

studies and perspectives

7

The migration
of health care workers
in the western hemisphere:
issues and impacts

Patricia Weiss Fagen, Ph.D.



ECLAC Office in Washington

Washington, D.C., december 2009



Canadian International
Development Agency

Agence canadienne de
développement international

Canada

This document was prepared by Patricia Weiss Fagen, Ph.D, Institute for the Study of International Migration, Georgetown University, Consultant to the Washington Office of the Economic Commission for Latin America and the Caribbean (ECLAC) of the United Nations. This document is part of the technical assistance activities of the Project “Strengthening Trade Related Capacities in the context of trade liberalization in the Americas”, financed by the Canadian International Development Agency (CIDA) and executed by the ECLAC Washington Office.

Inés Bustillo, Director, Raquel Artecona, Economic Affairs Officer and Rex Garcia, of the ECLAC Washington Office have overseen the preparation of the report as a whole.

The views expressed in this document, which has been reproduced without formal editing, are those of the authors and do not necessarily reflect the views of the Organization.

United Nations Publications

ISSN printed version: 1727-9909

ISSN online version: 1728-5437

ISBN: 978-92-1-121719-3

LC/L.3119-P

LC/WAS/L.105

Sales No.: E.09.II.G.98

Copyright © United Nations, February 2010. All rights reserved

Printed in United Nations

Applications for the right to reproduce this work are welcomed and should be sent to the Secretary of the Publications Board, United Nations Headquarters, New York, N.Y. 10017, U.S.A. Member States and their governmental institutions may reproduce this work without prior authorization, but are requested to mention the source and inform the United Nations of such reproduction.

Contents

Abstract.....	5
I. Introduction: health care workers and migration in the western hemisphere.	7
1. It is important to examine how the demands of elder care and health worker migration intersect the following reason	8
2. Policy interest but weak data.....	9
II. Health care gaps and immigrants in the United States and Canada	11
1. Defining the shortages.....	12
2. Health care migration: United States.....	13
3. Direct care workers and migration: Canada	16
III. The southern hemisphere: aging, migration and health care	17
1. Regional attention to aging populations:.....	17
2. Quality of national health care:	18
IV Health care providers, North and South	19
1. Categories of nurses as classified in the North.....	19
2. Nursing training and classifications in the South.....	20
V. The nexus of migration, health and eldercare	23
1. Gaps in services, gaps in information.....	23
2. Regional migration patterns	24
VI. Initiatives in Latin America and the Caribbean	25
1. Managing nurse migration in the Caribbean region	26
2. Low skilled health care workers, not yet “managed”	27
3. Other western hemisphere health care and migration related initiatives	28

4.	Upgrading health care provider skills.....	28
5.	Possible migration consequences of improving educational levels	29
VII.	Status, conditions and pay	31
1.	Conditions in sending countries.....	31
2.	Northern opportunities.....	32
3.	Professional mobility	33
VIII	The migration process and its requirements.....	35
1	Required examinations	35
2.	Recruitment practices	36
3.	Recruitment and ethics	37
IX.	Concluding observations and next steps.....	39
	Bibliography	41
	Studies and Perspectives series, Washington Office	
	Issues published	45
Tables		
TABLE 1	SELECTED COUNTRIES OF BIRTH OF FOREIGN-BORN LONG TERM CARE WORKERS, 2003-2007	13
TABLE 2	COUNTRY OF BIRTH OF CHILDCARE, HOME SUPPORT AND HEALTH CARE AND SOCIAL ASSISTANCE WORKERS, CANADA, 2001.....	15
Figures		
FIGURE 1	PERCENT OF LONG TERM CARE WORKERS IN THE U.S. WHO ARE FOREIGN BORN, 2003-2007.....	13

Abstract

Health care migration is a large and global business. Recruitment is decentralized, involves both public and private sector entrepreneurs, and is difficult to regulate. The countries of the western hemisphere are important players in the global health market but, with the partial exception of the Islands of the Caribbean, there is little cooperation among their governments to manage migration patterns or combine forces in order to achieve economies of scale and cost effective training facilities. A related area of concern within the realm of health is care for the elderly. In wealthy countries people are living longer but not necessarily healthy lives and require expanding levels of care as they age. Their care is likely to involve paid service providers who often originate from poorer countries. But the demographic and economic changes in the poorer countries make caring for the elderly more difficult there as well.

In the major migrant receiving western hemisphere countries, the United States and Canada, the concern is that domestically educated nurses will not be sufficient to meet growing demands. The recruitment of immigrant professionals in nursing fields helps fill existing gaps. The pages that follow outline a range of issues related to health care workers from the western hemisphere, their patterns of movement, their roles in the work force primarily in the United States and Canada, and the impacts of health care migration on source and receiving countries. The study tracks the largest segment of migrating health care workers: nurses and long term/direct care providers who perform nursing functions. It covers training, migration requirements, and ethical issues raised the flight of qualified health care givers and looks at efforts, especially in the Caribbean region to manage that flight.

I. Introduction: health care workers and migration in the western hemisphere

The pages that follow outline a range of issues related to health care workers from the western hemisphere, their patterns of movement, their roles in the work force primarily in the United States and Canada, and the impacts of health care migration on source and receiving countries. The study tracks the largest segment of migrating health care workers: nurses and long term/direct care providers¹ who perform nursing functions. It considers how health care migration responds to changing demographic patterns, especially in the more developed countries, in which the population is rapidly aging.

Noting that “the rich world is ageing fast, and the poor world is only a few decades behind” the London based *Economist* magazine (June 27-July 3, 2009, prepared a special report on the problems and, especially, the costs of aging populations. The issues raised by aging populations by no means are limited to health, but none of the affected nations have care systems in place that are prepared for the responsibilities they will face or the health care personnel they expect to require.

The analysis in these pages incorporates three areas currently raising concerns: 1) the inadequacies of human resources in the

¹ Both terms are used frequently and apparently interchangeably. The terms do not necessarily imply care for the elderly, as other categories of patients also require long term/direct care. As used, however, the terms designate persons working in institutions and home settings where elders predominate and charged with tasks essential for elder care.

health care field, North and South; 2) the consequences of aging populations for labor and social programs; and 3) the migration of health care workers in the hemisphere.² Concern about migrating health care professionals is long standing and global. Policy makers, medical and nurses associations, economists, and academics project future shortages of nurses in the major migrant receiving western hemisphere countries, the United States and Canada, as well as in Europe. A long term solution would be to prepare a larger cadre of domestic workers to deal with the elderly and to pay them attractive salaries; the shorter term solution now being pursued in hospitals and long term care facilities is to recruit immigrant professionals in nursing. There is, in fact, an ample available pool of potential immigrants from poorer countries who want to be accredited in the North and are willing to fill nursing and direct care positions at prevailing wage levels. However, as the source countries are now experiencing shortages of health care workers for the elderly and disabled populations at home, they too are rethinking their options.

This document is part of the technical assistance activities of the Project “Strengthening Trade Related Capacities in the context of trade liberalization in the Americas”, financed by the Canadian International Development Agency (CIDA) and executed by the ECLAC Washington Office.

1. It is important to examine how the demands of elder care and health worker migration intersect for the following reasons:

- (1) Elder care is a growing concern globally. In wealthy countries people are living longer but suffering ill health in the later years, thus requiring expanding levels of care as they age. Whether they are cared for in formal “nursing home” settings or in their own homes, their care is likely to involve paid service providers.
- (2) Health care migration is a large and global business. Recruitment is decentralized, involves both public and private sector entrepreneurs, and is difficult to regulate. Training is varied and far from uniform in quality. On the one hand, neither sending country nor receiving country governments are able to keeping track of migrating health professionals and, on the other hand, neither sending nor receiving countries have a clear understanding of the needs and gaps in the health delivery fields in their own countries.
- (3) The countries of the western hemisphere are important players in the global health market but, with the partial exception of the Islands of the Caribbean, there is little cooperation among their governments to manage migration patterns or combine forces in order to achieve economies of scale and cost effective training facilities. Although under discussion elsewhere in the hemisphere, no firm agreements are in place for managing migration or sharing human resources.
- (4) While elder care is a concern affecting multiple households, the *field* of elder care is rarely defined as such. There are gerontologists, i.e. doctors and nurses who specialize in medical problems affecting the elderly. More importantly, insofar as elder care is understood as essentially a medical problem, the broader aspects of such care (social, psychological, logistical, etc) remain unattended.

The governments in the countries producing migrant nurses face the double challenge of producing enough nurses for their own needs while not discouraging migration. The question that is much debated is whether it is worth while investing in advanced nursing education if the best trained nurses migrate. But, in order to be able to produce quality health care professionals at home, it is necessary to build and maintain educational facilities. This being the case, there is little added cost to

² This report builds in part on work carried out in 2008-2009, The Role of Migrant Health and Social Care Workers in Ageing Societies, a study conducted by researchers in the United States, the United Kingdom, Canada and Ireland. The objective of this long term and still ongoing work is to explore how foreign workers provide care for elderly in developed countries. The present author visited one of the source countries, Jamaica, in connection with the project and produced a report for the researchers.

educating more nurses than are likely to remain. There are widespread efforts to improve educational opportunities for nurses and to maximize the effectiveness of local resources. There is also more attention being paid to possibilities of sharing educational resources among countries. Some of the innovations in this area are promising and probably worthy of replication.

2. Policy interest but weak data

Data about migration patterns of care givers within and among countries is weak. Moreover, existing data is skewed toward the higher levels of health care professionals and as such is inadequate to address the problems health care and planning policy makers are facing: how to care for growing numbers of elderly people who need ongoing attention; how to factor in the recruitment and migration patterns of health care workers in planning, and how to enlist health care workers more effectively in national health delivery. This report touches primarily on the first two concerns, although the last is, ultimately, the desired goal.

Serious interest by policy makers in migrating nurses is a recent phenomenon, but accurate statistics are extremely difficult to find for several reasons:

- The attention of scholars has been devoted overwhelmingly to the education and migration of Registered Nurses, whose trajectory is usually documented by governments or nursing associations. Conversely, but more importantly, the other categories of nurse—those who are more engaged in day to day patient care—are hardly tracked at all.
- Even for the registered nurses, source and host country efforts to track their movements—such as by counting those who take and pass qualifying exams, who are recruited by agencies, who ask their respective governments for academic records, who receive special visas—provide partial and only indicative information.
- In the major migrant receiving countries, nursing qualifications are regulated and monitored primarily within states (the United States) or provinces (Canada) rather than nationally.
- Nursing is a field in which there is a very large turnover, and staff numbers change from year to year for reasons not related to migration.
- Within the nursing profession, there is a significant amount of mobility. In the south, the loss of highly qualified professionals opens the way for the promotion of nurses with lower levels of training and/or experience (The practice risks sacrificing the quality of service overall). In the north, migrants are often obliged to take lower status jobs than their experience warrants, but are able eventually to rise to higher levels. Likewise, both domestic and foreign educated health care workers in entry level health care jobs may take advantage of training opportunities to advance. The mobility factor is not followed statistically.

