

Trends In International Nurse Migration

The world's wealthy countries must be aware of how the "pull" of nurses from developing countries affects global health.

by Linda H. Aiken, James Buchan, Julie Sochalski, Barbara Nichols, and Mary Powell

ABSTRACT: Predicted shortages and recruitment targets for nurses in developed countries threaten to deplete nurse supply and undermine global health initiatives in developing countries. A twofold approach is required, involving greater diligence by developing countries in creating a largely sustainable domestic nurse workforce and their greater investment through international aid in building nursing education capacity in the less developed countries that supply them with nurses.

NURSE SHORTAGES IN DEVELOPED COUNTRIES have accelerated international nurse recruitment and migration, sparking debate about the consequences for sending and receiving countries and for the meeting of global health needs. The exchange of nurses between developed countries has been commonplace for years; likewise, the Philippines, with its government-approved program of producing nurses for export, is not a new subject of debate. From a global perspective, the controversy centers on the risk that escalating requirements for nurses in developed countries will deplete the supply of qualified nurses in less developed countries, thus crippling their health care systems. This is occurring at a time when international resources are finally available to address HIV/AIDS and improve immunization coverage around the world. The 2003 *World Health Report* concludes, for example, that Botswana's commitment to providing free antiretroviral therapy to all eligible citizens has been undermined not by financing but by the severe shortage of health personnel.¹ Also, developed countries may not be well served by international nurse recruitment if it prevents them from addressing the root causes of domestic nurse shortages.

This paper explores emerging patterns of international nurse migration. We focused on English-speaking countries that are actively recruiting nurses from de-

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veloping countries: the United States, Canada, the United Kingdom, Ireland, Australia, and New Zealand. These countries have comparable health care systems and predict needing more nurses than they are producing and retaining; their predicted nurse requirements are large enough to deplete the supply of qualified nurses throughout the developing world. Examination of recent patterns in nurse migration to these countries provides a glimpse to the future and the possible consequences on global health. It also illuminates some of the areas in which more information is needed and policy choices that require attention.

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The host countries that we examined have large nurse workforces, except for New Zealand, which is included because of its high dependence on nurses trained in other countries, and Ireland, which is included because of its recent escalation in nurse immigration (Exhibit 1). Each country's health workforce planning bodies project a sizable increase in national requirements for nurses within the decade. Foreign-trained nurses are a large share of the nurse stock only in New Zealand (although many are from other Commonwealth countries). However, because of the overall size of the nurse workforce in some of the host countries, the actual number of foreign-trained nurses is often substantial. For example, while foreign-trained nurses account for only 4 percent of employed nurses in the United States, their numbers total approximately 90,000.² Thus, if the United States follows the recent trends in the United Kingdom and Ireland and doubles its supply

EXHIBIT 1 Host Country Registered Nurse (RN) Workforce And Foreign Nurses' Contributions

Host country	Number of RNs in workforce	Predicted shortfall (shortfall year)	Foreign nurses as percent of workforce
US	2,202,000	275,000 (2010)	4
UK	500,000	53,000 (2010)	8
Ireland	49,400	10,000 (2008)	8
Canada	230,300	78,000 (2011)	6
Australia	179,200	40,000 (2010)	— ^a
NZ	33,100	— ^a	23

SOURCES: United States: E. Spratley et al., *The Registered Nurse Population, March 2000*; BHP, *Projected Supply, Demand, and Shortage of Registered Nurses: 2000–2020*; United Kingdom: J. Buchan et al., *International Nurse Mobility*; J. Buchan and I. Seccombe, *Behind the Headlines*; Chancellor of the Exchequer, *Budget Statement*; Scottish Executive, *A Partnership for a Better Scotland*; Welsh Assembly, *The Review of Health and Social Care in Wales*; Ireland: Health Services National Partnership Forum, *An Examination of Non-Practicing Qualified Nurses and Midwives in the Republic of Ireland*; Nursing Policy Division, Department of Health and Children, *The Nursing and Midwifery Resource*; Canada: L. O'Brien-Pallas et al., *Bringing the Future into Focus*; CIHI, *Supply and Distribution of Registered Nurses in Canada, 2000*; Canadian Nurses Association, *Planning for the Future*; Australia: Australian Institute of Health and Welfare, *Nursing Labour Force 2001*; T. Karmel and J. Li, *The Nursing Workforce—2010*; and New Zealand: Nursing Council of New Zealand. See endnotes in text for complete source information.

