



Registered Nurses'
Association of Ontario

L'Association des
infirmières et infirmiers
autorisés de l'Ontario

Recruitment of Internationally Educated Nurses (IENs)

Policy Brief

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Executive Summary

Since the 1630s and the arrival of apothecaries, nurses, and surgeons in New France, the people of what is now Canada have benefited from the healing arts of health-care professionals who have been internationally educated. The many contributions that internationally educated nurses (IENs) have made to health-care in Canada, and the many contributions that nurses educated in Canada have made to health-care while nursing internationally, are to be cherished. However, given the global nursing shortage, there is an urgent need to re-evaluate health human resources (HHR) policies that focus on the targeted recruitment of internationally educated nurses to Canada.

Consistent with the Universal Declaration of Human Rights and the position of the International Council of Nurses, the Registered Nurses' Association of Ontario (RNAO) recognizes the human right of individual nurses to migrate. RNAO has been a strong advocate in support of internationally educated nurses who choose to make Ontario their home. For example, the Association endorsed permanent funding for bridging programs for internationally educated nurses in its provincial-election political platform. While recognizing the right of individual nurses to migrate, the International Council of Nurses also "acknowledges the adverse effect that international migration may have on health care quality in countries seriously depleted of their nursing workforce."

The tension between the human right to migrate and the human right to health that is threatened by faltering health-care systems is at the heart of the dilemma of ethical recruitment of health care professionals. This tension is heightened by worsening global trends of economic and health inequalities on the one side and shortage of health care professionals on the other. This background paper outlines some of the underlying dynamics of globalization that are driving escalating nurse migration, identifies pertinent issues within this dilemma, and outlines divergent perspectives on recruitment.

Modern globalization, often characterized as an accelerated movement of information, capital, goods, and people across political and geographical borders, provides the underlying dynamic of nurse migration. A key "push" factor that has driven nurses from their home countries has been economic structural adjustment programs and fiscal restraint programs that resulted in cuts to health services, increased casualization of the nursing workforce, and nursing unemployment. Both industrialized and developing countries alike are faced with the paradox of nursing shortages existing alongside unemployed nurses.

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A key ethical concern in a context of global shortage of 4.3 million health workers is the growing disparity as poor nations with the fewest nurses lose them to wealthy countries with the most nurses. Africa is a compelling example of a region suffering from an exodus of health professionals. In that region, structural adjustment pushes nurses away by lowering standards of living and compromising work environments at the same time as

international recruitment pulls them to more affluent countries. While the Philippines is often

given as an ethical source from which to recruit nurses, new evidence suggests that the impact of massive nurse and physician-turned-nurse migration is increasing health disparities, especially in rural areas and among vulnerable populations.

Perceiving and utilizing IENs as a quick fix for developed countries that have not addressed their own HHR needs has a negative impact on those nations as well. Normalizing and expanding recruitment of IENs has potential implications for public safety, the viability of nursing as a self-regulating profession, and for the sustainability of the nursing workforce. Trade agreements and pressure to facilitate nurse migration raise significant concerns about threats of downward harmonization of nursing credentials that run counter to both public safety and self-regulation.

Is it possible to have “ethical” international recruitment? The evidence suggests that existing frameworks for ethical recruitment provide an insufficient basis to establish real-world recruitment efforts that are, in fact, ethical. Such is the case with the International Council of Nurses’ key principles to support an ethical framework for nurse recruitment. These principles are contingent on the International Council of Nurses’ premise which “condemns the practice of recruiting nurses to countries where authorities have failed to implement sound human resource planning and to seriously address problems which cause nurses to leave the profession and discourage them from returning to nursing.” It is a major concern that the ICN principles are not identifiable in any of the country examples this paper explores. Not a single developed or developing country effort, including the Canadian experience, actually responds to these principles in a visible way. In fact, in a recent analysis of policy responses to global health human resources flows, improved domestic HHR self-sufficiency was described as “widely endorsed but not followed.”

RNAO’s position is that the individual human right to migrate is not in question. What is in question are HHR policies in wealthy countries such as Canada that target HHR from poor countries as a solution to domestically created nursing shortages. RNAO fully recognizes Canada’s nursing shortage, and, alongside others, is working diligently to resolve it. Local solutions are both necessary and possible. The Association has consistently argued that this is a Canadian problem, and it demands Canadian solutions. In a number of research and policy documents, briefing notes, and election platforms over the years, RNAO has spelled out critical policies that are essential to resolve this challenge. These policies are not only feasible but also desirable to raise the quality of care for, and the health status of, Canadians.

Some of these policies are well underway and the results are extremely positive. This is the case with Ontario’s actions in recent years to increase the number of nurses, to increase the proportion working full time, to guarantee full-time work for new graduates, and to expand roles for nurses. Still, as our recommendations suggest, much remains to be done both in Ontario and across the country, including:

- Ensuring that government and those health organizations funded by the government do not engage in international recruitment of nurses and other health professionals.
- Ensuring that internationally educated nurses who make Ontario their new home face no systemic barriers to practise their profession.

- Establishing permanent funding for existing upgrading and bridging programs for internationally educated nurses who make Ontario their new home.
- Strengthening local HHR capacity through:
 - Substantive investments in nursing education across the country, including infrastructure, faculty and nursing seats.
 - Continued investment in workplace health, including adequate workloads, employment arrangements that match nurses' needs, professional opportunities, and best management practices.
 - Continued investments in patient safety and quality patient care, including continuity of care and care provider, best practices in clinical care, and improved interdisciplinary work.

The Association knows that these and other local solutions, designed to tackle the specific needs of jurisdictions and communities, will address the shortage of nursing and other health-care professionals. Trying to resolve our problems on the backs of other jurisdictions will only aggravate nursing shortages, including the one in Canada, on a global scale.

Introduction

Since the 1630s with the arrival of apothecaries, nurses, and surgeons to New France,¹ the people of what is now Canada have benefited from the healing arts of health-care professionals who have been internationally educated. The many contributions that internationally educated nurses (IENs) have made to health-care in Canada, and the many contributions that nurses educated in Canada have made to health-care while nursing internationally, are to be cherished. However, given the global nursing shortage, there is an urgent need to reevaluate health human resources (HHR) policies that focus on targeted recruitment of internationally educated nurses to Canada.

Consistent with the Universal Declaration of Human Rights² and the position of the International Council of Nurses,^{3 4} the Registered Nurses' Association of Ontario (RNAO) recognizes the human right of individual nurses to migrate. RNAO has been a strong advocate in support of internationally educated nurses who choose to make Ontario their home. For example, the Association endorsed permanent funding for bridging programs for internationally educated nurses in its provincial-election political platform.⁵ While recognizing the right of individual nurses to migrate, the International Council of Nurses also "acknowledges the adverse effect that international migration may have on health care quality in countries seriously depleted of their nursing workforce."⁶

The tension between the human right to migrate and the human right to health that is threatened by faltering health care systems⁷ is at the heart of the dilemma of ethical recruitment of health-care professionals. This tension is heightened by worsening global trends of economic and health inequalities on the one side and shortage of health care professionals on the other. This background paper will outline some of the underlying dynamics of globalization that are driving escalating nurse migration, identify pertinent issues within this dilemma, and outline divergent perspectives on recruitment.

Globalization as Underlying Dynamic of Nurse Migration

Modern globalization has been characterized as an accelerated movement of information, capital, goods, and people across geographical and political borders.⁸ The underlying ideology of globalization is neoliberalism, which asserts that market forces, left unfettered, lead to optimal societal outcomes.⁹ Nation states and their populations are urged to adopt "a triple prescription" of economic and political policies that: open their borders to trade; pursue deregulation policies of capital, labour, and the environment; and privatize many state functions.¹⁰ A side-effect of this triple prescription of trade liberalization, deregulation, and privatization is the "shrinking" or devolving role for the state and its ability to serve as an equalizing force in society.¹¹ Transnational corporations as "globalization's primary engines"¹² are associated with "formidable power and mobility" that "undermine the effectiveness of national governments to carry out essential policies"¹³ such as education, health, housing, and rural development. A global economy built around flexible or "just-in-time production" using enhanced information, communication, and transportation¹⁴ enables transnational corporations to migrate to locations with the cheapest labour, least environmental and labour regulatory oversight, and most

attractive tax structure.¹⁵ Vast wealth has been created by modern globalization, but so have increasing disparities in wealth and health inequities.¹⁶ Those dynamics that undermine the social determinants of health – such as food security, employment, social status, equality and the environment – and which also undermine health-care systems, are illustrated as **Appendix A: Potential Impacts of Globalization on Health and Health Care Systems.**

The danger of abandoning the ideals of state responsibility for universal access to primary health care, as articulated by the 1978 Declaration of Alma Alta, is that unconstrained private markets “are perhaps the most powerful globalizing force driving inequities in health.”¹⁷ The impact of restructuring health-care systems towards privatization increases control of transnational corporations over health services while shifting health-care resources away from universal access to primary health care and public health to more profitable enterprises. Using the logic of the market, these entail primarily specialized and tertiary care services in the main cities catered specifically to those who can afford to pay for such services.

International trade and investment negotiations, such as those to strengthen the General Agreement on Trade in Services (GATS) at the World Trade Organization (WTO), are “a vehicle for the expansion of business opportunities for transnational service corporations.”¹⁸ Corporate lobbies see trade negotiations as an opportunity to push for increased privatization of such essential private services as health care, education, water, and sanitation.¹⁹ Concern about the impact of trade agreements on health-care systems and the specific targeting of mobility of health-care professionals was reinforced during WTO negotiations by a number of demands calling for: limits on the ability of governments to provide and subsidize the public sector; limits on their ability to regulate health-care services in the public good; and opening health services to foreign service providers.²⁰

Furthermore, demands have been raised in international trade negotiations to liberalize the scope for internationally educated workers to work overseas, in particular, in nursing services. Among the demands, there are those to recognize foreign certification, eliminate residency and nationality requirements, eliminate “unnecessary” qualification requirements for nurses, extend “temporary” visas up to three years, and establish a specialized visa for mobility of professionals.²¹ These changes would exacerbate the already critical condition of health-care systems in developing countries, which would be the main recruiting ground for bringing professionals to Canada and other industrialized countries. In Canada, the concern with such demands is that they would likely lead to weakened licensing standards and qualification requirements for health professionals.²²

The impact of trade liberalization, deregulation, privatization, and a devolving role for the state has been especially devastating for developing countries. Economic structural adjustment programs (ESAP) or conditionalities were initiated by the International Monetary Fund (IMF) and the World Bank in response to concerns about debt repayment after the OPEC oil shocks of the 1970s. Countries undergoing structural adjustment were encouraged to devalue their currencies to increase exports, which resulted in decreased purchasing power for local people. Subsidies or price controls for basic food items, fuel, water, public transportation, sanitation, housing, and medicine were reduced or eliminated.²³ Deregulation meant to induce investment of foreign capital resulted in increased foreign ownership, capital mobility, and liberalization of

import controls. Public services in education and health were often privatized as “cost recovery” programs initiated user fees.²⁴

People who are poor, especially women and children, have disproportionately borne the human cost of economic structural adjustment programs.²⁵ ESAPs, “by failing to reduce poverty and often increasing it, have contributed to accelerating” the HIV/AIDS pandemic.²⁶ In those countries most severely affected, three decades of advances in longer life expectancies and reduced infant mortality were “annulled in the 1990’s due to the mutually reinforcing effects of poverty and AIDS.”²⁷ ESAPs have been linked with the “impoverishment of hundreds of millions of people” as “internal purchasing power has collapsed, famines have erupted, health clinics and schools have been closed down...the reforms have been conducive to resurgence of infectious diseases including tuberculosis, malaria, and cholera.”²⁸ Just as the need for health care is escalating, access to, and quality of, health-care services are declining, particularly in rural areas.^{29 30}

