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The migration of nurses: Trends, challenges, ethical concern and policies- India

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Abstract
The aim of the study was to assess and find out the scenario of Indian nurses with regards to Trends, challenges, ethical concerns and guiding policies which have strong impact on the level of nurses' migration. Further study focused on revealing information regarding OECD countries and their concern for shortcomings in nursing profession of origin countries and welcome benefits of receiving countries. Study materials are collected from various sources like books, journals, online data base and News paper cuttings of last two years from 2014-16. Findings revealed that migration was preferred most of the nurses for career advancements and financial outcomes and, more than one single push or pull factor is involved in migration. Over all the study concluded that Migration of nurses is necessary for professional growth of nurses and to achieve career advancements. Though migration is beneficial shortage of nurses must be handled carefully with managed migration to get fruitful outcome of migration.

Keywords: Migration of nurses, trends, challenges, ethical concern, policies on migration, OECD countries

Introduction
As the demand for nurses rises worldwide, commercial recruiters have become increasingly interested in the potential for exporting nurses from India to developed countries. While India does have a large potential labor pool that could be trained as nurses, at present India does not have enough professional nurses to meet its own domestic health service's needs.
Shortages of medical personnel in several developed countries are perceived to be central drivers of this phenomenon, and there are critical ramifications for developing countries (e.g., World Health Organization – WHO, 2006).
After a period of perceived excess supply in many developed countries in the 2010s, more recent years have seen an increased demand for health professionals, a growing concern about the need to provide healthcare services to aging populations, and an increasing focus on health human resources more generally.
This Article will provide an overview of migration of nurses: trends, challenges, ethical concern and policies, as well as a description of the current environment for international recruitment of nurses in India.

Why do nurses migrate
Of the current 175 million migrants that venture out for different lives, an increasing number are nurses and the majority of those are women.
"Traditionally, nurses travel for educational opportunities". "They want access to resources so they can learn and practice in a better way. Some migrate to be more autonomous. Others still just don't find the employment opportunities in their own countries."

Social status: most of the nurses do migrate not only for the sake of economic reasons but for the status and standard of living in abroad. Nurses are moving to raise their own professional standards and social status and dignity as well.

Job satisfaction: more than a status most of the nurses do find job satisfaction in overseas health care system set up rather than working in developing countries as social attitude towards nursing profession varies for any given country.

However, there are a series of 'pull' and 'push' factors that motivate a person to leave home and family to pursue other opportunities.

Other factors play a key role in "pushing" nurses out of their home country including an unsafe work environment, lack of political stability, high work-loads, or lack of economic remuneration.

The "pull" factors address some or all of those concerns and promise a better situation elsewhere.

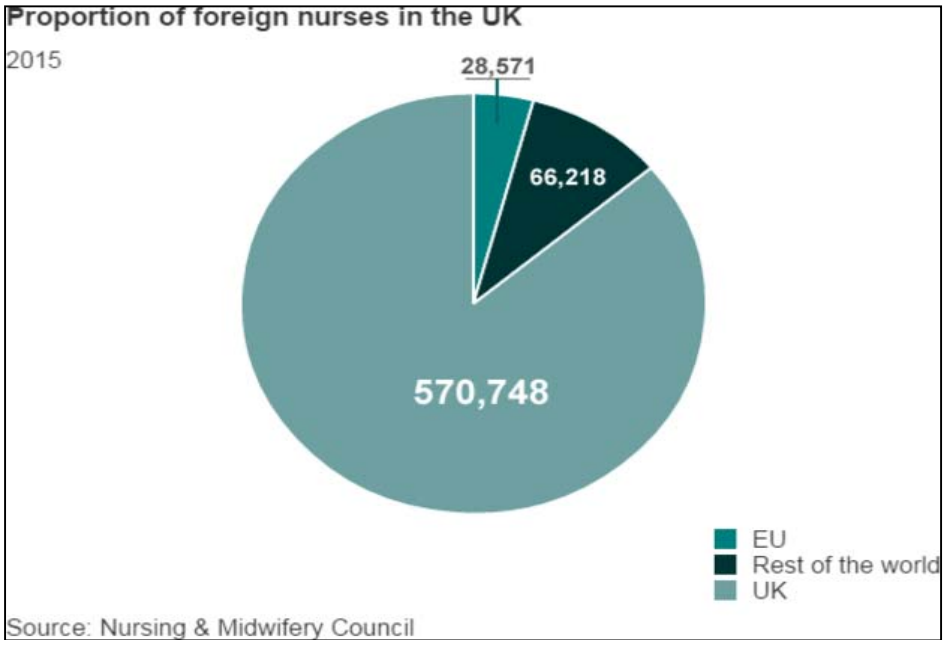
"Many of these nurses are also single parents and when you're faced with not only the financial needs of your children or perhaps elderly parents or even siblings, those financial constraints can become enormous. This is especially true in countries where family ties are strong and the responsibility for other family members is great."

Organization for Economic Cooperation and Development (OECD) Countries and Nurses Shortage:

The International Migration Outlook (Organization for Economic Cooperation and Development – OECD, 2007) [10] identifies "several international initiatives … formulating policy recommendations to overcome the global health workforce crisis".

