

Nurses on the Move: A Global Overview

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Objective. To look at nurse migration flows in the light of national nursing workforce imbalances, examine factors that encourage or inhibit nurse mobility, and explore the potential benefits of circular migration.

Principal Findings. The number of international migrants has doubled since 1970 and nurses are increasingly part of the migratory stream. Critical nursing shortages in industrialized countries are generating a demand that is fueling energetic international recruitment campaigns. Structural adjustments in the developing countries have created severe workforce imbalances and shortfalls often coexist with large numbers of unemployed health professionals. A nurse's motivation to migrate is multifactorial, not limited to financial incentives, and barriers exist that discourage or slow the migration process. The migration flows vary in direction and magnitude over time, responding to socioeconomic factors present in source and destination countries. The dearth of data on which to develop international health human resource policy remains. There is growing recognition, however, that migration will continue and that temporary migration will be a focus of attention in the years to come.

Conclusions. Today's search for labor is a highly organized global hunt for talent that includes nurses. International migration is a symptom of the larger systemic problems that make nurses leave their jobs. Nurse mobility becomes a major issue only in a context of migrant exploitation or nursing shortage. Injecting migrant nurses into dysfunctional health systems—ones that are not capable of attracting and retaining staff domestically—will not solve the nursing shortage.

Key Words. Nurse, migration, shortage

The number of international migrants on the move every year continues to increase. There has been a particularly marked growth in labor migration flows to industrialized countries in recent years (Zlotnik 2003). People with tertiary education accounted for nearly half the increase in migrants older than 25 years in the Organisation for Economic Co-operation and Development (OECD) countries during the 1990s (UN 2006). Women account for an increasing proportion of all migrants, reaching almost half of today's 191 million

international migrants (IOM 2005; UN 2006). Many more women are migrating independently of partners or families (Timur 2000), thus changing the social dynamic associated with the migration process in both source and destination countries. Women migrants are becoming agents of economic change as they enter the international labor market and participate in a new distribution of global wealth (IOM 2003).

HEALTH CARE PROFESSIONALS

Data presented in the 2006 World Health Report strongly support the direct link between positive health outcomes and the density of professional health care workers. The evidence highlights the difficulty in reaching targets where health systems are experiencing critical staff shortages. Countries having the greatest difficulty in meeting the UN Millennium Development Goals (MDGs) are faced with absolute shortfalls in their health workforce, seriously limiting their potential to respond equitably to even basic health needs (WHO 2006). The international recruitment and migration of health professionals affecting national workforce supply is now a significant item on the political agenda (Stilwell et al. 2003; ICN/FNIF 2006; WHO 2006).

Nursing increasingly can be characterized as a mobile profession. Thousands of nurses—the vast majority of them women—migrate each year in search of better pay and working conditions, career mobility, professional development, a better quality of life, personal safety, or sometimes just novelty and adventure (Kingma 2006). It is estimated that 30,000 nurses and midwives educated in sub-Saharan Africa are now employed in seven OECD countries¹ (WHO 2006). This article looks at nurse migration flows in the light of national nursing workforce imbalances, examines factors that encourage or inhibit nurse mobility, and explores the potential benefits of circular migration.

International Migration

The percentage of foreign-educated physicians working in Australia, Canada, the United Kingdom, and the United States is currently reported to be between 21 and 33 percent, while foreign-educated nurses represent 5–10 percent of these countries' nurse workforce. New Zealand reports that 21 percent

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of its nurses are trained abroad, a significant increase in the last decade (WHO 2006). In Switzerland, 30 percent of employed registered nurses are foreign educated and in at least one university hospital 70 percent of new recruits are from abroad (Artigot 2003). In 2005, 84 percent of the new entrants to the Irish nursing register were foreign-educated; a total of 60 percent if European Union source countries are excluded (An Bord Altranais 2005). In 2002, the number of foreign-educated nurse entrants to the U.K. Nursing and Midwifery Council Register exceeded the number of newly qualified nurses educated in the United Kingdom (Ball and Pike 2004). While the percentage of new foreign-educated nurse registrations in the United Kingdom has decreased in recent years (approximately 35 percent in 2004–2005) (NMC 2005), there is a reported bottleneck of 37,000 foreign nurses in the country waiting for clinical placements in order to fulfill accreditation requirements (Parrish and Pickersgill 2005).