Mandatory spending cuts to the public sector, often the largest employer in most developing countries, leads to widespread unemployment as well as dramatic cuts to health services.³¹ How structural adjustment programs affect the health sector and HHR may be illustrated by this example from Cameroon where the requirements of this type of approach

...resulted in suspending recruitment, strict implementation of retirement at 50 or 55, limiting employment to 30 years, suspension of any financial promotion, reduction of additional benefits (housing, travel expenses, etc.), and two salary reductions – totaling 50% and a currency devaluation resulting in an effective income loss of 70% over 15 years...in 1999, jobs in the public sector were about 80% unfilled, and Cameroon had a truly de-motivated workforce.”³²

It is difficult to keep a workforce motivated when those health professionals who remain are struggling to meet sustenance needs for themselves and their families. In addition to income losses from salary reductions and inflation, some health professionals remain unpaid for months. Health workers in Chad, for example, experienced delays of 4 to 7 months before being paid³³ and nurses in some developing countries may have to wait for 9 months before receiving their salaries.³⁴ Remaining health professionals often work in under-staffed facilities that are overburdened with patients (many with HIV/AIDS) and inadequate means to treat them.³⁵ In addition to lacking medication, oxygen, working equipment, and medical supplies, some facilities lack basics such as clean water and adequate lighting.³⁶ Deteriorating clinical conditions where even the most basic equipment and drugs are unavailable, “except those few rich enough to pay for any needed supplies,” leaves nurses demoralized³⁷ as this nurse from Nigeria explains:

We don’t have enough equipment. You see somebody suffering...and you know ‘this is what to do.’ But where are the things to use? And you just have to watch that person giving up. You feel like crying but... you just have to swallow it... it is... making one not to have that job satisfaction.³⁸

While these outcomes are most clearly visible in developing countries, the same logic of “fiscal restraint” is linked to the loss of full-time positions and subsequent casualization of the nursing workforce in Canada.³⁹ Building on the ongoing themes of trade liberalization, deregulation, privatization, and the downsizing of social services that were features of the Brian Mulroney, Margaret Thatcher, and Ronald Reagan governments of the 1980s, the Canadian federal budget brought in by Paul Martin in 1995 slashed transfer payments to the provinces and cut just about every federal program. By the time all the cuts were phased in 1998-1999, federal spending on government programs as a share of GDP had hit its lowest level since the late 1940’s, which, in comparison, was an era when federal expenditures did not include health care, seniors’ benefits, and the unemployment insurance system was much smaller in scale.^{40 41}

While the data on nurse emigration is incomplete, it is estimated that there was a gross outflow of approximately 27,100 RNs who emigrated permanently from Canada to the United States in the 1990s.⁴² This exodus coincides with the “largest employment displacement of nurses in recent Canadian history, characterized by massive layoffs as well as sharp increases in casual, part-time, temporary, and contract work.”⁴³ A choice to aggressively pursue nurses from countries with fewer resources to solve a problem which, while real in Canada, is primarily the result of Canadian political decisions, further deepens the ethical conflict related to this issue.

RNAO’s survey of Ontario RNs who left Canada between 1961 and 2000 found that 62.7% of the respondents identified downsizing, lack of employment opportunities, or lack of full-time employment as key reasons for leaving.⁴⁴ Lack of job opportunities was listed by almost 70% of the respondents who left Ontario in the years 1991 to 2000.⁴⁵ A more recent study of Canadian-educated nurses who migrated to the United States, specifically to North Carolina, affirmed the predominant reason for moving was the search for full-time employment.⁴⁶ A paradox found in industrialized and developing countries alike is that “nursing shortages exist side-by-side with the unemployment of thousands of nurses.”⁴⁷

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While globalization is the underlying dynamic, much of the literature in this area uses the framework and language of “push and pull” factors. These push and pull factors include:⁴⁸

Push Factors:

- **Underfunding of health-service facilities**
- **Poor remuneration and conditions of service, including retirement provision**
- **Lack of opportunities for postgraduate training**
- **Absence of established positions and career opportunities**
- **Governance and health-service management shortcomings**
- **Civil unrest and personal insecurity**

Pull Factors:

- **Greater financial rewards and improved working conditions**
- **Opportunities for further education and career advancement**
- **Attraction of centres of medical and educational excellence**
- **Availability of positions, often combined with active recruitment by prospective employing countries**

Implications of International Recruitment on Canadian Nursing and the Canadian Health-Care System

Between 2000 and 2005, internationally educated nurses made up between 6% and 8% of Canada's RN workforce.⁴⁹ Approximately 30% of these nurses graduated from nursing programs in the Philippines and about 19% graduated from the United Kingdom.⁵⁰ This contrasts with the higher proportion of physicians (22%) who were international medical graduates in 2005.⁵¹ Over half of IENs in Canada work in Ontario and they comprise 10.78% of the provincial workforce.⁵² Ontario is the province that leads in numbers of IENs from Sub-Saharan Africa with South Africa, Ghana, and Nigeria comprising the top three countries represented.⁵³ The most recent data on Canada's internationally educated health care professionals by country and occupation is for 2006 and is attached as **Appendix B**.

Did you know?

The Canadian Nurses Association projects a shortage in Canada of 78,000 RNs by 2011

The Canadian Nurses Association projects a shortage in Canada of 78,000 RNs by 2011 and 113,000 RNs by 2016.⁵⁴ A recent report by the Nursing Health Services Research Unit (NHSRU) stresses that "Ontario does not educate sufficient nurses to avoid a serious shortage in the future."⁵⁵ Given that international competition for

nurses is escalating and that without IENs, the nursing shortage in the province would be more severe, NHSRU suggests that "additional strategies (e.g. allowing nurses to take licensing examinations before migration to Canada) may be warranted."⁵⁶ In order to ensure a sufficient supply of nurses in the future, workforce planners in Ontario are urged to make contingency plans that will "entail decisions about how much emphasis should be placed on increasing nursing school graduates and what efforts should be made to recruit abroad or to encourage resident IENs to become eligible to enter the workforce."⁵⁷

"Ontario does not educate sufficient nurses to avoid a serious shortage in the future"

An alternative approach to recruiting IENs is to visualize the number of nursing seats as a deliberate public policy choice that needs to be problematized.⁵⁸ In 2007, the number of entry-to-practice graduates in Canada reached 9,447.⁵⁹ This was the first time in 30 years that this

number exceeded 9,000. During the same period, Canada's population has grown by approximately 39%.⁶⁰ In fact, in 1971 and 1972, there were 10,058 and 10,083 graduates respectively from Canadian nursing programs.⁶¹ Rather than an immutable force of nature,

support for nursing education and the resulting number of graduates from nursing programs are a function of policy choices and political will. Recent choices to support nursing education are starting to make a difference. In Canada, there was a 12.7% increase in the number of graduates from entry-to-practice programs from 2006 to 2007.⁶² There was a 40.3% increase in Ontario as 2,828 students graduated in 2007 compared with 2,015 in 2006.⁶³

Normalizing and expanding recruitment of IENs as a workforce strategy has potential implications for public safety, the viability of nursing as a self-regulating profession, and the sustainability of the nursing workforce. The Canadian Nurses Association's *Challenges to Self-Regulation* paper outlines many of the global and national challenges to self-regulation and attributes them to: increasing mobility of professionals; growing trade in health services; ongoing health sector reform; greater public interest in the quality of health services; increasing demands for transparency; and HHR issues.⁶⁴ Sweeping changes, especially in Alberta and British Columbia, undermine the nursing profession's ability to self-regulate with the objective of facilitating entry of IENs into the workforce. CNA articulates the concern that "changes are seeming to be pushed forward in order to ensure that the regulatory bodies register more individuals faster and may not have been sufficiently considered with respect to addressing public safety concerns."⁶⁵

Mireille Kingma of the International Council of Nurses notes that the potential power of trade agreements and pressure to facilitate nurse migration raises significant concerns about threats of downward harmonization of nursing credentials that could put in peril, for example, jurisdictional requirements for a four-year university program as entry for practice for nurses.⁶⁶ Governments may be challenged to demonstrate that a given measure established to protect standards is not more "trade-restrictive" than necessary.⁶⁷ The resulting legal and bureaucratic process may become costly and prolonged and the final outcome of a negotiated dispute judgment might be to "the detriment of professional standards."⁶⁸ Professional standards in some jurisdictions are already being diluted. New Mexico and California will take IENs from the Philippines who have not written or who have failed the Philippine national board exam and "have merely passed the U.S. licensing exam. This is a lower standard than the one to which USNs (U.S. educated nurses) are subject in these states."⁶⁹

Perceiving and utilizing IENs as a quick fix for developed countries that have not addressed their own HHR needs has a negative impact on destination countries, as well as on source countries. The International Council of Nurses "condemns the practice of recruiting nurses to countries where authorities have failed to implement sound human resource planning and to seriously address problems which cause nurses to leave the profession and discourage them from returning to nursing."⁷⁰

Importing IENs to work in developed countries is part of the larger dynamic of the feminization of global migration.⁷¹ Barbara Ehrenreich and Arlie Russell Hochschild make a compelling case that in addition to the brain drain, there is now a "care drain" as "women who normally care for the young, the old, and the sick in their own poor countries move to care for the young, the old, and the sick in rich countries, whether as maids or nannies or as day-care and nursing-aides."⁷² A dark side of this massive outsourcing of care work is just how 'hidden in plain sight' this dynamic is. Children being cared for by "two mommies" (the real one and the nanny) are

“learning a vast and tragic global politics. Children see. But they also learn how to disregard what they see. They learn how adults make the visible invisible.”⁷³

Perhaps a more tangible dynamic of concern is the extent to which importing IENs as a “flexible” workforce to meet expanded need replicates the “just-in-time” processes of transnational corporations with their shift from permanent to contingent, part-time, and casual employees.^{74 75} This trend of casualization of the nursing force is problematic given the strong evidence that increasing casualization of the nursing workforce due to health system restructuring has negative impacts on client care and erodes the ultimate sustainability of the nursing workforce.⁷⁶

“In the USA, a guaranteed supply of nurses from abroad means that hospitals do not have to raise nurses’ wages and improve their working conditions; likewise, universities will feel no pressure to raise nursing faculty salaries.”⁷⁷ In 1998, the Texas Nursing Association found that the prevailing wage fell from \$14 to \$11 per hour with the entrance of 500 IENs in an area where several health-care facilities were consolidating and downsizing. All the IENs in this example were found to be in the United States illegally. It was later determined that the lost salary opportunities for U.S. nurses totaled \$13 million over three years.⁷⁸

Wages and working conditions can also be perceived to be driven down by an influx of IENs who are in a more vulnerable position and consequently less prone to agitate for improvements in the working environment through such mechanisms as unionization. As one union organizer explained, “migrant nurses are more trusting of the hospital and more loyal to the institution. Internationally educated nurses don’t wish to rock the boat. Hospitals assume that they can control a foreign workforce more easily, that foreign recruits will be less involved in job action, more reticent to strike and complain.”⁷⁹ Cordial workplace relationships can also be compromised by perceived “reverse discrimination” when homegrown nurses “struggling with the daily realities of the workplace – low salaries, poor working conditions, high workloads, and few acceptable accommodation options – are amazed that the same efforts made to help migrant nurses settle are not routinely extended to them.”⁸⁰

Migrant workers, in general, tend to be disempowered and voiceless, and thus vulnerable to exploitation and discrimination. Many IENs experience exploitation at many points along their journey to their destination country in addition to experiencing racism and discrimination in a variety of forms. One IEN originally from Zambia and now nursing in the United Kingdom said, “I think you are made to realize what colour you are, something that you never thought about at home.”⁸¹ Internationally born nurses in one Canadian study were significantly more likely to be members of visible minorities; work more hours, including overtime; and experience more physical, verbal, and emotional abuse than their Canadian born counterparts.⁸² “Deskilling” and “brain waste,” when the skills and experience of migrant nurses are ignored⁸³ as they are given tasks below their capabilities, is a form of discrimination described as “both an emotional and professional insult.”⁸⁴ IENs recruited to hospital trusts in the United Kingdom are becoming deskilled in technical aspects of their clinical practice; the current practise of recruiting IENs “that are already qualified as trained nurses, has led to more, rather than less, wasteful recruitment practices.”⁸⁵