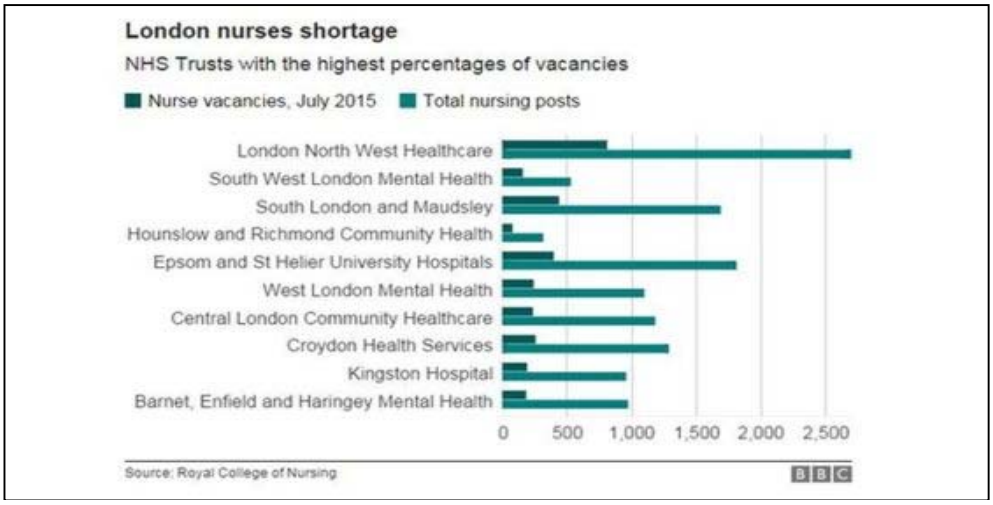
In response to these flows, in 2010 the WHO adopted a global code of practice on the international recruitment of health personnel with a focus on ethics and protecting less-developed sending countries (WHO, 2010).

Aligned with this initiative, several developed countries have devised their own protocols regarding the ethics of international health professional migration (e.g., Canada's ACHDHR, 2009; Norway's Directorate of Health and Social Affairs, 2007; UK Department of Health, 2011)



In 2015, the World Health Organization estimated that there was a shortage of more than 14.3 million health personnel across the world. Low-income countries were particularly hard-hit by shortages: of the 57 countries with a critical shortage, 36 were sub-Saharan African countries. Because the international migration of doctors and nurses has become increasingly visible, it is often seen as the main culprit behind these shortages.

This has led to a polarized debate between the negative aspects of migration like shortage of nurses in origin countries and the individual rights of health personnel to leave any country including their own.



In this context, policy discussions often occurred around the issue of compensation.

The work jointly carried out by the OECD and WHO provides a detailed picture of the magnitude of health workers migration and shows that the global health workforce crisis goes beyond the migration issue.

In any health system, the health worker determines the nature and quality of services provided. Data demonstrate that most health systems across the globe face nursing shortages, varying across regions and rural-urban distribution.

In response, there was a prolonged growth in physician and nurse density in OECD countries in the 1970s and 1980s, but the growth rates have slowed sharply since the early 1990s. Cost-containment policies, such as control of entry into medical school, and closure of hospital beds in the case of nurses, may explain much of the slowdown. In addition, trends such as the growing feminisation of the physician workforce, higher rates of part-time working and early retirement are also likely to have reduced hours worked by the average health personnel.

It is worthy to mention here that the Philippines is the largest supplier of nurses in the world, and the foremost example of managed migration of nursing workforce (Abella 1997). This country is losing trained nursing personnel much faster than it is possible to replace them. The majority of the Filipino nurses, 84.75 per cent, are reported to be working abroad. Many regions of the Philippines are facing severe a shortage of nurses (Lorenzo, Galvez-Tan, Icamina & Javier 2007).

It was reported by the Philippine Hospital Association (PHA) that in a time span of two years, 200 hospitals have been closed and around 800 hospitals are partly closed due to mass migration of nurses from the country (Philippine Hospital Association 2005).

Indian Nurses Shortage

According to the World Health Organisation, India will need 3.4 million nurses by 2020 to achieve the government's aim of a nurse-patient ratio of one nurse per 200 population.

Although nursing services are an integral part of both preventive and curative aspects of India's health system, the nursing estimates of the country shows that India has been facing a shortage of nurses since independence.

Studies show that professional, social and economic reasons are considered to be behind the nursing shortage in India. Similar reasons induce Indian nurses to look for migration opportunities in other countries.

India has 2,500 nursing diploma schools, 1,400 nursing degree schools and 381 MSc nursing colleges. Annually, the country produces around 80,000 nurses.

