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Imported Care: Recruiting Foreign Nurses To U.S. Health Care Facilities

Importing nurses is likely to remain a viable and lucrative strategy for plugging holes in the U.S. nurse workforce.

by Barbara L. Brush, Julie Sochalski, and Anne M. Berger

ABSTRACT: As U.S. health care facilities struggle to fill current registered nurse staffing vacancies, a more critical nurse undersupply is predicted over the next twenty years. In response, many institutions are doubling their efforts to attract and retain nurses. To that end, foreign nurses are increasingly being sought, creating a lucrative business for new recruiting agencies both at home and abroad. This paper examines past and current foreign nurse use as a response to nurse shortages and its implications for domestic and global nurse workforce policies.

WITHIN THE FIRST TWO DECADES of the twenty-first century, the U.S. population is projected to grow at least 18 percent, and the population age sixty-five and older will increase at three times that rate.[1] Meeting the demand for registered nurses (RNs) that an aging population will require will be a challenge. The U.S. Department of Health and Human Services (HHS) estimated that the United States was weathering a shortfall of 111,000 full-time-equivalent (FTE) RNs in 2000 and projected that this figure will grow to 275,000 by 2010.[2] That imbalance will nearly triple in the subsequent decade, reaching a shortfall of 800,000 FTE RNs by 2020.

This looming crisis has spurred public- and private-sector health care leaders to advocate for serious and creative solutions to bolster RN supply. U.S. health care facilities, which confront the nursing shortage twenty-four hours a day, are adopting a host of strategies to attract nurses to fill current nursing vacancies and to stave off future shortfalls.[3] Among these strategies is the recruitment and employment of foreign nurses. This is not a new phenomenon; U.S. health care institutions have done it for more than fifty years. What differs today, however, is the marked expansion of organized international nurse recruitment; the growth of private, for-profit agencies to do this work; and an increasing number of countries

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sending nurses abroad. Many of these countries are poorly positioned to surrender large numbers of qualified nursing staff.[4] The consequences for these sending countries have become the focal point of growing international debate that is rising to the highest policy-making levels, although with little resolution.[5] Overshadowed by that debate, the consequences for nurse migrants and their workplaces, for quality of care and patient outcomes, and for workforce planning efforts have received little attention. Meanwhile, the United States, while not the world's largest recruiter of foreign nurses, is recruiting greater numbers than it ever did in the past and is poised to greatly increase those efforts.[6]

We argue that the demand-driven U.S. nurse shortage represents a strong migratory "pull" factor for nurses throughout the world, which has stimulated the growth of for-profit organizations to serve as brokers to ease the way for nurses to emigrate. This is occurring, however, in the absence of a careful examination of the implications for nurse recruits and the impact on the health care delivery systems that both send and receive them.

The Foreign Nurse Pool: Then And Now

During the past fifty years the United States has regularly imported nurses to ease its nurse shortages.[7] Although the proportion of foreign nurses has never exceeded 5 percent of the U.S. nurse workforce, that figure is now slowly rising.[8]

The Philippines has dominated the nurse migration pipeline to the United States and to other recruiting countries.[9] Indeed, until the mid-1980s Filipino nurses represented 75 percent of all foreign nurses in the U.S. nurse workforce.[10] Their representation dropped to 43 percent by 2000 as more countries began sending nurses abroad.[11]

After slowing in the second half of the 1990s, nurse migration to the United States increased, with the Philippines still leading the way for an even larger group of countries. In 1995 nearly 10,000 foreign nurses received their U.S. RN licenses, representing almost 10 percent of all newly licensed RNs in that year.[12] By 1998 that proportion fell by nearly half, as the number of new foreign nurses entering the U.S. workforce fell more steeply than the number of new U.S. RNs (Exhibit 1). After 1998 the foreign nurse proportion steadily grew, topping 14 percent in 2003. The growth since 2001 is particularly noteworthy because it occurred as the number of U.S.-trained RNs rose, reversing declines since 1995.

