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International Nurse Migration: Crisis or Opportunity

Thank you for this opportunity to provide a few comments regarding nurse migration. I hope that my comments will be provocative and provide you with some food for thought. My comments are not facts and figures, but real world politics and market forces.

The title of this session is very appropriate, for nurse migration results in both opportunities and a deepening of a crisis. Let me start by saying that ANA is acutely aware of the impact that U.S. recruitment of foreign educated nurses has on many countries. While much of my talk speaks specifically to the U.S, please know that the ethical implications of immigration policy are always with us.

The United States health care industry has a long history of relying on foreign educated nurses as a source of nursing services. ANA and its constituent member associations have always welcomed foreign educated nurses to our country and we work to ensure that foreign educated nurses are treated with respect, that our immigration laws are fair, and that when there is a problem we work with the nurse immigrant to seek redress.

However, ANA is also confronted with a health care industry that does not value registered nurses as it does other health professions. Within, the context of the United States labor market, registered nurses' wages, benefits and working conditions are not commensurate with the level of responsibility and critical thinking that is the work of nurses.

During the mid-1990s, the U.S. health care industry undertook a major restructuring that resulted in nurses and other health care workers losing their jobs; put patient safety at risk; led to a severe decline in working conditions; and contributed to a 10 year long decline in nursing wages. ANA fought hard to educate policy makers and the public about this crises that was happening in our nation's health care system.

Starting in 1999, there began a discussion about a “looming nursing shortage.” The first response that was considered by the industry was to throw wide the immigration door to allow for a large influx of foreign educated nurses. It was not until the industry was pushed hard did it look at itself. It did not want to examine its own treatment of the domestic nursing workforce. It was reluctant to consider that real wages for registered nurses had declined during the period – a time in which the U.S. economy was described as “booming.”

The ANA took the position that broadly expanding U.S. immigration law to foreign educated nurses was not in the best interest of U.S. registered nurses. In fact, if the health care industry has access to a large number of foreign educated nurses there is no incentive for them to address the significant problems that exist with regard to the work environment and nursing wages.

This position is not reflective of ANA's interest in the world community of nursing. We believe that there is much to gain from mobility. ANA also recognizes that people – nurses – have a fundamental right to migrate. However, it is our belief that in order for all nurses who work in the U.S. to succeed and be treated with respect we must bring pressure to bear on the health care industry and employers to do the right the thing. Basic market forces suggest that ANA's advocacy on behalf of better wages and working conditions becomes much more difficult when the supply of registered nurses is such that employers do not have to compete for these services.

It is critical that you remember that the U.S. has a market driven health care system and while quality patient care is a goal this is often stymied by the focus on the cost of health care. In fact, if we did not have to worry about patient safety, access to health services, and all of the caring elements that are nursing, ANA might have had a policy that would suggest that keeping some nursing workforce shortage within the industry would be a good thing in that it would keep the pressure on the employers to maintain wages and working conditions.

Another issue that ANA has struggled with is the professional regulation of foreign educated nurses. Our world is not at a place where we are all educated the same or even practice the same from country to country. Nor, do we speak the same language. Given this, ANA along with the U.S. Commission on Graduates of Foreign Nursing Schools, supported a legislative measure that established a prescreening for all foreign educated health professionals, including nurses, that is linked to obtaining a national work permit or visa.

In general, this prescreening includes:

- a review of the nurses education in her home country to make sure that it is comparable to a U.S. educated nurse;
- a check of the applicant's home country license or registration to make sure that is unencumbered;
- English proficiency testing, both written and spoken; and for nurses,
- a predictor exam that is indicative of a nurse applicant's ability to pass the U.S. nurse licensing exam.

There was much consternation among other national nurses associations, foreign educated nurses, and employers who argued that in supporting this measure, ANA was being protectionist. The language requirement was considered to be particularly burdensome. However, it is ANA's perspective that this prescreening is necessary for public safety. In addition, all of the

prescreening elements relate to nursing practice. They are not arbitrary nor are they related to requirements such as national residency.

An anecdotal study done by the U.S. Department of Labor during the early 1990s and prior to passage of this legislation, looked at the areas where there was a large concentration of foreign educated nurses. The purpose of the study was to examine the impact on patient care and the impact on local nursing jobs. While there was no real measure of quality of care, significant concerns were raised with regard to language and the ability to communicate. What is nursing if it is not about being able to communicate?

Now it is true that the United States is fast becoming – if not multilingual – at least bilingual with the growth in our Hispanic population. Because of this, some have argued that nurses who can only speak Spanish should be able to work in the United States. The concern with this is that no part of the U.S. health care system functions in a silo. Eventually, that nurse or her patient will likely come in contact with the English speaking part of the system.

Finally, I would say that if the U.S. health care system continues down its current path and is not significantly reformed – a reform that leads to a more efficient utilization of nurses – than immigration will be a large part of our future. It is highly unlikely that the U.S. will be able to educate the 1 million nurses needed within the next 10 years to mitigate the nursing shortage. It is ANA's hope and indeed our fight to work toward reforming the U.S. health care system. Such reform of the system will lead to a reorientation away from sickness and hospitals toward prevention, community health and better management of chronic disease. Should this type of reform occur than the nursing profession will flourish.

Again, thank you for the opportunity to provide a few thoughts on this very important topic. I look forward to further dialogue and discussion.