Migration Flows

Traditionally, international nurse migration tended to be a North–North or South–South phenomenon, e.g., Irish nurses working in the United Kingdom, Canadian nurses practicing in the United States, Fijian nurses migrating to Palau. However, it is the rapid growth in international recruitment from developing countries to industrialized countries that has gained most media and policy attention in recent years (Dugger 2006; WHO 2006).

In 2000, over 500 nurses left Ghana for employment in the industrialized countries. That was more than twice the number of new graduates from nursing programs in the country that year (Zachary 2001). In Malawi, between 1999 and 2001 over 60 percent of the registered nurses in a single tertiary hospital (114 nurses) left for employment in other countries (Martineau et al. 2002). In 2003, a hospital in Swaziland reported that 30 percent of their 125 nurses were lost to work abroad (Kober and Van Damme 2006) and, between 1999 and 2001, Zimbabwe lost 32 percent of their registered nurses to employment in the United Kingdom (Chikanda 2005).

The directional flow of nurses may change over time. While Ireland was known for decades to be an exporting country with Irish nurses migrating to the United Kingdom, it is now an importing country recruiting mainly from the Philippines, Australia, India, South Africa, and the United States (Department of Health and Children 2001; ICN 2004). Established flows in South–North migration are also subject to change as more source countries enter the international labor market. For example, the number of countries

sending international nurse recruits to the United Kingdom has increased from 71 in 1990 to 95 in 2001 (Buchan and Sochalski 2004). The Philippines, once the leading source of nurse migrants to Ireland and the United Kingdom, was outranked by India in 2005 (HSE 2003, 2004; NMC 2005).

Some nurses take an indirect route to their final destination, using stops along the way to build up their skills and credentials. Forty percent of the surveyed Filipino nurses employed in the United Kingdom had previously worked in Southeast Asia and the Middle East (Opiniano 2002). Forty-three percent of working international nurses surveyed in London report they are considering relocating to another country, in many cases to the United States (Buchan et al. 2005). This duplicates the “carousel” movement of physicians that is already widely acknowledged, with the United States repeatedly identified as the epicenter of international migration (Martineau et al. 2002).

NURSING SHORTAGE IN INDUSTRIALIZED COUNTRIES

Despite a growing supply of registered nurses in absolute numbers, the relative inadequate supply of nurses has had a dramatic impact in recent years on patients and health care systems as well as economic and social development worldwide. High nurse vacancy rates are no longer the lot of developing countries alone (Simoens et al. 2005). With few exceptions, nurse shortages are present in all regions and constitute a priority concern (ICN 2004).

An upsurge in the employment of older, married, and foreign-born nurses improved the U.S. situation somewhat in 2002, reducing the vacancy rate in many health facilities across the country. According to the latest employment projections, however, the United States will still need more than 1.2 million new and replacement nurses by 2014 (Hecker 2005). The numbers in the cohort of older nurses is expected to decline after 2010 and the required 40 percent increase of young people enrolling in nursing programs to meet future domestic need is unlikely (Buerhaus et al. 2003).

There is a widely recognized shortage of specialized nurses in particular, e.g., critical care, emergency. In the United States, emergency departments often have more vacant nurse positions than the hospital’s average. They are considered at the breaking point, overcrowded with “boarded” patients waiting for in-service beds or diverting patients to other hospitals (IOM 2006). Sixty-eight percent of teaching hospitals and 69 percent of urban hospitals reported time on diversion in 2004. The most common reason cited was lack of staffed critical care beds (AHA 2005).

