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Overseas nurse recruitment: Ireland as an illustration of the dynamic nature of nurse migration.

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Overseas Nurse Recruitment: Ireland as an illustration of the dynamic nature of nurse migration

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Introduction

Worldwide there is a growing shortage of health workers, especially nurses [1, 2]. The numbers of trained nurses entering the labour market fall far short of the numbers needed to replace an ageing nursing workforce, those emigrating to more attractive labour markets, and early exits from professional nursing practice [1, 2, 3, 4]. Although historically a net exporter of nurses to countries such as the UK and the USA, in the 1990s Ireland began to encounter nursing shortages. With a domestic nursing workforce no longer 'queuing for work' [5], employers began to look further afield and initiated international recruitment campaigns to facilitate the migration of qualified nurses to Ireland. Despite being a newcomer to overseas nurse recruitment, the rate of recruitment to Ireland in recent years has been rapid and remarkable.

This paper reviews the literature on the supply and demand factors that determine the need for, and the international migration of, nurses. It presents national statistics on work visas issued and nurse registration in Ireland, so as to quantify the trends and scale of recent nurse migration to Ireland from outside of the European Union (EU); and presents more limited data on nurse emigration from Ireland. The paper discusses the deficiencies of the available data that are essential for national workforce planning; and concludes with a discussion of the implications of this heavy reliance on foreign nurse recruitment.

Market Forces - Demand Side

The number of nurses required by the Irish public sector health services is increasing, having risen 43% in fifteen years from 24,574 whole-time equivalent nurses employed in 1990 to 35,258 by December 2005 [6, 7]. Table 1 summarises demand side factors identified in the literature, e.g. the greater needs of an ageing population and increased complexity of health care; and also the effects of European Union policy changes: it is anticipated that changes to the nursing role will be brought about by the introduction of the European Working Time Directive, which will restrict the working hours of non-consultant hospital doctors and may result in the transfer of responsibilities to nursing staff. A yet-to-be quantified demand for nurses has arisen from the rapid expansion of the private and support sectors, including private hospitals and private nursing homes

[8]. Recent estimates suggest that approximately 9,000 nurses are employed in the private sector [9].

Table 1: Nursing Supply and Demand in Ireland [1,2,10-13]

Supply Shortage	Increased Demand
▪ Attractive alternative career opportunities for school leavers, nursing graduates and nurses ▪ Flexible working arrangements - a greater number of nurses required to fill available posts ▪ Inefficient utilisation of nurses ▪ Opportunities overseas for Irish-trained nurses ▪ Reduction of the standard working week for nurses following 2007 industrial action.	▪ Ageing population requiring more nursing care ▪ Increasing complexity of healthcare ▪ Poorly developed community services, leading to higher hospital occupancy rates ▪ Shortages in ancillary professions, e.g. physiotherapy ▪ Impact of the European Working Time Directive (EWTD), reducing doctors' working week. ▪ Transfer of care responsibilities from doctors to nurses

Market Forces - Supply Side

The number of students enrolled in nurse training programmes in Ireland has increased by 48% in the past decade, from 1,368 in 1995 [6] to 2,020 students by 2005 [14]. However, this potential supply is being eroded by the availability of overseas opportunities for Irish-trained nurses. Recent nursing graduates may also opt to use their skills and qualifications in careers other than nursing [13], especially given Ireland's booming Irish economy. The nurse supply shortage is also exacerbated by inefficient utilisation of nurses. As Aiken discusses, this is a generalised problem in developed countries, where nurses spend *'an inordinate amount of time in non-nursing tasks as a result of poor work design and underinvestment in information and other nurse-saving technologies'* [2]. In the Irish context, it has been recognised that *'nurses spend time on tasks that could fall within the remit of other personnel such as healthcare assistants'* [12]. Consequently there are plans for healthcare assistants to take on some of the nursing workload in order to free up nurses' time to apply their higher level of skills [9].

Changes in work practices have created various supply-side pressures. The introduction of flexible working arrangements in 2001 gave nurses the opportunity to avail of job-sharing, part-time or term-time working arrangements. *'Almost a quarter of all nurses*

now job share or work part-time hours' [12], requiring a greater number of nurses to fill available nursing posts. Furthermore, a Spring 2007 industrial dispute, which sought to secure improved pay and conditions for nurses, resulted in a commitment to reduce the standard working week for nurses from 39 hours to 37.5 hours by June 2008; with further reduction to 35 hours to be considered following a review by an independent commission. It is this supply-demand mismatch, which has worsened in recent years, resulted in the establishment of an overseas nurse active recruitment programme in 2001.