Human Right to Health Challenged by Growing Disparities

The World Health Organization estimates that there is a global shortage approaching 4.3 million health workers.⁸⁶ The greatest shortage in terms of absolute numbers is in South-East Asia, dominated by the needs of Bangladesh, India, and Indonesia.⁸⁷ Just considering nurses, physicians, and midwives, the estimated shortfall in South-East Asia is 1,164,001 therefore a 50% increase in this workforce is needed.⁸⁸ The greatest shortage in terms of relative need exists in sub-Saharan Africa where an increase of almost 140% is necessary.⁸⁹ With 36 of 46 countries in the African region designated as facing a critical shortage, this area has a shortfall of 817,992 physicians, nurses, and midwives.⁹⁰

Africa is described as the “epicentre of the global health workforce crisis” by the World Health Organization because of the enormous gap between population health needs and supply of health professionals.⁹¹ The African Region has 24% of the global burden of disease but only 3% of the health workers spending less than 1% of the world’s health financing, whereas the Region of the Americas has 10% of the burden of disease, and 37% of the world’s health workers spending 50% of the world health expenditure.⁹²

Africa is described as the “epicentre of the global health workforce crisis”

A key dynamic of concern is the growing disparity as poor nations with the fewest nurses are losing them to wealthy countries with the most nurses.⁹³

Ironically, for every two nurses recruited from overseas to work in the United Kingdom, one nurse certified in the United Kingdom emigrates. Many of these nurses end up in the United States, along with nurses from other developed countries such as Canada, Ireland, and Australia, all of which have their own nursing shortages. In effect, the nursing crisis is global, with developed countries stealing nurses from one another and developing countries subsidizing richer countries with nurses they cannot afford to lose. Entire public health systems are at risk of collapse because of the growing shortage of nurses in the developing world.⁹⁴

Did you know?

Of every two nurses recruited to work in the U.K., one nurse leaves for work in the U.S.

The Commission on the Future of Health Care in Canada, chaired by Roy Romanow, made the compelling argument that “as a member of the international community, Canada has an ethical responsibility to ensure that it does not attempt to solve its

shortages of health-care professionals on the backs of the less powerful, less wealthy and less developed nations.”⁹⁵ That those with the greatest global burden of disease and fewest economic resources are the least able to spare nurses may be illustrated by **Appendix C: Selected Population Health Indicators, Demographic and Economic Data, and Nurse Density.** By combining data from the *Human Development Report 2007/2008* and the *World Health Report 2006*, we can see that countries with the lowest

nurse to population ratio, lowest GDP per capita, youngest populations, highest infant mortality, and lowest life expectancies are subsidizing the areas with the highest nurse-to-population ratio, greatest wealth, older population, lowest infant mortality, and highest life expectancy.

For comparison purposes, please see **Appendix D: Selected Population Health Indicators and Health Care Professional Density by Province and Territory, 2005.**

Africa: Impacts of Recruitment on Source Countries

In 2000, the government of South Africa made an unprecedented appeal to then Minister of Foreign Affairs, Lloyd Axworthy. In 2001, the South African government made the same appeal to provincial and territorial health ministers to stop recruiting physicians and other health-care professionals from South Africa. André Jaquet, South Africa's High Commissioner to Canada, wrote to every health minister:

We are concerned that, given the shortages of health care specialists in Canada, the additional funding might be used to recruit doctors, nurses, oncologists, radiologists, pharmacists and other specialists in South Africa. Targeted recruiting of this nature by regional health authorities in some Canadian provinces in the recent past has already affected South Africa's ability to reform the poor health infrastructure inherited from our apartheid past, and this leaves us even less able to grapple with the serious HIV/AIDS pandemic.⁹⁶

Saskatchewan is the province most reliant on international medical graduates with 52.1% of the province's physicians being educated outside of Canada.⁹⁷ At the time of Jaquet's appeal, almost 1 in 5 of the province's 1,530 physicians (17%) earned their first medical degree in South Africa. These 260 physicians are equivalent to five years' output from the University of Saskatchewan's medical school.⁹⁸ Each physician represents an estimated net savings to Canada in educational costs ranging from \$950,000 for a family physician to \$1.5 million for a specialist.⁹⁹ In response to Jaquet's letter, only the province of Nova Scotia agreed to stop recruiting physicians from South Africa.¹⁰⁰ Saskatchewan's deputy minister of health, Glenda Yeates, when discussing the province's declining of this request said, "there is a free labour market in terms of health professionals."¹⁰¹

Recruitment of health professionals from South Africa remains endemic. The Canadian pharmacy chain, Shoppers Drug Mart, was recently described in a *Canadian Medical Association Journal* (CMAJ) editorial as "Poachers Drug Mart" for continued "active, targeted and systemic recruiting of employable pharmacists and other health professionals—better known as poaching—from South Africa's talent pool."¹⁰² A South African physician responding to this CMAJ article described his experience of being actively recruited and in turn, actively recruiting others:

I was recruited with paid airfare and travel costs, assistance with immigration, a lucrative contract with free housing and an income guarantee. Hundreds of other

South African physicians in Saskatchewan and Alberta have also been enticed to come to Canada. When I was in practice in small-town Saskatchewan, I in turn traveled to South Africa twice to recruit physicians to join my Canadian practice. The Regina Qu'Appelle Health Region recently went on recruitment drives to the United Kingdom and to the Philippines and proudly announced its successes in the local newspaper.¹⁰³

A recently published interview with Siphokazi Phillip, international relations coordinator for DENOSA, the professional association for South Africa's nurses revealed that:

...the recruitment of "all categories of health workers, with nursing being the most affected" continues apace in South Africa. He emphasized that Western health care associations recruit overtly through regular newspaper and magazine advertising campaigns. The biggest offenders, he says, are the US, Canada, Saudi Arabia, and the UK—apparently notwithstanding the efforts of the NHS and Britain's parliament—and such actions have dire "implications for the country, because they further deepen the staff shortages we have had for many years. The gap is getting wider."¹⁰⁴

Nurses constitute 45 to 60 per cent of the entire health workforce in Sub-Saharan Africa and they are responsible for providing a broad range of health services.¹⁰⁵ At discussions held at the World Health Assembly in 2004, African ministers reported that in the smallest countries in the regions, with populations of less than one million, the loss of even one skilled health care worker is significant.¹⁰⁶ One example is the Centre for Spinal Injuries in Boxburg, South Africa, which served several countries in the region, and which was forced to close when they could not find any replacements for their two anesthetists who were recruited to Canada.¹⁰⁷ The closure of health facilities and deteriorating quality of health services as overworked and sometimes unqualified staff attempt to substitute is "robbing some people from any meaningful access to health care."¹⁰⁸ From a 2004 report to the WHO executive board, we learn:

The heavy workload on staff working in difficult conditions – in one country, the outpatient attendance-to-nurse ratio rose from 623 in 1995 to 963 in 2000 at district hospital level – results in long waiting times for patients. Furthermore, inequity in access to health care is increasing. Rural areas have always been disadvantaged, but, with loss of health workers, some health facilities no longer function or are run by unqualified staff. The quality of education has reportedly declined in nursing and midwifery schools owing to emigration of teaching staff, and the remaining trainers are unable to cope with demand... Lack of supervision and mentoring is also a concern; senior, experienced staff are being lost through emigration.¹⁰⁹

Two forms of economic effects that are often identified are based on (i) lost investment in the training of those who emigrate and (ii) loss to national gross domestic product of contributions from departed health professionals.¹¹⁰ It is estimated that Ghana has lost \$60 million in training investment from health worker migration and that physicians leaving South Africa between 1989 and 1997 caused a loss of \$5 billion.¹¹¹ A study from Kenya found that the cost of educating one

nurse from primary school to college of health sciences is US \$43,180, and for every nurse that emigrates, Kenya loses about US \$338,868 worth of returns from investments.¹¹²

In January 2008, British Columbia announced the success of its targeted recruitment effort with the hiring of 521 nurses over two years from the United Kingdom.¹¹³ These experienced nurses were recruited with more than one year UK work experience in specialty areas and “may originally be from communities around the British Isles as well as countries such as Ghana, Jamaica, India, Zimbabwe and the Philippines.”¹¹⁴ It is important to understand the “pivotal role of the UK” in the loss of health professionals from Sub-Saharan Africa.¹¹⁵ In order to alleviate the nursing shortage in the UK, the National Health Service (NHS) employed a strategy of international nurse recruitment. In England, the NHS target was to increase the number of nurses by 20,000 by 2004 and this was accomplished by early 2002.¹¹⁶ A “major contribution” to meeting this staffing goal was accomplished by rapid and sustained growth in the level of international recruitment of nurses.¹¹⁷ More than 50% of the new nurse registrants in the UK were IENs in 2001 compared with approximately 20% just five years earlier.¹¹⁸ In 2002, Malawi lost almost 12% of its total estimated nurse stock with the new registration of 75 nurses in the UK.¹¹⁹ Data from the United Kingdom illustrates the differential impact of nurse migration on the source country nurse stock in **Appendix E**.

The United Kingdom is an important example in that the NHS has had guidelines for its employers requiring them not to target recruitment from South Africa or the West Indies since 1999. A Code of Practice for international recruitment for NHS employers was introduced in 2001 and revised in 2004.¹²⁰ It has been argued that the “overall impact of the Code is difficult to assess, given data limitations.”¹²¹ Longer-term trends in entrants do seem to indicate, however, that “there has been little sign of any consistent trend of reduction in inflow of nurses” from sub-Saharan Africa to the United Kingdom.¹²² In 2004-2005, more than 3,000 nurses entered the U.K. nursing register from developing countries on the “banned” list.¹²³ In 2004, “just two months after the health secretary, John Reid, pledged to strengthen the code of conduct on ethical recruitment,” the “erosion” of the Code “comes as hospitals with foundation status are to be exempt from a statutory obligation to adhere to the guideline.”¹²⁴ Under pressure to reduce waiting lists for knee and hip surgeries, the Department of Health “seemed to abandon its own principles and signed contracts to bring Netcare South African nurses on short-term contracts to help meet its targeted waiting list reductions.”¹²⁵

Exploring the “Philippines Model”¹²⁶

The Philippines has been described as the leader “in global nurse emigration”¹²⁷ and as the “largest exporter of nurses worldwide.”¹²⁸ It has been estimated that by the start of the 21st century that there were 250,000 Filipino nurses employed throughout the world.¹²⁹ However, precise figures on nurse migration from the Philippines are difficult to obtain and “generally underreported.”¹³⁰ From 1992 to 2003, the three top destinations of Filipino emigrant nurses have been Saudi Arabia, the United States, and the United Kingdom. These countries have employed 56.8, 13.14, and 12.25 per cent, respectively, of the cumulative total of Filipino nurses that have emigrated since 1992.¹³¹ Other common destinations listed for deployed Filipino nurses are Libya, United Arab Emirates, Ireland, Singapore, Kuwait, Qatar, and Brunei.¹³²

Recruiting nurses from the Philippines has been recommended as a staffing strategy as there is a surplus of nurses wanting to emigrate and nurse migration is an economic development strategy supported by the government of the Philippines.¹³³ Filipino nurses are “in great demand because they are primarily educated in college-degree programs, communicate well in English, and because governments have deemed the Philippines to be an ethical source of nurses.”¹³⁴ Producing nurses to export for financial gain has “stimulated several source countries, including India, Korea, and China, to adopt the ‘Philippines’ model.”¹³⁵ Aiken et al. would add some of the Newly Independent States of the former Soviet Union to the list and notes that this model is “based mainly on provision of private-sector education.”¹³⁶

The Philippines has been described as the leader “in global nurse emigration”

Starting in 1966, the Philippine government “deliberately encouraged entrepreneurial activity in the area of nursing education.”¹³⁷ As the table below demonstrates, the number of nursing schools in the Philippines has dramatically increased, almost doubling in number from 1998 to 2005. Rapid increases in the number of nursing programs have been accompanied by declines in the national pass rate of the Philippines national nurse licensure examination from 85% in the 1970s and 1980s, to only 45% to 54% between 2001 and 2004.¹³⁸ The 119 new nursing programs opened between 2004 and 2005 were mainly located in urban communities and 43 offered “abbreviated evening and weekend programs tailored to physicians.”¹³⁹ Given the evidence of programs with low pass rates, inadequate curriculum, and “ghost faculty,” the government forced 23 nursing programs to close in November 2004.¹⁴⁰

Number of Nursing Schools in the Philippines and Philippines Nursing Board Performance for Selected Years

Year	Number of Nursing Schools	Number of Examinees	Number of those who Passed	Passing (%)
1950	17			
1965	46			
1974	88			
1998	198	17,101	9,541	55.8
2004	251	25,294	12,581	49.7
2005	370	50,280	29,951	51.6

Source: 1950-1974 Brush, B. (1995). The Rockefeller Agenda for American/Philippines Nursing Relations. *Western Journal of Nursing Research*. 17 (5), 541.

