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Global Nurse Mobility: Implications for The Nursing Workforce and Health Systems

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Abstract

International migration of nurses has become a burning topic that touches upon the profession and the health-care system in the world. Prompted by differences in wages, professional and working environments, opportunities to advance their careers and geopolitical reasons, the migration of nurses between low and high-income countries has resulted in an intricate maze of problems. These are shortage of workers within the motherland, excessive dependence on expat trained personnel within the motherland and the ethical issues of the recruitment technique. As much as migration could bring personal and professional advancement to the nurses, it threatens to destabilize and impact negatively on the equity of health care in other parts of the world. The paper discusses why nurse migration occurs, the effects, and how governments have responded to such migration and notes that there is need to develop international coordinated migration policies to promote workforce sustainability planning and fair distribution of care among nations.

Keywords: ***Nurse migration, global health workforce, healthcare systems, brain drain, international recruitment, nursing shortages, health policy, ethical recruitment, workforce sustainability, global mobility.***

1.Introduction

During the past few decades, the phenomenon of nurse mobility has shifted form the background trend to the burning global health policy and workforce planning concern. The history of nurse migration is old; however, unlike the pioneer nurses, such as Florence Nightingale who studied in other countries, it has become a much more complicated phenomenon with more profound implications. As the world becomes more and more interconnected, as healthcare needs grow, and as the relative wealth of countries varies to significant degrees, the nurse mobility currently exists as the knot of confrontations between globalization in healthcare industry, the sustainability of the healthcare workforce, and ethical imperatives of both sending and receiving nations(1).

This international movement of nurses who migrate internationally, commonly known as nurse migration, is the transfer of educated nursing professionals across international borders, mostly as a result of the pursuit of an apparent economic advantage, professional growth and enhanced working conditions. On the one hand, receiving nurses develop professionally and in most cases benefit the healthcare context in which they work. On the contrary, this international health labour migration presents severe concerns. These are a trend of strengthening a weak healthcare in the low-resource countries, the lack of equal presence of talent, concerns on the quality of care and professional integration and the sustainability of health services around the world.

FIGURE 1 International Nurse Migration

In the modern era, nurse migration is not just an opportunistic decision anymore but rather it is an organized and policy oriented act within the globalized labor markets. The globalization of the healthcare industry has exposed healthcare services to market competition, where both the private and the public sector can move with ease

accessing talent around the world to address shortages in workforce. Countries faced with ageing populations and before the population becomes old modernize in the light of ageing populations and countries that did not have adequate training facilities, especially high-income countries in the United States, the United Kingdom, and even in the European regions are highly dependent on foreign trained nurses to balance their health sectors. Such as in a London or New York city, a significant percentage of the nursing personnel is constituted by immigrants and some may even be located in Philipines, South Africa, India, Caribbean.

Yet this reliance on low-cost foreign labor can be detrimental to the building of local systems of healthcare training. Rather than focusing on long-term sustainable workforce planning, which may take the form of better training infrastructures, higher nurse retention or more competitive employment terms many countries choose to fix the problem in the short term by international recruitment(2). The practice indirectly transfers the cost of training to source countries, which is crowded with many that have their national health workforce shortages.

In the meantime, there are serious ramifications to source countries. Developing countries such as the Philippines and India have emerged as top exporters of nursing workforce partly because of excess training as well as the lack of professional and economic opportunities in their respective health systems. A brain-drain of its most skilled and trained nurses is a common phenomenon in these countries and it leaves in their wake systems that are already overstretched and even under-resourced in terms of health care. These brain drain pipelines promote health inequalities and undermine the capacity of such countries to address even their most fundamental needs with respect to the health of their populations.

Besides, a network of push factors and pull factors influences the migration of nurses. Push factors are the factors underlying the emigration of nurses in the source nation, namely, low wages and working conditions, unstable political environment, professional lack of recognition, and lack of career growth as push forces. Pull factors on the other hand involve the attractions of lucrative wages, better training, fewer hazards of employment and assurance of improved standard of life in the foreign country. In most occasions, nurses abandon families and cultures as they seek to achieve better future to their children by means of remittance.