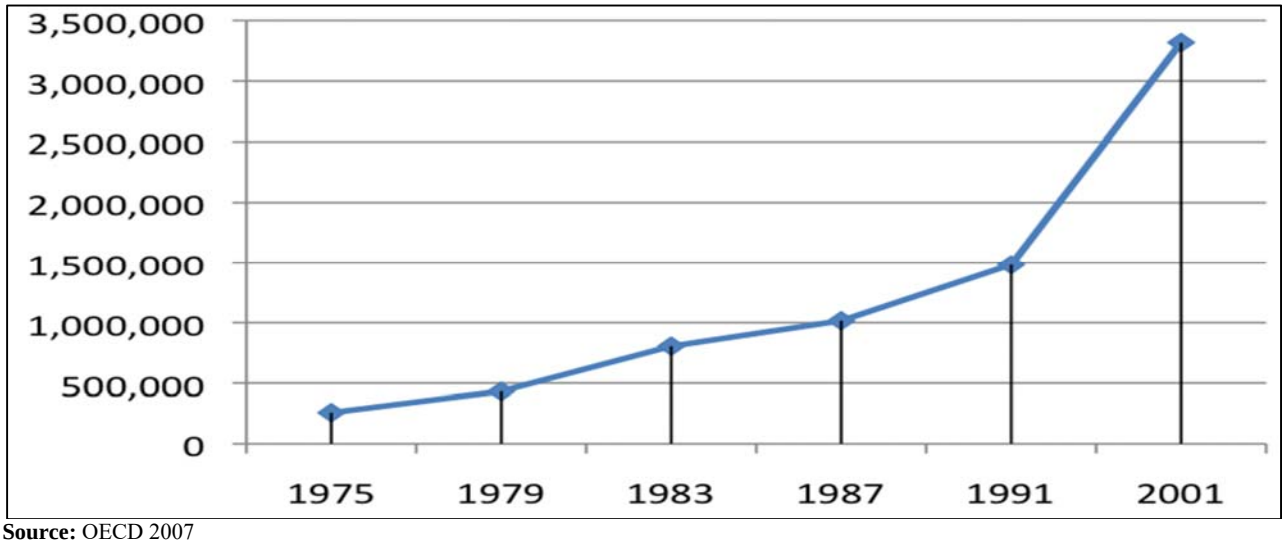
India has a capacity to train 89,850 diploma nurses, 51,650 graduate nurses and 2,940 postgraduate nurses per year.

However, over 20% of this number head to foreign shores every year. The ministry has therefore increased the retirement age of the faculty in nursing colleges to 70 years. The eligibility criteria to admission for diploma and degree has been relaxed by 5%.

"Recently, the Cabinet approved the setting up of 260 government nursing schools at the district level to meet the shortage of nursing staff,"

The high income countries have discovered India as a new source of well trained, English-speaking nurses to overcome their nursing shortages. This has resulted in mass migration of nurses from India, which in turn may lead to non-availability of standard quality health services especially to the poor section of the population in the country.

Migration of Indian Nurses



Source: OECD 2007

Strong political commitment is required for improving the nursing situation in India.

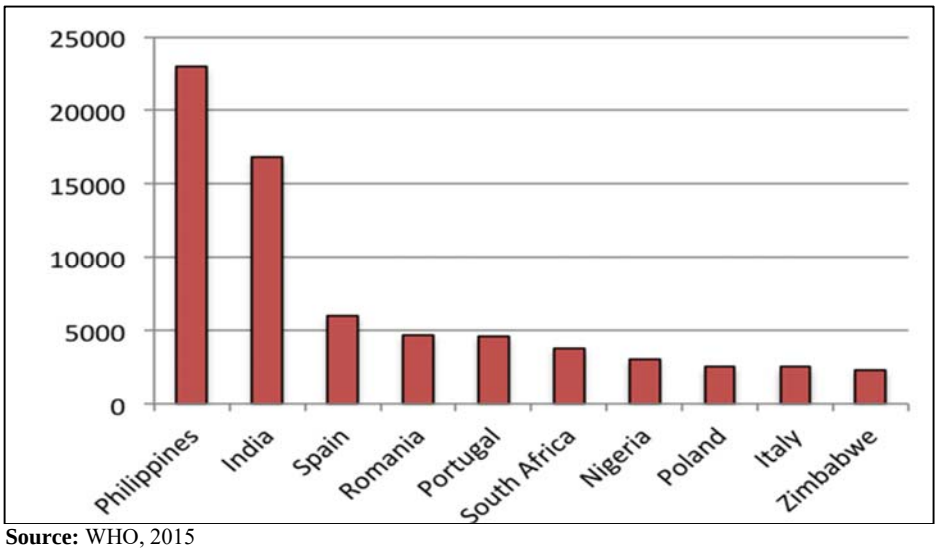
Nurses, along with other health care professionals, are involved in the direct delivery of health care to the population and therefore form an essential part of the health system.

To overcome these shortages, the developed countries are undertaking active recruitment of foreign nurses. Most of the nurses migrating to the high income countries come from the developing countries (Buchan & Scholaski 2004).

India is one of the major source countries providing nurses to the developed nations. The source country's health systems, especially the developing ones, face a severe loss of trained staff as the nurses migrate from both the public and private sector.

A country with an already dismal health system suffers more when nurses migrate to other countries.

Shortage of Indian Nurses in every year



Source: WHO, 2015

International Migration of Nurses From India- Trends And Facts

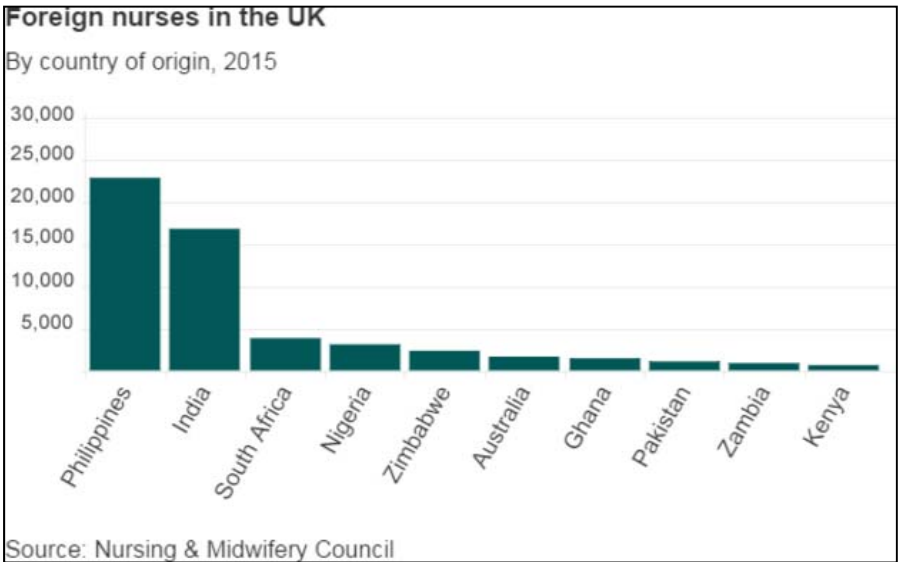
India has been discovered as a new source country for migration by the high-income countries to overcome shortage of nurses faced by them. The migration of nurses from India can be traced from the decade of 1970's.