Filipino nurses represented more than half of the foreign graduates taking the U.S. licensure exam in 2001 (Exhibit 2). Together, nurses from Canada, the United Kingdom, India, Korea, and Nigeria contributed about half that rate. The remainder were from thirty-five countries that were not found among the 1997 cohort.[13]

Upon coming to the United States, foreign nurses are employed in an increasingly diverse array of settings (Exhibit 3). Like their U.S. counterparts, the percentage of foreign nurses working in hospitals has steadily declined over the past decade, from 79.9 percent to 71.5 percent, as organizational and financing reforms

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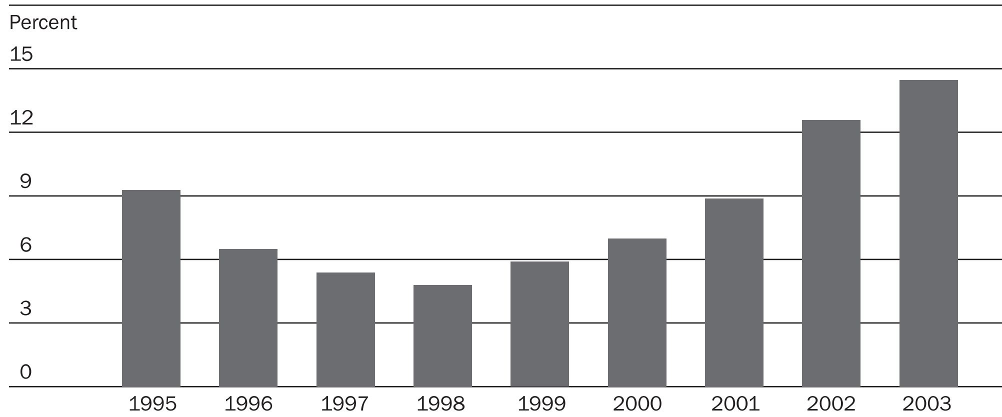
EXHIBIT 1
Percentage Of Newly Licensed Registered Nurses (RNs) In The United States Who Are Foreign Educated, 1995–2003



SOURCE: Authors' calculations using data from the National Council of State Boards of Nursing, various years.

have encouraged movement of patient care out of hospitals. At the same time, their numbers in public/community health and ambulatory settings have grown, also mirroring those of U.S.-trained nurses. Unlike domestic nurses, however, foreign nurse representation in nursing homes has risen from 7.4 percent to 9.3 percent.[14]

The Impact Of Migration: Home And Abroad

Nurses are enticed to leave their home countries by promises of better pay and working conditions; improved learning and practice opportunities; and free travel, licensure, and room and board.[15] Primarily female, nurses often have opportunities for wages unequaled in their own countries and thus become the means for substantial remittances. In 2004 the U.S. Department of Labor reported median annual earnings for RNs in 2002 as $48,090; in hospitals and nursing homes

EXHIBIT 2
Percentage Of First-Time, Foreign-Trained Registered Nurse (RN) Candidates For U.S. Licensure Examination, By Top Six Exporting Countries, 1997–2001

	1997	1998	1999	2000	2001
Total number of candidates	6,574	6,045	6,381	7,506	8,613
Philippines	26.0%	27.0%	29.0%	44.0%	52.0%
Canada	29.0	26.0	21.0	15.0	12.0
Korea	4.0	6.0	11.0	8.0	6.0
India	7.0	6.0	6.0	6.0	4.5
United Kingdom	5.0	5.0	4.0	4.0	3.0
Nigeria	5.0	4.0	4.0	3.0	2.0

SOURCE: Authors' calculations using data from the National Council of State Boards of Nursing, "Licensure and Examination Statistics," 1997–2001.