Similarly, in Western Australia “patients were left in emergency department corridors for up to two days before being admitted and there had been at least six cases during the month when all three teaching hospitals had asked to go on ambulance diversion at the same time” (ANJ 2002, p. 13). The Chief Medical Officer blamed the chronic shortage of nurses as the reason behind the chaos and inability to provide care.

Unable to meet domestic need and demand, many industrialized countries are looking abroad for a solution to their workforce shortages—the magnitude of current international recruitment is unprecedented (ICN 2005). Professionally active nurses have become prime resources in an increasingly competitive global labor market. Nurse migration is now a widely publicized and major issue, with profound ethical, socioeconomic—and of course health—implications.

International Recruitment

The heavy dependence of health systems on international recruitment and migration to fill their vacancies may exacerbate shortages in the countries of origin (ICN 2005). What was recently labeled as a short-term solution to the nursing shortage is now widely recognized as a permanent dimension of human resources management to ensure safe staffing (Chandra and Willis 2005). Today, mass recruitment campaigns have greatly enhanced the opportunities and incentives that encourage nurses to migrate (ICN 2004). In periods of critical shortage, countries have placed nurses on a list for preferential treatment streamlining the immigration process, e.g., United Kingdom, Australia, Switzerland (Simoens et al. 2005). In addition, economic policies, bilateral and trade agreements, and recent legislation are pointedly designed to facilitate nurse migration (ICN 2005; Simoens et al. 2005). For example, in response to the U.S. nursing shortage, a provision was recently included to a draft U.S. immigration bill (S2611) that would remove the cap on special visas for foreign nurses, allowing open-entry to all qualified foreign nurses (Dugger 2006).

While there has been much discussion on the potential impact of the General Agreement on Trade in Services (GATS), negotiations to facilitate the temporary employment of foreign health care workers have not progressed. Its future impact on global nurse mobility is therefore unclear (ICN 2005; WHO 2006). On the other hand, mutual recognition agreements (allowing for automatic reaccreditation and often linked to an economic cooperation policy) have encouraged nurse migration at the regional level, e.g., Protocol II of the Caribbean Community and Common Market (CARICOM), the North

American Free Trade Agreement (NAFTA), Trans-Tasman Agreement, Nursing Directives of the European Union. Within the Asia-Pacific Economic Cooperation (APEC), initial discussions have been held on the feasibility of an agreement which may then involve countries from the North and South.

NURSING SHORTAGE IN DEVELOPING COUNTRIES

Public sector reform, started in the mid-1980s, was executed through structural adjustment programs of the World Bank and the International Monetary Fund. These policies called for downsizing or zero growth in the public sector (Dovlo 2005). According to a World Bank evaluation undertaken in 2003, measures affecting the health sector for example in Cameroon included: suspending recruitment, strict implementation of retirement at 50 or 55, limiting employment to 30 years, suspension of any financial promotion, reduction of additional benefits, two salary reductions, and a currency devaluation. The combined impact of these policies resulted in an effective income loss of 70 percent over 15 years. Training for nurses and laboratory technicians was suspended for several years and schools closed. The report concludes that "in 1999, jobs in the public sector were about 80 percent unfilled, and Cameroon had a truly de-motivated health workforce" (Liese et al. 2003, p. 9). New graduates had difficulty finding jobs and large numbers remained unemployed. The consequences of public sector reform on health personnel in Africa were said to be very similar from one country to another.

Nurses migrating to industrialized countries often leave behind an already disadvantaged system, thus worsening the working conditions. The nurses who remain assume heavier workloads, experience reduced work satisfaction and low morale. This contributes to high levels of absenteeism and has an adverse impact on the quality of care (Chikanda 2005; Dovlo 2005). A country's health system is weakened by the loss of its workforce, and the consequences in certain cases can be measured in lives lost (WHO 2006). The insufficient presence of supervisors, mentors, and educators threatens not only current care delivery but the preparation of future generations of nurses.