Earlier, a few Indian nurses used to migrate because earning prospects were high. This helped them to send remittances back home, which were used for various purposes, e.g. building a new house, financing children's education and for a small business that the husband might start.

But, in the post-1980's there was a shift to mass migration of nurses from India, most of them belonging to the state of Kerala (Nair & Percot 2007) [9].

The majority of the nursing workforce in the country like UK is represented by Keralite Christians, who comprise a large section of the nurses migrating from India (Nair & Percot 2007).

The recruitment of nurses from India is mainly targeted from a few geographical locations. There are three recruitment hubs in the country, i.e. Kochi, Bangalore and Delhi. These centers facilitate migration of nurses to other countries like the US, the UK, Ireland, Singapore, New Zealand, Australia and the Gulf nations (Khadria 2007).



A nurse has two main options amongst the destination countries. An Indian nurse can migrate to the Gulf countries or they can take up employment in developed countries like the US, the UK, Ireland, etc.

For working in the Gulf countries, a nurse needs a minimum experience of two years. There are no qualifying tests required for working in these countries. They have only to appear for an interview which can even be telephonic. A nurse needs to pass some qualifying tests as CGFNS, NCLEX, and IELTS for working in the developed countries. The nurses might have difficulties in passing the IELTS. The multiple choice question format and required curriculum poses difficulties for Indian nurses. Preparing for the tests can be expensive and can act as an additional financial burden for the nurse hoping to migrate.

Qualifying tests and process

Type of test	Destination	Incurring cost	Processing time
IELTS	UK, Australia, Canada, Ireland and New Zealand.	7600 INR for registration to give test	Minimum 1 year after clearing exam
CGFNS	US	18000-25000 INR for registration to give test	Minimum 15 months after clearing exam
NCLEX	US	12000-15000 INR for registration to give test	Minimum 18 months after clearing exam

The nurses migrate to the Gulf countries mostly because of the easier employment criteria. It is also simpler and cheaper to migrate to Gulf nations as compared to the developed countries (George 2005, Gill 2009).

The recruitment agencies facilitating migration of nurses to Gulf countries as well as the nurse's friends, who are already working in Gulf countries, assist in her migratory process. They inform her about employment opportunities available in other countries through her friends and relatives working aboard.

This transnational network of nurses helps in disseminating relevant employment information to nurses working in India.

The Indian nurses migrating to other countries generally rely on their social network for adjusting to the new society of the destination countries (Gill 2009).

Among the Gulf countries, the preferred destinations are the United Arab Emirates, Qatar, Kuwait, Oman, and Bahrain as they offer better salary and good quality of life.

Saudi Arabia and Yemen are the least preferred destination countries. The Indian nurses experience social and religious restrictions in Gulf nations, especially in Saudi Arabia.

The Indian nurses employed in the Gulf have no opportunity of getting citizenship there, cannot own a house or business in the Gulf country and have few educational opportunities available for their children.

The married women migrating to Gulf nations cannot avail a family visa; only men are allowed to bring their family to Gulf countries. Thus, the problems faced by Indian nurses in the Gulf countries provoke them to look for employment in the developed countries (Percot 2006).

Some Indian nurses use Gulf nations as a transit point for migrating to developed countries. They try to save from their earnings either to pay for the hefty fees charged by the recruitment agencies, which are catering to markets of the developed countries or in order to prepare for the qualifying tests (Gill 2009).

Nursing is taken up by women as part of their family strategy in which their education and migration constitute a vital part of the entire process. The majority of nurses in India come from lower-middle class families (Percot & Rajan 2007). It costs around a lakh of rupees for a nursing diploma (*The Hindu* 2001).

Thus, the parents invest in the nurses' education, believing this will bear fruit once their child migrates. The remittance sent back home by nurses is not only used for family purposes but a part of it is also saved for the dowry required for the nurse's marriage.

The remittances are instrumental in a way for raising the social status of the family. The money is generally used for buying jewellery and other consumable goods or for building a new concrete house.

Migration to another country might give the Indian nurses an opportunity to live outside the prevailing strict family norms in India (Gill 2009).

Most of the women take up nursing profession because they have plans to work abroad. A nurse working abroad has better marriage prospects as she might be seen as a ticket for the groom to move abroad and to get employment there.

The preferences held by groom's family for choosing the prospective bride among nurses in descending order are the nurses with a citizenship of the developed countries, nurses who are working abroad with a work permit, one who has applied abroad and finally the nurses who are working in India.

Most of the migrant nurses go through arranged marriages. The migration opportunities available to nurses have lifted the social status accorded to nurses in India, especially among south Indian communities.

Most of the private hospitals in India offer an initial pay of Rs. 8000 to Rs. 9000 per month, whereas an Indian nurse can earn as much as Rs. 80,000 per month as a starting salary after migrating to the Gulf countries (*The Hindu* 2015, Percot 2016).