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EXHIBIT 3
Distribution Of U.S.-Trained And Foreign-Trained Nurses, By Setting, 1992 And 2000

	1992	2000
Hospital		
U.S.-trained	65.8%	58.7%
Foreign-trained	79.9	71.5
Nursing home/extended care facility		
U.S.-trained	7.0	6.9
Foreign-trained	7.4	9.3
Public health/community health		
U.S.-trained	10.0	13.1
Foreign-trained	4.5	8.4
Ambulatory care		
U.S.-trained	11.9	15.4
Foreign-trained	5.8	7.2

SOURCE: Authors' calculations using data from the Division of Nursing, Bureau of Health Professions, National Sample Survey of Registered Nurses, 1992 and 2000.

where foreign nurses worked, earnings averaged $49,190 and $43,850, respectively.[16] These figures contrast sharply with the $2,000–$2,400 annual salaries paid to nurses in the Philippines in 2002.[17]

■ **Shifting the nurse supply.** As the United States and other developed countries look to international nurse recruits to balance their national nurse supply and demand, however, sending countries are increasingly questioning the impact on their own health care systems. In perhaps the most striking example, the *Wall Street Journal* noted that the growing number of Filipino nurses migrating abroad is creating a domestic shortage and beginning to strain the Philippines' health care system rather than providing an economic benefit as it had in previous years.[18] A growing number of other countries are facing a situation similar to that of the Philippines. New offshore recruiting initiatives by developed countries have targeted English-speaking nurses from sub-Saharan Africa, Southeast Asia, and the Caribbean. Experienced nurses, especially those with specialty skills in surgical, neonatal, or critical care nursing, are in particularly high demand.

While the United States has only recently begun active nurse recruitment in South Africa, former Commonwealth countries such as the United Kingdom and Australia have already drawn large numbers of nurses from this area of the world. Between 1998 and 2002 the United Kingdom alone recruited 5,259 nurses from South Africa, along with 1,166 from Nigeria, 1,128 from Zimbabwe, and 449 from Ghana.[19] The accelerated recruitment of experienced African nurses is straining an already fragile health care infrastructure in many African countries, which have been battered by AIDS and deprived of resources because of economic and political upheaval.[20] Sixteen African countries have an average of 100 nurses per 100,000 population; ten countries average fifty nurses per 100,000; nine report twenty per

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100,000; and three have fewer than ten nurses per 100,000.[21] In stark contrast, U.S. and U.K. ratios are 782 and 847 per 100,000, respectively.[22] In 2000 more than double the number of new nursing graduates in Ghana left that country for positions abroad.[23] In response, the Ghanaian government is now begging recruiting nations to cease taking its nurses.[24]

■ **Economic burden.** The loss of qualified nurses places considerable economic pressure on exporting African countries.[25] In 1998 the United Nations Conference for Trade and Development estimated that every professional, ages 25–35, who migrated from South Africa represented an annual loss of $184,000 for that country.[26] Receiving countries obtain the financial benefit of the migrant's professional education and training, while sending countries bear these costs. The loss of valuable workers has been so costly that the South African Nursing Council has proposed an export tariff on nurses leaving to work abroad.[27]

Nurses' Technical And Cultural Competence

A key concern related to foreign nurses is whether they provide high-quality services to U.S. patients. Rosemary Stevens has argued that when discussing quality in an international context, one must distinguish between people's ability to perform specific tasks and their ability to communicate effectively with patients and other professionals to provide culturally appropriate care.[28]

The Commission on Graduates of Foreign Nursing Schools (CGFNS) was established in 1977 to ensure foreign nurses' technical and cultural competence prior to employment in U.S. health care institutions. Modeled after the Educational Commission for Foreign Medical Graduates (ECFMG), CGFNS verifies foreign nurses' credentials and educational qualifications and identifies those at risk for failing the U.S. nurse licensure exam (NCLEX-RN) prior to immigration.[29] A qualifying examination that assesses nursing proficiency and English language comprehension earns nurses a CGFNS certificate and eligibility for nonimmigrant occupational preference visas.[30]

Foreign nurses must supply evidence that they completed prescribed amounts of didactic and clinical instruction as "first-level nurses." Defined by the International Council of Nurses (ICN), this is a measure of technical competence regardless of national background.[31] The final step in the process is passing the NCLEX-RN. Passing nurse licensing and English proficiency tests remains the marker for establishing competence among foreign nurses. No studies to date have determined whether foreign nurses' cultural orientation and technical competence produce differences in patient outcomes when compared with their domestic counterparts.