Left with an inadequate nursing workforce, many developing countries lack the resources to implement programs to improve the health of the poor. In Lesotho, with a shortage of 700 nurses, the implementation of a government campaign for confidential HIV testing and counseling was postponed (IRIN 2006). In Swaziland, the nursing shortage is considered the main obstacle for

the expansion and long-term maintenance of critical antiretroviral therapy programs (Kober and Van Damme 2006).

For many developing countries, a serious consequence of the nursing shortage is the heavy nurse to patient workload, which in turn continues to drive nurse migration. A nurse from the main referral hospital in Lesotho reports that 70 nurses tend to almost 3,400 patients, an average of close to 50 patients per nurse (Associated Press 2006). In Malawi, a major hospital reported that half of its nursing posts were vacant, and only two nurses were available to staff a maternity ward with 40 births a day (ICN 2004). In Zimbabwe, the Minister of Health Care and Welfare estimates the nurse to patient ratio to be 1:700 but researchers found that nurses working in provincial hospitals may work with a nurse to patient ratio of 1:522 while in district hospitals the ratio may be as high as 1:3,023 (Chikanda 2005). Such ratios cannot support excellence in health care delivery.

The Paradox of Unemployed Nurses

Yet, within a context of shortage there are nurses in developing countries, professionally qualified but without employment. This is a modern paradox—nurses willing to work but refused posts by national health systems unable to absorb them, not for lack of need but for lack of funds and/or sector reform restrictions. WHO confirms that “paradoxically, . . . insufficiencies often co-exist in a country with large numbers of unemployed health professionals” (2006, p. xviii). For example, although half of all nursing positions in Kenya are unfilled, a third of all Kenyan nurses are unemployed (Volqvartz 2005). Despite reports that Kenya must double its hospital nursing workforce to achieve the MDGs, 7,000 registered nurses were unemployed at the beginning of 2006 (Associated Press 2006). In South Africa, there are 32,000 nurse vacancies in the public sector and 35,000 registered nurses are either inactive or unemployed (OECD 2004).

“Ghost workers”—persons who appear on payrolls but do not exist at workplaces—block access to health worker positions. An estimated 5,000 ghost workers exist in Kenya alone (Dovlo 2005). This further worsens nurse to patient staffing ratios by giving an on-paper illusion that hospitals are adequately staffed.

PERSONAL MOTIVATION

Although migration theory has been evolving for many decades, determining why nurses migrate is a complex matter, and no one theory has yet captured

all the forces that influence an individual's decision to move. Traditionally, migration was thought to occur when the perceived cost of moving is less than the perceived cost of staying (Lowell and Findlay 2002). This economic theory does not, however, explain why migration occurs in the absence of wage incentives or why migration flows do not increase from a given country when wage incentives are comparatively more significant. For example, when the earnings are adjusted for purchasing power, the nurse wage in Australia and Canada is about 14 times the nurse wage in Ghana and about twice the nurse wage in South Africa. If wages were the decisive factor, more Ghanaian nurses than South African nurses should migrate because the rewards would be much greater. In fact, the proportion of health workers who intend to emigrate from South Africa is approximately equal to that in Ghana, suggesting that factors beyond pay also influence workers' decisions (Vujicic et al. 2004).

While financial incentive is not the only factor, there is no doubt that it plays a key role in the migration decision-making process. Remaining in one's country of birth is the norm and many field studies demonstrate that most people do not wish to emigrate (IOM 2003). Similarly, most nurses are reluctant to leave their home countries and would be willing to stay if offered a living wage. When Fijian nurses learned that their government might soon reclassify their profession in the public-sector pay scale, thus improving their access to a competitive wage, nurses postponed their decision to migrate (Lutua 2005). Brown and Connell's recent research suggests that the relative income of nurses within their home countries is a critical influence on attrition and migration (2004). The substantial wage disparities found between nurses and other professional workers within the country are felt to be denigrating, a major source of frustration, and now a recognized motivating factor in attrition and international migration (Simoens et al. 2005).