A nurse, who goes abroad, mainly saves for three purposes, i.e. for sending remittances back home, for dowry and for future savings. It is difficult for a nurse to have sufficient savings from her earnings in India. Thus, she realistically chooses a suitable option, i.e., migrating to other countries.

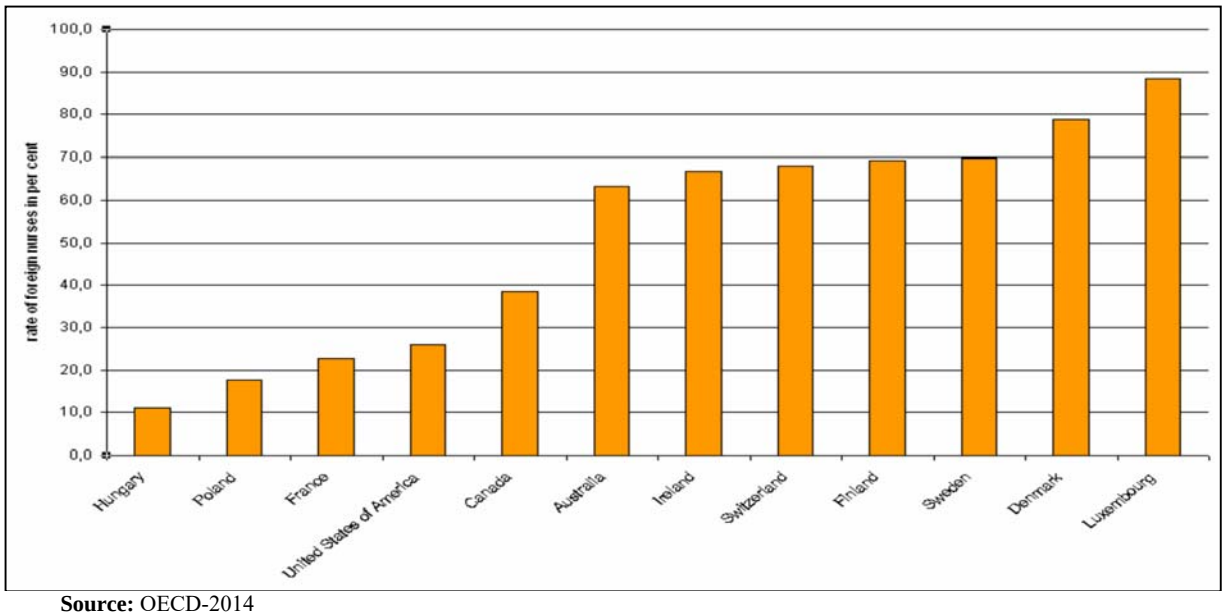
The migrants might hold themselves back from integrating in the society of the destination country, thus leading to alienation from the foreign culture (Troy, Wyness & McAauliffe 2007).

Poor institutional accommodation, low salaries, high cost of living can be some of the other problems faced by Indian nurses in the developed countries (Garbayo & Maben 2009).

Migration is an on-going process with few chances of the nurses coming back to India. The government of India sees a positive factor in the increase of foreign opportunities for Indian nurse.

The National Commission on Macroeconomics and Health mentions "*in fact, with the large number of opportunities opening up for employment in foreign countries, particularly for nurses, it would be to India's advantage to focus on expanding the number of colleges and nursing schools alongside efforts to ensure good quality to make them employable*" (GOI 2005, p. 63).

The rate of Foreign nurses in different countries- Percent



Source: OECD-2014

The share of foreign-trained nurses tends to be lower than for doctors. In Sweden, for example, less than 3% of nurses were foreign trained in 2008 compared with over 18% for doctors.

Similar findings apply to most OECD countries but not in Ireland which has the second highest nurses to-doctor ratio in the OECD (5 to 1) and where about 47% of the nurses were foreign-trained in 2008 compared with almost 36% for doctors.

That being said, migration of nurses has increased in many OECD countries since 2000. However, in the United Kingdom and Ireland, between 2001 and 2008, new registrations of foreign-trained nurses decreased by a factor of 4 and 2.7, respectively.

In the meantime, permanent migration of foreign registered nurses to Australia increased six-fold, while it was multiplied by three in Canada. In the United States, the number of foreign-trained nurses passing the licensing examination has quadrupled between 2001 and 2007, before decreasing significantly in the last two years.

In Sweden, Denmark and Switzerland, inflows of foreign-trained nurses peaked around 2003 before decreasing significantly until 2006. Since then, growth in migration flows seems to have resumed.

Push (*i.e.* reasons why people might want to emigrate) and pull (reasons why a country might seek to attract immigrants) factors for migration could nonetheless be affected.

On the one hand, the deterioration of the economic conditions in countries of origin could provide further incentives to look actively for employment opportunities abroad. On the other hand, people who have recently left the health workforce in OECD countries to take up other types of jobs, may consider returning to the health sector because of the greater job security.

These short- or medium-term effects should not distract attention from some of the more structural reasons why some OECD countries rely on migration of healthcare professionals.

Push and Pull Factors

Apart from *economic factors, dissatisfaction* with working conditions and unhappiness with prevalent *social attitudes* towards nurses were identified as being of crucial importance for the international migration of Indian nurses.

The migration of health workers is not new: nurses and physicians have sought employment abroad for many reasons, including high unemployment in the health-care labour market in their home country.

