Editorial

Nursing workforce education, migration and the quality of health care: a global challenge

Throughout the world, the supply of skilled nurses is notoriously volatile, with major shifts into and out of the workforce as economies fluctuate. In the USA, Staiger et al. [1, 2] believe that the current surge in new registered nurse (RN) graduates will only partially alleviate future shortages. They predict that when the US unemployment rate drops to 6.5%, large numbers of nurses will retire or return to part time work leading to a return of regional shortages. They further suggest that the unprecedented expansion of health-care insurance coverage beginning in 2014 under the US Affordable Care Act of 2010 will likely increase the demand for nurses just as the supply is declining.

Shifts in the US nursing labor market affect the nursing workforce in many other countries. Like many developed nations, during nursing shortages the USA turns to international recruitment. As the last 7-year nursing shortage began to wane, fully 12.2% of newly licensed nurses in 2007 were foreign educated, according to the National Council of State Boards of Nurses. During those years a major constraint on international recruitment was the country visa caps, which led to a backlog of nurses awaiting visas in countries like the Philippines and India. However, US immigration reform in 2013 may remove these caps enabling tens of thousands of foreign-educated nurses (FENs), who are already pre-approved for visas and waiting in the queue, to emigrate to migrate to the USA [3].

The volatility of the international demand for nurses likely has major implications for the quality of care in the USA and in sending nations. In destination countries, research to date clearly demonstrates that more nurses are better. Years of research has shown that lower nurse-to-patient staffing ratios save lives [4]. In the poorest sending nations, exploratory research suggests that massive out-migration has had a negative impact on quality [5, 6]. On the other hand, some nations, such as the Philippines and India, purposely overproduce nurses with the intent of promoting migration and increasing remittances. Understanding the impact of this ‘export model’ on quality of care in sending nations is a complex research challenge that has yet to be seriously undertaken.

Returning to the question of how international nurse recruitment affects the quality of care in the USA, Felber and Aiken’s study in the period of 2006–07 is the first to examine the impact of additional FENs under varied conditions. Their study offers a point of departure for research on the relationship between international recruitment patterns and the quality of care in the USA and in other countries. The authors find that among hospitals with inadequate nurse staffing ratios, high reliance on FENs, in particular over 25% FENs on staff, is associated with higher rates of mortality and failure to rescue. They offer as one possible explanation that hospitals with adequate staffing ratios are better able to supervise FENs.

As with all research that attempts to associate a certain class of worker with outcomes, it is especially important to be cautious about policy conclusions in advance of fully understanding the causal pathways that may be at play.

The key challenge of this study is potential sample bias, be it at the level of hospital variation, including management styles, or the FEN population itself. We know, for example, that FENs are not a monolithic group. Indeed, it is possible that the circumstances of their recruitment and integration into the USA could be an even more important factor than the fact that they were born in, and received their nursing education, in a country other than the USA.

Since the central independent variable of this study is ‘foreign educated’, let us begin with variation in nursing education among countries. The conceptual model assumes that nursing education in Canada, Philippines, India, South Korea and Jamaica, just to name a few of the countries that account for a high level of nurse migration, may be radically different from that in the USA. Interestingly, however, when the authors controlled for being Canadian, they found no effect on their results. Since the Canadian’s nursing education system is probably the most similar to the USA [7], the question arises as to whether other specific countries should be included in the model.

Or perhaps something else is driving the observed differences. I would argue that ‘time in the Unites States’ could be a critical variable for at least two reasons. First, based on the American Community Survey, we know that more than two-thirds of foreign-born nurses that entered the USA after age 21 are US citizens [8]. Presumably FENs who are US citizens are different from those who recently arrived; they are likely to be better acclimated to the US health-care system, and differences in culture and language are likely mitigated.
The second reason that ‘time in the USA’ could matter concerns the types of contracts most FENs have to sign when they are first recruited. Recruitment can happen in four different ways: (i) self-directed through the internet or social networks, (ii) directly by an employer, (iii) through a placement agency that is usually paid by the employer per person recruited and (iv) through international staffing agencies that recruit, employ and then ‘lease’ FENs to hospitals on a long-term basis [9]. When a contract is signed before a nurse migrates, wages are often set without accounting for work experience and the nurse often enters with an entry-level position. FENs stay in these jobs because contracts commit them for up to 4 years and include high penalties for those who resign. These wage disparities have been confirmed in the National Sample Survey of RNs. On average, FENs earn 7% less than their American counterparts during their early years in the USA. But after 6 years, FENs tend to earn more than American nurses largely because their education levels are higher and they work more hours [10].

A survey of FENs recruited the USA between 2003 and 2007 suggested additional challenges for immigrant nurses. Just over 50% of FENs in the survey experienced one or more of the abuses addressed in the ‘Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Health Professionals to the United States’, such as having documents withheld, not receiving copies of the contract, modification of a contract without consent and not knowing their work location on arrival in the USA. [11, 12]. FENs recruited by international staffing agencies had the highest odds of experiencing problems.

Should future research confirm that either time in the USA, or type of recruitment contract prove to be associated with lower quality of care, the policy implications would, of course, be quite different than those suggested by Felber and Aiken. Rather than suggesting that international recruitment should be eliminated, the focus would logically be on supporting FENs with better clinical, cultural and language programs. Indeed, if hospitals with poor nurse staffing ratios are the ones that have neglected to provide transition programs for their new arrivals, those institutions should take note. Developing such programs would be consistent with the recent Institute of Medicine report on the Future of Nursing, which called for residency programs to help both new graduates, and those transitioning from one practice setting to another [13].

Similarly, should the recruitment contract turn out to be a key driver of poor quality, the policy focus should be on making the marketplace for FENs more fair and transparent. Issues such as the lack of labor mobility and wage discrimination should be addressed through regulations and voluntary codes. More specifically, if future studies determine that hospitals with poor nurse staffing ratios and high FEN dependency are more likely to use international staffing companies, then the emphasis should be on the practices of these agencies.

The quality implications for other countries are also complex. To be sure, all nations should strive to be largely self-sufficient in the education of their health workforce. Moreover, the recruitment of nurses from nations experiencing severe health workforce shortages has ethical implications that go beyond the question of quality outcomes. Both the notion of self-sufficiency and the impact on countries’ healthcare systems should be taken seriously, and have indeed been enshrined in the ‘World Health Organization Global Code of Practice on the International Recruitment of Health Personnel’ [14]. But for those nations like India and the Philippines that have thousands of nursing that trained with the intent to migrate, and no decent jobs for them at home, the ethical implications deserve further reflection. In their case, shutting them out of nursing jobs in countries with high demand for nursing services on the basis of quality seems, at best, premature.

References

12. Voluntary code of ethical conduct for the recruitment of foreign-educated health professionals to the United States, 2008.


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