1990’s-2005, performance Brush, B. & Sochalski, J. (2007). International Nurse Migration: Lessons from the Philippines. *Policy, Politics, & Nursing Practice*. 8 (37), 40, 41, 44.

Nurses’ average monthly wages in the Philippines of US \$170 (\$2,040 per year) cannot compete with salaries of nurses in developed countries.¹⁴¹ Given that “nurses working overseas can make in 1 year what it would take 20 years to earn at home,”¹⁴² it is perhaps not surprising that other professionals are migrating to nursing. In order to obtain employment in the United States and

improve their earning power and pension benefits, in 2004 “numerous Filipino engineers and lawyers – and even one fifty-five-year-old judge—took the nursing licensure exam.”¹⁴³ With Filipino physicians earning US \$300 to \$800 per month,¹⁴⁴ there is “new and growing phenomenon” of physicians retraining as nurses (known as “nurse medics”). In 2001, approximately 2,000 physicians became nurse medics, by 2003 that number had increased to about 3,000, and in 2005, there were approximately 4,000 physicians enrolled in nursing schools nationally.¹⁴⁵ The result of this professional migration is that in 2004, the Philippines Hospital Association estimated that 80 per cent of all public sector physicians had already, or were currently, re-training as nurses.¹⁴⁶

Did you know?

A nurses’ average monthly wage in the Philippines is \$170 US

Researchers note that “hard evidence regarding the impact of massive nurse migration is only now beginning to be assembled.”¹⁴⁷ The Philippine Hospital Association reports that 200 hospitals closed over 2003-2005 due to staff shortages and that 800

hospitals have partially closed services in several wards.¹⁴⁸ Nurse-to-patient ratios in district and provincial hospitals have gotten worse as they have increased from one nurse to between 15 and 20 patients in the 1990s to one nurse for between 40 and 60 patients currently.¹⁴⁹ The continual loss of experienced nurses means that there is a perpetually negative effect on the training of staff replacements and a negative impact on quality of patient care.¹⁵⁰ The National Statistics Office has found that in 2002-2003, the proportion of Filipinos dying without medical attention has reverted to 1975 levels with 70 % of deaths unattended.¹⁵¹ Declining access to health services is also marked by a drop in immunization rates among children, which have dropped from 69.4 per cent in 1993 to 59.9 per cent in 2003.¹⁵²

Remittances from overseas Filipino workers engaged in all occupations increased from US \$290.85 million in 1978 to US \$10.7 billion in 2005.¹⁵³ Focus groups done with Filipino health care workers, some of whom planned to leave the Philippines, “revealed that individual migrants and their families were seen as primary winners of the exodus” while the respondents viewed “the Filipino health-care system and society in general as the losers in the migration equation.”¹⁵⁴ A nurse educator who owns a “training center for nurses bound for abroad” has expressed the view that “while Filipinos are still the preferred health workers, they may soon be facing stiff competition from the Chinese and the Indians who have come to realize the financial windfall from the export of nurses to developed countries.”¹⁵⁵

This is not a question only of individual decisions to emigrate; instead, it is about explicit economic policies driven by international organizations such as the World Bank that actively promote such an agenda.¹⁵⁶ As countries start to run out of natural resources to export, they are being encouraged to start exporting their people. The re-packaging of human beings, in this case nurses, as exportable ‘commodities’ calls into question the whole concept of ‘human’ rights. The New Economics Foundation points out that global inequities in wealth, wages, and opportunities are driving migration, and “remittance euphoria” can obscure the reality that the poverty-reduction impact of remittances is limited and may be seen as a substitution for more sustainable development strategies.¹⁵⁷

The construction of human beings as exportable sources of revenue inherently places them and their families in a vulnerable position. The accounting of hard currency does not take into consideration the social costs of migration. Nurses and their families are torn apart in order to build a future. Although migration is often presented as a “personal choice,” in fact, “that yawning gap between rich and poor countries is itself a form of coercion, pushing Third World mothers to seek work in the First for lack of options closer to home.”¹⁵⁸ For millions of people seeking a better life, “migration has become a private solution to a public problem.”¹⁵⁹ This private solution has caused Filipino children to “suffer from the extraction of care from the global south to the global north.”¹⁶⁰ Kingma points out that Filipino nurses, who have the longest history with migration, may also have the longest history of abuse.¹⁶¹

Political Economy of International Recruitment

Recruiting IENs is not a series of isolated activities but a confluence of economic and political factors engaged in by a variety of actors, active both in the developed (destination) and the developing (source) countries. Recruitment of IENs across the globe is a profitable industry and a source of financial and political capital for a number of stakeholders, including:

- “Intellectual Manufacturing Sector”¹⁶² or Nursing Education: Both for-profit, private nursing educational programs and entrepreneurial, public nursing educational programs find educating nurses for export to be profitable.¹⁶³ Private programs that charge “exorbitant prices” force students into heavy debt, which in turn is an incentive to find better-paying jobs overseas in order to repay loans.¹⁶⁴ Efforts to regulate the proliferation of nursing programs may be thwarted by those who control nursing education programs and who may not be nurses. The Dean of the University of the Philippines College of Nursing, Leonor Malay, said, “despite our Herculean efforts to stop the opening of more and more colleges and schools, we are helpless because the hospitals that open these schools are owned by doctors, who as a group are very strong and powerful.”¹⁶⁵
- Health-Care Organizations and Hospitals: Examples of entrepreneurial health-care organizations include private hospitals setting up companies for the sole purpose of grooming Indian nurses for foreign export.¹⁶⁶ Moving from Asia to Africa, a private health-care organization in South Africa, Network Healthcare Holdings, runs five nursing schools with two thousand entry-level nurses in training to ensure its labour supply.¹⁶⁷
- Evolving Role of Recruitment Agencies: While previously recruitment agencies mainly served to broker information on employment opportunities, today some recruitment agencies are financing and offering scholarships and establishing educational institutions of their own.¹⁶⁸ Recruitment agencies in India have found that an investment of US\$4,700-7,000 in training a nurse can earn as much as \$47,000 once the nurse is placed abroad.¹⁶⁹
- Employers: “The nursing and care labour markets respond, like other labour markets, to opportunities for employers to exploit patterns of employee vulnerability.”¹⁷⁰ Employment patterns of nurse migration reinforce patterns of disadvantage based on class, gender, race and ethnicity.¹⁷¹

- **Organized Crime / Human Trafficking:** “The owner of a chain of private nursing homes brought more than five hundred foreign nurses into the United States illegally. These nurses were employed by hospitals, nursing homes, and clinics in thirty-five states across the country, earning substandard wages and living in crowded and at times unsanitary conditions. Some of the registered nurses were hired as nurses’ aides and paid hourly rates as low as five dollars per hour. At least fifty of these nurses and their illegal visas were “passed on” – sold – to other unscrupulous recruiters at the price of \$1,000 to \$1,500 each. At the same time, nurses were charged \$7,000 for the privilege of participating in the scheme.”¹⁷²
- **Educational and Consulting Services Related to Credentialing:** The Commission on Graduates of Foreign Nursing Schools, for example, is an “immigration-neutral non-profit organization” that screens IENs seeking temporary or permanent occupational visas in the United States. Their revenues have increased from \$2.5 million in 1996 to \$18 million in 2004, “almost all from fees charged to nurses.”¹⁷³
- **Moving Money:** In 2004, workers’ remittances sent through formal banking channels are estimated to have reached \$100 billion.¹⁷⁴ Intermediary enterprises that transfer money home may charge from 13% to 25% commission.¹⁷⁵
- **Remittances as part of the Global Investment Market:** In some countries, remittances are being offered as collateral for the creation of bonds on the global investment market. It is estimated that “developing country issuers could potentially raise about \$7 billion a year using future remittance-backed securitization.”¹⁷⁶
- **Political capital related to HHR and Quality Health Services:** Voters’ concerns about wait times, and other health service quality issues such as patient safety, prominent in the media, may make recruitment of IENs attractive to political leaders as a “quick fix”.¹⁷⁷
- **Political capital related to international trade regimes:** Different politicians and different Ministries may have competing political priorities or the same priorities, but for different rationales. Politicians interested in supporting increased trade in services may support deregulation of professional qualifications and standards through a process of downward harmonization to facilitate international nurse migration.¹⁷⁸

An example of some of the mechanics of recruiting IENs as well as the reinforcing of mutual interests may be illustrated by a 10-day nurse recruitment trip to the Philippines in March 2008. The rationale for this trip that was given by the Saskatoon Health Region is that “we’ve clearly heard from a wide range of stakeholders, as well as nurses themselves and the union that represents them, that we have to pursue a more aggressive nursing recruitment strategy.”¹⁷⁹ Representatives of this recruiting team included: Saskatoon Union of Nurses, Saskatchewan Institute of Applied Science and Technology, University of Saskatchewan college of nursing, Saskatchewan Registered Nurses’ Association, the Ministry of Immigration, and the Prince Albert, Prairie North, Sunrise, Saskatoon, and Regina Qu’Appelle health regions. Over those 10 days, they interviewed 150 people, made 105 offers of employment, and had 105 people accept the offers.¹⁸⁰

On the Saskatoon Health Region's website they explain that as part of their ethical recruiting focus, "steps are taken not to disrupt or harm health systems in other countries."¹⁸¹ After describing how the recruitment team will be respectful, truthful, and not exploitive, it states that the Region will "not hire more than 10 nurses from a single site and not more than 3 nurses from a single unit."¹⁸² During the trip, members of the team had a meeting with government officials from the Philippines and it was "said many times during this day that Saskatchewan was setting a new international standard by:

- Coming in as a province with multiple regions working in collaboration to recruit nurses,
- Bringing a clear ethical recruitment statement and living by it, and
- Working with our training institutions and universities to try and establish a partnership with St. Paul's University, a rural nursing college in Iloilo."¹⁸³

Interviewers shared that many of the nurses being interviewed had many responsibilities and were looking to provide a better life for their families. They are impressed by the humility, politeness, and enthusiasm of the candidates. One candidate had to check with her family before accepting a job offer as "recently there have been a number of incidents where Philippine nurses have gone abroad and either had their passports confiscated and could not return to the Philippines or were seriously abused by their employers."¹⁸⁴

In a follow-up story reporting that Saskatchewan was expecting nearly 300 nurses from the Philippines due to the recruitment drive, Health Minister Don McMorris affirmed a commitment of hiring 800 new nurses over the next four years "whether it's recruiting in Saskatchewan, the Philippines or other provinces."¹⁸⁵ Just to underscore the importance of globalization as an underlying dynamic of nurse migration, a correspondent for Japan's NHK broadcasting corporation visited Regina to interview Saskatchewan's Immigration Minister, Rob Norris, on the province's IEN recruitment plan. Sparked by media reports on efforts to recruit IENs from the Philippines, Japan is looking at Saskatchewan as a model in order "to bolster its own ranks of nurses and caregivers by turning to countries such as Indonesia and the Philippines."¹⁸⁶

Other Canadian jurisdictions are also looking to the Philippines and other international sites as a means to meet domestic HHR challenges. Alberta is courting 1,400 international nurses as part of a recruitment drive for Calgary and Edmonton hospitals, and utilizes the same rationale. The "Alberta health authorities say they practise ethical recruiting practices, hiring in nations where there are enough medical staff. The Philippines, for example, trains more nurses than it requires."¹⁸⁷ The governments of British Columbia, Alberta, Saskatchewan, and Manitoba have all announced plans to recruit internationally educated nurses in order to address domestic HHR challenges.