NOTES: Nurse workforce surveys are conducted at different points in time in each country. Data were obtained from the most recent country reports. Corresponding years for number of RNs in workforce: United States, 2000; United Kingdom and Canada, 2001; Ireland and New Zealand, 2002; Australia, 1999.

^a Not available.

of foreign-trained nurses to 8 percent over the decade, some 100,000 additional nurses would be recruited from predominantly developing countries, which could lead to more aggressive recruitment of nurses from the Caribbean and other countries with limited numbers of nurses. Moreover, the addition of 100,000 foreign-trained nurses would not close the projected U.S. shortfall.

The host countries have at least twice as many nurses for their populations as the source countries have (Exhibit 2). Moreover, the accuracy of data on nurses in developing countries is doubtful, and Exhibit 2 likely overestimates, possibly by a wide margin, the actual numbers of qualified nurses because of the use of broad definitions of the term *nurse* to reflect workers with different qualifications.³

A number of factors motivate nurses in the source countries to migrate. Some countries, despite their own domestic health care needs, cannot create enough jobs for the health professionals they train, thus motivating them to emigrate. The infusion of international funding for HIV/AIDS and immunization programs could help to create more jobs for nurses. However, poor wages, economic instability, poorly funded health care systems, the burdens and risks of AIDS, and safety concerns are other factors that “push” nurses to leave developing countries. Additional factors “pull” nurses to developed countries, including higher wages, better living and working conditions, and opportunities for advancing their education and expertise. Remittance income from nurses is a major source of hard currency for developing countries and has motivated the Philippines to train nurses for export and other countries to try to follow their example. Most nurses emigrate with short-term work permits. Common wisdom is that few nurses from developing countries, particularly sub-Saharan Africa, ever return to their countries of or-

EXHIBIT 2
Registered Nurse (RN)-To-Population Ratios Among Major Host And Source Countries For Foreign Nurses

Host country	RNs per 100,000 population	Source country	RNs per 100,000 population
US	782	South Africa	472
UK	847	Philippines	418
Ireland	804	Zimbabwe	129
Canada	741	Nigeria	66
Australia	941	India	45
NZ	841		

SOURCES: United States: E. Spratley et al., *The Registered Nurse Population, March 2000*; United Kingdom: J. Buchan et al., *International Nurse Mobility*; J. Buchan and I. Seccombe, *Behind the Headlines*; Ireland: Nursing Policy Division, Department of Health and Children, *The Nursing and Midwifery Resource*; Health Services National Partnership Forum, *An Examination of Non-Practicing Qualified Nurses and Midwives in the Republic of Ireland*; Canada: L. O'Brien-Pallas, et al., *Bringing the Future into Focus*; Australia: Australian Institute of Health and Welfare, *Nursing Labour Force 2001*; and New Zealand: Nursing Council of New Zealand. See endnotes in text for complete source information.

NOTES: Data for host countries were obtained from the most recent country reports. Host country data: United States, 2000; United Kingdom and Canada, 2001; Australia, 1999; and Ireland and New Zealand, 2002. Data for source countries were obtained from the World Health Organization and represent the WHO's most recent data. Source country data: South Africa and Philippines, 1996; Zimbabwe, 1995; and Nigeria and India, 1992.

igin, but there is almost no data with which to validate this notion.

■ **United States.** It is widely assumed that the United States is the largest importer of nurses because of the size of its health care system, its favorable wage structure, and media attention to international recruiting activities by U.S. hospitals.⁴ Indeed, since 1998 foreign-trained nurse entrants to the U.S. nurse workforce have increased at a rate faster than that of U.S.-educated new nurses. The number of nurses trained abroad has more than doubled as a percentage of U.S.-trained registered nurses (RNs), from six per hundred in 1998 to fourteen in 2002.⁵ Peter Buerhaus and his colleagues recently estimated that nurses born outside the United States accounted for about a third of the increase in employed nurses nationally since the mid-1990s, although it is not known for sure how many were trained abroad.⁶

Despite these increases, the United States is not the world's largest importer of nurses. U.S. requirements for licensure and restrictive immigration policies, not a lack of demand or interest, have limited the entrance of foreign-trained nurses to the United States. All U.S. nurses must pass the National Council Licensure Examination (NCLEX-RN) to practice as RNs. To take the exam, foreign applicants must demonstrate that their education meets U.S. standards—most notably, that their education was at the postsecondary level. Also, nurses trained in countries in which English is not the primary language must also pass an English proficiency test (the Test of English as a Foreign Language, or TOEFL). The U.S. Commission on Graduates of Foreign Nursing Schools (CGFNS) offers an exam in many countries that is an excellent predictor of passing the NCLEX-RN. The CGFNS exam reduces the number of foreign-trained nurses who travel to the United States expecting to work as RNs who cannot pass the licensing exam.