Overseas Nurse Recruitment

Overseas nurse migration is frequently *'the solution of choice'* [13] for health systems seeking to bridge the gap between demand for and supply of nurses. Overseas nurse recruitment is a cheaper and quicker option compared to scaling-up indigenous training [15]. As reported by Buchan and Secombe, *'the nurses are trained elsewhere, at someone else's expense, and can be recruited and working in the UK within a few months – not the four years it would take to commission and train a UK educated nurse'* [16]. Initially, overseas nurse recruitment was considered a short-term solution as it was anticipated that an increase in training places for Irish nurses would negate the need for migrant nurses [17]. It was recognised that the change from a three year training to a four year degree programme for nurse education would result in a gap year in 2005, which would need to be filled in the short term by overseas recruited nurses [12].

Methods

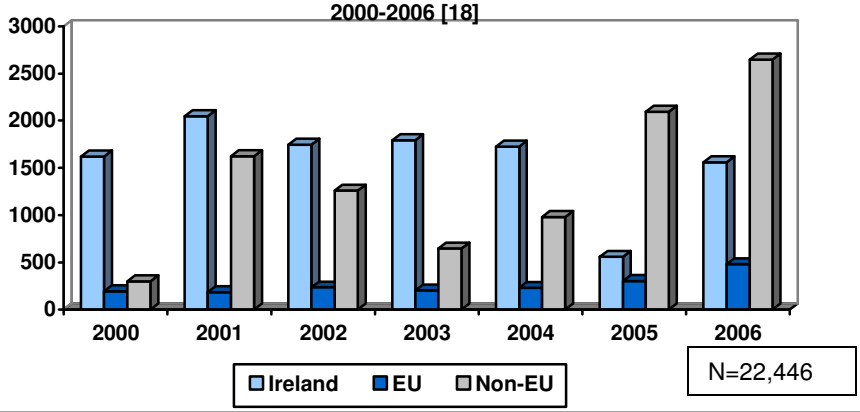
This paper presents and illustrates nurse registration data from the Irish Nursing Board [18] and work authorisations/work visa (working visas) data from the Irish Government Department of Enterprise, Trade and Employment [19]. These are compared with data on the proportions of foreign nurses in other developed countries [20] and with recent trends in nurse immigration to the United Kingdom [21].