Crisis And Opportunity

In April 2002 the Workforce Commission for Hospitals and Health Systems, convened by the American Hospital Association (AHA), issued its recommendations to health care leaders for confronting the current nurse shortage and avert-

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ing the predicted shortfall. Flexible staffing options and improved working conditions, methods to simplify work and improve nurses' quality of life, and fostering more meaningful work were prominent among the strategies offered.[32] The AHA has also advocated for federal legislative initiatives that are targeted at building and maintaining the U.S. nursing workforce.[33]

These responses have yet to dampen the strong demand for foreign nurse labor. Hospitals and nursing homes are independently recruiting nurses overseas as well as hiring recruitment agencies to secure nurses on their behalf. Because of the profitability of this latter strategy, new recruitment agencies are cropping up both within the United States and in other recruiting countries. Many U.S.-based agencies also have offices in sending countries to facilitate the process.

■ **The agencies.** In recent years recruitment agencies have been placing foreign nurses in larger numbers in states that attracted both large and small numbers of nurses in the past. In 1992 California and New York were home to nearly half of all foreign nurses in the United States. By 2000 their shares of foreign nurses had declined to 38 percent, while the combined shares of the next most frequent locations—Florida, Illinois, Michigan, New Jersey, and Texas—rose to equal them. More than half of the remaining states saw increases in their shares of foreign nurses.[34]

Venkat Neni's Global Healthcare Recruiters provides a good example of the marketing allure of foreign nurses in states that previously did not typically recruit or employ international nurses. A physician in India before immigrating to the United States, Neni founded his Wisconsin-based agency in 2002. In less than a year he successfully supplied 145 nurses from India to Milwaukee's Columbia St. Mary's and Oshkosh's Mercy Medical Center. In November 2002 he and executives from Covenant Healthcare System in Milwaukee traveled to India and hired another 100 nurses. In an interview with the *Milwaukee Journal Sentinel,* Neni shared his goal to recruit an additional 500 nurses to Wisconsin by 2004, estimating profits to exceed $5 million.[35] Neni's earnings pale in comparison with those of more established firms.[36]

On average, hospitals pay recruiting agencies $5,000–$10,000 per nurse.[37] In return, nurses contract to work from two to three years in the hiring institution. In the Covenant Healthcare System example, Global Healthcare agreed to fully refund the recruiting fee to the hospital if a nurse recruit failed to continue working past three months. The hospital was partially repaid if nurses fell short of their three-year commitment.

■ **The hiring facilities.** Although hospitals agree that the initial cost of recruiting foreign nurses is higher than that of hiring domestic nurses, many feel that they save money in the long run because of reduced turnover and the agency's assurance of full or partial remuneration if recruited nurses fail their contractual obligations. Recruiting abroad may also be less costly than raising salaries, increasing benefits, and providing other economic incentives needed to retain domestic nurses. Under the terms and conditions of hiring foreign nurses from recruiting agencies, therefore,

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hospitals enter into a relatively risk-free arrangement that provides further incentive for procuring staff abroad. Strategies for such recruitment at one facility are described in a 2003 AHA report on workplace innovations.[38]

The advantages of recruiting foreign nurses have had particular appeal for long-term care facilities. Since 1989 nursing homes have secured foreign nurses through an "attestation" process stipulated in the Immigration Nursing Relief Act (INRA).[39] In recent years recruitment agencies have capitalized on the crisis in long-term care staffing, partnering with nursing home operators to provide nurses from several countries.[40] Long-term care institutions will likely continue to look abroad to fill nearly 14,000 staff RN and 25,100 licensed practical nurse (LPN) vacancies.[41]