In 2002, 19,903 nurses applied to take the CGFNS screening exam, 17,496 actually took the exam, and 5,718 passed. Slightly more than 3,000 took the TOEFL, and most passed. Visa screen certificates were issued to 3,482 foreign-trained nurses. The United States does not have immigration legislation giving priority to nurses as a specific occupational category, so getting a visa is not assured after passing the CGFNS exams. Data on the actual number of nurses entering the United States each year are not readily available. Using the above statistics provided by CGFNS, that number appears to be fewer than 5,000 nurses—not a large number in the context of a workforce of more than two million nurses.

The North American Free Trade Agreement (NAFTA), contrary to expectations, has not greatly influenced the immigration of nurses from Mexico. Such immigration was limited under NAFTA to 5,000 per year initially, a limitation that has now expired. However, because most nursing education in Mexico is at the secondary-school level, few Mexican nurses can meet U.S. requirements for licensure and English language proficiency, and only small numbers have emigrated. Canada has long been a source of nurses for the United States, especially in border states, where Canadian nurses' credentials are generally accepted by en-

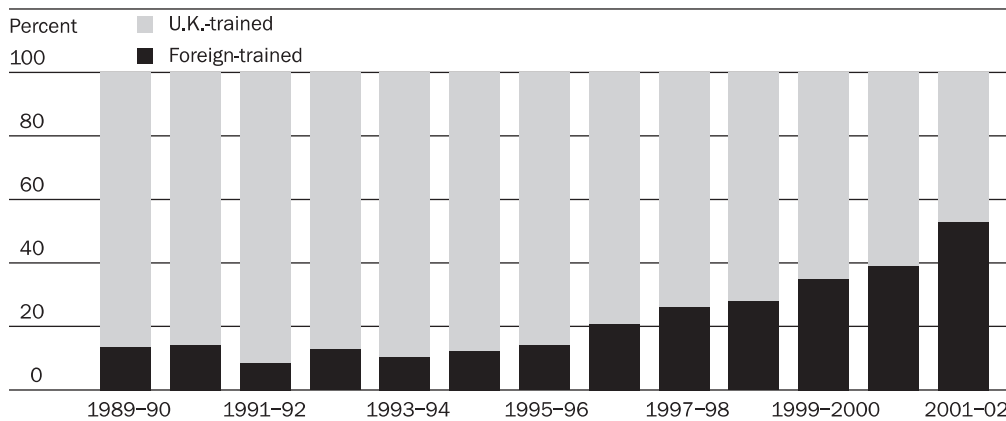
dorsement because of the comparability in educational and licensure requirements.

■ **United Kingdom.** The British National Health Service (NHS) is going through an unprecedented period of funding increases, with planned growth in the size of the nurse workforce. More “new” nurses are being trained in the United Kingdom, and there are attempts to attract home-based “returners” back to nursing employment, but there has also been an explicit policy of active international recruitment from certain source countries. In 2002, for the first time, more nurses joined the U.K. register from overseas (16,155) than from education sources within Britain (14,538) (Exhibit 3).⁷ Between 1999 and 2002 the number of foreign-trained nurses based in and eligible to practice in the United Kingdom more than doubled, to 42,000.⁸

Some sectors of the U.K. health system have developed a high level of dependency on foreign-trained nurses and thus are motivated to sponsor extended work permits. One out of four nurses in London are from overseas, and some private health care organizations are staffed by as many as 60 percent overseas-trained nurses.⁹ The main source countries are not European Union countries but the Philippines, South Africa, and Australia, with sizable increases as well from India, Zimbabwe, and a number of other African countries. These numbers follow well-established trade patterns, as is common in international migration.¹⁰

The United Kingdom is at the center of the controversy over nurse migration because of the sizable numbers of nurses emigrating from sub-Saharan Africa. The U.K. Department of Health published an ethics code in 1999 with subsequent revisions that prohibit direct recruitment of nurses from Africa by the NHS.¹¹ However, African nurses are still coming in substantial numbers via private-sector recruitment and are eventually finding jobs in the NHS. The number of nurses on

EXHIBIT 3
Percentage Of New U.K.-Trained And Foreign-Trained Nurses Added To The UKCC/NMC Register, 1989–90 To 2001–02



SOURCE: J. Buchan et al., *International Nurse Mobility: Trends and Policy Implications* (Geneva: World Health Organization, 2003).