The issues are not only focused on labor shortages and income inequality, however. Importation of nurses trained abroad jeopardizes the quality of care, language and cultural inclination issues as well as ethical nurse recruitment. There is evidence that despite the argument that foreign-trained nurses are able to provide competent care, there exist tendencies of discrimination, stereotyping and failure to be fully integrated into their professions because of barriers in the system. Most of them feel non-valued, overworked or marginalized in their new settings-having made important contributions. It is also possible that language barriers and culture shock of local medical protocols might complicate communication with patients and other colleagues that may have a negative effect on the outcomes of patients.

Nurse migration is, on the other hand, associated with some clear advantages. Cases are frequent when migrant nurses acquire the useful knowledge and experience which develops their practice and opens new limits in their career. Others come back home with greater competencies, which develop capacities back home. Moreover, the transfer of migrant nurses has an important monetary impact in the families and the communities within source countries and to the source country economy. Migration has in fact brought about paradigm shifts even in the social status of the nurses in some cultural settings as the profession has become appealing to the younger generations particularly women.

2. Reframing Nurse Migration

The migration of nurses has ceased to be an isolated issue of labor in the modern world, it has become a pattern that is closely interlaced with the process of globalization and transnational economies in the 21 st century. The migration of international nurses is not just a matter of the mobility of the workforce but it needs to be reflected in the direct consequences of liberalized market systems as well as the characteristic of demographic change accompanied by the commercialization of care. Globalization of healthcare provision into the international trade systems, development of multinational corporations in the healthcare sector, and the changing dynamics of demographics in both high and middle income countries have been some of the reasons behind the dynamics of the international nurse movement(3).

The essence of this problem is in the fact that healthcare has become a market commodity, instead of being regarded as a public good. It has been further enabled by the international treaties like the World Trade Organization General Agreement on Trade in Services (GATS) that enables a commodity that is health to be traded

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across the borders in the same manner as the consumer goods. With more powerful corporate logic and investment priorities affecting health systems, more efficiency, cost-saving and speed of deployment of workforce have been prioritized over development of domestic workforce. In such economy, nursing international recruitment ceases to only be rational but is likely to be financially lucrative. The practice of employing a foreign educated nurse could be cost effective and time saving as compared to the time and the cost that will be spent in local education and training that will take years to plan and invest in.

Multinational corporations that own chains of hospitals and elderly care and rehabilitation centers, in particular have become potent agents in determining the demand of nurses. In some of the countries, such as Germany, Sweden, and the UK, there are substantial developments of the healthcare infrastructure wherein it is managed and owned by the private corporations; some of which even have international developments. These companies usually conduct en masse hiring of nurses in the countries that form Asia, Africa, and Eastern Europe to fulfill staffing requirements at maximum labor costs. Some of these companies are even publicly traded firms whose stockholders demand financial growth, a factor that further increases the demands to focus on them by ensuring efficiency rather than long-term national policies on workforce building.

Demographic change is also another factor that contributes towards such global demand of nurses. The population in richer countries, especially in Western Europe, North America, and some eastern Asia is aging very fast. The number of the elderly that needs long-term and chronic care has been higher than the increase of the national nursing workforce. At the same time, the model of traditional family-based care is losing ground because of the changes in the social structure, related to a sharp increase in the urban population, a decrease in the average size of a household, and a significant increase in the number of women in the active workforce. In such settings, professional nursing has been forced to grow at a very fast rate to replace the reduced amount of informal caregiving. The end result is a rising and pressing need to fill skilled care workers-a need that local training pipelines have not always been ready to respond to.

The response of most developing and middle-income countries has been to adjust their education system to feed this world labour pool e.g. the Philippines, India, Nigeria and Ghana. The schools of nursing in such countries are merely trained to serve the domestic demands but also to intentionally overproduce number of graduates that serve the demands of the global market. This practice is at times supported by governments in these areas as they consider nurse migration as a way of economic growth by using the remittances. Labor migration is even an official state policy in the Philippines, where nurses represent one of the biggest shares of its foreign workforce(4). This is an export production strategy of nurses that begs some ethical and strategic questions like: can countries afford exporting trained health professionals when many of their own citizens are having access to basic fair?