It was found that nurses working in the private sector and from some linguistic and religious groups were particularly prone to migration.

Nurses working in the government sector seemed to be more worried about being unable to adjust to working conditions abroad and therefore less keen to migrate. The fact that they enjoyed better pay scales, a more relaxed work atmosphere and more facilities may have also played a part here.

What seemed to be vital to the decision to migrate for a large number of government sector nurses belonging to the so-called 'Forward' and 'Middle' Castes was that they were being crowded out of promotional avenues as a result of the government's policy of Reservations in Promotions for Scheduled Castes and Tribes.

In particular, countries that have more migration in general, and notably those which have more highly skilled migration, tend to have more migrant health workers.

From the perspective of potential migrants, the push and pull factors driving the migration of personnel broadly coincide with those that apply to highly skilled workers in general.

Wage differentials across countries play an important role, but are not the only determinant, as other factors such as the possibility to offer a better and safer future to their children may also be determinant.

Very often indeed, migration of health workers will be a symptom of the difficulties faced by the health system, and more generally the society, of the country of origin rather than its direct cause.

Other Factors for Migration:
However, there are certain key features of the health-care labour market that give rise to new concerns about the international movement of health workers.
First, new communication technologies are shaping a global labour market through electronic access which means that jobs, and often education for jobs by distance learning, are available internationally, as are visa applications and access to processes. It is commented that certain sets of skills and competencies are so specialized or in such short supply that they are being sourced globally.
Second, *rising incomes, new medical technology, increased specialisation of health services*, and population ageing are pushing up demand for healthcare workers in OECD countries.
Third, despite the lack of doctors and nurses in many developing countries, the first motivation for migration is often linked to more and better employment opportunities abroad (*encompassing salaries, working conditions, career advancement, etc.*).

Impact of Nurses Migration
Three main findings emerge from the OECD/WHO work with regard to the impact of health workers' migration on origin countries.
First, a significant share of international movements is occurring between OECD countries, even though the bulk of migration flows is originating from developing and emerging countries.
Around 2000, nurses born in the Philippines (110 000) and doctors born in India (56 000) accounted for the bulk of the immigrant health workforce in the OECD, but the second and third most important origin countries were the United Kingdom and Germany. As of 2000, slightly fewer than 40% of all migrant doctors and 30% of migrant nurses in OECD countries originated from another OECD country.
Secondly, the outflow of health personnel from large origin countries such as India or Russia – albeit large in absolute terms – remains low compared with the size of their total workforce.
In addition, some countries with a percentage of their health personnel abroad manage to maintain relatively high numbers of health workers at home. This is the case notably for countries that train nurses for export, such as the Philippines, some Caribbean states and, increasingly, China.

Problem
International migration is fuelled by the recruitment efforts motivated by critical shortages experienced in the destination countries.

Temporary: Recruiting nurses from abroad however does not address the basic causative factors for the local shortage and represents merely a redistribution of shortage globally.

Patient's safety: Foreign-educated nurses must be properly oriented and integrated into the health care team if quality care is to be provided. If this is not done properly, patient safety is threatened.

Integration: Society must also accept these nurses, welcoming them into their communities and facilitating their integration into social networks which may be more difficult when cultural differences are greater.

Loss: If the nurses' education was publicly funded in the source country, there is concern that this represents a significant loss of investment for the population and government left behind.

Exploitation: As the majority of nurses are women and migrant populations are known to be more vulnerable, issues of gender exploitation may need to be addressed, i.e. effective prevention and protection measures must be put in place.

Solution
Export: No discussion of nurse migration can exclude a look at the economic impact on countries from which nurses migrate. Migrant workers send money home to their families and this income is often an incentive for source countries to initiate, maintain or increase the export of their nationals.
In aggregate, remittances sent through formal channels are more than twice the size of international aid flows (World Bank 2006) and estimated to be US$ 232 billion in 2005 (UN 2006).
Econometric analysis and household surveys suggest that unrecorded remittances sent through informal channels may conservatively add 50 per cent (World Bank 2006).

Emancipation: Nurse migrants are not only contributing to the generation of new wealth but may be pioneers in an informal social movement towards gender emancipation.

Quality of life: Finally, the decision to migrate is motivated by the desire to improve an individual's quality of life. In many cases, the move will provide opportunities for professional development, the ability to practice acquired skills, improving work and living conditions, and accessing finances that will help their families.

Challenges
Meeting the nursing need
Rather than addressing the underlying problems that drive nurses to seek opportunities elsewhere, such as increasing salaries and benefits, some countries have tried to implement bans on nursing emigration or in the case of many industrialized countries, have turned to the world market to supply their demand.
As a result, the international migration of nurses has become a multi-billion dollar industry. "It's difficult to come up with a sum of money involved in nurse migration,
"But it's clear that the trade and services of the industry has generated all sorts of business ventures that support it either through education, through companies that facilitate immigration, recruitment agencies, travel agencies, banks, and even telephone companies that cater to the immigrant nurse that wants to call home."

A new adjustment
The challenges of nurse migration are not just those that drive the traveling nurse to leave her home country. There are also the questions surrounding her journey and her new country of employment.
Once these nurses have had their qualifications recognized, have tested for licensure in another country, and have had their visas approved, they then have to deal with adjusting to

a new country, a new health care system, and new cultural expectations.

"These nurses have a license to practice but they're unfamiliar with the health system, or some of them may have problems with communication. Although you may be fluent in a language, you many not be at ease with its slang or medical terminologies."

