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8. INTERNATIONAL TRADE AND THE NURSING PROFESSION

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Facilitating nurse mobility and promoting high standards of nursing care globally are issues as relevant today, on the cusp of a new millennium, as they were following World War II when Europe began to focus on the free movement of goods, services and people. Given that nursing personnel make up the largest group of health care providers, it comes as no surprise that mobility is an important issue for the nursing profession, governments, employers, policy-makers, the public, and other provider groups.

The sweeping changes of this decade (sociopolitical, economic and technological) impact all aspects of society. Globalization, deregulation and/or re-regulation, decentralization, privatization, competition, advances in biomedicine and communications, and rising public activism are changing the role of the state and the place of individuals, groups and nations globally. New strategic alliances in trade and new trade agreements and networks are accelerating interest in professional mobility. Today's environment tends to promote the reduction of barriers to movement across borders. If so, it is vital that there be mechanisms to assure that quality nursing care is provided, equity exists in processes, and continuing attention is given to health care and working conditions in each country.

Nursing personnel account for up to 70% of health care staffing and provide 80% of direct patient care, facts which, in part, explain why governments, employers, the public and the profession are concerned about supply and demand issues. The majority of the Member States of the World Health Organization report a resource imbalance in the nursing sector. This usually is interpreted as a shortage or a surplus. However, it also includes poor distribution and misutilization of nurses. While it is preferable to deal with work force imbalances locally, remedies often involve attracting personnel from other nations. Similarly, governments with an oversupply are looking at creative ways to export such expertise. These scenarios make mobility an important aspect of the resource equation.

WHY NURSES MIGRATE

Nurse migration is an international phenomenon and enables nurses to achieve personal and professional goals[1]. Mobility ensures that nurses can earn a living, continue their education, experience other cultures, expand professional experience, and so on. This may mean living in one country and working or studying across borders, moving to another country, or providing care across borders via telecommunications, air ambulance, and so forth. For the majority it continues to mean moving to a new country or living in one and working in another.

For most nurses who leave their country in order to work, workforce imbalances and salaries and working conditions lie behind their decision. Today there are many situations where nurses cannot find jobs in their own country, and must move, work across borders, or retrain in another field. Recently, these situations are increasingly the result of health sector reform and the reshaping of health care delivery as opposed to a search for learning experiences.

While health sector reform creates new opportunities for nursing, it also often involves layoffs, reassignments, and limited opportunities for new graduates to gain experience. Because competence is equated with practice, the lack of opportunity to work may jeopardize licensure in some countries. In all situations it makes the nurse less attractive to potential employers.

Poor salary and working conditions, or the lure of better ones, entice many to leave their country for another. Research has shown that management and compensation practices particularly affect the degree to which nursing shortages are experienced in health institutions. In many countries employers have failed to address long standing deficiencies related to hours of work, salary, continuing education, staffing levels, security, housing and day-care facilities[2]. The result is that there may be qualified nurses unwilling to work. This pseudo shortage could often be corrected through effective work force planning and, particularly, by addressing retention strategies.

Other work-related reasons why nurses choose to migrate include the opportunity to learn new knowledge and skills, and to practice in innovative environments and more autonomously. Nurses move for new cultural experiences, to study, or to be with families. Regrettably there are cases where the move is for personal safety and political reasons.

NURSE SUPPLY AND DEMAND TODAY

[1] International Council of Nurses, *Nurse Retention , Transfer and Migration.* Geneva, 1992.

[2] INC, op. cit.

As noted earlier a nursing work force imbalance exists almost everywhere. There are too few or too many nurses wanting to work. There are countries that regularly import nurses and those that educate for export. Still others experience cyclical problems[3]. Ad hoc cost-driven decision-making has led to increasing dissatisfaction and current problems[4].

This decade has seen countries move almost overnight from shortage to surplus situations as part of health care reform. Education reform, new service demands, demographic shifts and refugee movement have also been important factors. Currently the United Kingdom is experiencing a severe shortage and there are also shortages in Africa, and in such countries as Denmark, Israel, Italy and Norway. The Middle East routinely relies on nurses educated elsewhere. The situation in some countries is fairly balanced at present while others are experiencing shortages of specialty staff. This means they have sufficient nurses available but not trained in a specialty, so specialty positions are underfilled. In other situations, as mentioned earlier, some countries have enough nurses but not enough willing to work in the profession.

Surpluses exist as well. North America has experienced this situation since the early 1990s as governments began restructuring health care. As they closed hospitals or downsized them, they adjusted skill mixes thereby diluting the professional:nonprofessional ratios. They also moved services to the community, often without creating an equivalent number of new jobs, employing less costly, less skilled personnel and/or neglecting to offer retraining opportunities.

Surpluses routinely exist in some countries such as the Philippines, and surpluses are likely soon in other parts of Asia. With the Asian economic downturn, work force readjustments are beginning. Already South Korea has changed its laws to permit mass layoffs, and hospital hiring freezes are in place.