Summary: Why Support International Recruitment

Proponents of international recruitment argue that nurse migration provides health-care organizations and the community with the opportunity to improve patient safety and promote health by increasing staff in an efficient and cost-effective manner. Nursing in different cultures is a valuable type of learning that increases the knowledge, skills, and understanding of the

migrating nurse and it provides a more culturally diverse nursing workforce for Canadian clients who represent countries from around the globe. Nurses have a basic human right to migrate.

Counter-Argument:

Global economic and HHR policies that tear families apart by encouraging nurses to leave their loved ones in order to give them a future are inherently unjust and unethical. Nurses have a basic human right to migrate but it should be based on an authentic choice rather than economic coercion. Promises not to disrupt the health system conflict with overwhelming evidence on how international recruitment of nurses is eroding access to health care in poor countries.

Summary: Why Reject International Recruitment

While individual nurses have an absolute human right to migrate, individuals, families, and communities are faced with fundamental threats to their very existence with the loss of nurses and other educated citizens seeking a better life. Nursing losses are devastating both in the possibility of addressing health inequities through progress on the social determinants of health and to ensure access to a functioning health care system. Those who are healthiest, wealthiest, and are relatively rich in HHR should not be recruiting from those with the greatest burden of disease, with the most fragile infrastructure, and the fewest nurses. Instead, there must be transformational change so that macroeconomic policies support the means for all to have what is needed to live in dignity and hope in their home countries, if they so choose. Local changes can start with building and nurturing indigenous nursing talent by creating and maintaining a vibrant nursing profession and healthy work environments.

Counter-Argument:

Transforming an increasingly globalized world is complicated, difficult, and overwhelming. Rather than considering the big picture, why not assist a few individuals to escape from hardship so that they can build new lives and make excellent contributions to another part of the world that also needs their talents. Some individuals are going to exercise their given right to migrate so why not give them every assistance to make a smooth transition?

Is it Possible to Have “Ethical” International Recruitment?

While none of the consulted works present easy answers, many of the evolving works on this subject do suggest key principles for consideration in an ethical recruitment framework.

One such ethical framework proposes that nurse migration policies and procedures can be developed to “satisfy primary health care ethics if they 1) leave developing countries enhanced rather than depleted, 2) contribute to national health outcomes consistent with essential care for all, 3) base policies on community awareness and participation, 4) address common nursing labour issues, and 5) ensure equitable and clearly understood financial arrangements.”¹⁸⁸

The fundamental problem with this ethical position is that real world recruitment does not conform to these principles, and is unlikely to do so in the foreseeable future. The evidence presented in this paper shows how international recruitment 1) leaves developing countries

depleted of essential HHR, 2) reduces the ability of countries to address national health outcomes consistent with essential care for all, 3) consists of policies that do not engage community awareness and participation, 4) does not address common nursing labour issues, and 5) does not ensure equitable and clearly understood financial arrangements.

An alternative position argues that “developed countries like Canada have at their disposal not only access to much greater financial and other resources necessary to meet the health needs of Canadians, but its relative prosperity, political and social stability gives it a much greater range of policy options to choose from than is the case with the nations of the developing world. One must keep in mind that whatever the shortcomings of Canada’s health-care system and of its HHR situation, it is a situation that stems largely (but not entirely) from choices made and not made by Canadian governments at both the federal and provincial level. Thus, in the debate over the recruitment of internationally educated health professionals, there should be a clear bias in favour of policy choices that do the least harm to those countries that have fewer resources and fewer policy options.”¹⁸⁹ This is a direct corollary with the ethical principle of nonmaleficence – first do not harm.

Existing frameworks for ethical recruitment provide an insufficient basis to establish real-world recruitment efforts that are, in fact, ethical. Such is the case with the International Council of Nurses’ key principles to support an ethical framework for nurse recruitment, which include:

- Effective human resources planning, management and development, leading to national self-sustainability
- Credible nursing regulation
- Access to full employment
- Freedom of movement
- Freedom from discrimination
- Good faith contracting
- Equal pay for work of equal value
- Access to grievance procedures
- Safe work environment
- Effective orientation/mentoring/supervision
- Employment trial periods
- Freedom of association
- Regulation of recruitment¹⁹⁰

These principles are contingent on the International Council of Nurses’ premise which “condemns the practice of recruiting nurses to countries where authorities have failed to implement sound human resource planning and to seriously address problems which cause nurses to leave the profession and discourage them from returning to nursing.”¹⁹¹ It is a major concern that the ICN principles are not identifiable in any of the examples this paper has explored. Not a single developed or developing country effort, including the Canadian experience, actually responds to these principles in a visible way. In fact, in a recent analysis of policy responses to global health human resources flows, improved domestic HHR self-sufficiency was described as “widely endorsed but not followed.”^{192 193}

Recruitment drives that are described as being explicitly launched from an ethical perspective, such as the Saskatchewan experience bringing nurses from the Philippines, fail a number of the criteria, including the test of national (or, in this case, provincial) self-sustainability (since they are explicitly engaged to resolve their nursing shortage), and certainly fail a criteria such as “leav[ing] developing countries enhanced rather than depleted.”¹⁹⁴ Despite the commitment to “not hire more than 10 nurses from a single site and not more than 3 nurses from a single unit,”¹⁹⁵ the health and social impact on the Filipino people, reviewed earlier, is unavoidable. Thus, they do not constitute ethical efforts according to the ICN or other¹⁹⁶ criteria.

It is unlikely we will ever see ethical recruitment in practice. The first ICN principle, “Effective human resources planning, management and development, leading to national self-sustainability,” negates the need for international recruitment. Countries (and provinces) engage in IEN recruiting since they do not want (or are unable) to uphold this ethical principle.

Conclusion and Recommendations

RNAO’s position is that the individual human right to migrate is not in question. What is in question are HHR policies in wealthy countries such as Canada that target HHR from poor countries as a solution to domestically created nursing shortages. RNAO fully recognizes Canada’s nursing shortage, and, alongside others, is working diligently to resolve it. Local solutions are both necessary and possible. The Association has consistently argued that this is a Canadian problem, and it demands Canadian solutions. In a number of research and policy documents, briefing notes, and election platforms over the years, RNAO has spelled out critical policies that are essential to resolve this challenge. These policies are not only feasible but also desirable to raise the quality of care for, and the health status of, Canadians.

Some of these policies are well underway and the results are extremely positive. This is the case with Ontario’s actions in recent years to increase the number of nurses, to increase the proportion working full time, to guarantee full-time work for new graduates, and to expand roles for nurses. Still, as our recommendations suggest, much remains to be done both in Ontario and across the country, including:

- Ensuring that government and those health organizations funded by the government do not engage in international recruitment of nurses and other health professionals.
- Ensuring that internationally educated nurses who make Ontario their new home face no systemic barriers to practise their profession.
- Establishing permanent funding for existing upgrading and bridging programs for internationally educated nurses who make Ontario their new home.
- Strengthening local HHR capacity through:
 - Substantive investments in nursing education across the country, including infrastructure, faculty and nursing seats.
 - Continued investment in workplace health, including adequate workloads, employment arrangements that match nurses’ needs, professional opportunities, and best management practices.

- Continued investments in patient safety and quality patient care, including continuity of care and care provider, best practices in clinical care, and improved interdisciplinary work.

“Trying to resolve our problems on the backs of other jurisdictions will only aggravate nursing shortages...”

The Association knows that these and other local solutions, designed to tackle the specific needs of jurisdictions and communities, will address the shortage of nursing and other health-care professionals. Trying to resolve our problems on the backs of other jurisdictions will only aggravate nursing shortages, including the one in Canada, on a global scale.

Dynamic	Potential Impact on Health	Potential Impact on Health-Care Systems
<i>Growth of “Information Society” or “Knowledge Economy”</i>	Rapid advances in science and technology have profound implications for prevention and treatment of disease for those who can afford access. Internet and other mass media allow for rapid diffusion of new possibilities for treatment thereby generating demand and iatrogenic possibilities. Increased connectivity raises possibilities for increased global solidarity and mobilization of social movements that could impact determinants of health while underscoring the “digital divide.”	Increasing complexity of technology expands need for specialization of health-care workers and facilities while escalating costs. Raised public awareness may generate disappointment based on unrealistic expectations. Increasingly knowledgeable “health-care consumers” may challenge traditional authority of medicine. Telemedicine and telehealth expand the scope for consultation and treatment of patients geographically distant and for continuing education of health-care workers.
<i>Trade liberalization: Increasing fluidity of “casino economy” and capital aggregation</i>	Volatility of flows may precipitate crisis such as “Asian Flu” of 1997 causing hunger, massive unemployment, and social disruption. George Soros and others make fortunes betting against currencies. Corporate fraud causes unemployment and loss of pensions for employees while executives thrive. Poverty increases vulnerability to illness and death. Income and wealth inequalities widen within and between societies (accompanied by morbidity and mortality disparities distributed by class).	Economic instability leads to contraction of health-care services at the same time as health needs increase due to declining standards of living. Corporations within the health-care industry also generate profit through fraud and criminal conspiracy.
<i>Trade liberalization: Capital chases cheapest labor and most generous tax incentives across national borders</i>	Unionized, higher paying jobs in manufacturing sector disappear as non-union, low pay service work increases in North America. Unemployment, underemployment, and lack of work control associated with increased morbidity and mortality. Overwork, underpay, and marginal working conditions task health of workers with jobs.	Expenditures on luring transnational companies siphon off money available for social expenditures, including health services. Unions decline in strength in health sector as work is outsourced and sophisticated propaganda argues for “need to be competitive.”

Dynamic	Potential Impact on Health	Potential Impact on Health-Care Systems
<i>Trade liberalization: “free trade” regime privileges rights of corporations over needs of civil society including vigorous protection of “intellectual property rights.”</i>	Chapter 11 of NAFTA allows corporations to sue nation states over health and safety regulations that might decrease profits (e.g. gasoline additives.) As markets in industrialized countries decrease for addictive substances such as alcohol and tobacco, corporations turn to developing and newly emerging economies for new markets. Other products, such as milk formula, become lethal when vigorously promoted to families in developing nations. Without adequate access to clean water or resources to purchase sufficient quantities of the product once breast milk has dried up, children die from gastroenteritis, dehydration, and malnutrition.	“Biopiracy” of indigenous people and their cultural practices by corporations may result in people having to pay for commodified versions of their traditional healing practices or therapies derived from their own genetic material. Ultimate implications of NAFTA, GATT, and WTO for ability of nation states to control their own health care systems uncertain. Aggressive propulsion of “intellectual property rights” mitigates against development of generic pharmaceuticals and other technologies at affordable cost.
<i>Trade liberalization: promotes unchecked industrialization, urbanization, and unsustainable consumption patterns</i>	Environmental degradation in the form of air, water, and land pollution introduces toxins and provokes violence over increasingly scarce resources such as fresh water and food. Increases of ultraviolet radiation from ozone depletion cause skin cancers, cataracts, and immunosuppression. Global warming shifts patterns of vectors of infectious diseases, causes death from heat waves, trauma from floods and storms, and famine from drought. Poor people are typically disproportionately affected by all of the above.	Health-care systems are complicit with normalizing “natural disasters” as apolitical events. Lack of surveillance of differential impacts on poor people and unwillingness to track root causes of environmental degradation naturalizes and depoliticizes disasters.
<i>Devolving State: Deregulation</i>	Dismantling and declining enforcement of regulations exacerbates environmental degradation; threatens food, water, product, and services safety; and encourages labor exploitation.	Canadian Health Coalition campaigns against deregulation or regulatory changes designed to “re-regulate” in economic favor of biotechnology and pharmaceutical industries.