Both expanded nurse education and migration are variously being promoted on grounds of aging populations. However, the elderly are only one segment of the population not adequately covered by health care networks. Moreover, none of the research uncovered for this project has examined the actual needs of elders in terms of the health care and other support they require (e.g. are larger numbers of nurses at the higher professional levels more needed than larger numbers of less well trained care-givers?). One very new program in the University of the West Indies is beginning to consider caring for the aging in terms of its non-medical and medical elements.³

³ Interview with Dr. Gillian Barclay director of PAHO office Barbados, April 21, 2009.

II. Health care gaps and immigrants in the United States and Canada

Numerous hospitals, nursing homes, and long term health care facilities are meeting growing labor demands in the health field largely by employing immigrants. It is expected that shortages of nurses will expand to some 800,000 by 2020 and this is attributed to the rapidly aging population. (Pittman 2007a).⁴ Shortages of nurses and other health care providers are clearly linked to demands posed by the country's older citizens.

America's aging population is generating an increasing demand for their care and foreign-born workers will supply an important part of that demand. Yet, there has been relatively little research that addresses the role that the foreign born play in the long term care (LTC) for the elderly population. In 2007, the Institute of Medicine (IOM) ...conducted an in-depth analysis of the health care workforce by reviewing education and training, models of care, and public and private programs for health care workers engaged in caring for America's aging population. The IOM's resulting report finds that as the population of seniors grows to approximately 20 percent of the population in the next couple of decades, they will face a health care workforce that is too small and critically unprepared to meet their needs.⁵

⁴ See also Pittman, Aiken and Buchan, 2007, Special issue of the Health Research and Education Trust DOI, 2007 elaborating these points.

⁵ IOM (Institute of Medicine), 2008. *Retooling for an Aging America: Building the Health Care Workforce*, National Academy of Sciences, <http://www.nap.edu/catalog/12089.html>. Cited in Martin, et. al. 2009, 39.

In Canada, where some 35 percent of all seniors of 85 or more live in institutional settings (Bourgeault, et. al. 2008, 25) a similar shortage of health care workers is found. Canada expects a shortfall of registered nurses that may reach 100,000 by 2016 (Little 2007, 1326). Nursing shortages in Canada are longstanding. During the 1990s large numbers of Canadian educated nurses were emigrating from the country—primarily to the United States—due to unsatisfactory domestic employment conditions. The movement of nurses and other professionals to the United States continues to this day although conditions have improved and the numbers of departures is reduced. In the 1990s, when Canada experienced the emigration of skilled workers in several fields, immigration policies came to be viewed as a way to compensate for the losses of skilled workers due to migration. In this context the government has considered immigration as a pro-development strategy. Nursing was recognized late in the process as one of the sectors in which the country lacked sufficient human resources. With the publicly funded health system under strain, health officials have sought to address the shortages by recruiting immigrant nurses. The shortages of professional nurses have decreased and emigration is less prevalent but supply is still well under demand (Little 2007, 1343-1344).

Canada is experiencing a shortage of care workers and this shortage is expected to become that much more acute with the aging of the population....According to the 2006, Census Canada's population age 65 and over stands at 4.3 million. (13.7%); 1.2 million are aged 80 and over (3.7%). The aging of the population is expected to continue over the next 3 decades and is expected to reach 9.8 million by 2036, doubling the senior's share of the population to 25.5% (Statistics Canada 2007). Many older adults suffer from one or more chronic disability and the likelihood increases with age. Further, with aging, vision, mobility, hearing, cognition, perceptual ability and general physical endurance may decline. This has implications for the care of the elderly and for the growing workforce that provides this care (Bourgeault et. al, 2008, 10).

1. Defining the shortages

While there are shortages at all levels both in the United States and in Canada, the shortages of registered nurses are best documented. In both cases, gaps in domestic supply of nurses are explained primarily by the limited capacities of current nursing schools and nursing programs to graduate sufficient numbers. Nursing education has not expanded sufficiently in Canada, the United States or in most other countries of the hemisphere to accommodate employment needs. In the United States, there are virtually no government subsidies to encourage expansion. There are few scholarships for nurses, who usually come from modest economic backgrounds⁶ (Aiken 2007, 1312).

Other factors are relevant: shortages of nurses are most acute among those who engage in direct patient care. The most highly educated native nurses, north and south, are drawn to specialized areas or administrative and management positions in which the work is physically less challenging and hours are regular. The problems of finding adequate numbers of qualified Licensed Practical Nurses (LPN) and direct caregivers are well known, especially by the long-term health institutions that employ a large number of them but, curiously, obtaining more data on this group has not been a research or policy priority.⁷ In fact, most of the nurses migrating from south to north in the western hemisphere have training that qualifies them for positions as LPNs rather than RNs. Employment opportunities for LPNs are all but certain to expand in nursing homes and home care-situations as the number of elder patients also expands.

In the northern developed countries, immigrants are most visible as caregivers in institutional settings where elderly reside, particularly in urban areas. That said it remains to be seen if present

⁶ For example, potential students in other fields deemed in the national interest, e.g. foreign language training, are encouraged with scholarship programs.

⁷ This author considers it puzzling that the literature on nurses is so heavily weighted toward the RNs. In fact, LPNs and Nurses' Aides are as important, if not more so, in considering present and future needs, especially for elder care.

shortages of long term health care workers will require increasing the supply of immigrant workers moving from south to north. Canada has initiated a program targeted specifically for the temporary migration of long term caregivers. In 1992 Canada adopted the Live-in Caregiver Program (LCP) which was intended to remedy the shortage of live-in caregivers by allowing foreigners to work in these roles. The migrants in question were to perform a range of activities, including but not limited to care for elderly. (They also provided childcare, help for the disabled, and home support for senior citizens.) The program was and remains small, and consists mainly of women from the Philippines. Among the actual caregivers interviewed in the Canadian study, most had arrived by various means and found their positions thanks to word of mouth and informal networks (Bourgeault 2008 5-6).

In the United States, where there are no indications of systematic recruitment of foreign long-term caregivers by the government, institutions complain of being short-staffed. In previous research undertaken on related themes, this author found little support for the notion of recruiting low skilled health care workers. Indeed, in areas with high immigrant populations, there is probably already an ample supply already of such workers. Domestic labor prevails in parts of the country where there is less low-wage immigrant labor. Undoubtedly, the labor pool both of domestic and foreign born workers would expand if working conditions were improved. The question of recruiting low skill workers remains relevant for the future, however, in view of the dire predictions of growing shortages of nurses in the professional categories able to attend to the increasing elderly population. Logic dictates that consideration be given to the long term/direct caregivers as well. At this time, there has been no assessment of long term caregiver needs as against available human resources from within the country and potentially from outside of it.

2. Health care migration: United States

Among foreign-born professional health care workers in the United States, 37 percent come from Asian origins, 25 percent from the Philippines alone, while another 22 percent come from the Caribbean Islands. Africa is the source of 15 percent, while Canada and Europe together supply just 13 percent of professional care workers. About 16 percent of immigrant nurses in the United States come from Latin America and another 9 percent from the Caribbean (Pittman et al 2007, 15). The United States is the major destination for immigrants generally, nurses included.⁸

In all national groups, long term care workers far exceed professional care workers (Table 2). The health care migrants from India and the Philippines have the highest proportion of professional to direct care ratios. In these countries nurse training is high quality and taught in English; it is intentionally aimed at the English speaking countries in the developed world. Among immigrants from the Americas, Mexicans and Central Americans have the highest proportion of direct care to professional health care jobs.

Data on long term care workers is not widely available, but can be calculated for the United States, as shown in the tables below, by using figures from the Census Bureau's American Community Survey 2003-2007.⁹ The first of the following two tables shows a strong presence of foreign born among long-term health care workers in all relevant categories. Immigrants are especially concentrated in low-skilled direct care jobs, which comprise the majority of jobs in the long term health care sector. The second table shows the percentages and countries of origin of foreign workers in health fields in the United States.

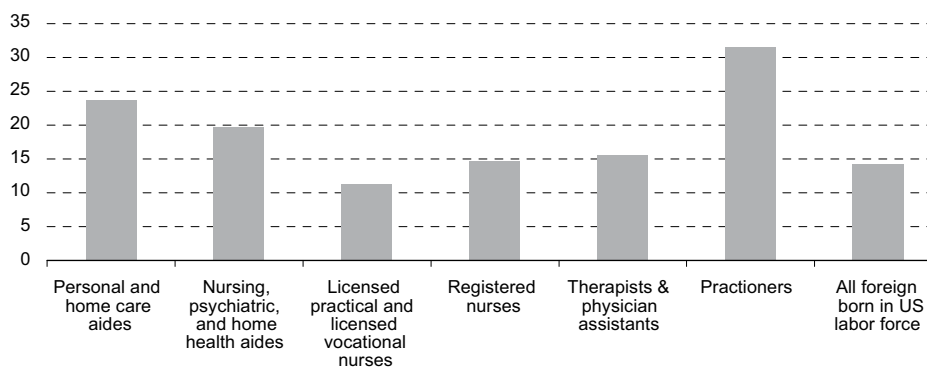
Half of foreign direct care workers come from the western hemisphere; 29 percent from the Caribbean and 21 percent from Mexico and Central America. Mexico alone supplies 15 percent of direct

⁸ The United States receives 80 percent of emigrants overall from Western Hemisphere countries followed distantly by Spain (Tokman, 2008, 16).

⁹ In the American Community Survey, the US Census Bureau uses large samples of the US population. The information here, compiled by Lindsay Lowell of the Institute for the Study of International Migration, looks at the demographic information related to the foreign born population and identifies long term care workers within this sample. The work is found in Susan Martin et. al. 2009.

care workers and Jamaica and Haiti supply another 17 percent. (Martin, et. al. 2009, 19-20). Country-wide, the percentage of foreign born in health care work is not high, but is very much concentrated in some areas.¹⁰

FIGURE 1
PERCENT OF LONG TERM CARE WORKERS IN THE U.S.
WHO ARE FOREIGN BORN, 2003-2007



Source: Tabulations of American Community Survey.

