of Nursing.

SAFH (Norway Registration Authority for Health Personnel) (1992–2002). *Annual statistics on overseas recruitment.* Oslo, SAFH.

Salt J (1997). *International movements of the highly hkilled.* Paris, Organisation for Economic Co-operation and Development (Directorate for Education, Employment, Labour and Social Affairs, International Migration Unit, Occasional Papers 3).

Sochalski J, Ross S, Polsky D (2003). *Model of the international migration of nurses*. Philadelphia, PA, University of Pennsylvania.

South Australia Nursing Board (1988–2002). *Annual statistics*. Adelaide, South Australia Nursing Board.

Stalker P (1997). *Refugees and migration*. London, One World International. Available at: http://www.oneworld.net (accessed 23 September 2002).

Stalker P (2000). *Workers without frontiers: the impact of globalization on international migration*. Boulder, CO, Lynne Rienner Publishers.

Tacoli C, Okali D (2001). *The links between migration, globalisation and sustainable development. World Summit on Sustainable Development*. London, International Institute for Environment and Development (IIED) in collaboration with the Regional and International Networking Group.

Timur S (2000). Changing trends and major issues in international migration: an overview of the UNESCO programmes. *International Migration*, 165:255–269.

US Department of Health and Human Services (DHHS) (2000). *National sample of registered nurses*. Rockville, MD, DHHS Health Resources and Services Administration.

US Department of Health and Human Services (2002). *Projected supply, demand, and shortage of registered nurses: 2000-2020.* Rockville, MD, DHHS Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis.

van Doorn J (2000). *Migration, remittances and small enterprise development*. Geneva, International Labour Organization. Available at: http://www.ilo.org/public/english/employment/finance/download/remit2.pdf (accessed 25 November 2002).

Voluntary Services Overseas (2001). *Education at whose expense? United Kingdom teacher shortages filled at the cost of the world's poorest children, warns VSO.* London, Voluntary Services Overseas, Press Statement available at: http://www.vso.org.United Kingdom/media/aug2001_2.htm (accessed 18 December 2002).

Watson R, et al. (2003). Differences and similarities in the perception of caring between Spanish and United Kingdom nurses. *Journal of Clinical Nursing*, 12:85–92.

World Bank (2002). *World Bank development indicators database*. Washington, DC, World Bank.

World Health Organization (WHO) (2001). Strengthening nursing and midwifery. Resolution WHA54.12 in: *Fifty-fourth World Health Assembly: summary records of committees*. Geneva, World Health Organization (WHA54/2001/REC/3).

WHO (2002). *Developing evidence-based ethical policies on the migration of health workers: conceptual and practical challenges.* Paper prepared for the Workshop on Human Resources and National Health Systems: Shaping the Agenda for Action. Geneva, December 2002.

Xaba J, Phillips G (2001). *Understanding nurse emigration: final report*. Pretoria, Trade Union Research Project, South Africa.

Yan, J (2002). Caribbean nurses develop strategy for nurse shortages. *International Nursing Review,* 49:132-134.

Yi M, Jezewski M (2000). Korean nurses' adjustments to hospitals in the USA. *Journal of Advanced Nursing*, 32(3)721–729.

Appendix 1. Recommendations on a country-level minimum database to monitor the international flow of nurses

This appendix sets out recommendations for the data that should be collected at national level in order for governments to be able to monitor accurately the flows of nurses into and out of their countries and, if desired, to develop an understanding of individual motivations.

It should be noted that developing, in isolation, a minimum database to track international flow would not be as effective as establishing an integrated system for collecting the complete broader range of nursing workforce data. In particular, if international flows were tracked in isolation it would not be possible to assess their relative impact in comparison with flows to and from internal sources and destinations. In particular, annual production of newly qualified nurses within the country is a critical comparative measure.

The minimum database is based on an approach that collects data on each individual nurse. This information would then be aggregated to provide country-level data. The three columns in the matrix below contain the following information.

- **minimum data** — basic information about each nurse. This is necessary for the establishment of a minimum database.
- **additional data** — other items which, while not being essential, may also be collected as supplementary and relevant information. The balance between minimum data and additional data will vary from country to country, depending on resources and need.
- **attitudinal information** — the motivations and experiences of individual nurses. This information could be obtained by questionnaires applied to samples of nurses on exit or entry, or by surveys of newly arrived nurses.