Dynamic	Potential Impact on Health	Potential Impact on Health-Care Systems
<i>Devolving State: Privatization</i>	Structural adjustment programs that privatize water, energy, and other essential services increase costs to individuals and vulnerability of poor to disease and death.	Structural adjustment programs that privatize health services and impose user fees decrease access globally for poor and working classes especially. Market solutions are aggressively promoted for public health systems in industrialized countries that experience “crisis” in access or quality of care caused by underfunding or “death of a thousand cuts.”
<i>Devolving State: Retreat from Universalism and Welfare State</i>	The web of the “social safety net” frays as people do not receive essential services. Shorter hospital stays and increased reliance on homecare has shifted responsibility from institutions to individuals and families with women caregivers disproportionately under stress from multiple demands.	Delisting of medical services from public health plans and increasing deductibles for prescription drugs shifts cost burden from public to unwell individuals. Armstrong et al argue that privatization and health-care reform is having a negative impact on many women in Canada as health-care workers and as caregivers.

Source: Mulrooney, L.A. (2004). *Coolers for the Mark(et): Organized Medicine and Health Care Reform in the United States and Canada*. (Doctoral dissertation, University of Hawai’i at Manoa, 2004), 133-136.

Appendix B: Canada's Internationally Educated Health Care Professionals, 2006

Country	Licensed Practical Nurses	Registered Nurses	Physicians	Occupational Therapists	Total
Philippines	177	6,102	224	45	6,548
United Kingdom	424	3,556	2,122	108	6,210
India	39	1,104	1,334	78	2,555
South Africa	10	211	1,939	28	2,188
United States	146	1,273	465	103	1,987
Ireland	*	132	1,092	19	**
Hong Kong	72	936	202	25	1,235
Poland	34	670	410	0	1,114
France	0	398	428	*	**
Egypt	0	18	563	0	581
Australia	9	363	176	6	554
Jamaica	24	351	182	0	557
Pakistan	12	131	364	5	512
New Zealand	9	231	100	17	357
Germany	**	197	120	**	331
Other Countries	267	4,163	3,959	82	8,471
Total	1,232	19,836	13,680	524	35,272

Source: Canadian Institute for Health Information (2007). *Canada's Health Care Providers, 2007*. Ottawa: Author, 43.

*Value suppressed in accordance with CIHI privacy policy; cell value is from 1 to 4.

**Value suppressed to ensure confidentiality; cell value is 5 or greater

Appendix C: Selected Population Health Indicators, Demographic and Economic Data, and Nurse Density

HDI Rank ^a	Country	2005 Life Expectancy at birth ^b years Female	2005 Life Expectancy at birth years Male	Infant Mortality Rate ^c 2005	Under Five Mortality ^d 2005	Pop under Age 15 yrs % of total 2015	Pop aged 65 years + % of total 2015	GDP ^e US \$ billions 2005	GDP per capita ^f 2005 PPP ^g US \$	Nurses ^h Per 1,000
1	Iceland	83.1	79.9	2	3	20.0	14.2	15.8	36,510	13.63
2	Norway	82.2	77.3	3	4	17.7	17.0	295.5	41,420	14.84
3	Australia	83.3	78.5	5	6	17.9	16.1	732.5	31,794	9.71
4	Canada	82.6	77.9	5	6	15.6	16.1	1,113.8	33,375	9.95
5	Ireland	80.9	76.0	5	6	21.1	12.4	201.8	38,505	15.20
8	Japan	85.7	78.7	3	4	12.5	26.2	4,534.0	31,267	7.79
12	USA	80.4	75.2	6	7	19.8	14.1	12,416.5	41,890	9.37
16	UK	81.2	76.7	5	6	17.2	18.1	2,198.8	33,238	12.12
81	China	74.3	71.0	23	27	18.5	9.6	2,234.3	6,757	1.05
90	Philippines	73.3	68.9	25	33	32.5	4.7	99.0	5,137	1.69
121	South Africa	52.0	49.5	55	68	30.2	5.5	239.5	11,110	4.08
128	India	65.3	62.3	56	74	28.7	5.8	805.7	3,452	0.80
135	Ghana	59.5	58.7	68	112	35.1	4.3	10.7	2,480	0.92
136	Pakistan	64.8	64.3	79	99	32.1	4.3	110.7	2,370	0.46
141	Swaziland	41.4	40.4	110	160	36.5	3.8	2.7	4,824	6.30
148	Kenya	53.1	51.1	79	120	42.5	2.6	18.7	1,240	1.14
151	Zimbabwe	40.2	41.4	81	132	35.2	3.7	3.4	2,038	0.72
158	Nigeria	47.1	46.0	100	194	41.3	3.0	99.0	1,128	1.70
164	Malawi	46.7	46.0	79	125	44.6	3.1	2.1	667	0.59
165	Zambia	40.6	40.3	102	182	43.4	3.0	7.3	1,023	1.74

Sources: All data from United Nations Development Programme, (2007). **Human Development Report 2007/2008**. New York: Author. 243-246, 261-264, 277-280, 326-329 except for nurse density data, which is from World Health Organization, (2006). **World Health Report 2006: Working Together for Health**. Geneva: Author, 190-198.

Definitions and Technical Notes for Table from the Source Documents for Appendix C:

- a) Human development Index (HDI) is a composite index measuring average achievement in three basic dimensions of human development—a long and healthy life, knowledge, and a decent standard of living. Countries from 1 to 70 are ranked as high, countries 71 to 155 are ranked as medium, and 156 to 177 are ranked as low on the HDI.
- b) Life expectancy at birth is the number of years a new born infant would live if prevailing patterns of age-specific mortality rates at the time of birth were to stay the same throughout the child’s life.
- c) Infant mortality rate is the probability of dying between birth and exactly one year of age, expressed per 1,000 live births.
- d) Under-five mortality rate is the probability of dying between birth and exactly five years of age, expressed per 1,000 live births.
- e) Gross domestic product (GDP) is the sum of value added by all resident producers in the economy plus any product taxes (less subsidies) not included in the valuation of output. It has been converted to US dollars using the average official exchange rate reported by the International Monetary Fund.
- f) GDP per capita is the gross domestic product divided by midyear population.
- g) Purchasing power parity (PPP) is a rate of exchange that accounts for price differences across countries, allowing international comparisons of real output and incomes. At the PPP US\$ rate used in this table, PPP US\$1 has the same purchasing power in the domestic economy as US\$1 has in the United States.
- h) The World Health Organization defines human resources for health as “the stock of all individuals engaged in the promotion, protection or improvement of population health.” The occupational category that this data reflects for nurses “includes professional nurses (and midwives), auxiliary nurses and enrolled nurses, and other nurses such as dental or primary care nurses.” World Health Organization, (2006). **World Health Report 2006: Working Together for Health**. Geneva: Author, 164.

Appendix D: Selected Population Health Indicators and Health Care Professional Density by Province and Territory, 2005

	Life Expectancy at birth Female	Life Expectancy at birth Male	Infant Mortality Rate	RNs per 1,000	LPNs per 1,000	Physicians per 1,000
Newfoundland & Labrador	80.9	75.6	6.2	10.68	5.24	1.93
Prince Edward Island	82.1	77.4	2.2	10.44	4.39	1.44
Nova Scotia	81.8	76.7	4.0	9.32	3.34	2.18
New Brunswick	82.4	77.2	4.1	9.99	3.51	1.72
Quebec	82.9	77.7	4.6	8.37	2.14	2.15
Ontario	82.7	78.5	5.6	7.10	1.94	1.76
Manitoba	81.4	76.6	6.6	9.56	2.20	1.79
Saskatchewan	82.1	76.6	8.3	8.63	2.21	1.56
Alberta	82.7	77.8	6.8	7.97	1.61	1.88
British Columbia	83.5	78.8	4.5	6.50	1.14	1.99
Yukon			0.0	9.70	1.80	2.05
Northwest Territories			4.2	13.15*	2.38	1.03
Nunavut			10.0	13.15*		0.46
Territories	79.9	73.5				
Canada	82.7	78.0	5.4	7.76	2.00	1.90

Data Sources: Population health data from Statistics Canada (2008). *Deaths*. Ottawa: Health Statistics Division, 12, 15. HHR data from Canadian Institute for Health Information (2007). *Health Care in Canada 2007*. Ottawa: Author, 16-17.

*includes both Northwest Territories and Nunavut

Appendix E: Differential Impact on Source Country Nursing Stock by Number of Newly Registered Internationally Educated Nurses in the United Kingdom, 2002

Country	Number of New Registrations	Registrations as a Percentage of Source Country Nursing Stock
Malawi	75	11.63
Haiti	54	6.10
Gambia	10	5.77
Swaziland	12	5.47
Zimbabwe	473	2.80
Botswana	100	2.80
Philippines	7,235	2.21
Mauritius	62	2.20
Dominican Republic	56	2.17
Zambia	183	1.54
New Zealand	443	1.34
Ghana	195	1.34
Jamaica	18	1.03
South Africa	2,114	1.01
Australia	1,342	0.82
Kenya	155	0.55
Nigeria	432	0.49
India	994	0.21
Canada	79	0.03
United States	122	0.00

Source: Adapted from Table 2 of Ross, S., Polsky, D., & Sochalski, J. (2005). Nursing Shortages and International Nurse Migration. *International Nursing Review*. 52 (4), 258.

References

-
- ¹ Gelfand, T. (1987). Medicine in New France. *Medicine in the New World: New Spain, New France, and New England*. Edited by Numbers, R. Knoxville: University of Tennessee Press.
- ² Article 13 (2) of the Universal Declaration of Human Rights adopted in 1948 by the United Nations states that, “Everyone has the right to leave any country, including his own, and to return to his country.”
- ³ International Council of Nurses (ICN) (2007). *Position Statement: Ethical Nurse Recruitment*. Geneva: Author.
- ⁴ International Council of Nurses (1999). *Position Statement: Nurse Retention, Transfer and Migration*. Geneva: Author.
- ⁵ Registered Nurses’ Association of Ontario (2007). *Creating a Healthier Society: RNAO’s Challenge to Ontario’s Political Parties*. Toronto: Author, 28.
- ⁶ ICN (2007), 1.
- ⁷ McIntosh, T., Torgerson, R. & Klassen, N. (2007). *The Ethical Recruitment of Internationally Educated Health Professionals: Lessons from Abroad and Options for Canada*. Ottawa: Canadian Policy Research Network, 18.
- ⁸ Daulaire, N. (1999). Globalisation and Health. *Development*. 42 (4), 22.
- ⁹ Steger, M. (2002). *Globalism: The New Market Ideology*. Lanham, Md.: Rowman & Littlefield.
- ¹⁰ Shakow, A. & Irwin, A. (2000). Terms Reconsidered: Decoding Development Discourse. *Dying for Growth: Global Inequity and the Health of the Poor*. Monroe: Common Courage Press, 54.
- ¹¹ Neubauer, D. (1997). The Incredible Shrinking State, or: Will There be Social Services When the State Goes Out of Business. Paper presented at the University of Hawai’i at Manoa.
- ¹² Neubauer, D. (2000). Assaying the Frontiers of Globalization: Explorations in the New Economy. *American Studies*. 41 (2/3), 16.
- ¹³ Barnett, R. & Cavanagh, J. (1994). *Global Dreams: Imperial Corporations and the New World Order*. New York: Simon & Schuster, 19.
- ¹⁴ Neubauer, D. (2000), 18-21.
- ¹⁵ Barnett & Cavanagh (1994).
- ¹⁶ Mulrooney, L. & Neubauer, D. (2006). Globalisation, Economic Injustice, and Health. *Australasian Journal of Human Security*. 2 (1), 33-50.
- ¹⁷ Chen, L. & Berlinguer, G. (2001). Health Equity in a Globalizing World. *Challenging Inequities in Health: From Ethics to Action*. Evan, T., Whitehead, M., Diderichsen, F., Bhuiya, A., & Wirth, M. (eds.). New York: Oxford University Press, 40-41.
- ¹⁸ Labonte, R. (2003). Globalization, Trade, and Health: Unpacking the Links and Defining the Policy Options. *Health and Social Justice: Politics, Ideology, and Inequity in the Distribution of Disease*. Hofrichter, R. (Ed.) San Francisco: Jossey-Bass, 485.
- ¹⁹ Labonte, (2003), 485.
- ²⁰ Registered Nurses’ Association of Ontario (2003). Letter to Prime Minister Jean Chrétien on the Impact of GATS Negotiations on Health and Nursing Services.
- ²¹ Registered Nurses’ Association of Ontario (2003).