The other definitive sign of the era of global nurse mobility is the phenomenon that can be termed transnational care corridors routes where nurses can be found to migrate regularly to particular receiving countries since these regions are consistently recruiting nurses. An example can be the migration of nurses of India, South Africa, and the Philippines who tend to go to the United Kingdom, the United States, Canada or Australia. The bilateral agreements, simplified licensing policies, and clinical training by sharing the English language are some of the corridors supporting these corridors. Although these corridors enable effective mobility, they are also prone to turn into extractive pipelines that gradually deprive source countries of their talents and scuttles local healthcare systems on a long-run basis.

Moreover, the liberalization of market in health care has permitted the flourishment of medical tourism which is yet another layer of nurse migration. There is a new trend with high-income country patients traveling to middle-income countries such as India, Thailand, or Mexico to access affordable surgery and treatment services and thus hospitals in these countries are improving their facilities and hiring nurses who are multilingual and have international training and education. By doing so, even domestic healthcare of source countries is subsequently bound to global mobility where national institutions start tailoring their services towards foreign customers at the prospective of sacrificing domestic reachability.

There is one specific trend that has received insufficient attention, i.e. the informal or shadow market on care work, especially in Europe. Elderly care in a majority of Western families, particularly in Italy, Austria and Germany households are zoned off by non-formal institutions to employed migrant women based on informal terms- usually unqualified and under-qualified migrant women. These carers are mostly of Eastern European heritage or Balkan origin and they reside in the houses of aged and provide the elderly with fulltime care at low-wages and with lack of their labor rights. Although this system addresses a significant unmet need in elderly service, it encourages

labor exploitation and further discourages governments to come up with extensive eldercare systems based on trained professionals.

There is also the issue of an international harmonization of regulation and quality assurance which comes alongside the globalization of nurse migration. The education quality, language skills, and clinical experiences in different countries differ, so in most of the cases, international nurses who change the environment in which they operate can experience challenging transitions. There is disparity in the distribution of licensing examinations, professional accreditation and adaptation programs and most of the nurses join host systems without proper orientation or training. Not only does it impact on the degree of integration of nurses, but may have grave consequences on the level of patient safety and care.

Still, the nursing profession also has some opportunities in globalization. Enhanced global mobility can initiate career development, exposure to best practices and inter-cultural competence among the nursing professionals. Internationalization of nursing education and cross-border knowledge exchange are becoming vital issues that create fresh debates concerning the harmonisation of curriculum standards and the global standards of practice. With proper management in terms of both ethics and strategy nurse migration may transform into a proactive transnational model of health solidarity and vice versa.

Nevertheless, strong international policy coordination is required in order to reach this vision. International organizations such as the World Health Organization, International Council of Nurses or the national governments should step out of the one-sided approach and create a balanced multilateral system where the interests of the sending and receiving nations would be equalized in an attempt to meet the terms of the issue. Ethical recruitment policies, equitable pay models, and investments in local training are not only policy issues, but also ethical requirements in the health economy that is globalized(5).

3. Trends, Data, and Geographic Shifts

Nurse migration has become one of the prominent patterns of global health workforce movements that reconstruct the structures, the efficacy, and viability of healthcare systems across the world. Although its ethics and systemic consequences are also discussed widely, the notion of migration of nurses requires careful exploration of the migration dynamics patterns, numbers, and a strategic policy that would drive the multifaceted movement of human resource. The migration has stopped becoming random and incidental, it is now organized, encouraged and in many cases planned by bilateral agreements, economic differences and labour supply and demand imbalances. In the given section, we will discuss the statistical picture of the world nurse migration, dwell upon the countries of origin and destination along with matter-of-course trends during the last 20 years and new changes affecting the future of nurse labor markets.