Worse, is that many nurses are denied an orientation period even when they are promised one. This is also a problem faced by nationals, who receive little or no orientation either because of the shortage or due to lack of incentive.

Exploitation

Part of the concern surrounding the international migration of nurses is that it opens the door for potential exploitation.

For example, it can start off by the fact that nurses are asked to pay recruitment agencies a fee to find them employment abroad. In some cases, this fee can extract up to six months' salary form a nurse, and worse, just provide access to employment *information*, rather than a position. Many nurses don't realize that hospitals are responsible for paying the fees and that these agencies are in fact, double-billing – a practice illegal in many countries.

Another concern is contract substitution. In this situation, a nurse arrives in her destination country and because she has to trust others to deal with her immigration papers, customs, and other matters, she hands her travel documents to agency representatives.

"The agencies then tell the nurse that unless she signs a new contract, she won't get her documents back. "In some cases this can mean that having signed up to work for an acute hospital at $100,000 a year, for example, the nurse has to accept a job at $30,000 at a nursing home."

There is also a great deal of fraud and abuse in accommodation. Because many times new migrants don't know any better, they are made to live in particular apartments where the rent is doubled, and they have to pay additional "fees" and "surcharges" to the landlord.

Finally, it's important to note that men and women in nursing are at equal risk of recruitment abuse and other workplace exploitation, including violence (physicial and psychological), but it occurs more frequently to women because they make up the majority of nurse migrants. The exception is sexual harassment where women are more likely to be the victims.

While these cases are rare, they do happen, and they need to be addressed simultaneously with the questions of nurse recruitment and migration.

Finding Answers

Many ministers of health in developing countries claim that they cannot hope to compete with salaries offered in places like the United States and Canada and as such, they can't stem the tide of nurses leaving their countries.

"Nurse migration" "would not be such a big issue if there wasn't a nursing shortage."

"Migration is and will continue to be a part of our lives, especially with increasing globalization. If we deal with the need to migrate, we'll address the nursing shortage, and migration will not be an issue, it will be enrichment."

Ethics and Policies to Overcome

Receiving countries need to expand education and training capacity. The objective should not necessarily be "self-sufficiency" but should be to avoid becoming excessively dependent on foreign health personnel to fill domestic needs.

In addition, OECD countries could adopt a portfolio of policies aimed at making the best use of the existing health workforce by

1. Improving retention (particularly through better workforce organization and management policies);
2. Enhancing integration in the health workforce (such as by attracting back those who have left the health workforce);
3. Adopting a more efficient skill mix (such as by developing the role of advanced-practice nurses and physicians' assistants); and
4. Improving productivity (by, for example, linking payment to performance).

Different countries are likely to choose different mixes of these policies, depending, among other things, on the flexibility of their health labour markets, institutional constraints, and cost.

Source countries need to strengthen health workforce retention. Such policies should focus on rural areas, as there seems to be a link between internal and international migration. (Most international migrants come from urban areas although the most acute shortages tend to be in rural areas.)

To address this concern, WHO has been developing a programme of work, including a set of global recommendations, on health workforce retention in rural and remote areas

(see *www.who.int/hrh/migration/retention/en/index.html*).

Although from a financial perspective improving retention in developing countries is rather challenging – lower income countries are not in a position to close the wage differential with higher income countries – other measures have been shown to be effective to improve retention, such as improving working conditions and health workforce management, providing better equipment, and facilitating professional development.

Scaling-up domestic training of health workers will often also be required. These policies require better governance and long-term financial commitments that, in many cases, will not be achievable without support from the international community.

Strengthening international co-operation is therefore one of the key policy responses needed. A number of "codes of practice" on the ethical recruitment of international health workers have been created over the past few years. These initiatives have served to raise awareness in public opinion and among policymakers, as well as to improve policy coherence for development.

Ethical and Policy issues in source countries

Some national governments and government agencies (for example, in the Philippines) are attempting to encourage outflow of nurses from their country. This may have a financial imperative, to encourage the generation of remittance income; it may be a response to labour market oversupply; or it may be an attempt to develop a long-term improvement in the skills base of the nursing workforce by encouraging short-term outflow to other countries where training is available.

Bonding: For most source countries, however, outflow of nurses is a problem rather than a policy initiative. Some countries have initiated or examined various policy responses to attempt to reduce outflow by including bonding nurses to home employment for a specified period of time after completion of training, or attempting to negotiate a fee in compensation from the departing nurses or the destination country.

Regulatory: Preventing nurses from leaving through the use of monetary or regulatory barriers is one policy response, but it does nothing to respond to the push factors that have stimulated the nurses' desire to leave and is also contrary to notions of free mobility of individuals.

Career prospects: Other policy responses to reducing outflow would relate to a more direct attempt to reduce the push factors, by tackling poor pay and career prospects, poor working conditions, and high workloads; responding to concerns about security; and improving educational opportunities.

Clearly there is a financial cost involved in such initiatives, but national governments must be confident that nurses are receiving fair and equitable treatment within existing financial constraints and that they are not being disadvantaged because nursing work is undervalued relative to other professions.

Managed migration: Another policy response is to recognize that outflow cannot be halted where principles of individual freedom are to be upheld, but then to work at ensuring that such outflow that does occur is managed and moderated. The "managed migration" initiative being undertaken in the Caribbean is one example of coordinated intervention to attempt to minimize the negative impacts of outflow while seeking to secure at least some benefit from the process.