Like other immigrants, foreign-born nurses and especially long term health workers tend to live in metropolitan areas, about 96 percent of the latter compared with just 73 percent of native workers.¹¹ Somewhere between two-thirds and three-quarters, estimating from data available, live in just 24 metropolitan areas and, tellingly, roughly one-quarter of all foreign-born long term health care workers reside in the New York metropolitan area. In contrast, only one-quarter of native long term health workers are found in the 24 preferred places of residence for the immigrant workforce. Only one in twenty five native long term health care workers live in New York (Martin et. al. 2009, 20; Fiscal Policy Institute 2007, 20).

TABLE 1
SELECTED COUNTRIES OF BIRTH OF FOREIGN-BORN
LONG TERM CARE WORKERS, 2003-2007

Region and nation of birth	Percent of Occupational Group			Percent of Workforce		Total Count
	Direct care workers	Professional care workers	Total	Direct care workers	Professional care workers	
Total	79.2	20.8	100.0	100.0	100.0	2 917 229
United States born	77.7	22.3	100.0	79.1	86.6	2 351 748
Foreign born	85.6	14.4	100.0	20.9	13.4	565 481
Foreign born	85.6	14.4	100.0	100.0	100.0	565 481
Canada	59.0	41.0	100.0	0.7	3.1	6 072
Mexico & Central America	95.0	5.0	100.0	21.3	6.7	108 689
Mexico	95.3	4.7	100.0	15.3	4.5	77 645

¹⁰ The tables were compiled from American community Survey data 9, Table 2. The analysis is drawn from Martin, et. al. 2009

¹¹ Data on registered nurses is found in Aiken, 2007, 1308

TABLE 1 (concluded)

Region and nation of birth	Percent of Occupational Group			Percent of Workforce		Total Count
	Direct care workers	Professional care workers	Total	Direct care workers	Professional care workers	
El Salvador	95.6	4.4	100.0	2.4	0.7	12 080
Guatemala	96.8	3.2	100.0	1.1	0.2	5 665
Honduras	95.8	4.2	100.0	1.0	0.3	5 254
Nicaragua	93.5	6.5	100.0	0.7	0.3	3 475
Caribbean & Atlantic Islands	88.7	11.3	100.0	29.0	21.9	158 187
Jamaica	88.3	11.7	100.0	9.0	7.1	49 348
Haiti	85.9	14.1	100.0	8.1	7.9	45 721
Dominican Republic	95.4	4.6	100.0	5.0	1.4	25 376
Trinidad and Tobago	90.9	9.1	100.0	2.2	1.3	11 933
Cuba	88.1	11.9	100.0	1.5	1.2	8 022
South America	88.3	11.7	100.0	6.9	5.4	37 888
Guyana	86.1	13.9	100.0	2.5	2.4	13 985
Colombia	88.6	11.4	100.0	1.4	1.1	7 470
Peru	90.7	9.3	100.0	1.1	0.6	5 627
Ecuador	93.8	6.2	100.0	0.8	0.3	3 992
Europe	85.5	14.5	100.0	10.0	10.1	56 638
Poland	85.8	14.2	100.0	1.5	1.4	8 318
Ukraine	89.3	10.7	100.0	1.4	1.0	7 440
Russia	89.1	10.9	100.0	1.3	1.0	7 323
Germany	75.8	24.2	100.0	0.7	1.3	4 354
England	66.3	33.7	100.0	0.5	1.6	3 975
Romania	89.7	10.3	100.0	0.6	0.4	2 970
Ireland	79.8	20.2	100.0	0.2	0.3	1 411
Asia	74.8	25.2	100.0	18.5	37.1	119 936
Philippines	69.8	30.2	100.0	9.7	25.0	67 181
India	61.5	38.5	100.0	1.4	5.1	10 683
China	90.8	9.2	100.0	1.9	1.1	10 000
Vietnam	90.1	9.9	100.0	1.2	0.8	6 239
Korea	78.7	21.3	100.0	0.7	1.1	4 098
Africa	82.3	17.7	100.0	11.7	15.0	68 979
Nigeria	76.0	24.0	100.0	2.3	4.3	14 698
Africa, ns/nec	82.8	17.2	100.0	1.8	2.2	10 358
Ghana	88.7	11.3	100.0	1.6	1.2	8 799
Liberia	86.0	14.0	100.0	1.4	1.4	8 028
Kenya	86.5	13.5	100.0	1.2	1.2	6 972
Ethiopia	80.3	19.7	100.0	0.7	1.0	4 010
Oceania	94.0	6.0	100.0	0.9	0.3	4 546

Source: Tabulations of the American Community Survey.

Note: Average population for the 2003-2007 period and total observations under 100 excluded.

3. Direct care workers and migration: Canada

Canadian figures for long term/direct care workers are more difficult to calculate on a national basis, and the statistics differ markedly from one province to another. These workers appear in the census as childcare and home support workers or health care and social assistance workers and without places of origin. Separate surveys at the provincial level seem to show that in Canada, as in the United States, there are significantly larger numbers of foreign origin home care workers in urban centers in heavily immigrant areas than in the country as a whole (Bourgeault 2008, 20).

TABLE 2
COUNTRY OF BIRTH OF CHILDCARE, HOME SUPPORT AND HEALTH CARE
AND SOCIAL ASSISTANCE WORKERS, CANADA, 2001

(Source Census data)

Country of Birth	Childcare and home support workers	Health Care and Social Assistance
Europe	537	2197
Philippines	455	961
Central and South America, Caribbean	283	1505
China & Hong Kong	121	296
Africa	83	252
United States	76	497
South East Asia: Other	68	393
India	62	436

Source: Census data

III. The southern hemisphere: aging, migration and health care

Regional organizations, including ECLAC, have reported on migration policies and impacts, as well as on the development consequences of health care gaps. As in the north, southern analysts have been rethinking options and policies regarding health care needs. They are doing so in a context of aging populations, poor quality of national health care systems, and consequences of migration for both. As will be discussed below, health care advocates are urging greater policy attention to be paid to possibilities for sharing human resources in health on a regional basis.

1. Regional attention to aging populations

In April 2002, the Second World Assembly on Ageing was held in Madrid, Spain, to call attention to the demographic transformation and expected doubling of the population over 60 years old from 10 to 21 percent by 2050. The resulting Plan of Action called upon participating governments, to take actions at national and international levels that would incorporate older persons into development, advance their health and well being and ensure enabling and supportive environments for the elderly. The conference called attention to the impacts of urbanization and the migration of younger people.¹² The Latin American and Caribbean governments participating in the Conference met in November 2003 in Santiago Chile and approved *A Regional Strategy for the Implementation in Latin America and the Caribbean of the Madrid International Plan of Action on Ageing*. (UN

¹² Full report and recommendations is found at www.UN-ngis.org/pdf/MIPAA/pdf

ECLAC 2004) Taking as a point of departure that the global demographic transformation was strongly reflected in the region, the report noted:

The fact that the population structure is growing older poses challenges that are made more complex by traits of the process itself and by the situation in the region. First, the population is ageing at a more rapid pace, and will continue to do so in the future, than the rates recorded in the past by today's developed countries. Second, this is taking place in a context of high poverty rates, a high and rising rate of labour force participation in the informal market, persistent and acute social inequity, a low level of institutional development and limited social security coverage (UN ECLAC 2004, Annex 1, Parag. 4).¹³

Many countries of the region lack sensitized personnel trained to care for older persons. Despite the fact that all older adults have the right to be treated by health-care personnel who have been trained to deal with the problems most commonly suffered by the elderly, a significant percentage of such personnel lack training in public health and ageing, gerontology and geriatrics. This problem is worsened in a number of countries, particularly in the Caribbean, by the selective emigration of health-care professionals, especially nurses, to developed countries (UN ECLAC 2004 Annex 1, Parag. 28).

The ECLAC report similarly recommended (in objective four) the “pursuit and promotion on the main aspects of ageing at both country and regional levels”(UN ECLAC 2004, parag.52).

2. Quality of national health care

The documents discussed in this report strongly indicate that health officials in the Caribbean and Latin America understand the need for a reassessment of their health care systems. This is undoubtedly a consequence of attention to Millennium Development Goals and rising awareness of the importance of social indicators in development strategies. Within this framework, there is a fuller recognition of the consequences of migration by health providers at all skill levels, as well as a greater recognition of the importance of serving the needs of the elderly in their own populations.

¹³ See also CELADE, El envejecimiento y las personas de edad: Indicadores sociodemográficos para América Latina y el Caribe. LC/L 2987, March 1009.

IV. Health care providers, North and South

While all segments of the health care industry—physicians, pharmacists, therapists, technicians, etc.—perform fundamental services for the elderly in the population, the ongoing and long term care of elders is handled by nurses with varying levels of medical skills. People advancing in age need medical attention for age-related and other illnesses. Traditionally, family members have taken responsibility for day-to-day care of the aging—with very mixed results. In the wealthier countries of North America, and to a growing extent in middle income countries in the southern hemisphere today, family members and the elders themselves are contracting assistance from persons who have at least a minimum health care experience.

1. Categories of nurses as classified in the North

Who is a nurse? Each country has classified its nurses according to education and job skills. One of the obstacles to clarifying the issues involved in nurses' migration is the confusing array of terms, differently used in different settings, and the inconsistent requirements for achieving a nursing certification. Migrants from south to north are employed according to the classifications used in the receiving countries. These classifications and the terminology vary somewhat within and between the United States and Canada, but can be summarized as follows:

Nurse Practitioners NP: A person with a degree in nursing and additional education in specialized areas, able to prescribe drugs and perform some medical procedures.

Registered Nurses RN: RNs encompass persons with an associate degree in nursing, a bachelor's of science degree in nursing or a nursing diploma from a specialized institution. To be licensed, RNs must complete the National Council Licensure Examination NCLEX-RN.¹⁴ RNs are engaged in patient care in hospitals, clinics, emergency rooms, and nursing homes. RNs have supervisory roles over licensed nurse practitioners and nurses' aides.

Licensed Practical Nurses (or licensed vocational nurses) LPN: The LPNs work in all sectors of health care, including home care. They are especially needed on the staffs of nursing care facilities. LPN training is found in community and junior colleges or in vocational and technical schools. The programs can be completed in a year but graduates are required to pass the NCLEX-PN examination to obtain a practical nursing license. Their work involves direct patient care and they perform basic bedside patient services under the supervision of registered nurses and physicians. There are numerous training programs that enable LPNs to rise to RN status.