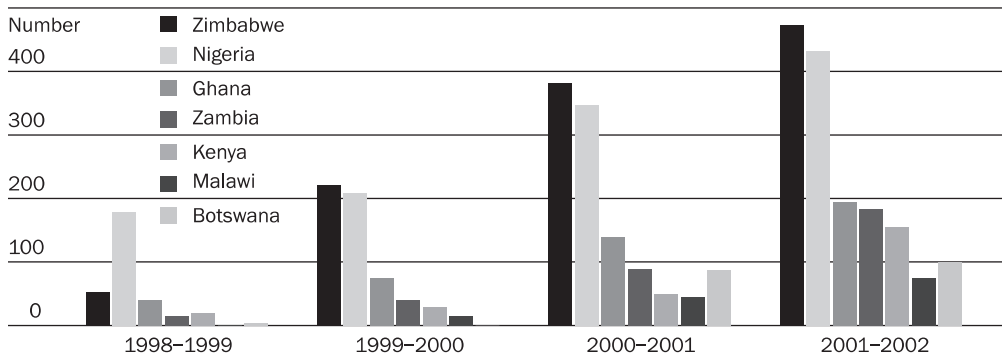
NOTES: UKCC is the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting, NMC is the Nursing Midwifery Council.

the U.K. register from Africa has been increasing steadily (Exhibit 4).

All nurse applicants to be registered for employment in the United Kingdom are subject to credentials review by the Nursing and Midwifery Council (NMC). Applicants with first-level general nursing qualifications from European Union (EU)/European Economic Area (EEA) countries have the right to practice in the United Kingdom and other EU countries because of mutual recognition of qualifications across countries. However, little movement of nurses takes place across national borders within the EU, despite trade agreements facilitating such movement, because of language barriers and the absence of substantial push/pull factors within Western Europe. These dynamics will change when a number of relatively poorer countries join the EU in 2004, such as the Czech Republic, Slovenia, Poland, and others. In anticipation of the EU expansion, the Netherlands and the United Kingdom are already in discussions with Poland and Hungary about nurse recruitment, and Norway has been recruiting nurses from Poland.¹²

No direct examination is required for foreign-trained nurses to practice in the United Kingdom; instead, the NMC assesses nurses' overall credentials, including evidence of proficiency in English, and ascertains that an employer has agreed to provide employment for the period of the work permit. Data comparable to those of the results of the pass rate for the U.S. CGFNS exam are not available. However, the NMC's annual report states, "A relatively small number of applicants for registration from overseas were accepted onto the register the first time...A majority require a period of adaptation/supervised practice in a clinical setting."¹³ Employers play more of a role in the United Kingdom than in the United States in preparing new immigrants for practice as qualified nurses. In 2001–02, for example, 3,437 foreign-trained U.K. nurse applicants were accepted at their first application, but almost five times that many (15,064) were accepted that year. The absence of an exam might make it easier for foreign-trained nurses to eventually practice as a

EXHIBIT 4
Number Of New Registered Nurse (RN) Registrants In The United Kingdom Coming From Selected African Countries, 1998–2002



SOURCE: J. Buchan et al., *International Nurse Mobility: Trends and Policy Implications* (Geneva: World Health Organization, 2003).

qualified nurse in the United Kingdom than in the United States.

■ **Ireland.** Ireland is a noteworthy example of the potential for additional developed countries to join the ranks of current major host countries in active international nurse recruitment. For years Ireland produced more nurses than it could employ, and Irish nurses were highly sought after by other developed countries, including the United Kingdom and the United States. The recent Irish economic boom resulted in the expansion of jobs for nurses in Ireland, so much so that the number of jobs exceeded the domestic supply of employed nurses. Thus, Ireland became a major host rather than a source country and now recruits actively overseas, especially in the Philippines.¹⁴ Long-standing nurse migratory patterns between the United Kingdom and Ireland have totally reversed: Ireland is now a major destination for U.K. nurses instead of vice versa.¹⁵ And, as in the United Kingdom, Ireland is now importing more new entrants to nursing than it is training domestically.