Implications For The Future

The current U.S. nurse shortage and the profitability in recruiting foreign nurses to fill nurse vacancies will undoubtedly increase the interest in, and pressure for, additional means to increase foreign nurse recruitment. Changes in immigration policy, recruitment practices, and licensure requirements will also permit a greater flow of foreign nurses to U.S. health care facilities. For example, the cost of immigration, initially shouldered by migrating nurses, is now transferred to the facilities themselves. The NCLEX-RN examination is being offered overseas, beginning in 2004, in an effort to facilitate the licensure process.[42] Recruitment agencies are now routinely based in the Philippines, India, and other key locations to aid nurses' access to information, English language classes, and exam preparation courses. Newer recruitment strategies now offer U.S.-based master's-level education to foreign nurses as a further incentive for migration.[43] A recent *San Francisco Chronicle* article reported that as many as 3,000 physicians in the Philippines had begun training to become nurses for export to the United States because of the much higher salaries they could earn.[44]

Although foreign-trained nurses now account for around 5 percent of the total U.S. nursing workforce, they represent a growing percentage of newly licensed nurses. Moreover, growth in the domestic production of nurses since 2002 did not diminish interest in foreign recruitment among employers. Indeed, Peter Buerhaus and his colleagues note sizable growth in the number of foreign-born nurses in the United States during this period.[45] And while interest in foreign nurses accelerates during nurse shortages, it also appears to endure beyond shortage cycles. In 1988, during the last major U.S. nurse shortage, there were 3.7 foreign-trained nurses in the United States per 100 U.S.-trained nurses. In 1996, a time of record domestic nurse production and a slowdown in hospitals' demand for nurses because of industrywide workforce restructuring, the ratio rose to 5.1.[46] Consequently, if nurse vacancies continue in health care facilities, and domestic production falls short of the demand, then foreign nurses are likely to remain a viable and increasingly lucrative strategy for plugging holes in the U.S. nurse workforce.

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■ **Ethics of recruiting.** Increased international recruitment requires that several policy issues be explicitly addressed. The international debate over the responsibilities of recruiting nations toward countries whose nurses are being recruited, many of which are developing countries, has produced a range of proposals—from ethical recruitment guidelines and codes of practice to financial compensation for sending countries.[47] The British National Health Service and the ICN, for example, have both issued ethical guidelines for foreign nurse recruitment.[48] Others have voiced concern about the long-term viability and ethics of foreign nurse recruitment in the face of a global nurse shortage.[49]

To date, the ethical guidelines have had only a modest short-term impact on recruiting practices, and the compensation proposals continue to be debated without resolution. If the United States maintains its role as a major nurse recruiter, then it should join this international dialogue. This dialogue should not be focused solely on recruitment practices but should place equal emphasis on strategies to reform work environments to improve nurse retention and reduce avoidable demand.

■ **Quality issues.** Little is known about whether the quality of nursing care differs between foreign- and U.S.-trained nurses. While the certification process assures competency in educational training and language, differential quality of clinical care has not been assessed. Quality of care could be affected by, among other things, poor orientation and training of new foreign nurses who are assimilating into the U.S. health care system. The development and evaluation of more comprehensive orientation and training activities are warranted and have been recommended by the AHA.[50] An assessment of the quality of care and patient outcomes is likewise needed and should include an appraisal of the cultural competence foreign nurses bring to patient care.[51]

■ **Workforce strategy issues.** Finally, U.S. workforce planning efforts require the development of systems that monitor the inflow of foreign nurses, their countries of origin, the settings where they work, and their impact on the nurse shortage. Increasing demand for foreign nurses in the face of greater domestic production is a signal that domestic efforts are insufficient to keep up with demand. A broader-based workforce strategy that balances foreign nurse recruitment, domestic production, and concerted retention efforts is needed to ensure that the nursing care needs of the public will be met.

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