Ethical and Policy issues in destination countries

Retention: A central concern for destination countries is to assess the relative contribution of international recruitment compared with other key interventions — such as home-based recruitment, improved retention, and return of non-practising nurses — in order to identify the most effective balance of interventions.

Home-based solutions, such as improving staff retention through provision of flexible working hours or improved working conditions and attracting returners through part-time career opportunities, may be more cost-effective than international recruitment.

Efficiency: The second policy challenge for destination countries can be characterized as the "efficiency" challenge. If there is an inflow of nurses from source countries, how can this inflow be moderated and facilitated so that it makes an effective contribution to the health system?

Regulatory process: Policy responses include improving the regulatory or certification process to enable these nurses to obtain registration more easily; fast tracking their visa or work permit applications; developing coordinated, multi-employer approaches to recruitment; developing multi-agency approaches to coordinated placement and (where necessary) providing initial periods of supervised practice or adaptation as well as language training, cultural orientation and social support.

There can be a tension between the pressure to accelerate inflow of these nurses and the need to maintain regulatory processes and standards. Countries that are currently heavily reliant on inflow of international nurses have seen policy attempts to speed up the process of inflow; in some cases, these attempts have been opposed by stakeholders who fear a potentially negative impact on standards and patient safety.

Ethical challenge: The third policy challenge of destination countries is the "ethical" challenge. Is it justifiable, on moral and ethical grounds, to recruit nurses from developing countries? The simple response is that it should not be justifiable to contribute to brain drain from other countries, but a detailed examination of the issue reveals a more complex and blurred picture.

"Active" recruitment by employers or a national government in the destination country has to be contrasted with individual decisions, as the nurses themselves may have taken the initiative to move across a national border.

Currently, it is not possible to quantify the relevant flow related to active recruitment as a proportion of total recruitment, but some countries have put in place mechanisms to support active recruitment of large numbers of nurses.

Temporary migration, related to a temporary oversupply in one country or to a managed exchange of staff, has to be differentiated from planned, permanent migration attributable to pull factors in the destination country.

Some countries have developed a policy response to attempt to manage the balance between ethics and efficiency. England and Ireland have initiated ethical guidelines for employers recruiting nurses from other countries.

However, in practice, these guidelines tend to focus more on the practicalities of recruitment than on any moral considerations. A different approach has been adopted by Norway, which has announced an annual restriction on the number of nurses that can be recruited by its governmental agency, and this recruitment is based on government to government agreements.

The capping of the number of recruits limits the impact of active recruitment. The impact of the ethical guidelines is difficult to assess, because they have been in place only a short period of time.

The initial guidelines from England (which cover only NHS employers) did have a short-term impact in reducing inflow from named developing countries, but overall the inflow has since increased.

The Norwegian approach of setting a state recruitment target is more effective in limiting the impact on other countries.

Management of Outflow

Managing the migration of health-care workers

To manage migration effectively it is necessary for governments and other agencies to develop a more strategic approach towards regulating the flow of health workers between countries.

Each country has to develop its own strategy for dealing with the issue of migration in its own context. It is clear that migration does not exist outside the development of health systems and that a range of policy and strategy interventions is required to address the broader health-systems issues that influence the retention, recruitment, deployment, and development of health workers.

Improving data collection

Having reliable data about the health-care workforce is key to good workforce planning. Establishing and maintaining appropriate information systems on human resources, including a database on migration, is a vital first step.

Diallo discusses the use and reliability of available data sources and acknowledges the difficulties in finding accurate data. He recommends a process of triangulation of different sources to give the most comprehensive overall picture.

Data from destination countries are much more accurate than data from source countries.

Financial and non-financial incentives

In many developing countries health-care systems are suffering from years of underinvestment, and for health-care workers this has resulted in low wages, poor working conditions, a lack of leadership, and few incentives of any kind.

Korte et al., studying the motivation of health-care workers in four developing countries in Africa, have observed that low job satisfaction and motivation affect the performance of health workers as well as acting to push people to migrate.

Their study has found that non-financial incentives are important in motivating heath care workers both to do a good job and to continue working in public health services; these incentives include training, study leave, the opportunity to work in a team, and support and feedback from supervisors.

Some incentives were found to work well to retain staff in rural areas. These included providing housing and transport, agreeing the number of years that will be spent in a rural location (rather than expecting a worker to remain there in-definitely), offering further training, and offering financial incentives.

These findings support previous work on motivation and indicate that even simple, relatively low-cost measures may have a positive effect on the motivation of health workers and on retention.

Agreements between countries

Recognizing the inevitability of migration and building in opportunities for health workers to work overseas for limited periods of time is possible through bilaterally negotiated agreements, for which temporary visas are granted, or through institutional agreements to take (or even exchange) workers.

This type of scheme is being tried between the United Kingdom and South Africa, apparently with some success

Action by destination countries

Destination countries may address workforce issues that affect migration. Ironically, some of their problems are the same as those of the source countries, though without the extreme adverse effects that result from the loss of health workers from already struggling health-care systems.

Improving staff retention is an obvious but necessary strategy that destination countries can implement. This may be done through a range of incentives, such as introducing flexible employment contracts, improving working conditions, offering performance-related pay, and offering overtime pay.

Implementing retention strategies will reduce the number of posts for migrants, and therefore the attraction of moving.

Conclusion

The Article concludes that Migration of nurses is necessary for professional growth of nurses and to achieve career advancements.

Though migration is beneficial shortage of nurses must be handled carefully with managed migration to get fruitful outcome of migration.

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