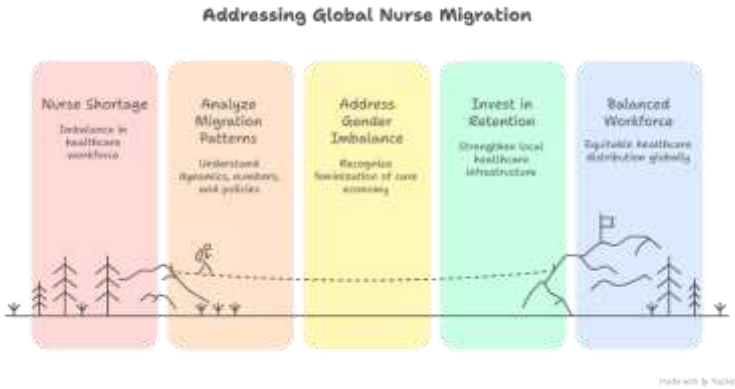

FIGURE 2 Addressing Global Nurse Migration

The International Organization for Migration (IOM) notes that currently more than 280 million individuals are forward of their country of birth, and there are nearly one in 35 persons worldwide, who are migrants. A major share of these immigrants includes highly trained health care professionals especially nurses who form the largest group of specialists in the health industry. Nurse migration is not part of selective international corridors; but encompasses continents and a whole assortment of countries as both exporters and importers of healthcare workforce.

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The phenomenon of women overrepresentation in nurse migration is among the most studied tendencies in the nursing migration field in general, with the whole care economy being feminized. The profession of nursing has long been and remains traditionally performed by a woman and the international movement of people has resulted in what is commonly called by many scholars nowadays as the global care chain. In this chain nurses, who are mostly in the Global South, move to other higher income states to attend to the aging populations leaving behind; their children, aged parents and the communities that depend on them. This gendered flow of feminized migration captures the gendered aspects of global labour markets as well as the emotional sacrifice that the migrating health professionals have to incur.

The Philippines is the leading source of international nurses as measured by the volumes of its professionals. In the last 20 years, the number of nurses among Filipinos migrating to work in foreign countries such as the United States, United Kingdom, Canada and Middle East has exceeded 250,000 in number. Nurse migration has been institutionalized by the Philippine government into the official labor export policy implemented with an infrastructure of nursing schools that produce graduates who are prepared to work in foreign countries. This is also the case with India, a country whose number of nurses trained to work across the world is ever increasing. The two nations also have a surplus of nursing graduates compared to the domestic nursing job market, but to an ironic extent, they both have an in-country shortage of nurses in rural or underserved areas(6).

Another region that produces nurses that migrate to other countries is Africa. As an example, there has been emigration of nurses in Zimbabwe and South Africa especially to UK and Australia. The number of Zimbabwean nurses registered in the UK in the year 2001 alone exceeded those trained within the country in the same year. Such disproportion highlights a major concern in sub-Saharan Africa: emigration rates are high, and while little might be done to invest in retentive value of health professionals, health infrastructures in sub-Saharan Africa are weak and unable to take on both ordinary and emergent health demands.

4.Drivers of Global Nurse Migration

International migration of nurses is never caused by one factor, therefore, they arise as an intertwined tangle of economic, social, political and professional reasons. One factor cutting to its core is the presence of two conflicting influences on the one hand the forces that drive nurses out of their home countries (popularly known as push factors) and the forces that encourage them towards the destination countries (popularly known as pull factors). However, such concepts are terms that are helpful in understanding, yet they can cover up the structural processes that are the causes of disparities in healthcare workforces throughout the world.

Migration as a nurse is hardly made lightly around the world. It does not just imply geographical movement of an individual who is usually a professional but it also implies breaking of family bonds as well as cultural boundary divisions as well as re-defining oneself within new systems. To others, however, migration is the only available escape to economic security, professional or personal development. Multiply those individual choices again by thousands of times, and you have the geography of care around the globe and the fissures in global health governance.

4.1 The Origin Countries Economic Pressures and Professional Constraints

Push factors that affect nurse migration include economic instability and the under-investment in the healthcare infrastructure which are some of the most widespread. Nurses have to deal with poor remuneration that fails to match the requirements and the significance of their tasks in many low-income and middle-income nations. Indicatively, in most countries in sub-Saharan Africa and South of Asia, the salaries of nurses are very low in comparison to the salaries of others with similar education background hence engaging in a different field say technology or finance. Such economic inequalities not only lower the morale of the nursing staff but also compel most of them to find jobs in other countries in an attempt to make their families.