■ **The Philippines.** The Philippines is the leading primary source country for nurses internationally by design and with the support of the government. The 2001–2004 Medium Term Philippines Development plan views overseas employment as a key source of economic growth.¹⁶ Filipino nurses are in great demand because they are primarily educated in college-degree programs and communicate well in English, and because governments have deemed the Philippines to be an ethical source of nurses. A motivator for the Philippines to produce nurses for export is remittance income sent home by nurses working in other countries. In 1993 Bruce Lindquist reported that Filipinos working abroad sent home more than \$800 million in remittance income.¹⁷ No other country produces many more nurses than are needed in their own health care systems at a level of education that meets the requirements of developed countries.

However, the Philippines may be reaching a natural limit in its ability to provide enough nurses for escalating worldwide demand. An estimated 85 percent of employed Filipino nurses (more than 150,000) are working internationally. About one-fourth of the total number of nurses employed in Philippine hospitals (some 13,500) reportedly left for work elsewhere in 2001.¹⁸ There has been recent debate that the growing global demand for Filipino nurses is so great that emigration of nurses could be threatening the country's health care quality.¹⁹ It is estimated there are more than 30,000 unfilled nursing positions in the Philippines.²⁰ In 2001 the United Kingdom, Saudi Arabia, Ireland, Singapore, and United States were the most common destinations for Filipino nurses.²¹

A number of less developed countries, such as India, China, and some of the Newly Independent States of the former Soviet Union (NIS), aspire to train nurses for export following the Philippine example. That model is based mainly on the provision of private-sector education. Countries considering the development of nurses for export face challenges because of limited access to capital to build an appropriate nursing education infrastructure that meets Western standards and by the emigration of nurse faculty and leaders to developed countries.

Policy And Managerial Implications

Developed countries' growing dependence on foreign-trained nurses is largely a symptom of failed policies and underinvestment in nursing. Although a detailed review of explanations for current nursing shortages is beyond the scope of this paper, several issues are pertinent. First, developed countries have not done all they can to create a sustainable professional nurse workforce that meets their needs. In 2003 more than 11,000 qualified students were turned away from U.S. nursing schools because of capacity limitations. Unlike in most other countries, nursing education in the United States is largely financed by students and their families, a financial barrier for many applicants. In the 1990s the United Kingdom greatly reduced the number of new nurses being trained there. While there have been recent policy interventions to reverse the downward trend, the United Kingdom is still dealing with the legacy of its underinvestment in nursing education, as is Ireland. Sustained underinvestment in nursing education is a theme across the countries that are now turning to aggressive international recruitment.

Second, the work environments of nurses in developed countries, especially in hospitals, are deficient in many correctable ways.²² Most notably, nurses—who presumably are in short supply—are spending an inordinate amount of time in nonnursing tasks as a result of poor work design and underinvestment in information and other nurse-saving technologies.²³ Associated high levels of nurse burn-out, dissatisfaction, and turnover have added to perceptions of nurse shortages.

The world's nurse supply appears insufficient to meet global needs now and in the future. Countries that use the most nurses should make the biggest investments in nursing education in both their own and the developing countries from which they recruit nurses. It is not common for developed countries to invest their international aid in nursing education, and this should change to help build sustainable nursing education infrastructures in developing countries.

Ethical recruitment guidelines provide a strategy for responsibly managing international nurse recruitment, although to date the first test case—the U.K. Department of Health guidelines—has been disappointing. Since 1999, when those guidelines were established, the outflow of nurses from sub-Saharan Africa to the United Kingdom has greatly increased, and emigration from South Africa has quadrupled. The challenge is in enforcement of the guidelines, especially considering the private, entrepreneurial character of international recruitment.

The most promising strategy for achieving international balance in health workforce resources is for each country to have an adequate and sustainable source of health professionals. A two-prong strategy is required for this to happen. First, developed countries must be more diligent in exploring actions to stabilize and increase their domestic supply of nurses and moderate demand through strategic investments. Second, even without the exodus of so many qualified health professionals to work in developed countries, most less developed countries do not have the health care workforce capacity to respond to the health problems of their

citizens that also can threaten global health. Making health, especially nursing, a legitimate focus of international aid and democracy building is needed.

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