-
- ²² Registered Nurses' Association of Ontario (2003).
- ²³ Gloyd, S. (2004). *Sapping the Poor: The Impact of Structural Adjustment Programs. Sickness and Wealth: The Corporate Assault on Global Health*. Cambridge: South End Press.
- ²⁴ Schoepf, B., Schoepf, C. & Millen, J. (2000). Theoretical Therapies, Remote Remedies: SAPs and the Political Ecology of Poverty and Health in Africa. *Dying for Growth: Global Inequity and the Health of the Poor*. Monroe: Common Courage Press.
- ²⁵ Gibbon, P. (1992). The World Bank and African Poverty, 1973-91. *Journal of Modern African Studies*, 30,193-220.
- ²⁶ Schoepf, Schoepf, & Millen. (2000), 107.
- ²⁷ Schoepf, Schoepf, & Millen. (2000), 107.
- ²⁸ Chossudovsky, M. (1997). *The Globalisation of Poverty: Impacts of IMF and World Bank Reforms*. London: Zed Books, Ltd., 33.
- ²⁹ Schoepf, Schoepf, & Millen. (2000), 109-112.
- ³⁰ Kingma, M. (2006). *Nurses on the Move: Migration and the Global Health Care Economy*. Ithaca: Cornell University Press, 27.
- ³¹ Kingma (2006), 26.
- ³² Liese, B., Blanchet, N. & Dussault, G. (2003). *Background Paper: The Human Resource Crisis in Health Services in Sub-Saharan Africa*. Washington: World Bank, 9.
- ³³ World Health Organization (2006). *World Health Report 2006: Working Together for Health*. Geneva: Author, 77.
- ³⁴ Oulton, J. (2004). Nurse Migration: Let's Tackle the Real Issues. *International Nursing Review*. 51 (3), 137.
- ³⁵ World Health Organization (2006), 24.
- ³⁶ World Health Organization (2006), 81.
- ³⁷ Aboderin, I. (2007). Contexts, motives and experiences of Nigerian overseas nurses: understanding links to globalization. *Journal of Clinical Nursing*. 16 (2), 2242.
- ³⁸ Aboderin, I. (2007), 2242.
- ³⁹ Little, L. (2007). Nurse Migration: A Canadian Case Study. *Health Services Research*. 42 (3), 1337.
- ⁴⁰ McQuaig, L. (1998). *The Cult of Impotence: Selling the Myth of Powerlessness in the Global Economy*. Toronto: Penguin Canada, 98.
- ⁴¹ Yalnizyan, A. (2004). *Squandering Canada's Surplus: Opting for Debt Reduction and "Scarcity by Design."* Ottawa: Canada Centre for Policy Alternatives, 4.
- ⁴² Little (2007), 1337.
- ⁴³ Grinspun, D. (2003). Part-time and Casual Nursing Work: The Perils of Healthcare Restructuring. *International Journal of Sociology and Social Policy*. 23 (8-9), 61.
- ⁴⁴ Registered Nurses' Association of Ontario (2001). *Earning their Return: When & Why Ontario RNs left Canada, and What Will Bring Them Back*. Toronto: Author, 4.
- ⁴⁵ RNAO (2001), 5.
- ⁴⁶ McGillis Hall, L. (2008). Gone South: Canadian Nurse Migration to the U.S. Presentation to the Health Human Resources Migration International Policy Symposium at the University of Toronto, September 27 2008.
- ⁴⁷ Oulton, (2004), 137.

⁴⁸ These factors are consistent in the literature. This particular framing is from Eastwood, J., Conroy, R., Naicker, S., West, P., Tutt, R., & Plange-Rhule, J. (2005). Loss of health professionals from Sub-Saharan Africa: the pivotal role of the UK. *Lancet*. 365 (9474), 1895.

⁴⁹ Canadian Institute for Health Information (2007). *Health Care in Canada 2007*. Ottawa: Author, 18.

⁵⁰ CIHI, *Health Care in Canada 2007*, 18.

⁵¹ CIHI, *Health Care in Canada 2007*, 19.

⁵² Blythe, J. & Baumann, A. (2008). *Supply of Internationally Educated Nurses in Ontario: Recent Developments and Future Scenarios*, February 2008. Number 9.

Hamilton: Nursing Health Services Research Unit, McMaster University, 7.

⁵³ Labonte, R., Packer, C., Klassen, N., et al. (2006). *The Brain Drain of Health Professionals from Sub-Saharan Africa to Canada*. African Migration and Development Series No. 2. Cape Town, South Africa and Kingston, Ontario: Southern Africa Migration Project and Queen's University, 19.

⁵⁴ Canadian Nurses Association (2008). *Issues Discussion at Annual General 2008: Internationally Educated Nurses*. Ottawa: Author, 1.

⁵⁵ Blythe & Baumann, (2008), 7.

⁵⁶ Blythe & Baumann, (2008), 5.

⁵⁷ Blythe & Baumann, (2008), 22.

⁵⁸ "To 'problematize' is to engage a group in the task of codifying reality into symbols which can generate critical consciousness and empower them to alter their relations with nature and oppressive social forces. Problem-posing is a logically prior task which allows all previous conceptualizations of a problem to be treated as questionable. Problematization recognizes that 'solutions' are often difficult because the wrong problems are being addressed." Heaney, T. *Issues in Freirean Pedagogy*. Accessed Nov. 5, 2008:

<http://www3.nl.edu/academics/cas/ace/resources/Documents/FreireIssues.cfm#Glossary>

⁵⁹ Canadian Nurses Association and the Canadian Association of Schools of Nursing (2008). *Nursing Education in Canada Statistics 2006-2007*. Ottawa: Authors, 4.

⁶⁰ Canadian Nurses Association and the Canadian Association of Schools of Nursing (2008), 4.

⁶¹ Fraser, R. (No Date). Number of physicians, dentists and nurses, population per physician, dentist and nurse, number of graduates of medical and dental schools and nursing programs, immigration and emigration of physicians, Canada, 1871 to 1975. Table B82-92. Ottawa: Statistics Canada. Accessed September 15, 2008:

<http://www.statcan.ca/english/freepub/11-516-XIE/sectionb/sectionb.htm>

⁶² Canadian Nurses Association and the Canadian Association of Schools of Nursing (2008), 5.

⁶³ Canadian Nurses Association and the Canadian Association of Schools of Nursing (2008), 5.

⁶⁴ Canadian Nurses Association (2008). *Issues Discussion at Annual Meeting 2008: Challenges to Self-Regulation*. Ottawa, Author, 4.

⁶⁵ CNA (2008), *Challenges to Self-Regulation*, 5.

⁶⁶ Kingma (2006), 158-172.

-
- ⁶⁷ Kingma (2006), 160.
- ⁶⁸ Kingma (2006), 160.
- ⁶⁹ Gorman, A. (2007). Unbalanced Care: Nurse Migration in the Philippines. *The Heinz School Review*. 4 (4), December 4, 2007.
- ⁷⁰ International Council of Nurses (2007).
- ⁷¹ Ehrenreich, B. & Hochschild, A. (2002). Introduction. *Global Woman: Nannies, Maids, and Sex Workers in the New Economy*. Ehrenreich, B. & Hochschild, A. (Eds.) New York: Metropolitan Books. 1-13.
- ⁷² Hochschild, A. (2002). Love and Gold. *Global Woman: Nannies, Maids, and Sex Workers in the New Economy*. Ehrenreich, B. & Hochschild, A. (Eds.) New York: Metropolitan Books, 17.
- ⁷³ Ehrenreich, B. & Hochschild, A. (2002). 12.
- ⁷⁴ Korten, D. (1995), *When Corporations Rule the World*. West Hartford: Kumarian Press.
- ⁷⁵ Grinspun, D. (2002). A flexible nursing workforce: realities and fallouts. *Hospital Quarterly*. Fall 6 (1), 79-84.
- ⁷⁶ Grinspun, D. (2003). Part-time and Casual Nursing Work: The Perils of Healthcare Restructuring. *International Journal of Sociology and Social Policy*. 23 (8-9), 54-80.
- ⁷⁷ Editorial: Poaching Nurses from the Developing World. *Lancet*. 367(9525), 1791.
- ⁷⁸ Gorman, A. (2007). Unbalanced Care: Nurse Migration in the Philippines. *The Heinz School Review*. 4 (4), December 4, 2007.
- ⁷⁹ Kingma (2006), 118.
- ⁸⁰ Kingma (2006), 75.
- ⁸¹ Kingma (2006), 73.
- ⁸² O'Brien-Pallas, L. & Wang, S. (2006). Innovations in Health Care Delivery: Responses to Global Nurse Migration—A Research Example. *Policy, Politics & Nursing Practice*. Supplement to Volume 7 (3), 49S-57S.
- ⁸³ Allan, H. (2007). The rhetoric of caring and the recruitment of overseas nurses: the social production of a care gap. *Journal of Clinical Nursing*. 16, 2208.
- ⁸⁴ Kingma (2006), 71.
- ⁸⁵ O'Brien, T. (2007). Overseas nurses in the National Health Service: a process of deskilling. *Journal of Clinical Nursing*. 16, 2235.
- ⁸⁶ World Health Organization (2006), 12.
- ⁸⁷ World Health Organization (2006), 12.
- ⁸⁸ World Health Organization (2006), 13.
- ⁸⁹ World Health Organization (2006), 12.
- ⁹⁰ World Health Organization (2006), 13.
- ⁹¹ World Health Organization (2006), xix.
- ⁹² World Health Organization (2006), xix.
- ⁹³ Pittman, P., Aiken, L. & Buchan, J. (2007). International Migration of Nurses: Introduction. *Health Services Research*. 42:3, 1275.
- ⁹⁴ Chaguturu, S. & Vallabhaneni, S. (2005). Aiding and Abetting—Nursing Crises at Home and Abroad. *New England Journal of Medicine*. 353(17), 1763.
- ⁹⁵ Romanow, R. (2002). *Building on Values: The Future of Health Care in Canada—Final Report*. Saskatoon: Commission on Future of Health Care in Canada, 244.