In addition to the salaries, the conditions of work in most of the countries are considered as influential debarring factors. Job dissatisfaction occurs due to chronic understaffing, worn-out infrastructure, insufficient medical equipment, and the inability to participate in a continuing education. Nurses working in certain areas undergo a higher rate of stress and lack of patient safety as they are obliged to work outside the line of their training. The former not only gains burnout effect but also dissolves professional identity and the belief of future in the domestic system.

Additionally, the systems of healthcare are politically neglected in most of the source countries. Although nursing has been the backbone in patient care, it is often ignored when it comes to policy determination in the country.

Potential growth advancement, specialisation or leadership is poor. Consequently, high flyer or well-educated nurses tend to feel pent up. This inability to be recognized and experience mobility in their professions becomes the major incentive to find professional space in places that recognize and would reward their ability.

4.2 Instability in Gendered Migration and Sociopolitical Instability

Wider sociopolitical realities are also factors of influencing migrations. Some of the triggers of emigration that can be used are conflict, corruption, political instability, and insecurity. The potential health risks that nurses may experience in fragile states or post conflicts include threats to their own security, delayed or non-payment of salaries or even open violence in the settings of hospitals(7).

The gender issues influence further migration patterns. Given that most nurses are women throughout the world, there is a great number of them who migrate to meet not only professional but also societal and family demands. In many cases, they end up as the main earners of extended families and the prospect of sending home remittances, therefore, becomes a major determinant in migrating. In some countries such as the Philippines the remittances made by the workers abroad most of who are nurses are contributing billions to the economy of the country. But this is paid at the individual cost as migrant nurses often abandon their own children or dependants and they develop emotional as well social tensions.

Interestingly, not every nurse migration may be caused by desperation. In a couple of countries especially by the middle-income groups, the migration is considered as a kind of strategic mobility. Nurses can either decide to work overseas on a temporary basis to acquire experience, highest level of credentials or to become marketable. Such a migration is frequently presented as a form of aspiration- an investment in oneself with the idea of being able to come back home, more skilled. Nevertheless, not all of them come back because on the one hand, there is the condition in a foreign country newer and more appropriate, on the other hand, there are no ways to reintegrate in the country.

4.3 Border Control: Rewards and Recruitment in Destination Countries

The strain of shortages in nursing work force on the high income countries is the major factor in the pull side of the equation. Countries like the United States, United Kingdom, Canada, Australia and some of the Gulf states have experienced increased pressure in healthcare provision associated with aging population, burdens of chronic diseases and poor number of available nurses trained in the country. In place of investing in the growth or attracting new works right at once, most of these nations decided to hire alien nurses to cope them temporarily.

The major players in this are the recruitment agencies. These agencies recruit foreign trained nurses usually on behalf of a health ministry or a series of privately owned hospitals and they do so on a proactive basis and may provide relocation packages, visa sponsorship, and other benefits. Although this is an effective way of institutionalized recruitment, ethical concerns are created, especially when the target population of recruitment is in itself an area of critical lack of supply(8).

Other states have created fast-track licensure and visa route to foreign-trained nurses. As an example, the US has a category of work visas dedicated to health professionals, whereas in the UK NHS has developed organised overseas recruitment with specific orientation and bridging activities. These avenues are also appealing to migrants, and bolster the idea that nursing is a profession that can be transported anywhere in the world.

Other than the economic benefits, the professional status, state of the art clinical conditions and the opportunities of continuous education are also strong attractors. Other career options in technologically advanced hospitals, use of evidence-based practices, or working as a specialized worker or educator, nurse practitioners are not always available and impossible in the countries where the migrants work. Migration is a way to achieve life goals of many by fulfilling their professional dreams and avoiding the strict hierarchies or inactive states back home.