PATTERNS OF RECRUITMENT AND MIGRATION

In 1989 the International Council of Nurses (ICN) studied the recruitment of nurses from abroad by polling national nurses' associations[5]. The results showed the following patterns of recruitment:

- North America recruits from Argentina, Australia, Canada, Chile, Colombia, Cyprus, Denmark, Hong Kong, India, Ireland, Jamaica, Japan, Mexico,

[3] J. Oulton, Nurse Migration: Everyone's concern. *International Nursing Review*, vol. 43(6), 1996. p. 160.

[4] IHHRD, *Integrated Health Human Resources Development.* Ottawa Integrated Health Human Resources Development Project, 1995.

[5] International Council of Nurses, Recruitment of Nurses from Abroad. Geneva, 1989. Unpublished.

Netherlands, New Zealand, Norway, Panama, Philippines, Sweden, Taiwan, Trinidad and Tobago, and the United Kingdom;

- Middle East recruits from Australia, Belgium, Canada, Denmark, Germany, India, Ireland, Kenya, Malaysia, Netherlands, New Zealand, Norway, Philippines, Sweden, Trinidad and Tobago, and the United Kingdom;

- Europe recruits from Argentina, Austria, Belgium, Denmark, India, Ireland, Netherlands, New Zealand, Philippines, and Sweden;

- Western Pacific recruits from Hong Kong, Ireland, Netherlands, New Zealand, Philippines, Taiwan, Tonga, and the United Kingdom.

The same survey showed that, in most cases, private agencies were involved in recruiting, while about 25 per cent of respondents also noted hospital and government involvement. To a lesser degree individuals, missions and other organizations were involved. A number of countries had no involvement in foreign recruitment for a variety of reasons including sufficient local resources, immigration laws, low salaries, varying educational backgrounds, preference to nationals, language, and lack of professional recognition.

Nursing migration today is thought to be lower overall than 10 years ago, though global statistics are not readily available. Migration from the Caribbean has been a long standing issue due to poor wages, currency devaluation and, more recently, safety in the work setting. However, because of the lack of jobs in North America and other parts of the Caribbean, the rate of migration is slowing. To address current dramatic shortages, Caribbean countries appear to be recruiting from each other rather than addressing the root causes: poor pay and working conditions. The costs of recruitment and turnover are high, and the islands also lose the financial investment made in educating those who leave.

The United Kingdom is attracting nurses from Finland where there is a temporary surplus. Israel has had an influx of nursing personnel from Europe but these are still learning the language and meeting registration requirements. Austria has recruited Philippine nurses and Italy is attracting nurses from Panama.

SECURING EMPLOYMENT ABROAD

Nurses are faced with a number of barriers in securing work, and serious employment problems once in the work setting. Regulatory barriers are among the first to be encountered. Certain regional regulation agreements have been implemented, for example, in the Caribbean and among Nordic countries. While the European Union (EU) has addressed this issue, barriers continue for others entering EU countries, and for other parts of the world.

The most common approaches to eliminating regulatory barriers have been mutual recognition and harmonization of standards. National nurses' associations of the fifteen countries in the EU have worked diligently at this for the past four decades and have lobbied successfully for the acceptance of the fundamental points concerning the training of generalist nurses. This forms part of the Directives of the Nurse Responsible for General Care[6]. During this same time the European Commission moved away from the concept of harmonization to one of recognition, which means that a person recognized as a professional in one Member State must be recognized as such in all other Member States, provided the profession concerned is a regulated one[7]. However, nursing, through its committees, continues to address mutual standard setting in general as well as specialized nursing education. One way this is being achieved is through the development of core curricula in areas such as cancer care.

Nurses within the EU have few barriers to movement, as work permits are not required. They are eligible to apply for jobs and, once employed, are registered/licensed provided the employer is satisfied. Despite this, there is limited movement within the EU, primarily because of language.

Other countries and regions are also addressing regulatory barriers. The North American Free Trade Agreement calls for the development of mutually acceptable standards for licensing and certification for a number of professions, including nursing. Each country must agree to nondiscriminatory practice towards each others' citizens, and licensure and regulation requirements in a country must be clear, measurable and verifiable to the other countries[8].

Beginning in 1994, a Trilateral Initiative for North American Nursing was implemented. This is a collaborative venture involving nursing groups from Canada, Mexico and the United States of America and aims to address common professional standards with the goal of strengthening nursing and, in turn, improving health care. The first phase of the initiative has been completed. During this time representatives of 35 nursing, governmental and other organizations identified similarities and differences in nursing education, standards and practice and drew up recommendations on developing mutually acceptable criteria for licensing and certification[9].

In 1994 the governments of the eighteen nations of the Asian Pacific Economic Cooperation declared a common resolve to free and open trade by the year 2020. Similar networks and initiatives are operating in Africa and the Caribbean. Nurses associations and regulatory bodies in both these regions are committed to harmonization of education standards and entry requirements into the profession. Nurses in the English-speaking Caribbean sit for the same

[6] S. Quinn and S. Russel, *Nursing*: *The European Dimension.* London, Scutari Press, 1993.