Other factors—political forces, poverty, age of the migrant, past colonial and cultural ties between source and destination countries, facilitated emigration process, employment/educational opportunities for family members, and existing diaspora (transnational communities)—also play an important role (Padarath et al. 2003). A WHO study of four African countries showed the major reasons behind health worker migration are better remuneration, safer environment, living conditions, lack of facilities, lack of promotion, no future, and heavy workloads, in that order (WHO 2006). This is similar to the “push” factors that encourage Caribbean nurses to emigrate: financial, poor working conditions, lack of professional development opportunities, lack of promotion opportunities, noninvolvement in decision making,

and lack of support from supervisors (PAHO 2001). A better life and livelihood are at the root of decisions to migrate (WHO 2006).

BARRIERS TO MIGRATION

Once nurses make the decision to migrate, they must surmount several significant barriers. The process of requalification, the cost of a physical transfer, the need to learn a new language (or technical terminology), adapting to different clinical practices, and time-consuming as well as costly immigration procedures are all challenges (Chandra and Willis 2005; Kingma 2006). While the process may be streamlined in certain cases for immigration purposes, accreditation is an important professional and patient safety measure that must be strictly maintained. National regulatory bodies have the responsibility to ensure the competence of the nurse workforce delivering care.

One of the hurdles to migration, communication, is also a cornerstone of patient care. Patients convey their concerns, describe their pain and symptoms, and report changes in health status to professionals who need to understand. Nurses must be able to speak with one another, other members of the health care team, and patient families. They need the current and technical language fluency to communicate under stress and duress. Language has tended to restrict the choice of destination country, encouraging Moroccan nurses to work abroad in France while Ghanaian nurses seek employment in the United Kingdom (OECD 2002). As the pool of nurses in traditional source countries shrinks, however, new source countries are being approached and language barriers are no longer impermeable (Kingma 2006). The introduction of Cuban nurses in Botswana and Chinese nurses in Australia are proof of the new diversity in migration channels.

Social Implications

Among the migration barriers, leaving one's family and community and establishing oneself in a new country are perhaps the most taxing, on a personal as well as professional level. Adjusting to a new culture, environment, and, at times, the disappearance of a familiar social support system can be difficult. One of the most serious problems migrant nurses encounter in their new community and workplace is that of racism and its resulting discrimination (Chandra and Willis 2005). Migrant nurses are frequent victims of poorly enforced equal opportunity policies and pervasive double standards. To

determine how frequently this occurs is difficult as incidents are often hidden by a blanket of silence and rarely openly acknowledged (Kingma 1999). Some migrant nurses have, however, reported dramatic situations on the job where colleagues purposefully misunderstand, undermine their professional skills, refuse to help, and sometimes bully them, thus increasing their sense of isolation (Hawthorne 2001; Allan and Larsen 2003; Kingma 2006).

International Migration Policy

With the increase in nurse migration, there have been initiatives to develop an international migration policy. In response to the complex issues surrounding nurse mobility, government, and professional bodies have set up commissions, proposed regulations, issued statements, passed legislation, and even tried to enact bans that would limit migration. Many double standards and vested interests exist. For example, when Nelson Mandela requested the United Kingdom to stop recruiting nurses from South Africa, his country was employing physicians from other resource-scarce developing countries—notably 78 percent of the rural physicians were not nationals at the time (Martineau et al. 2002).

There have been various attempts made to provide guidelines that dissuade aggressive recruitment practices targeting developing countries faced with critical nursing shortages. Yet, can migration be controlled or managed without infringing individuals' freedom of movement and exposing the recruitment process to even greater corruption and double standards? Is the delicate balance maintained between the human and labor rights of the individual and a collective concern for the health of a nation's population?