Nurses Aides (Auxiliary nurses, Certified Nursing Assistants) CNA: They receive a secondary school degree or its equivalent. They then enter a training program that varies from six weeks to three months. Nursing aides certification in the United States and Canada requires successfully completing a training program but no standardized exams. Nor is there a formal regulating body that monitors the training programs, although individual states/provinces, departments may have their own regulatory mechanisms. Certification and licensing requirements vary by country and state/province in the United States, Canada and Latin America. CNAs are the major care providers in nursing homes, hospices, assisted living facilities and home care that serve the elderly and disabled.

Direct care or home care assistants who are hired through formal agencies typically have had the same training as nurses aides. As such, they can perform most traditional nursing tasks. A home caregiver—or personal assistance caregiver—, to whom we refer here, is different from a personal service worker who does not require or usually have formal training. A personal service worker, normally hired directly by clients rather than through agencies may not have or need training. There is considerable variation in the kind of care provided at homes. Often the client needs a service provider primarily to help with household chores, shopping and personal care; additionally caregivers may perform a few medical tasks such as administering medications and checking vital signs. At this lowest rung in the professional health care hierarchy, relatively untrained workers, native or immigrant, can become home caregivers.

The last two categories encompass the majority of long term health care providers.

2. Nursing training and classifications in the South

In Latin America and the Caribbean, nurses are not classified in quite the same ways as in the North. The major difference is that nurses are not required to pass standard national examinations once they have received degrees and certificates from registered institutes.¹⁵ Universities and institutes in the larger countries of the hemisphere are beginning to prepare nurses with internationally recognized degrees (e.g. Jamaica, Brazil, Argentina, Chile), to require senior level nurses to obtain bachelors degrees, and to offer an additional masters or Ph.D degree in nursing. Nurses with higher educated levels are generally administrators or managers with little responsibility for direct patient care. There are programs, as well, to train nurse specialists (e.g. for emergency room oversight, surgery assistance, management activities).

¹⁴ The NCLEX tests are required for licenses in the field of nursing. They were created and re maintained by the National Council of State Boards of Nursing (NCSBN).

¹⁵ Researchers consulted government regulations for practicing nursing and requirements for migrating nurses in Mercosur, Andean and Caribbean countries.

For the most part, nurses' training begins after secondary school or even before, and is completed in a year or two. The majority of nurses trained in the Latin American and Caribbean countries graduate with a technical degree in nursing—as Nurse Technicians—which is approximately the equivalent of the level of LPN in the United States and Canada. They practice in hospitals and other institutions and advance in salary and benefits largely on the basis of seniority. Like their counterparts in the United States and Canada, they may seek additional specialized training and then placed in more demanding and better paid positions. Or, these nurses with technical degrees may migrate to the United States and Canada as LPNs and later upgrade to RNs.

Terminology is most inconsistent at the lower skill levels. In Argentina and Uruguay an auxiliary nurse must have completed secondary school and in Uruguay, the auxiliary nurse should have nursing training at the university level. In other words, an auxiliary nurse in these countries is the equivalent of a technical nurse or LPN. However, auxiliary nurses in Brazil usually receive technical training prior to completing secondary school and therefore are the equivalent of the United States/Canada Nurses aides.¹⁶ Auxiliary nurses, no matter how defined, are found in all health care institutions. At the bottom of the hierarchy are the nursing staff members working in hospitals, institutions or homes, whose training is virtually all “on the job.” They take positions requiring menial work but, as they increase their abilities, they may be given more responsible tasks.

¹⁶ These distinctions have been pieced together primarily from Stiebler Vieira, Ana Luiza, et. al 2006, writing on nurses in Mercosur for the Brazilian Ministry), Mazza Claret, Raquel 2006 and from career information in SENAC, <http://www.senac.br/guideprofissoes>.

V. The nexus of migration, health and eldercare

It is evident in the countries of the north that health care services have come to depend on individuals who have migrated from elsewhere, but awareness of the extent and consequences of health care migration has come more slowly to the South. The awareness is most strongly felt in the Caribbean countries with their high migration levels. As will be discussed below, governments in the Mercosur region also have been weighing advantages of sharing health care resources and making it easier to receive immigrants. The aging population in these more affluent countries is a factor. The concerns about the results of “brain drain” in the field of health are longstanding, but until recently were focused mainly on the migration of health care providers at the highest professional levels. Nurses’ migration was long underway before it became a public concern because nurses were not necessarily viewed as full fledged professionals. Now that the absence of these nurses is producing worrisome gaps in service in their countries of origin, measures like those described in the following section are taking hold.

1. Gaps in services, gaps in information

The Pan American Health Organization PAHO has been a major player in promoting hemisphere-wide improvements in health care. In 2005 two researchers from PAHO, in support of the International Council of Nurses (ICN), undertook a comprehensive study of health care resources and the nursing workforce in particular (Malvárez and Castrillón 2005). The resulting study confirmed widespread shortages and inadequacies in the health care systems in Latin American and Caribbean nations and called

attention to the poor data available upon which future health policies might be based. The report recommended more consistent monitoring and greater efforts to fill information gaps (Malvárez and Castrillón, 2005, 3).

The PAHO study, the studies in the Health Research and Educational Trust volume, the analyses of nursing associations in the United States and Canada, the National Sample Survey of Registered Nurses, reports of the World Health organization, and a number of other studies have provided data and explained migration trends among the higher professional levels of nurses. A large portion of the studies in the literature are the work of the nurses themselves, writing for medical journals and nursing associations. Thanks to such efforts, it is possible to address the predicted shortages with solutions based on increasingly solid information. In the source countries the information is being used by advocates for innovations in managed health care migration, as described below.

1.1 Specific information gaps regarding caregivers

In developed countries and even more so in less developed countries there is an acute information gap in accounting for the omnipresent caregivers at the low skill end of nursing who attend to a wide range of vital tasks for elderly people. The high visibility of immigrant workers engaged in elder care attests to the role of migration, but the dynamics of that migration remain a little studied phenomenon. Although large numbers of such caregivers are engaged in fulfilling essential services for the elderly, neither their education/training nor their movements have been monitored systematically.

In the institutions where elderly patients receive care, one finds a considerably larger number of lower skilled/long-term caregivers employed than higher skilled registered nurses and licensed practical nurses. Whether the long-term caregivers are immigrant born or country nationals is not readily apparent because the facilities that hire them do not record places of origin. But all anecdotal reports from urban areas and areas with high immigrant population attest to large numbers of immigrants on staff. Generally, the registered and licensed practical nurses serve as managers and supervisors in these institutions. Caregivers with minimal or no medical training are employed even more often in private homes, having obtained their positions through both formal mechanisms and informal networks.

While the institutional long term care facilities so prevalent in the north are less frequently found in the south, elders located in urban areas are often cared for in nursing homes and/or hospital settings. Whether in formal facilities or in a home setting, countless caregivers render personal assistance to elderly people unable to fully attend to their own needs, and administer basic medical procedures. Undoubtedly much, if not most elder care is delivered by family members or persons with little or no training. In countries where immigrant labor is frequently used for low-skilled work and domestic labor generally, immigrants are likely to be hired to care for elderly persons, (e.g. Nicaraguans in Costa Rica; Bolivians, Peruvians, Ecuadorans and Paraguayans in Argentina, Brazil and Chile). In these situations, the caregivers are usually classified as domestic labor. They may or may not seek further training and achieve degrees in nursing, as is the case with domestic health care workers, but this phenomenon is not systematically monitored.

2. Regional migration patterns

Regional migration patterns in the south are poorly monitored but may represent a growing trend. The largest number of professional health workers in the regional pool consists of the Cuban doctors and nurses who are contracted by their government to serve needs in other Latin American countries. It is hard to imagine that the Cuban outreach will be imitated by the medical corps of other countries in the hemisphere. Some 13 percent of all migration from the region takes place between and among countries in the region (Tokman 2008, 16). And, as described below, it is difficult for health professionals to validate degrees and gain certification to practice in a country, even a neighboring country, other than their own.

VI. Initiatives in Latin America and the Caribbean

The countries most often cited as having suffered from the loss of nursing and other medical personnel are in Africa. The Caribbean nations are also cases in point, however, given the longstanding and high rates of migration. Among¹⁷ these, the Caribbean countries in CARICOM are actively engaged in finding solutions to the emigration of so many nurses. The Caribbean Regional Nursing Body, the Caribbean Nurses' Organization, the Pan American Health Organization, and the regional governments have established partnerships with universities and health related institutions in the developed countries to advance regional education and improve educational standards and competencies in nursing (Salmon, et. al 2007, 1361). Working with CARICOM governments, they seek ways to balance the losses of skilled workers and strains on national facilities that accompany migration to the United States and Canada with options to keep more and better prepared resources in the region. Although most of the programs initiated in this framework are small, regional authorities are committed to pursuing both resource sharing within the region and seeking flexible arrangements with source country institutions.

Source country governments in the Caribbean and elsewhere tend to be divided as to how they consider the impact of nurse migration: while a Ministry of Finance will be pleased at the prospect of steady remittance flows, the Ministry of Health will lament the loss of essential human resources, and the Ministry of Planning will seek better control over the process of recruitment and numbers of departures. Throughout the region

¹⁷ See Bibliography

governments are actively seeking ways to better address the health needs of their own population without either interfering with individual freedom to move or sacrificing needed remittance revenue.

1. Managing nurse migration in the Caribbean region

It is useful to examine in some depth the situation in the Caribbean region both because of the historical pattern of migration and because the current innovative steps being taken at a regional level to save and reorient the health care field in response to economic realities and the ongoing migration may become a regional model. The Caribbean region, as used here, encompasses the regular members of the Caribbean Community and Common Market or CARICOM. CARICOM, consisting primarily of small island nations, has fifteen full members: Antigua, Barbados, the Bahamas, Barbados, Belize, Dominica, Grenada, Haiti, Guyana, Jamaica, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago.¹⁸ The majority of the member countries are Anglophone and a common English language facilitates both inter-island exchanges and migration to the United States and Canada. Caribbean migration to the UK has fallen as the British government has tightened entry rules for commonwealth residents and as more nurses have arrived from Africa.

Caribbean workers, highly skilled, less skilled and unskilled, migrate as a matter of economic necessity. The primary destinations historically have been the United States, Canada and the UK. Health migration is only one part of the longstanding pattern of migration from the Caribbean nations. It is not possible to count the out-migration, but various indicators may be used to estimate numbers and trends; e.g. the numbers of nurses taking qualifying exams; the numbers who are recruited by the major agencies, the numbers requesting their official school transcripts.¹⁹ Health care harmonization now has become a key area for CARICOM efforts to enhance regional cooperation in trade relations and human capital development. Since its establishment in 1963, CARICOM has played a leading role in orienting economic, social and health issues in the region. The CARICOM Conference of July 2006 specifically included nurses in the free movement of labor agreements enacted in the framework of the Caribbean Single Market and Economy, thus facilitating the migration of nurses between the islands (Yan 2006, 72S; Salmon, et. al, 2007, 1356). The governments of the region, working through the CARICOM mechanisms and with Pan American Health Organization PAHO support small, but promising initiatives to support regionally based health care resources.