[7] Quinn, op. cit.

[8] V. Maroun, World Trade and Nursing. *Collegian*, vol. 4(4), 1997. pp. 32-33 and 40.

[9] Maroun, op. cit.

registration exam. And the countries of central, south, and eastern Africa, working through the East, Central and South African College of Nursing, are drawing up common standards and competencies. The aim in both regions is to enhance nurse mobility and to ensure quality nursing care.

While considerable work is under way to decrease barriers, meeting licensure requirements usually means nurses must pass language exams. Because degrees, diplomas and continuing education obtained abroad may not be considered equivalent, upgrading courses may be required. Often the nurse must pass a licensing exam prior to being allowed to practice.

Aside from regulatory barriers, language is perhaps the greatest obstacle nurses face. Ability to converse with patients and providers is critical if safe, quality care is to be provided. Residency requirements pose problems in some countries though trade initiatives are discouraging these. Establishing and maintaining a balance between trade considerations, such as nondiscrimination, and the quality of care concerns that may arise with itinerant practice, present new challenges for governments and the professions.

Once hired there remain a number of challenges for the new employee. If the nurse has been recruited by an agency there may be hidden charges such as agency fees. Some nurses have experienced an imposed unpaid orientation period, a different rate of pay from that of nationals, and different working conditions. There is anecdotal evidence of recruited nurses required to do more night or weekend shifts or work in less "popular" or prestigious units.

Other difficulties the new immigrant must overcome include cultural adjustments. Working in vastly different cultures, nurses unaccustomed to the different mores and traditions may experience ethical dilemmas. Different modes of practice and, in some instances, real limitations in terms of supplies, equipment, and therapies evoke ethical queries. Counselling about the new culture as well as advice on labour and licensing laws in the host country will help to some degree.

TRENDS, ISSUES AND OPPORTUNITIES

There is no doubt that the freedom to choose to move should be the right of every nurse. At the same time it is important that mobility not be used as the routine approach to managing nursing resources. To do so delays consideration of effective local measures that would improve recruitment and retention, and long-term health planning of human resources[10].

Nursing leaders readily agree that nurse migration has both positive and negative aspects. The impact on quality care is a primary concern for the profession, particularly when it creates a brain drain. It is acknowledged as a needed temporary means to provide experts skilled in an area. However, when

[10] ICN, op. cit., 1992.

masses of nurses leave a country it means making do with less skilled or fewer staff. This is currently a fear for parts of central, south and eastern Africa as new opportunities open up in South Africa.

One positive aspect of nurses going abroad to work is that they bring back new ideas and ways of doing things. For the same reason nurses from abroad bring new ideas and methods to the host work place[11]. In many instances the alternative to employing out-of-country nurses is to "make do" with a different skill mix or fewer staff. This results in poorer standards, more complicated care giving and greatly increased needs for supervision by qualified personnel. The use of experienced clinical nurses to supervise auxiliary staff often removes the nurse from direct patient care and underutilizes valuable competencies.

Nurse leaders emphasize the importance that the out-of-country nurses should be culturally sensitive, know the language, and not agree to accept less pay than nationals receive. In some countries non nationals are displacing more experienced nationals and this creates tremendous strain in the work environment. And, in the backlash to limited employment opportunities for their own citizens, some countries are restricting immigration of nurses.

Concern for quality care also requires the professions and the public to insist on standards that ensure the public access to competent nursing care. This means that effective planning of nursing resources must be in place, with sound linkages to broader planning of health human resources, and to health system planning and public policy in general. It also means that global standards and ways to monitor, test, and improve national standards need to be in place.

Open borders offer opportunities for nurses to practice in new as well as traditional ways. Advances in technology provide almost endless learning experiences. Consultation, video visits, teaching and therapy can be provided even when the nurse is on another continent. Rapid transit means nurses can physically serve clients in a number of countries on the same day.

Globalization has created wide interest in competencies, standards, regulation, and collaborative approaches. Strategic alliances are commonplace in nursing education, research and practice. Hospitals and agencies in one country are managing health care in many others far distant and distinct from their own. Transnational chains of health facilities are increasingly more common.

We are seeing more government emphasis on competencies than credentials for regulatory purposes, and increased interest by the public in credentials as evidence of excellence. More emphasis in all spheres of nursing is being placed on transcultural concepts and international health is being taught as part of many nursing programs. International semestering is becoming more common and universities are more open to giving credits for courses taken in foreign universities. Considerable changes in regulation will be required shortly to accommodate the need for new modes of international recognition for programs and people.

[11] International Council of Nurses, *Career Mobility in Nursing*. Geneva, 1993.

Today, nurses from different countries collaborate on joint projects in education, management, research and care delivery. At the heart of each initiative is a determination to enhance nursing practice and people's health world wide. To succeed, ease of access to new opportunities is critical. We look forward to the day when excellence in nursing knows no borders.