To date, numerous codes of practice on ethical international recruitment—or similar instruments—have been introduced at national and international levels, e.g., U.K. Code of Practice, Commonwealth Code of Practice, International Council of Nurses (ICN) Position Statement on Ethical Nurse Recruitment. Their effectiveness is yet to be demonstrated (WHO 2006) and the support systems, incentives/sanctions, and the means for monitoring their implementation continue to be weak or nonexistent (Willets and Martineau 2004). Buchan and Sochalski argue that codes are flawed by the “inadequacy of information systems needed for policy analysis and decision-making” (2004, p. 5). For example, codes tend to assume migration is a permanent loss to the source country (Kingma 2006). If temporary migration predominates, however, such mobility may result in a netgain.

DATA

Most countries do not collect data on who migrates, the migrants' motives, or the length of stay abroad (IOM 2003). Health policy experts and researchers have long argued that the kind of reliable and relevant data upon which good nursing workforce policy depends is simply unavailable (Stilwell et al. 2003; ICN 2004; WHO 2006). Current data tend to be "fragmented, inconsistent, incomplete, and not comparable nationally or internationally" (Baumann et al. 2004, p. 4). Furthermore, much of the quantitative research on nurse migration is based on qualification verifications that document an intent or interest to migrate and not actual employment abroad. Better databases and collection systems still need to be developed.

ECONOMIC IMPACT ON SOURCE COUNTRIES

No discussion of nurse migration can exclude a look at the economic impact on countries from which nurses migrate. Migrant workers send money home to their families and this income is often an incentive for source countries to initiate, maintain, or increase the export of their nationals. In aggregate, remittances sent through formal channels are more than twice the size of international aid flows (World Bank 2006) and estimated to be U.S.\$232 billion in 2005 (UN 2006). Econometric analysis and household surveys suggest that unrecorded remittances sent through informal channels may conservatively add 50 percent (World Bank 2006).

The share of global remittances going to developing countries has increased from 57 percent in 1995 to 72 percent in 2005 (UN 2006). The International Organization for Migration believes that remittances are at least as effective in targeting the poor in developing countries as the aid currently available (IOM 2003). The World Bank estimates that remittances are associated with declines in the poverty headcount ratio in several low-income countries exporters of nurses—by 11 percent in Uganda, 6 percent in Bangladesh, and 5 percent in Ghana (2006).

There is evidence that remittances more than compensate for the economic losses connected with the departure of health professionals (OECD 2002), although some studies assuming permanent migration conclude the loss to the source country is more substantial (Kirigia et al. 2006). While remittance data are seldom occupation-specific, research from the South Pacific by Connell and Brown suggests that nurses are more likely to be remitters and that

they remit larger amounts than other migrants. Their research showed that unlike other groups, nurses' remittances do not decrease with duration of absence. Connell and Brown conclude that the estimated cumulative value of the nurses' remittances is "likely to exceed the training cost of nurses within Tonga and Samoa" (2004, p. 10). In London, more than 50 percent of the surveyed international nurses (75 percent from the Philippines, 70 percent from South Africa) reported that they regularly send remittances to their home country. Fifty percent of Filipino and South African nurses remit 26 percent or more of their income (Buchan et al. 2005). The nurse diaspora contributes to the welfare of the families left behind as well as the national economy of their country of origin.

In Africa, with the exception of Nigeria and Cameroon, remittances account for considerably more than foreign direct investment. This represents a crucial contribution to the regional growth potential and economy. In major nurse exporting countries, total recorded remittances constitute a significant proportion of the gross domestic product (GDP), e.g., 10 percent for the Philippines, 14 percent for Jamaica, and 8.5 percent for Uganda (IMF 2003). Remittances to India represent 2 percent of the GDP but 10 percent of the gross domestic savings. When looking at Kerala state (known for the production of nurses), remittances represent 25 percent of its GDP (Debabrata and Kapur 2003). Remittances constitute a key source of national finance and nurses participate in the creation and allocation of these funds.