While nobody contemplates significantly limiting migration opportunities for nurses and other medical personnel, everyone agrees that the CARICOM nations should look to filling regional rather than national health needs. Presently, the out-migration of health professionals has required the recruitment of nurses from other countries including Cuba, Nigeria, Ghana, and India (Hickling 2009, 7). Current efforts are aimed at broadening the options available for would-be migrants so that the region does not sacrifice its own health care needs, and the countries do not lose the remittance and learning benefits of migration. To this end, CARICOM has fostered partnerships for migration policy research among academic institutions, one of which, Managed Migration, based at the Mona campus in Jamaica, is especially relevant to this study. A new area of research and practice being formulated at the time of this writing is to define and formulate comprehensive structures and practices for elder care.

Once held in low esteem, locally trained nurses now are recognized as valuable resources, both for “export,” (and remittances) and for national well being. Once performing work that was little valued at home and with educational profiles that were disparaged abroad, nurses from the Caribbean now are sought after internationally. Presently their governments are investing in their preparation and retention. University programs have been upgraded, especially the Mona branch of the University of the West Indies which, according to its Director, offers a program that turns out internationally

¹⁸ Associate members are British Virgin Islands, Turks and Caicos, Anguilla, Cayman Islands and Bermuda. Observers are Aruba, Colombia, the Dominican Republic, Mexico, Netherlands Antilles, Puerto Rico and Venezuela.

¹⁹ The Jamaican Nursing Council maintains that the most accurate way of determining the number of nurse being recruited is to count the requests for transcripts, since these are required for immigration (Hickling 2009, 8).

recognized RNs.²⁰ In 2004, the nursing school introduced a Bachelor of Science degree in Nursing. Nurse training has generally shifted from on-the-job-hospital instruction—the more typical pattern in developing countries—to training in academic settings with hospital practice. Mona’s nursing school is open to all qualified students from the Caribbean community, thanks to the CARICOM Single Market and Economy mechanism.

Caribbean researchers report an average 42 percent vacancy for nurses for all the islands (Salmon, et al 2007 1354, 1358). Nevertheless, for all the reasons elaborated in the paragraphs above, migration will remain a necessity. While all domestic sectors accept, and sometimes embrace, the migration of skilled professionals, they strive to find ways to keep sufficient numbers of health professionals in the country.

The encompassing term “managed migration” has become the most discussed option for health care professionals facing difficult choices between remaining at home in the Caribbean or moving to other countries where they will be better paid and will have more opportunities for education and advancement.

The dialogue on health care migration is shared throughout the Caribbean Islands and both the concept and the solutions proposed are regional rather than national constructs. There have been regional policy initiatives, enabled by the establishment of the Caribbean Single Market, that include the free movement of nurses and doctors within the Caribbean area. The health sectors in Jamaica, as well as in Barbados, St. Vincent and Trinidad and Tobago, Granada, etc. see abundant reasons to plan together. Not only CARICOM but, as noted, the Pan American Health Organization Office of Caribbean Program Coordination (PAHO/CPC) is actively supporting regional cooperation in the health field and particularly as related to nurse migration. PAHO has done a great deal to foster human resource development and to underwrite costs associated with regional wide initiatives aimed at managing migration in the health field (Salmon et. al, 2007, 1361).²¹ Regional professional associations also encourage multilateral approaches.

A number of initiatives have been reported, although most are small scale and, as yet affect few people. The Health Planning unit in St. Vincent has a bilateral agreement from health care employers in the United States that the latter will reimburse St Vincent for the training costs of nurses. Granada has agreed to share with Antigua its facilities for the training of nurses and trains for both countries in Granada. St Kitts has established an offshore nursing school to serve the global market for professional nurses. The facility is funded in partnership with a foreign investment organization. Reportedly, nurses from Jamaica have been able to divide their work time between a hospital in Miami and one at home (Salmon et. al. 2007, 1365; IOM, 2006, 13).

2. Low-skilled health care workers, not yet “managed”

The most numerous category in the nursing profession in the Caribbean and indeed throughout the hemisphere, is the (equivalent of) nurses’ aides. These nurses are on the front line in their own countries and outside for attending to elderly patients. The schools where they are trained have few if any academic entry requirements. While the students are encouraged to take the necessary subjects to allow entry into the higher level programs in the field of nursing, they are not obliged to do so. According to Jamaican informants, the schools are frequently operated by retired registered nurses who have established their own nursing homes for the elderly and are likely to have had some experience working with the elderly in North America.

The Government of Jamaica now intends to standardize the curriculum in these schools and ensure that the curriculum meets international standards. To this end, the schools are being reviewed by a government agency the National Council on Technical and Vocational Training (NCTVET) for the

²⁰ Interview with Dr Hermi Hewitt, Director of the School of Nursing at Mona in Jamaica, Tuesday 19th February 2008, conducted during previous field work for a related project.

²¹ Among its activities, mainly in collaboration with ministries of health throughout the Hemisphere, the Pan American Health Organization has also collaborated with and supported the nursing profession.

purposes of accreditation.²² Upgrading the existing, large pool of low skill health care workers will enable them to handle more difficult responsibilities. This also enhances job mobility because it allows people to improve their capacities; but if not well managed and monitored, the practice risks saving money while sacrificing quality.

Turning to the international ramifications, low skilled caregivers have proven themselves internationally marketable in the developed countries. With growing numbers of elderly people potentially in need of care, countries in the Caribbean may benefit from the wages earned by low skilled workers in health related jobs. As anyone who is familiar with workers in nursing homes in the United States will attest, Caribbean origin caregivers are strongly represented and much in demand in East coast facilities.²³ It is possible that supplies of low skilled direct care workers are sufficient for now and for the near future in the developed countries given the numbers already in place. But this is not at all clear.

3. Other western hemisphere health care and migration related initiatives

Governments in the region are placing greater priority on nursing education generally in order to improve health care and relieve shortages. It is too early to tell what the migration implications of these improvements, if any, may be in the southern hemisphere. Nevertheless, there are indications in the Mercosur region of discussions aimed at promoting greater movement of resources and labor. (Stiebler Vieira et. al 2006, 39-40). Health care resources are assuming a higher priority in these discussions. Mercosur's Health Commission has been considering establishing norms and procedures for increased harmonization in health education and epidemiology studies and toward more shared expertise and human resources.²⁴ The objective would be mutual recognition among educational institutions of each other's degree granting programs. Presently, requirements vary for similar nursing degrees. Mercosur leaders have agreed to share more information about their health resources (Stiebler Vieira et. al 2006, 39-40).

Another initiative, still less developed than the above, is in the framework of the newly created Unión de Naciones Suramericanas (UNASUR). This entity, which is a political rather than a common market entity, was constituted in May 2008 and includes members from both the MERCOSUR and Andean Community of Nations. Among its proposals are measures aimed at health care harmonization. Taken together, the various proposals could move southern regional entities in a similar direction to that of CARICOM.

4. Upgrading health care provider skills

Increasingly, governments in the region are concluding that the best remedy for their shortages is to use existing human resources more efficiently and improve their quality. (To be sure, the shortages in the south are being recognized primarily because of concerns to improve health care systems overall rather than because of large scale out-migration.) Institutions in the south are committed to upgrading the qualifications of the nursing pool to enable local universities to produce a larger portion of the nursing pool, as well as to allow nurses in lower grades to acquire higher levels of competence. This strategy is expected to produce sufficient and sufficiently trained nurses for domestic needs while not cutting back significantly on the (relatively small) number that migrate.²⁵ For example, in Brazil, the number of

²² Fagen 2008, p.9

²³ The account of a nursing home in New York by Nancy Foner (1994).gives an enlightening glimpse into this world. According to the author and informants from the Service Employees International Union that has organized large numbers of these workers, the situation has not changed since the book was published.

²⁴ http://www.mrree.gub.uy/mercosur/GrupoMercadoComun/Reunion48/AnexoIX/Anexo_09.html

²⁵ On the educational front, Brazil now has 32 post-graduate programs in nursing, of which 18 are masters programs and 14 are Ph.Ds. (Lorenzini Erdmann 2008 available at <http://74.125.47.132/search?q=cache:SK2HdvgyuO4J:www.scielo.br/scieloOrg/php/articleXML.php%3Fpid%3DS0080-342008000200001%26lang%3Dpt+Desafios+da+Enfermagem+na+CAPES:+produtos+>

undergraduate nursing schools doubled between 1995 and 2003 and the number of graduates almost tripled. More students have obtained bachelors in nursing, it is believed, because work environments and academic requirements have been made more flexible (Filho, et al., 2006, 166). In the Andean countries and Mexico there are several institutions for advanced degrees in nursing: Peru has seven Master's degrees in nursing, two one-year specialization programs and one doctorate.²⁶ Colombia has at least three Master's degrees in Nursing and eight one-year post graduate specialization.²⁷ Mexico has some twelve Master's degrees in nursing, one Master's in Social Gerontology and a one one-year post-graduate specialization; and one doctorate in nursing.²⁸

PAHO has supported nurses' associations and governments in efforts to upgrade nurse educational facilities and professional standards overall. Concluding that a disproportionate amount of nursing care needs in several countries were being provided by staff with only basic training, PAHO began some twenty years ago supporting efforts to upgrade staff training. Over these years, technical training has been made available to large numbers of persons who previously had only in-service hospital training, qualifying them as auxiliary nurses. PAHO has supported auxiliary nurses to be converted into nursing technicians and, progressively, auxiliaries and technicians are being converted to professional nurses (Malvárez and Castrillón 2005, 20-21).²⁹ The Group of Nursing Professionals of Central America and the Caribbean has been active since the 1990s in seeking to improve poor educational standards and facilities and generally professionalize nursing in Mexico and Central America (Salas and Zárate 1999 in Malvárez and Castrillón 2005, 45). In the Mercosur region³⁰, the Regional Council of Nursing (Consejo Regional de Enfermería, CREM)—comprised of national associations, and serving as a political forum for professional and educational issues and nursing research in the region—has an agenda similar to that of Central America. The overall strategy being followed is to improve the quality of the nursing force in place.

When highly qualified nurses migrate, the health systems are likely to rely on the lower trained nurses to replace them, whatever the disadvantages of doing so. Therefore health and planning officials seek both to train more qualified nurses while, at the same time, finding ways to improve training and quality of care at the bottom.