	Minimum data[a]	Additional data[b]	Attitudinal information
Inflow/ outflow	• Numbers leaving (by destination) • Numbers leaving (by source) • Qualifications of leavers and joiners • Sex • Race/ethnicity • Age profile	• Work location of leavers • Year first qualified as a nurse	• Reasons for coming/ leaving (using typology)
Stock of nurses	• Total number • Numbers working in nursing • Qualifications • Sex • Race/ethnicity • Age profile	• Geographical distribution • Numbers by main type of work location • Length of stay	• Career plans • Previous career history • Cultural adaptation issues • Job satisfaction

[a]This information constitutes the minimum database.
[b]Additional data that could be considered.

Countries may also wish to examine in greater detail the motivations of nurses for moving and their career plans (the third column in the matrix). This is best achieved through surveys (for example, in collaboration with national nurses' associations) or by using structured focus groups.

This minimum database is recommended for the purpose of monitoring and policy analysis. If detailed statistical modelling on research is proposed, it would be necessary to obtain a broader range of economic and demographic data (see Sochalski, Ross & Polsky (2003) for examples).

Appendix 2. Methods used in this study

A. Country case studies

A standard template was developed to facilitate the collation of relevant data from key informants: the registration council (or equivalent), representatives of national nursing associations and representatives of government agencies. The registration council was regarded as the key source of data on inflow of nurses. A country correspondent had been identified to facilitate information gathering and data collection.

In practice, the standard template could not be applied satisfactorily across the countries because of the differences in the types of data collected, and because of variations in the approaches used for registering and licensing nurses. Countries with a federated structure (Australia and USA) present particular problems in terms of aggregating data and preventing double counting of data.

The country-level data were collated and forwarded to the report authors, who prepared a draft country report.This draft was returned to country correspondents for review and verification.

B. Focus groups

Correspondents in Australia, Ireland and Norway were asked to identify and contact groups of recently arrived international nurses and ascertain if they were willing to feed back information relating to their experiences of recruitment and motivations for having moved to the country. In Norway, the Norwegian chapter of the Philippines Nurses Association assisted in this process; in Australia and Ireland the contact was made via hospitals known to have recently recruited from abroad. The nurses were assured confidentiality in their responses. The discussion guide used to obtain their views is presented below:

Discussion guide for nurse focus group discussions

(to be conducted with a group (approx. 6–10) of recently arrived international nurses)

Demographic details. Personal information about the participants:

- age
- sex
- qualifications
- year when first qualified as a nurse
- country in which they trained as a nurse
- other countries in which they have worked as a nurse.

Coming to [the country]

- What information were they given about [the country] and the employer, before they decided to come to [the country] to nurse?
- Why did they choose [the country]?
- Who paid for travel costs?
- (Where a recruitment agency was involved) What was the role of the agency? Did it charge a fee? Who paid any fee?
- What checks were made about their qualifications, skills, language capabilities? How were they verified, and by whom?)

Arriving in [the country]

- What specific support, information or counselling has been made available to them since they arrived?
- Were they provided with any housing support by employer?
- What have been the main problems they have experienced since arriving to work?
- How long do they plan to stay nursing in [the country]?
- (If work permit is required) What time period of permit do they have?. Will they plan to try and extend their length of stay in [the country]? If so, why?

Nursing in [the country]

- What are the main differences between nursing in home (previous) country and [this country]? Check specific issues related to different technology, medication, nursing practice.
- What has been the attitude of other nurses, doctors, and other health workers?

Why did the nurses want to work in [the country]?

Ask each of the nurses to complete a copy of the table below, ticking one box in each line and indicating the importance of each factor in motivating them to move from their home country to [the country].

How important was each of these factors in motivating you to move from your home country?	**Very important**	**Quite important**	**Not at all important**
1) attracted by pay and/or better standard of living			
2) attracted by enhanced career opportunities			
3) unplanned move, as a result of a spouse or partner moving			
4) nursing qualification used to “finance” travel			
5) acquisition of new knowledge and techniques, planning to return to use in home country			
6) acquisition of post-basic qualifications, planning to return to use in home country			
7) employed on fixed term contract; either awaiting improved job prospects in home country, or planning to move on to other country			
8) other			

Which of the factors listed in the above table is the single **MOST** important reason for motivating you to move from your home country?
(give the number of the factor here: …………………………..)

Evidence and Information for Policy
Department of Health Service Provision
World Health Organization
Geneva
http://www.who.int