-
- ⁹⁶ Ehman, A. & Sullivan, P. (2001). South Africa appeals to Canada to stop recruiting its MDs. *Canadian Medical Association Journal*. 164 (3), 387.
- ⁹⁷ Canadian Institute for Health Information (2005). *Distribution of Physicians in Canada: Beyond How Many and Where*. Ottawa: Author, 26.
- ⁹⁸ Ehman and Sullivan (2001), 387.
- ⁹⁹ Labonte, R., Packer, C., Klassen, N., et al. (2006), 42.
- ¹⁰⁰ CBC News (2001). South Africa asks Canada to stop stealing doctors away. February 7, 2001.
- ¹⁰¹ CBC News (2001).
- ¹⁰² Attaran, A. & Walker, R. (2008). Editorial: Shoppers Drug Mart or Poachers Drug Mart? *Canadian Medical Association Journal*. 178 (3), 265.
- ¹⁰³ Morris, J. (2008). Letter: Recruiting Foreign-Trained Professionals. *Canadian Medical Association Journal*. 178 (8), 1035.
- ¹⁰⁴ Krotz, P. (2008). Poaching Foreign Doctors. *The Walrus*, June 2008.
- ¹⁰⁵ Dovlo, D. (2007). Migration of Nurses from Sub-Saharan Africa: A Review of Issues and Challenges. *Health Services Research*. 42 (3), 1375.
- ¹⁰⁶ Kingma, M. (2006). *Nurses on the Move: Migration and the Global Health Care Economy*. Ithaca: Cornell University Press, 180.
- ¹⁰⁷ Kingma, (2006), 179.
- ¹⁰⁸ Physicians for Human Rights (2006). *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa*. Boston: Author, 21.
- ¹⁰⁹ World Health Organization (2004). Recruitment of Health Workers from the Developing World. Report to the Executive Board. Geneva: Author, 3, cited by Kingma, (2006), 181.
- ¹¹⁰ Dovlo (2007), 1382.
- ¹¹¹ Dovlo (2007), 1382.
- ¹¹² Kirigia, J., Gbary, A., Muthuri, L, et al. (2006). The Cost of Health Professionals' Brain Drain in Kenya. *BMC Health Services Research*. 6, 89.
- ¹¹³ British Columbia Ministry of Health (2008). Press Release: Recruitment Campaign Brings Experiences Nurses to B.C. January 29, 2008, 1. Accessed September 7, 2008: http://www2.news.gov.bc.ca/news_releases_2005-2009/2008HEALTH0011-000115.pdf
- ¹¹⁴ British Columbia Ministry of Health (2008), 1.
- ¹¹⁵ Eastwood, J., Conroy, R., Naicker, S., West, P, Tutt, R., & Plange-Rhule, J. (2005). Loss of health professionals from Sub-Saharan Africa: the pivotal role of the UK. *Lancet*. 365 (9474), 1893-1900.
- ¹¹⁶ Buchan, J. (2002). International recruitment of nurses: United Kingdom case study. Scotland: Queen Mary University College, 7.
- ¹¹⁷ Buchan, 8.
- ¹¹⁸ Ross, S., Polsky, D., & Sochalski, J. (2005). Nursing shortages and international nurse migration. *International Nursing Review*. 52 (4), 253.
- ¹¹⁹ Ross, S., Polsky, D., & Sochalski, J. (2005), 258.
- ¹²⁰ Buchan, J. (2007). International Recruitment of Nurses: Policy and Practice in the United Kingdom. *Health Services Research*. 42 (3), 1331.
- ¹²¹ Buchan, 1332.
- ¹²² Buchan, 1332.

-
- ¹²³ Buchan, 1332.
- ¹²⁴ Mulholland, H. (2004). Reid reneges on overseas staff pledge. *Guardian*. July 26, 2004.
- ¹²⁵ Kingma, 131.
- ¹²⁶ Brush, B. & Sochalski, J. (2007). International Nurse Migration: Lessons from the Philippines. *Policy, Politics, & Nursing Practice*. 8 (37), 44.
- ¹²⁷ Brush, B. (1995). The Rockefeller Agenda for American/Philippines Nursing Relations. *Western Journal of Nursing Research*. 17 (5), 541.
- ¹²⁸ Lorenzo, F., Galvez-Tan, J., Icamina, K. & Javier, L. (2007). Nurse Migration from a Source Country Perspective: Philippine Country Case Study. *Health Services Research*. 43 (3), 1406.
- ¹²⁹ Ball, R. (2004). Divergent development, racialised rights: globalised labour markets and the trade of nurses—The case of the Philippines. *Women's Studies International Forum*. 27, 119.
- ¹³⁰ Lorenzo et. al., 1407.
- ¹³¹ Lorenzo et al., 1411.
- ¹³² Lorenzo et. al. 1411.
- ¹³³ Gamble, D. (2002). Filipino Nurse Recruitment as a Staffing Strategy. *Journal of Nursing Administration*. 32 (4), 175. This author affirms: “Using a value-added vendor-based foreign recruitment model is most leveraged if implemented by large hospitals and systems seeking to place 50 or more workers at a time. Rigorous selection practices aimed at finding a vendor that follows an ethical framework and a one-stop shopping or turnkey approach supports the best economic return on investment for hospitals and systems.”
- ¹³⁴ Aiken, L., Buchan, J. Sochalski, J. Nichols, B. & Powell, M. (2004). Trends in International Nurse Migration. *Health Affairs*. 23 (3), 69-77.
- ¹³⁵ Brush & Sochalski, 44.
- ¹³⁶ Aiken et al., 69-77.
- ¹³⁷ Kingma, 22.
- ¹³⁸ Brush & Sochalski, 40.
- ¹³⁹ Brush & Sochalski, 40.
- ¹⁴⁰ Brush & Sochalski, 40-41.
- ¹⁴¹ Brush & Sochalski, 40.
- ¹⁴² Brush & Sochalski, 40.
- ¹⁴³ Kingma, 23.
- ¹⁴⁴ Brush & Sochalski, 40.
- ¹⁴⁵ Lorenzo et. al. 1410.
- ¹⁴⁶ Lorenzo et. al. 1410.
- ¹⁴⁷ Lorenzo et. al. 1413.
- ¹⁴⁸ Lorenzo et. al. 1414.
- ¹⁴⁹ Lorenzo et. al. 1414.
- ¹⁵⁰ Lorenzo et al. 1413.
- ¹⁵¹ Lorenzo et. al. 1414.
- ¹⁵² Lorenzo et. al. 1414.
- ¹⁵³ Lorenzo et al. 1407-1408.

-
- ¹⁵⁴ Lorenzo et al., 1413.
- ¹⁵⁵ Estella, C. (2005). Substandard nursing schools sell dreams of a life abroad. *Philippine Center for Investigative Journalism*. 20 March 2005.
- ¹⁵⁶ World Bank. (2006). *Global Economic Prospects 2006: Economic Implications of Remittances and Migration*. Washington: Author.
- ¹⁵⁷ Mitchell, S. (2006). Migration and the remittance euphoria: development or dependency? London: New Economics Foundation.
<http://www.neweconomics.org/gen/uploads/2jewuy45gyeqd455pu3ngu5503102006173651.pdf>
- ¹⁵⁸ Hochschild, A. (2002). 27.
- ¹⁵⁹ Hochschild, A. (2002). 18.
- ¹⁶⁰ Parrenas, R. (2002). The Care Crisis in the Philippines: Children and Transnational Families in the New Global Economy. *Global Woman: Nannies, Maids, and Sex Workers in the New Economy*. Ehrenreich, B. & Hochschild, A. (Eds.) New York: Metropolitan Books, 53.
- ¹⁶¹ Kingma, 111.
- ¹⁶² Kingma, 80.
- ¹⁶³ Kingma, 80-90.
- ¹⁶⁴ Kingma, 84.
- ¹⁶⁵ Kingma, 84.
- ¹⁶⁶ Guardian News Service (2004). India Exporting Nurses to UK and US. September 23, 2004.
- ¹⁶⁷ Kingma, 86.
- ¹⁶⁸ Kingma, 89.
- ¹⁶⁹ Khadria, B. (2007). International Nurse Recruitment in India. *Health Services Research*. 42 (3), 1434.
- ¹⁷⁰ Smith, P. & Mackintosh, M. (2007). Profession, market and class: nurse migration and the remaking of division and disadvantage. *Journal of Clinical Nursing*. 16 (12), 2218.
- ¹⁷¹ Smith & Mackintosh, 2213.
- ¹⁷² Kingma, 111.
- ¹⁷³ Kingma, 97.
- ¹⁷⁴ Kingma, 108.
- ¹⁷⁵ Kingma, 108.
- ¹⁷⁶ Kingma, 196.
- ¹⁷⁷ Kingma, 123.
- ¹⁷⁸ Kingma, 158.
- ¹⁷⁹ Saskatoon Health Region. (2008). Saskatoon Health Region to recruit Filipino nurses. *E-Connect*. 3 (4), February 18, 2008, 1.
- ¹⁸⁰ Saskatoon Health Region (2008). Saskatoon Health Region welcomes new nurses from the Philippines
http://www.saskatoonhealthregion.ca/news_you_need/media_centre/media/2008/recruitment_trip.htm
- ¹⁸¹ Saskatoon Health Region. (2008) Nurse Recruitment Trip to the Philippines: Ethical Recruiting.
http://www.saskatoonhealthregion.ca/news_you_need/media_centre/media/2008/recruitment_trip_ethics.htm

-
- ¹⁸² Saskatoon Health Region. (2008) Nurse Recruitment Trip to the Philippines: Ethical Recruiting.
http://www.saskatoonhealthregion.ca/news_you_need/media_centre/media/2008/recruitment_trip_ethics.htm
- ¹⁸³ Saskatoon Health Region (2008). Giving Back. March 5, 2008
http://www.saskatoonhealthregion.ca/news_you_need/media_centre/media/2008/recruitment_trip.htm
- ¹⁸⁴ Saskatoon Health Region (2008). Successful Mission. March 7, 2008
http://www.saskatoonhealthregion.ca/news_you_need/media_centre/media/2008/recruitment_trip_030708.htm
- ¹⁸⁵ Benjoe, K. (2008). Nearly 300 nurses from Philippines coming to Sask. *Leader-Post*, March 11, 2008
- ¹⁸⁶ Hall, A. Sask.recruitment plan interests Japan media. *Leader-Post*, July 31, 2008.
- ¹⁸⁷ Lang, M. (2008). 1,400 nurses courted: job offers part of campaign to meet huge Alberta need. *Calgary Herald*, March 16, 2008.
- ¹⁸⁸ McElmurry, B., Solheim, K., Kishi, R., Coffia, M, Woith, W., & Janepanish, P. (2006). Ethical Concerns in Nurse Migration. *Journal of Professional Nursing*. 22 (4), 226.
- ¹⁸⁹ McIntosh, T., Torgerson, R. & Klassen, N. (2007). *The Ethical Recruitment of Internationally Educated Health Professionals: Lessons from Abroad and Options for Canada*. Ottawa: Canadian Policy Research Network, 18.
- ¹⁹⁰ International Council of Nurses (2007).
- ¹⁹¹ International Council of Nurses (2007).
- ¹⁹² Labonte, R. (2008). Ethics Writ Large: Policy Responses to Health Worker Migration. Presentation to the Health Human Resources Migration International Policy Symposium at the University of Toronto, September 27, 2008.
- ¹⁹³ Commission on the Social Determinants of Health (2008). *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Final Report on the Commission on the Social Determinants of Health*. Geneva: World Health Organization, 106.
- ¹⁹⁴ McElmurry, B., Solheim, K., Kishi, R., Coffia, M, Woith, W., & Janepanish, P. (2006). Ethical Concerns in Nurse Migration. *Journal of Professional Nursing*. 22 (4), 226.
- ¹⁹⁵ Saskatoon Health Region. (2008) Nurse Recruitment Trip to the Philippines: Ethical Recruiting.
http://www.saskatoonhealthregion.ca/news_you_need/media_centre/media/2008/recruitment_trip_ethics.htm
- ¹⁹⁶ McElmurry, B., Solheim, K., Kishi, R., Coffia, M, Woith, W., & Janepanish, P. (2006). Ethical Concerns in Nurse Migration. *Journal of Professional Nursing*. 22 (4), 226.