5. Migration consequences of improving educational levels

In addition to adding better trained nurses to the labor force, Mexican and Central American efforts to upgrade health care education are likely to affect the composition of the migration pool in the North. Mexico and Central America are important sources of health care workers to the United States and to a smaller degree to Canada. The limited data suggest that the majority of health workers from this region are now low skilled workers, employed in long term health care institutions and home care in the North. However the low pay scales for professional nurses and other care workers, especially in Mexico, ensure a stream of nurses in all categories.³¹ The PAHO Study by Malvárez and Castrillón estimated that 2,000

altamente+qualificados.&hl=en&client=firefox-a&gl=us&strip=1 As of 2003, Chile had 1 masters degrees and 1 PhD. Joffre-Aravena and Paravic-Klijn 2007 http://scielo.isciii.es/scielo.php?pid=S1132-2962007000100011&script=sci_arttext

²⁶ <http://www.educaedu.com.pe/maestria/enfermeria>; <http://cursos.universia.net/PE/curso/2796/Doctorado-en-Enfermeria.jsp>

²⁷ http://www.educaedu-colombia.com/nf/search.php?txtBusquedaBase=Busca+tus+Cursos&tipo_curso_hidden=0&categoria_hidden=0&tipo_impact_hidden=0&provincia_hidden=0&txtBusqueda=Enfermeria&allDefault=Todos+los+Cursos&cboCat=0&cboMod=0&cboProv=0

²⁸ http://maestria.emagister.com.mx/maestria_enfermeria-tematica-456.htm;
http://www.educaedu.com.mx/nf/search.php?txtBusquedaBase=Busca+tus+Masters&tipo_curso_hidden=2&categoria_hidden=0&tipo_impact_hidden=0&provincia_hidden=1&txtBusqueda=Enfermeria&allDefault=Todos+los+Masters&cboCat=0&cboMod=2&cboProv=0

²⁹ The authors cite a PAHO study of 2004 that indicated over a hundred thousand conversions in this line

³⁰ Its members are Argentina, Brazil, Paraguay and Uruguay.

³¹ The overview by Malvárez and Castrillón only notes that there are large numbers of medical migrants and that Mexican nurses associations assist nurses to migrate, p. 20

nurses left Panama yearly and nurses in the hundreds annually left Nicaragua but their destinations are not clear.

This scenario is less likely in South America. Nurses in the southern hemisphere migrate less than do those in the Caribbean, Mexico and Central America. South America medical professionals are as likely to go to Spain as to either to North America or to another country in the hemisphere if they migrate at all. Where shortages are acute, immigrant nurses from Africa and from other countries of the hemisphere are recruited in North and South America, but their impacts are small.³²

³² A relatively small number of migrants—some 91—with nursing degrees were working in Brazil in 2005, of whom 39, mostly Peruvians, moved to the North to fill severe shortages in that part of the country. The impact was meaningful and the move brought them comparatively high wages. Steibler Vieira et. al. 2006, *Revista* 4-8.

VII. Status, conditions and pay

1. Conditions in sending countries

Working conditions and salaries have been the driving forces pushing migration, south to north and among the countries of the region. The most comprehensive review of information related to the situation of health care and health care personnel in Latin America is the above cited work of two officials in the Pan American Health Organization, PAHO, in 2005. While the study is more a general description than a data-based report, it reviews information from several countries. The report critically assesses the conditions under which nurses work:

Working conditions for nurses typically consist of work overload, long days, rotational shifts, night work, frequent changes in service and psychological strain from handling critical situations. Staff are continually exposed to biological chemical and physical hazards, constituting a threat to their health ... (Malvárez and Castrillón, 2005, 22).³³

The Caribbean island nations have maintained relatively high educational levels in general, and for senior level health care workers in particular. The combined effect of good professional preparation, opportunities for employment in the north and poor conditions at home have made migration an attractive option. Nurse migration has long been of concern.

³³ In this report, Malvárez and Castrillón are citing a report presented in 2000 by S. Orrego, MC Castrillón and RM Nájera, published in Cantabria, Spain, 2000.

In countries with available data, 42 percent of nursing positions throughout the region were unfilled in 2005 (figures of CARICOM and PAHO). The most common reported reasons for resignation were poor remuneration, limited opportunities for professional development and career mobility, noninvolvement in the decision-making process, poor working environment, and lack of support from supervisors (Salmon, et al. 2007, 1359).

Nurses' salaries, as may be expected, vary from country to country. In Nicaragua they are as low as US\$120 a month and only slightly higher in Mexico, while in Costa Rica nurses in public hospitals receive US\$1,117 (figures from 2004, 1999 respectively). Salaries in other countries range from about US\$400 to US\$800 (Malvárez and Castrillón 2005, 23). The Deputy Program Manager of the office of Caribbean Community Development estimated that the salary of a nurse in the Caribbean would be approximately one third of what it would be in the United States (Kassim, 2006, 13). Salaries increase with seniority, and specializations.

The economic downturn of 2008-09 compounds the problems of salaries and conditions. Well before the current economic crisis, however, hospitals were reporting deteriorating infrastructure, equipment that was out of date and in disrepair and long hours for little pay. These problems are not unique to poorer countries but more pervasive. Importantly, in these countries nurses not only are paid poorly but have few protections against injury or work-related illness. While not a factor of the economy, nurses in developing countries also complain of a lack of respect for their profession generally, very much in contrast to the high level of respect for physicians (Deyal 2008, 6). These are the challenges health officials and planners are only now beginning to address as the consequence of nurse shortages becomes apparent.

2. Northern contrasts

Nurses in particular have much to gain monetarily by migrating north. Despite the many testimonies to the reluctance with which they leave homes, families and workplaces in order to migrate, earning more and being able to send money back in remittances are major incentives for leaving. Salaries for registered nurses in the United States generally range from US\$20 per hour to US\$30. They are generally calculated by the hour, since nursing schedules are irregular.³⁴ An RN, therefore, can expect earnings of US\$50 to US\$60,000 per year. The annual pay for LPNs is roughly US\$30 to US\$40,000 a year,³⁵ varying, of course, by schedules, institutional locations and specific job requirements. The salaries for registered nurses are so far superior in the north as compared to the south that analysts conclude that small incremental salary raises in the latter would not decrease the motivation to migrate to any appreciable degree. However, additional significant changes toward creating safer and more rewarding conditions might make a difference (Aiken 2007 1316) .

The immigrants in the United States and Canada who are working in hospitals, nursing homes and long term care facilities as nurses aides can hardly be said to live well. The conditions of work and pay for home caregivers may be better or worse, but often are paid only slightly more than household maids. The lowest paid and lowest ranking personal health and home care aides in the United States earn, on average, from \$340 to \$380 a week depending on the numbers of hours worked.³⁶ The work by all accounts is difficult, physically and emotionally, and people in these occupations are clearly in the category of “working poor,” often with family member dependent upon federally funded programs. Nevertheless, there are opportunities for employment and both conditions and salaries surpass what low skilled immigrants can expect to earn in their countries of origin. The more favorable conditions are buttressed by the fact that many of the facilities where nurses' aides work are unionized. The unions not

³⁴ [http://www.payscale.com/research/US/Job=Registered_Nurse_\(RN\)/Hourly_Rate/by_Years_Experience](http://www.payscale.com/research/US/Job=Registered_Nurse_(RN)/Hourly_Rate/by_Years_Experience)

³⁵ [http://www.payscale.com/research/US/Job=Licensed_Practical_Nurse_\(LPN\)/Salary](http://www.payscale.com/research/US/Job=Licensed_Practical_Nurse_(LPN)/Salary)

³⁶ Based on figures from the American Community Survey, 2007. <http://census.gov/acs>, tabulated in Susan Martin, et al 2009. Table 6.

only have advocated on behalf of workers; wages and working conditions, but also underwrite training so that they can improve their status.³⁷

The task of caring for elderly family members, it should be noted, can be turned into an employment opportunity. Medicaid in California will pay a stipend when elderly recipients bring family members to care for them. This possibility has helped numerous immigrants to come to the United States and enter the labor market, albeit near the bottom of the low paid job market.³⁸

3. Professional mobility

It is important to note that in all countries, nurses can and do move up the occupational hierarchy with some frequency. A 2004 National Sample Survey of Registered Nurses by the Health Resources and Services Administration of the Department of Health and Human Services Administration showed that among RNs who said they had worked previously in other health care positions, over 65 percent had held positions as nurses' aides and 24 percent as LPNs (HRSA 2004, 4). As noted above, immigrants from the western hemisphere countries working in the health professions in the North often serve in lower status positions when they first arrive even if they have completed educational programs at the highest levels available in their own countries. While skill-level downgrading is a common phenomenon among immigrants in the United States and Canada, so too, reportedly, is the process of upgrading upon further training and expanded English language facility. Upgrading serves all parties: employees gain better pay, more responsibility and better conditions; their employers are more likely to retain the upgraded workers and therefore reap the benefits of their experience and familiarity with the work required.

³⁷ Interviews, Enid Eckstein, SEIU 1199, April 16, 09

³⁸ Interview with Professor Susan Chapman, University of California School of Nursing, San Francisco, April 22, 2009.

VIII. The migration process and its requirements

1. Required examinations

To work in the United States or Canada, foreign-educated nurses, both registered and licensed practical nurses, need to pass several challenging examinations. When unable to pass these examinations, as frequently occurs, they work as lower status nurses' aides unless and until they can meet requirements. For employment in the United States and Canada, nurses from the English speaking countries, including the Caribbean have an advantage because the examinations are administered in English (except for Quebec). The Philippines are, by far, the major suppliers of RNs in the United States (and Canada), followed by other Asian countries and other developed countries.

Trained nurses are desired immigrants, but achieving the appropriate certifications is daunting. In the United States, all nurses need to establish their nursing qualifications through the National Council Licensure Examinations NCLEX (either the NCLEX-RN or NCLEX-PN), and immigrants also must pass the TOEFL English language proficiency exam. The NCLEX is intended to establish that practitioners meet common standards. For those educated outside of the United States it establishes that they have achieved the same educational standards as United States-trained nurses (Rosenkoetter, M. M., & Nardi, D. A. 2007, 305-15). The test is both difficult and expensive, especially if a failure on the first try requires taking it again. As noted above, migrating nurses who take the NCLEX examination prior to emigration will, upon passing the exam, receive visas with guaranteed green cards for themselves and their families.