Besides, the accessibility of language and familiarity with the culture determine the preferred destination of nurses. Migration flows usually go smoothly when the countries have a history of colonialism or share the same language. As an example, the nurses of India, Ghana, and the Philippines tend to move to the English-speaking countries because there are less linguistic issues, and the clinical terminologies are close to each other.

4.4 Ethical Paradox

The ethics of nurse migration is dubious despite the seeming two-way benefits. Improving their living conditions, while the host countries find in migrants workers to occupy unmet labor markets urgently, the healthcare systems of the respective home countries tend to be the ones left behind more weakened. Emigration of a few hundred nurses of a low income country can forcibly disarm health care provision in rural settlements or unserved hospitals(9).

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This presents an ethical conundrum to the nations receiving destination and international health regulatory agencies. Is it necessary that high income countries pay sending countries? Is there an imposition or suggestions of limits of recruitment in regards to areas of critical shortage? How can remittance assist in compensation over the workforce depletion? Such questions have spurred attempts such as the WHO Global Code of Practice on the International Recruitment of Health Personnel that promote ethical recruitment and sustainability of health workforce in source countries.

5.Conclusion

International nurse migration is a long-standing strong and sustained initiative in the world healthcare system that, on the one hand, presents life-altering experiences to people and, on the other hand, reveals inherent structural weaknesses in sending and receiving countries. With healthcare systems growing more transparent and interrelated, the cross border transfer of nurses is no longer a phenomenon, rather, a normalized, sometimes even a required solution to the reality of workforce ₺Share workforce distribution, training capacity, demographic pressure, and health care infrastructure dispar forces coupled with increased transparency and interrelatedness of healthcare systems.

But this migration is not benevolent at all. It demonstrates a problematic system of imbalance where the low and middle-income nations have to bear the burden of producing nurses who become a part of the health care system of the rich countries. These countries of origin, many of which already experience shortages of nurses, under-investment in population health and lack of institutional capacity are made even more vulnerable, as in many cases, they cannot even address basic health needs of their citizens. On the other hand, the inflow of skilled labour is an advantage to the high-income countries that in many cases do not invest in long-terms solutions to the problem that include development of domestic labour force, improvement of working conditions and nurse retention models.

Although nurse migration may be seen as a mutually beneficial trade where migrants are better off and countries provide their vacant workplaces, the situation is more based on ethics. The numbers are agonising tales of sacrifice, aloneness, and structural inequality. Migrant nurses often experience discrimination there, cultural displacement and occupational impediments. In addition, their exit creates a vacuum in what they left in their home countries and is hard to replace unless major policies and capital investments are made.

Instead, the migration must be made legitimate, ethical and sustainable without putting any restrictions to the freedom of movement as it is a human right to travel. Practices such as the WHO Global Code of Practice on the International Recruitment of Health Personnel should be more than an aspirational set of policies; they should have a binding status formed into bilateral agreements and international labor policy. Destination countries which enjoy the services of foreign-trained nurses need to generate support towards training programs in source countries, devise reasonable compensating systems, and not conduct recruitments in areas where there are severe constraints in the workforce supply.

It is also significant that the focus will have to change, with reactive recruitment being changed into proactive investment. High-income countries have to be responsible and take measures to make their own nursing education systems, better working conditions, and to provide meaning in career advancement which will make nursing as an attractive and sustainable career choice. In the meanwhile, source states need to be assisted, (by financial donations, experience-sharing, global collaboration) in developing resilient health systems that will be conducive to the retention of talent and to provide the nurse with opportunities of growth without migration.

Last of all, the testimonies of migrant nurses should be bounced right up to the middle of this dialogue. Their experience would point in the direction of improved integration policies, creating a multicultural work ethic, and supporting the creation of a more inclusive working environment. In case of ethical and strategic control of migration, the global profession of nursing can be strengthened, allowing the exchange of knowledge, transnational cultural awareness, and common standards of care.

In a world where health concerns such as pandemics and aging populations are health challenges that must be solved by means of cross-border response, nurse migration must no longer be seen as a symptom of inequality but the driver of change. How we value, support and invest in our crossers of borders is central to the future of healthcare, as the delivery of care.

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Conflicts of interest

The authors have no conflicts of interest to declare

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