BRAIN CIRCULATION

Finally, issues embedded in the brain drain/brain gain debate must be addressed. In general, migration is increasingly seen as a means for development and a better distribution of global wealth (IOM 2003). While some developing countries are "hemorrhaging" from nurse migration, others are benefiting from exchange programs, channeling remittances to public sector development projects, or finding migration a solution to high unemployment levels (ICN 2005).

Brain drain, brain gain, and brain circulation are all possible scenarios that result from nurse mobility. *Brain drain*, which implies a loss to the source country of vital skills, professional knowledge, and management capacity, is only relevant as a concept if linked with permanent migration. If migrants return to their home country (or the country that has invested in their

education), they will once again be a national resource, even an enriched resource if their acquired skills and knowledge are put to good use.

There has been an increasing mix of temporary/permanent migration (Timur 2000) with a noted growth in temporary migration (Findlay and Lowell 2002). Many observers believe that the return rate is quite high—at least 50 percent of skilled emigrants return from most stints abroad, which tend to be for a period of 5 years (Lowell and Findlay 2002). Buchan et al. found that 85 percent of the international nurses surveyed planned to stay in the United Kingdom for 5 years or less (2005). Several researchers have documented that the rate of return for nurses is higher than for physicians (Padarath et al. 2003) suggesting that brain circulation is of particular relevance to nursing workforce policy.

As studies from the Caribbean demonstrate, migration is an integral part of the region's development process. One of its characteristics is circular flow. For example, Brown interviewed 80 Jamaican nurses who had emigrated to the United States to work and later returned to their home country. Among these nurses, 24 percent had traveled abroad to work at least five times, 20 percent on at least six occasions. Eighty-eight percent of these nurses now working in Jamaica intended to travel abroad again (1997).

For circular migration or *brain circulation* to work effectively, the particular needs of migrant nurses must be met. The ICN declares that numerous migrant nurses have been “employed under false pretences or misled as to the conditions of work and possible remuneration and benefits. . . Internationally recruited nurses may be particularly at risk of exploitation or abuse; the difficulty of verifying the terms of employment being greater due to distance, language barriers, cost, etc.” (ICN 2001, p. 5). These problems will not disappear with market competition or voluntary codes of practice. Concrete steps must be taken to regulate the recruitment process and to ensure the respect of workers' rights. A new focus on return migration is also required so that the mobility loop can be closed.

SYMPTOM

International migration is a symptom—even an exaggeration—of the larger systemic problems that make nurses leave their jobs and, at times, the health sector. The data clearly show that no matter how attractive the pull factors of the destination country, little migration takes place without substantial push factors driving people away from the source country (Kingma 2006). Migration is frequently a decision individuals make because of the constraints

experienced in the workplace or the broader society. Nurse migration is pushed, pulled, and shaped by a constellation of social forces and determined by a series of choices made by a multitude of stakeholders. International mobility is a reality in a globalized world, one that will not be regulated out of existence. It becomes an issue only in the context of shortages or migrant exploitation and abuse. If South–North migration is to be reduced, the need to migrate must be addressed rather than artificially curb the flows. If migrant exploitation is to be eliminated, the recruitment process (including recruitment agencies) must be regulated and workers' rights must be upheld.

The challenge of ensuring sufficient numbers of nurses in health services around the world will only be met when serious attention is focused on retention issues—equal opportunity salary scales and significant improvements in health sector working conditions. Until they are addressed, retention problems will continue to sabotage training and recruitment efforts. Injecting migrant nurses into dysfunctional health systems—ones that are not capable of attracting and retaining domestic-educated staff—is not likely to meet the growing health needs of national populations.

ACKNOWLEDGMENT

The author thanks Jennie Solis for research assistance.

NOTE

1. Canada, Denmark, Finland, Ireland, Portugal, United Kingdom, United States.

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