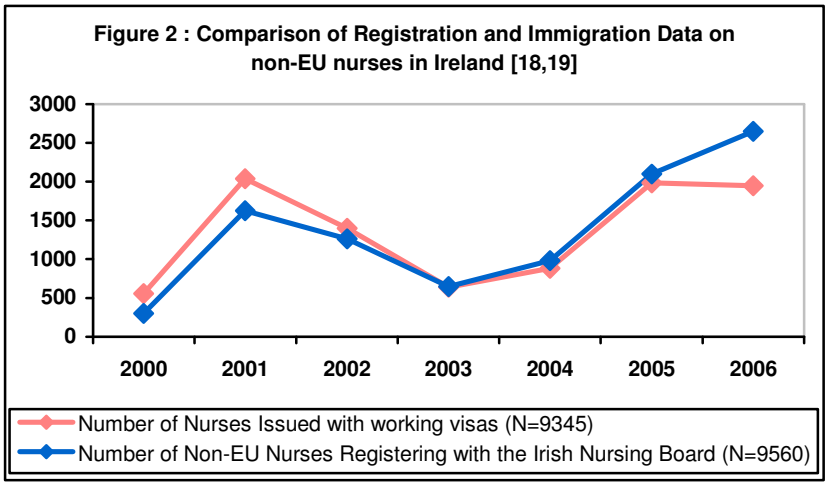
Findings

Nurse registration and work permits

Data from the Irish Nursing Board show the number of overseas (including EU and non-EU) trained nurses that have registered in Ireland since 2000 and the proportion of the nursing register they now constitute (Figure 1). However, professional registration data have limitations, as discussed by Buchan and Sochalski [22]: registration from overseas may indicate *intent* to migrate to a specific country rather than actual migration. Furthermore, nurses who have since left the profession may maintain their registration. However, data on the number of nurses to have been issued with Irish working visas between 2000 and 2006 show close correlation between the working visas and nurse registration data (Figure 2). Although the issuing of a working visa again does not necessarily equate with immigration, three factors support the hypothesis that the data reflect actual foreign nurses starting work in Ireland: the use of two separate sources of data, their close correlation; and because the processes for a nurse applying for registration and then permission to work in Ireland suggest serious intent to migrate and to take up employment in Ireland. Together, these figures suggest that the increased demand for overseas nurse migration did not abate and may have continued to increase following the training gap year of 2005. Figure 1 also demonstrates that whereas the number of EU nurses registering in Ireland has remained low between 2000 and 2006, the proportion of non-EU nurse registrations rose from 14 per cent in 2000, to account for 57 per cent of new registrations in 2006 [18].

Figure 1: Nurses Newly Registered with the Irish Nursing Board 2000-2006 [18]





The deficiency in the data to is that they do not indicate how many of those migrant nurses are actually employed in Ireland, in which sectors they are employed; and whether they have moved jobs or migrated onwards (or returned to their home countries) since their initial registration and acquisition of a work permit. The shortage of reliable data relating to migrant nurses exemplifies what are common deficiencies within health systems. Buchan and Sochalski have identified the type of data required to enable policy analysis and workforce planning [22]: data on the total number of nurses, their qualifications, gender, age and race/ethnicity; and – crucially – data on the number of migrant nurses entering and leaving employment. As well as providing an indication of the rapid rate of nurse migration to Ireland in recent years, the register indicates the extent to which overseas nurse migration has altered the profile of the nursing register. December 2006 data show that 16 per cent (10,381) of those on the active register of the Irish Nursing Board were from non-EU countries and 21 percent (5%) from other EU countries were trained outside of Ireland [18]. Table 2, based on 2004 data (and therefore showing a lower figure for Ireland), compares the proportion of foreign-born nurses in Ireland with selected OECD countries.

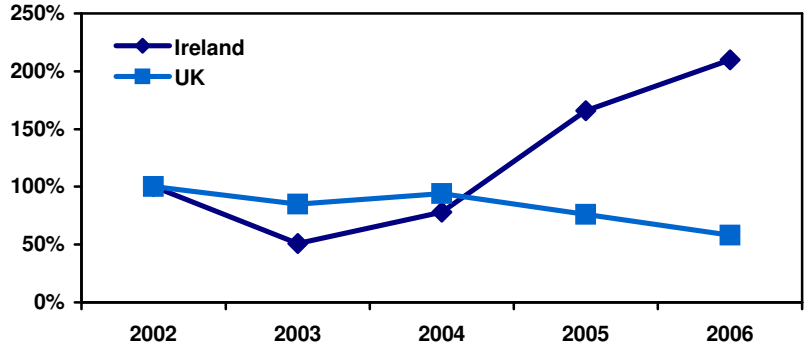
Table 2: Proportion of Foreign-Born Nurses in Selected OECD Countries [20]

Country of Residence	Foreign Nurses as a % of Total
AUS	24.8%
NZL	23.3%
CAN	17.2%
GBR	15.2%
AUT	14.5%
IRL	14.2%
USA	11.9%
DEU	10.4%

It is clear that Ireland, which up to recently was a net exporter of nurses, is quickly reaching levels comparable to those found in countries with a much longer history of immigration of skilled staff. The rapidity of nurse migration to Ireland is evident in that 92 percent of the non-EU nurses registered with the Irish Nursing Board in 2006 had first registered between 2000 and 2006; and 50 percent of all new entrants to the Register between 2000 and 2006 have come from abroad [18]. This illustrates an even greater reliance on overseas nurse migration than in the UK, where approximately 40 percent of new entrants in recent years have been from overseas [16].

Although the number of overseas nurses registering in the UK is far greater than in Ireland – approximately 62,000 overseas nurses joined the UK register between 2002 and 2006 [21] in comparison with 7,634 in Ireland [18], non-EU nurses constitute a much higher proportion of new entrants in Ireland than in the UK. In the UK, 2002 was the only year in which the number of overseas and nurses from the European Economic Area combined (at 53%) exceeded the number of UK entrants to the register. In comparison, EU and non-EU nurses accounted for 67per cent of all new registrations to the Irish nursing register in 2006 and 81 per cent in 2005, the year of the gap in Irish nurse graduations. Taking 2002 levels of non-EU nurse registration in the UK and Ireland as a baseline figure (figure 3) and measuring the annual percentage change in the level of non-EU nurse registration, it is apparent that by 2006 the level of non-EU registration had reduced by 42 per cent in the UK and increased by 110 per cent in Ireland.

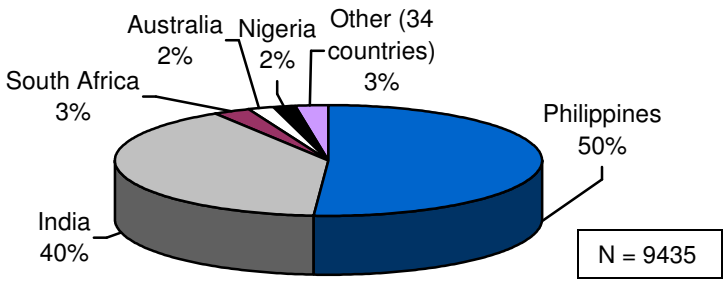
Figure 3: Percentage Change in the Number of Overseas Nurses Newly Registered in Since 2002 [18,21]

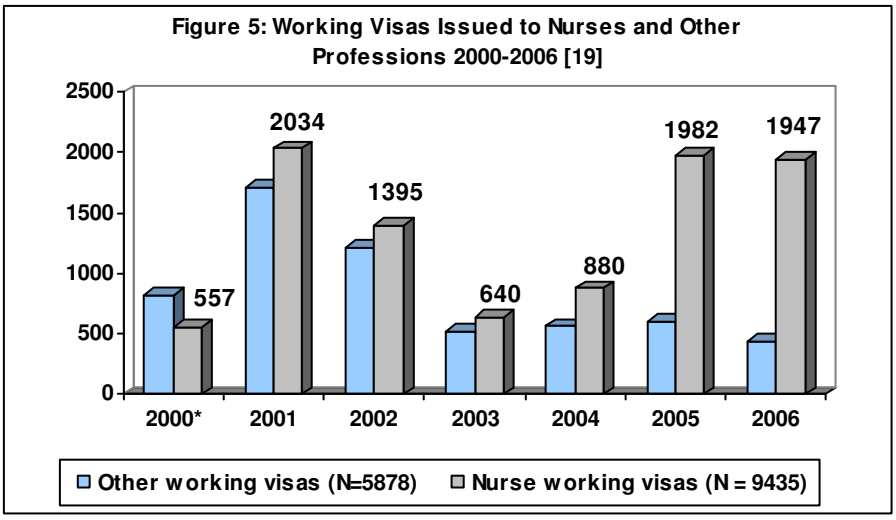


Nurses and the Working Visa Scheme

To facilitate the migration of registered nurses to Ireland, nursing was one of the professions to benefit from the introduction of a 'fast track' working visa scheme in 2000. The scheme was introduced to enable skilled migrant workers and their families to migrate to Ireland and focussed on sectors such as information technology, construction and healthcare, where Ireland was experiencing skills shortages. The working visa scheme marked a new departure for Irish immigration policy and saw Ireland join the ranks of more established immigrant countries, such as the USA, Australia and Canada, which have long used skilled migration programmes to fill skills gaps within their workforce. The working visa scheme offered better conditions than those previously available to migrant nurses in that working visas were issued for two years and provided the holder with improved entitlements to family reunification, the right to change employer without reapplying for a visa and the right to obtain multiple re-entry visas [24]. The working scheme operated from June 2000 until December 2006, and in that time, working visas were issued to over 9,000 non-EU nurses. The vast majority (90%) of these nurses originated from the Philippines and India (Figure 4).

Figure 4: Nationality of Nurses issued with Working Visas 2000-2006 [19]





The significance of nurse migration in the context of overall skilled migration to Ireland is revealed by the fact that nurse migration accounted for 62% of all working visas issued between June 2000 and December 2006 (Figure 5), with nurses averaging around 75-80% of those receiving work permits in 2005 and 2006. Although the working visa scheme entitled the holder to avail of family reunification, spouses thus admitted had no automatic right to work and this became the focus for a successful lobbying campaign by migrant nurses in association with the Irish Nurses Organisation [25]. In launching the modifications to the working visa scheme, specific reference was made to the need for Ireland to retain migrant nurses in the face of global competition. As the then Minister for Enterprise, Trade and Employment outlined:

> *'For sometime now I have been concerned at our continued capacity to attract and retain highly skilled personnel where their spouses do not have what is, in effect, an automatic right to work in this country. This problem is perhaps most acute in relation to some 4,500 highly trained nurses from outside the EEA (European Economic Area) who do not face this difficulty in other countries'* [26].

Although the working visa scheme played an important role in facilitating nurse migration to Ireland, data from the scheme provide an incomplete record of all non-EU nurses in Ireland, mainly because it was only operational between 2000 and 2006. The data also exclude nurses employed on other types of work permits and those non-EU nurses entitled to work in Ireland on the basis of being the spouse of an Irish/EU national, the parent of an Irish born child, or a refugee.

Nurse Emigration

In terms of nurse *emigration,* The Irish Nursing Board also collates statistics on the number of verification requests received annually, i.e. verifications on nurses registered in Ireland that are sought by nurse registration boards in other countries. These data provide some insight into another dimension of nurse migration, i.e. the emigration of nurses (Irish and non-Irish) from Ireland. These statistics have similar deficiencies to the nurse registration data as a measure of nurse emigration: they are an indicator of desire/intent to emigrate and the nurses in question may subsequently decide not to emigrate.

In 2005, the Irish Nursing Board received verification requests relating to 973 nurses, 70 per cent of whom were Irish and 23 per cent of whom were non-EU nationals [18]. Half of the verification requests in 2005 came from Australia, with a further 30 per cent coming from the UK [18]. A similar pattern emerged in 2006, with verification requests received on behalf of 877 nurses, 66 per cent of whom were Irish and a somewhat higher proportion (28 per cent) of who were from non-EU countries. Sixty four percent of all verification requests in 2006 came from Australia [18]. Verification requests were submitted for 207 nurses from India and the Philippines in 2006 alone [18], indicating that, at least for some migrant nurses, Ireland is a stepping stone en route to employment in other developed countries.

Although the statistics provide a pointer to the important phenomenon of nurse emigration from Ireland, far more information is needed to accurately profile Ireland's nurse emigrants. It is also impossible to tell whether the nurses who emigrated did so on a temporary or permanent basis. Many young Irish people take a 'year out' in Australia and a proportion of Irish nurse emigration may be relatively short-term in nature. It is also likely that these figures under-represent the total level of nurse emigration, particularly return-to-home country migration by nurses. Sending countries such as Philippines and India are not represented in the statistics in that nurses from these countries will mainly retain their home country registration while working overseas. Other countries, such as Saudi Arabia, which have traditionally been destination countries for both Irish nurses and migrant nurses, are also absent from the verification list. Comprehensive data are lacking (and needed) on the destination country for nurse

emigrants from Ireland, along with information on their nationality, gender, qualifications, age and year of qualification [22].

Data Deficiencies

An issue in relation to nurse migration internationally is the fact that *'reliable and relevant data upon which good nursing workforce policy depends are simply unavailable'* [13]. This is as true in Ireland as elsewhere. The statistics from the Department of Enterprise, Trade and Employment and the Irish Nursing Board provide an important starting point in measuring the scale of nurse migration to Ireland, by indicating the number of non-EU nurses who have (probably) come to work in Ireland in recent years. However, neither provides a comprehensive picture of how many migrant nurses currently work in Ireland or the impact that nurse migration is having on specific sectors of the health system. For instance, recent research by the Irish Nursing Homes Organisation has revealed that the sector employs a high proportion of migrant nurses*, 'the report states that, on average, 43 per cent of nursing staff in private nursing homes now come from overseas. In the former northern area health board (north Dublin) some 74 per cent of nursing staff in private nursing homes are from overseas'* [27]. An unknown number of foreign nurses may also be working in the formal and informal care system, while applying and waiting for registration with the Irish Nursing Board.

Although the national network of National Nursing and Midwifery Planning and Development Units collate valuable data on nursing and midwifery turnover in both public and private sectors, they do not distinguish between Irish and non-Irish nurses. As a result, their reports add little to the knowledge pool in relation to the impact of nurse migration on the nursing workforce in Ireland. Such gaps in the available data restrict our ability to fully understand the dynamics of nurse migration and its impact on the nursing workforce in Ireland. Similar data deficiencies have been encountered by nurse migration researchers internationally [13, 16, 22, 23, 28]. A further concern in the Irish context is the 'patchiness' [13] and interrupted nature of the available data. For instance, while this paper presents statistics on the number of working visas issued to non-EU nurses and their countries of origin, this level of detail is only available up to December 2006, when the working visa scheme ended. More recent data on the number of working visas issued to non-EU nurses is contained within a broad 'medical and nursing' category. Specific details, such as the specific occupation or nationality of those

within the medical and nursing professions issued with work permits since January 2007, are unavailable.

The Irish Health Service Executive Employers Agency published detailed statistical reports on the adaptation placements undertaken by non-EU nurses between January 2003 and December 2005. No further reports have been published. The Agency also published a regular national survey of nursing resources, containing statistics on the number of nurses recruited from abroad from November 2002 until March 2006, when it apparently ceased. The stop-start nature of data collection, combined with the limitations in the type of data collected, make it difficult to understand the dynamics of nurse migration in Ireland and impossible to track trends and factor nurse migration, in any meaningful sense, into nurse workforce planning.

Conclusion

A complex interaction of national and international factors impact upon the demand for and supply of nurses in the Irish health system. Many of these, such as the success of the Irish economy and the subsequent availability at home as well as abroad of attractive career options for nurses, lie outside the control of the health system. Other factors, such as the supply of nurse graduates and the projected demand for nurses arising from changes in work practices, advancements in healthcare or demographic changes, can be factored into nursing workforce strategies to ensure that domestic supply keeps pace with demand. Ireland's current reliance on foreign trained nurses indicates a failure to produce and retain sufficient nurses to meet the growing demand at home. Instead, supply-needs have been met via active overseas nurse recruitment. This has been a successful strategy to date and the fact that Ireland has encouraged almost 10,000 non-EU nurses to work in the Irish health system in recent years is testament to that success. There is a need firstly to acknowledge the significant contribution made by migrant nurses to the Irish health system, while recognising that their arrival is just the first step in addressing the recruitment challenge facing the health system.

Consideration must be given to the long-term sustainability of Ireland's reliance upon overseas nurse recruitment, particularly in light of global competition for nurses. As Kingma has stated, *'at any moment, recruited nurses can return to their homeland or migrate to another country if better conditions are offered'* [13]. To ensure an adequate

supply of migrant nurses in the future, Ireland must compete internationally to attract migrant nurses, while also struggling to retain both Irish and migrant nurses; and – at the same time – it must increase its domestic supply. As this global competition intensifies, the key question is whether Ireland will continue to attract migrant nurses and from where they will be sourced. Unless domestic supply is increased significantly and home-trained nurses are retained, Ireland's success or failure in this international recruitment market could have significant repercussions for the Irish health system.

Ireland's practice of relying on migrant nurses to supply its nursing workforce is the result of policy failure, a policy failure with global repercussions. For instance active overseas nurse recruitment may reduce the ability of the sending country to meet its own nursing needs, a consideration that should resonate with Ireland, a country with considerable experience of loss of its work force through emigration. Although ethical guidelines published by the Department of Health and Children in 2001 [29] recommend that Irish employers recruit only from countries that support the overseas nurse recruitment, compliance with these guidelines does not mean that Ireland's recruitment of significant numbers of nurses is without consequence for the sending countries. India and the Philippines, countries from which Ireland has sourced the bulk of its migrant nursing workforce, have reported the loss of their more experienced nursing staff to emigration [30, 31], resulting in emigration-induced ward and hospital closures [30] and mass resignations [31].

Given the global inequalities that exist, *'policies to increase domestic production and retention of nurses in wealthy countries are no longer just a national imperative; they are also an international responsibility'* [32]. Perhaps it is time for Ireland to revisit the potential ethical implications, as well as the sustainability, of this level of reliance on migrant nurses. Overseas nurse recruitment raises important policy and ethical considerations for Ireland. However, a pre-requisite is the need for comprehensive, detailed and consistent data collection that would enable policy makers to accurately quantify the effects of nurse immigration and emigration to the workforce and the sustainability of nurse migration as a recruitment solution. Ireland should no longer rely on incomplete or anecdotal evidence to drive policy and practice in an area so essential to the Irish health system and with global implications.

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