The United States based National Council of State Boards of Nursing and the Commission on Graduates of Foreign Nursing Schools CGFNS have conducted surveys of foreign educated nurses, and used the results to insist on maintaining standards. The CGFNS examinations are widely used in source countries to sort out those nurses who are likely or unlikely to qualify for success in the NCLEX examinations required for immigration as RNs. In Canada, provincial or territorial nursing regulatory bodies, likewise, keep track of emigration and immigration, and conduct surveys and monitor quality. The professional associations insist on quality control among foreign educated (and domestic) nurses and, in so doing, they have held the line against pressures to recruit more widely and with less rigorous standards.

Canada's programs for recruiting foreign health workers combine private and public sector mechanisms. The profession is publicly regulated to ensure competence. Immigrants must have graduated from recognized schools, pass language tests and a national licensing examination. There are province level regulations in addition to national ones. It is frequently the case, therefore, that nurses who are recruited or otherwise wish to migrate to Canada are given immigration preferences because of their profession. But, once arrived they are unable—or unable in the absence of more training—to practice nursing because of the requirements. The failure rate for the Canadian Registered Nurses Examination and provincial level exams is high for immigrants in their first attempt. At its highest, in 2002, only 68 percent of applicants passed the exam on the first try and the percentage was lower the following year. Among nurses educated in Canada, about 93 percent generally pass the exam on the first try (Little 2007, 1341).

Nurses migrating from one to another country in the southern hemisphere may not confront national level examinations, but they are obliged to formally validate degrees and credentials from their own countries. That process is often fraught with difficulties. As described, countries in the hemisphere have committed to upgrading nursing programs (PAHO/WHO, 2007, Appendix B)³⁹ and perhaps to harmonizing professional certification processes. It is hoped that this process will facilitate the movement of nurses from one to another country.

Nationally based nurse associations in all countries are important in maintaining health care standards. In countries where migration has been heavy, these associations have joined in the recruitment policy debate and their influence has been significant.

2. Recruitment practices

The present shortages of nurses and projections that the shortages will grow as societies age have brought increased efforts to recruit nurses wherever they can be found. Both governments and private sector institutions in the wealthier countries are recruiting foreign educated nurses and facilitating their entry. Because the task of identifying, vetting and processing foreign nurses for immigration is long, costly, complicated and frequently produces less than hoped for results, the institutions using these nurses have turned to professional recruiters to fill their needs. This, in turn, has opened the way for an array of profitable agencies that specialize in recruitment.⁴⁰ The recruitment agencies sometimes work in a single source country, but often develop business contacts in several countries which may be on different continents. The most comprehensive study on recruitment to date found 18 recruitment agencies working in Latin America and 11 in the Caribbean. The regional total tops the 25 firms operating in Africa (Pittman et. al 2007, 19). The recruiters work most often for hospitals, but also, to a smaller extent, for nursing homes and other long term care facilities. Where health care is publicly managed, the agencies may be contracted by government entities.

³⁹ The PAHO campaign to strengthen primary health care at all levels includes insistence on better educational and training, recruitment and retention programs for human resources in health.

⁴⁰ Recruiting agencies have been working since the 1990s but the number has grown from 30 to 40 agencies engaged in both domestic and international recruitment to over 200 after 2000. Pittman et. al. 2007, 9-10.

Hospitals are major consumers: In the United States in 2003, 72 percent of foreign educated registered nurses worked in hospitals; most of the remainder in nursing homes and a few in other long term care facilities or home care. Nursing homes are the major consumers for LPNs. Over 80 percent of the LPNs who are recruited work in nursing homes or long term care/home care settings (Pittman et. al. 2007, 11, 12). Long term care facilities face major vacancies in both categories and have partnered with recruitment agencies both for registered nurses and licensed practical nurses (Brush et. al. 2004, 5).

Although hospitals and other user institutions pay for each nurse recruited by a recruitment agency (at \$15-20,000 per RN recruited on average) (Pittman et. al. 2007, 14) and have no guarantee that the individual will fit their needs, they contend that recruiting foreign educated nurses is in their best interest. A major reason is that the latter are obliged to stay in place for two to three years, which gives a cushion of stability in the face of very high domestic nurse staff turnover (Brush et. al. 2004, 5).

Nurses from Latin America or elsewhere migrate for many reasons, but it is the active and sometimes aggressive recruitment that encourages and facilitates the migration process for most of them. They may be recruited by a university hospital in California, by the government of a province in Canada, a private hospital in Miami, or a publicly subsidized nursing home in New York.

The process offers decided advantages to applicants. The agencies take care of the processing charges, the cost of taking the NCLEX and English language exams, credentialing, air travel to the United States and sometimes additional training. Nurses arrive, therefore with a job in place, often a place to live, and accompanied by their families, whose members have their green cards already in place. With the substantial gains in salaries, the nurses can send remittances to the family members who remain behind. Nurses are charged for breach of contract should they leave the position before completing the time agreed to. This can be a serious problem if the reason for breaking the contract is that working conditions are not as promised. A significant percent of nurses report being fined because they did not perform services they were not contracted to perform (Pittman et. al. 2007, 14). Once hired, the recruited foreign educated nurses are paid the same as domestic nurses. Barring abuses, it is indeed a tempting prospect when combining the salaries and other benefits.

The recruiting agencies, by and large, are interested in registered nurses although they also seek LPNs, primarily for long term care facilities. It does not appear that long term health care workers are recruited while still living in their countries of origin.

Placement agencies also are important in finding positions for nurses in all categories already in the country. The placement is usually contracted by the day or hour. Smaller institutions and larger ones seeking temporary workers will contract workers from placement agencies. In this case the nurses register as clients of the agency, the latter place them and they receive wages well below what is paid to the agencies (Brush et. al. 2004, 7).

3. Recruitment and ethics

In addition to being on the vanguard of quality control, nurses associations have been leading forces in insisting on attention to the ethics of recruiting nurses from countries where their services are badly needed. The Canadian Nurses Association has issued a strong statement on the ethics of recruitment⁴¹ affirming the right to migrate but condemning “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...” It calls attention to the dire unmet needs in sending countries, such as the scarcity of health care workers in Haiti, beset as it is with HIV/Aids. It condemns misleading and overly aggressive recruitment practices and urges stronger regulation and monitoring. The Nurses Association recommendations carry considerable weight in Canada because its health system is publicly managed; some—but not all—provinces prohibit recruiting in developing countries. In the United States, however

⁴¹ Code of Ethics for Registered Nurses (2008 Centennial Edition) http://www.cna-nurses.ca/CNA/practice/ethics/code/default_e.aspx

much nurses associations and other public interest groups call attention to the ethical dimensions, it is more difficult to enforce ethical/quality standards because the clients by and large are private. However, binding measures affecting recruitment could be issued by foreign nurse education accrediting institutions or possibly Medicare provisions for provider conditions (Aiken 2007, 1316).

IX. Concluding observations and policy implications

The nurses who are migrating to the United States and Canada are better off in many ways than had they remained in their countries of origin. They earn higher wages and with which they can support people at home, and they have more professional mobility. When they are recruited for specific posts, they can bring their families with them. But the price is high, as it is for nearly all immigrants who leave homeland and close family and friends, and the work is hard. Hospitals, nursing homes, hospices and similar facilities in the United States and Canada are better able to meet growing demands thanks to the immigrant nurses. The fact that it is apparently easy to recruit foreign nurses, however, arguably, reduces pressures that might otherwise exist to expand domestic nursing educational facilities.

The countries of origin that are investing in the education of larger numbers of nurses but face large scale migration of the nurses once they have graduated, are facing growing demands with fewer human resources. While it is clear to all concerned that some nurses, often the best prepared, are destined for “export” and expected to benefit the country through their remittances, health delivery suffers generally at home and quality health care suffers in particular.

The report has described attempts to mitigate the loss of nurses by means of regional arrangements for sharing people, information and educational facilities. This remedy is furthest developed in the Caribbean where migration is longstanding. It is well established that caregivers with relatively little training are working in homes and long term care facilities where their services are in much needed. Are those who qualify for their jobs with short term courses sufficiently trained for the work they are

doing? Are they appropriately trained for elder care? Unlike nursing education, the curricula for these short term courses are not uniform, from place to place and rarely evaluated. Jamaica's program to form specialists in elder care, now in preparation, is a promising endeavor that will engage health care personnel at all levels. It may offer special benefits to non-medical caregivers who are specialists in caring for elderly people.

There is no evidence that the quality of nursing suffers when the practitioners are of foreign origin. One can thank nurses associations as well as national and international health organizations for insisting on standards of quality in the profession throughout the hemisphere. Nursing quality, however, does deteriorate when a hospital experiences the departure of qualified nurses which it cannot replace, and fills the vacancy with a far less qualified health caregiver who is not likely to be recruited.

This report questions the notion that an aging population simply demands more and higher quality nurses and argues that a better assessment of the kinds of health related services needed. Of course, elderly people are more likely to have ailments and are more frequent users of caregivers than other population sectors, outside of the chronically ill. As the population of older people increases so will the need for people to care for them. But the equation: more elders = greater need for immigrant nurses, is not so straight forward. We need to assess:

(1) What kind of caregivers are most needed for meeting the needs of the elderly, i.e. what balance among RNs, LPNs and long term caregivers? Is there a greater role than is commonly recognized for non-medical social services that benefit elders and/or for psychological attention? How these questions are addressed has implications north and south for policies of educating nurses, recruiting immigrant nurses, training and monitoring domestic and foreign born long term caregivers.

(2) What is the cost-benefit assessment of employing immigrant nurses and immigrant caregivers? The managers of institutions in the north find it attractive to recruit from other countries, but it may be in the national interest, as well, to expand educational opportunities for domestic caregivers at all levels and to ensure decent conditions under which the lower segments of the care giving population work. To some extent, unionizing these lower status workers has helped both immigrant and domestic labor alike and research on the impacts would be useful.

(3) Several countries in the western hemisphere have taken steps to improve the quality of their nurses, largely by increasing the number of degree granting programs. This should help overall national health care standards. Yet, there is no way to avoid the fact that the better educated nurses will be sought outside of their own countries. This reality adds to the attractiveness of mechanisms that allow people to divide their time between working in their home country and working in another nearby country.

(4) The health planners in the Caribbean area are rightly proud of the initiatives aimed at freer movement of workers and educational opportunities within the CARICOM region. As the process of managed migration unfolds, it will be important to assess its impacts in that region and the potential for similar endeavors in other regions.

The nursing profession is global, every bit as much as international telecommunications and manufacturing. While accepting the reality of a freely moving population of caregivers, however, governments obviously need to give priority to establishing viable and sustainable health systems that meets needs of the population as a whole. If governments bemoan the loss of nurses but do little or nothing to improve the conditions under which the nurses are working, the nurses will leave. Their departure cannot be blamed solely on unethical recruiters. If large segments of the poor are without any access to health care of any kind, it matters little to them that health workers are migrating.

It is a reasonable proposition that when wealthy countries actively recruit health care workers from poorer countries, the former have a responsibility to give something back to the latter. Such support could take the forms of greater support for education and advanced technological training, modernization of health facilities, equipment and materials, and direct support for medical personnel delivering health services for the poor.

Bibliography

- Aiken, Linda H (2007). “U.S. Nurse Labor Market Dynamics are Key to Global Nurse Sufficiency” *Health Services Research*. June; 42 (3 Pt 2): 1299–1320.
- American Health Care Association (2008). “Report of Findings 2007: AHCA Survey. Nursing Staff Vacancy and Turnover in Nursing Facilities,” July 21, 2008
- Barclay, Dr. Gillian (N/D). “Health Workforce Migration and the Caribbean region Presentation”. Pan American Health Organization, office of Caribbean Program Coordination. Available at www.iom.edu/File.aspx?ID=56503 (Accessed June 18, 2009)
- Bourgeault, Ivy Lynn, et al. (2008) “The Role of Immigrant Care Workers in an Aging Society” Draft, Mc Master University, University of Ottawa, Queens University.
- Brush, Barbara L. Julie Sochalski and Anne Berger (2004). “Imported Care: Recruiting Foreign Nurses to U.S. Health Care Facilities,” *Health Affairs*, 23, no.3. 78-87.
- Canadian Nurses Association (2005). “The Regulation and Supply of Nurse Practitioners in Canada,” Canadian Institute of Health Information. September 6, 2005
- Deyal, Tony (2003) “Hasta la Vista, Paradise!” *Perspectives in Health Magazine*, PAHO, Vol 8, No. 2.
- Fagen, Patricia Weiss and Hilary Hickling (2008) “Source Country Health Workers: Jamaica Case,” Draft, ISIM, Georgetown University.
- Kallick, David Dyssegaard. (November 2007). “Working for a Better Life: A Profile of Immigrants in the New York State Economy.” Fiscal Policy Institute. Available at <http://www.fiscalpolicy.org/immigration2007.html> (Accessed June 18, 2009).
- Foner, Nancy. (June 1994) “*The Caregiving Dilemma: Work in an American Nursing Home.*” University of California Press.

- Health Resources Services Administration, (2004): “Findings from the National Sample Survey of Registered Nurses, 1980-2004,” US Department of Health and Human Services. Available at <http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/2.htm> (Accessed June 18, 2009)
- Hickling, Hilary (2009) “The Caribbean single Market and Economy and the Migration of Physicians and Nurses” Unpublished manuscript prepared for PAHO, Caribbean Regional office.
- Joffre-Aravena, Viviane; Paravic-Klijn, Tatiana (2007). “Postrado en Enfermería en Chile” , *Index Enfermería*, Granada, v. 16, n.56, 2007
- Kassim, Dr. Halima S. (2006) “Health Migration: CARICOM Perspective” presented in *Report of the Caribbean Regional Workshop* organized by the International Organization for Migration, Curacao, Netherlands Antilles 5-8 November, 2006
- Kingman, Mireille (2006) “Nurses on the Move: Migration and the Global Health Economy”. Ithaca, NY: Cornell University Press.
- Little, Lisa (2007) “Nurse Migration: A Canadian Case Study” in Pittman et al, *Health Research and Educational Trust*.
- Lorenzin Erdmann, Alacoque (2008). “Desafios da Enfermagem na CAPES, produtos altamente qualificados” *Revista da Escola de Enfermagem da USP*.
- Lowell, B Lindsay and Abdeslam Marfouk (March 2007). “Are the Forces Driving South-North emigration Varying between skilled and Unskilled Workers”? Institute for the Study of International Migration. Georgetown University and Université Libre de Bruxelles.
- Malvárez, Silvina Maria and Maria Consuelo Castrillón Aguedelo (2005) “Overview of the Nursing workforce in Latin America.” *Issue Paper 6*, Pan American Health Organization.
- Martin, Susan, B. Lindsay Lowell, Elzbieta M. Gozdiak, Mary E. Breeding and Micah Bump (February 2009) “The Role of Migrant Care Workers in Ageing Societies: Report on Research Findings in the United States,” Institute for the Study of International Migration.
- Pan American Health Organization (2007) “Renewing Primary Health Care in the Americas.” Position Paper of the Pan American Health Organization/World Health Organization. Washington, DC. Available at www.ops-oms.org/English/AD/THS/OS/PHC-position-paper.pdf (Accessed June 18, 2009)
- Pittman, Patricia, Amanda Folsom, Emily Bass, Kartryn Leonhardy (2007) “U.S.-Based International Nurse Recruitment: Structure and Practice of a Burgeoning Industry.” Academy Health, November 2007. Available at <http://www.hrresourcecenter.org/node/1957> (Accessed June 18, 2009)
- PulseHR (January 22, 2008) “Recruitment of Foreign Nurses: USA.” Available at www.pulsehr.com/Foreign_Nurse_Recruitment.html (Accessed June 18, 2009)
- Rosenkoetter, M. M., & Nardi, D. A. (2007) “American academy of nursing expert panel on global nursing and health: White paper on global nursing and health.” *Journal of Transcultural Nursing*, 18(4).
- Salmon, Marla E, Jean Yan, Hermi Hewitt and Victoria Guisinger (2007) “Managed Migration: The Caribbean Approach to Addressing Nursing Services Capacity,” in *Health Research and Educational Trust*, 1354-1372,
- Steibler Vieira, Ana Luiza, et al. (2007) “Enfermeiros Imigrantes no Brasil: Características Socio-Economicas e Culturais”
- Steibler Vieira, Ana Luiza (2006) “Imigrantes no Brasil: o Caso da Enfermagem,” *En Saude*, 2006:06 (7): 11-20
- Stiebler Vieira, Ana Luiza, et. al. (2006) *Os Enfermeiros no Mercosul: Recursos Humanos, Regulacao e Formacao Profissional Comparada*. Rio de Janeiro: Ministério de Saude.
- Thomas-Hope, Elizabeth (2002) “Skilled Migration from Developing Countries: Study on the Caribbean Region.” Geneva: International Labor Office, International Migration Programme.
- Tokman, Victor E. June (2008) “Movilidad internacional de personas y protección social.” United Nations, UN Economic Commission for Latin America and the Caribbean and the International Development Bank.
- UN Economic Commission for Latin America and the Caribbean-ECLAC, LC/L.2079. (February 26, 2004) “Report of the Regional Intergovernmental Conference on Ageing: Towards a Regional Strategy for the Implementation in Latin America and the Caribbean of the Madrid International Plan of Action on Ageing.” Santiago Chile, 19-21 November 2003.
- UN Economic Commission for Latin America and the Caribbean-ECLAC UN/POPP/MIG-7CM/2008/08 (November 18, 2008) “Activities Carried out by ECLAC in the Area of International Migration, Human Rights and Development.”
- United Nations (April, 2002). “Report of the Second World Assembly on Ageing.” Madrid. Available at www.un.org/ageing/secondworld02.html (Accessed June 18, 2009).

US Department of Health and Human Resource, Bureau of Health Professionals (2009). “Chapter 7. Current Data Collection Practice: CNA Registries” in *Nursing Aides, Home Health Aides, and Related Health Care Occupations -- National and Local Workforce Shortages and Associated Data Needs*. Available at <http://bhpr.hrsa.gov/healthworkforce/reports/nursinghomeaid/chapt1.html> (Accessed June 18, 2009)

Yan, Jan. (August 2006) “Health Services Delivery: Reframing Policies for Global Nursing Migration in North America—A Caribbean Perspective,” *Policy, Politics and Nursing Practice*, Supplement to Vol. 7, No. 3 Sage Publications.

Interview list

Dr Gillian Barclay, Director, Pan American Health Organization, Barbados regional office, April 21

Professor Susan Chapman, School of Nursing, University of California, San Francisco, April 22, 2008

Enid Eckstein, Director, Service Employees International Union, Boston

Professor Nancy Foner, Department of Sociology Hunter College, April 9, 2009

Dr. Hermi Hewitt, Director School of Nursing, University of West Indies, Jamaica, February 19, 2008

Professor Joanne Spetz, School of Nursing, University of California San Francisco, April 21, 2009



Series

ECLAC
WASHINGTON
OFFICE

ECLAC

studies and perspectives

Issues published

A complete list as well as pdf files are available at

www.cepal.org/publicaciones

www.eclac.org/washington

7. The migration of health care workers in the western hemisphere: issues and impacts, Patricia Weiss Fagen, Ph.D., LC/L.3319-P, LC/WAS/L.105, Sales No. E.09.II.G.98, (US\$10), 2009.
6. Latin America: the missing financial crisis, Arturo C. Porzecanski, LC/L.3059-P, LC/WAS/L.104, Sales No. E.09.II.G.57, (US\$10), 2009.
5. Observatorio del control aduanero a las importaciones de Estados Unidos: estándares técnicos, Raquel Artecona y Fernando Flores, LC/L.3058-P, LC/WAS/L.103, N° de venta: S.09.II.G.56, (US\$ 10), 2009.
4. The global financial crisis: what happened and what's next, Inés Bustillo and Helvia Velloso, LC/L.3009-P, LC/WAS/L.101, Sales No. E.09.II.G.15 (US\$ 10), 2009.
3. Promoting corporate social responsibility in small and medium enterprises in the Caribbean: survey results, Georgina Núñez (coord.), LC/L.2930-P, LC/WAS/L.98, Sales No. E.08.II.G.62 (US\$ 10), 2008.
2. La exportación de alimentos a Estados Unidos: principales desafíos para América Latina y el Caribe y guía de acceso a la información, Raquel Artecona and Carlos Seneri Berro, LC/C.2865-P; LC/WAS/L.96, Sales No. E.08.II.G.10 (US\$ 10), 2008.
1. Status of agrifood regulatory coordination under the North American Free Trade Agreement, Ronald D. Knutsen and Rene F. Ochoa, LC/L.2797-P, LC/WAS/L. 91, Sales No. E.07.II.G.131 (US\$ 10), 2007.

-
- Readers wishing to obtain the listed issues can do so by writing to: Distribution Unit, ECLAC, Casilla 179-D, Santiago, Chile, Fax (562) 210 2069, E-mail: publications@cepal.org; or to Publications, ECLAC Washington Office, 1825 K Street, NW, Suite 1120, Washington, DC 20006, USA, Fax (202) 296-0826, E-mail: info.eclacwash@eclac.org.

Name:
Activity:
Address:
Postal code, city, country:.....
Tel.:..... Fax: E-mail: