

1-9-2012

Nurse migration and health workforce planning: Ireland as illustrative of international challenges.

Niamh Humphries

Royal College of Surgeons in Ireland, nhumphries@rcsi.ie

Ruairi Brugha

Royal College of Surgeons in Ireland

Hannah McGee

Royal College of Surgeons in Ireland

Citation

Humphries N, Brugha R, McGee H. Nurse migration and health workforce planning: Ireland as illustrative of international challenges. *Health Policy*. 2012 Sep;107(1):44-53.

This Article is brought to you for free and open access by the Department of Epidemiology and Public Health Medicine at e-publications@rcsi.ie. It has been accepted for inclusion in *Epidemiology and Public Health Medicine Articles* by an authorized administrator of e-publications@rcsi.ie. For more information, please contact epubs@rcsi.ie.

Attribution-Non-Commercial-ShareAlike 1.0

You are free:

- to copy, distribute, display, and perform the work.
- to make derivative works.

Under the following conditions:

- Attribution — You must give the original author credit.
- Non-Commercial — You may not use this work for commercial purposes.
- Share Alike — If you alter, transform, or build upon this work, you may distribute the resulting work only under a licence identical to this one.

For any reuse or distribution, you must make clear to others the licence terms of this work. Any of these conditions can be waived if you get permission from the author.

Your fair use and other rights are in no way affected by the above.

This work is licenced under the Creative Commons Attribution-Non-Commercial-ShareAlike License. To view a copy of this licence, visit:

URL (human-readable summary):

- <http://creativecommons.org/licenses/by-nc-sa/1.0/>

URL (legal code):

- <http://creativecommons.org/worldwide/uk/translated-license>
-

Nurse Migration and Health Workforce Planning: Ireland as Illustrative of International Challenges

Humphries, N¹, Brugha, R², McGee, H³

¹ Department of Epidemiology, Division of Population Health Science, Royal College of Surgeons in Ireland, Dublin

² Head of Department of Epidemiology, Division of Population Health Sciences, RCSI, Dublin.

³ Dean, Faculty of Medical and Health Sciences, RCSI, Dublin

Abstract

Ireland began actively recruiting nurses internationally in 2000. Between 2000 and 2010, 35% of new recruits into the health system were non-EU migrant nurses. Ireland is more heavily reliant upon international nurse recruitment than the UK, New Zealand or Australia.

This paper draws on in-depth interviews (N=21) conducted in 2007 with non-EU migrant nurses working in Ireland, a quantitative survey of non-EU migrant nurses (N=337) conducted in 2009 and in-depth interviews conducted with key stakeholders (N= 12) in late 2009/early 2010.

Available primary and secondary data indicate a fresh challenge for health workforce planning in Ireland as immigration slows and nurses (both non-EU and Irish trained) consider emigration. Successful international nurse recruitment campaigns obviated the need for health workforce planning in the short-term, however the assumption that international nurse recruitment had 'solved' the nursing shortage was short-lived and the current presumption that nurse migration (both emigration and immigration) will always 'work' for Ireland overplays the reliability of migration as a health workforce planning tool. This article analyses Ireland's experience of international nurse recruitment 2000-2010, providing a case study which is illustrative of health workforce planning challenges faced internationally.

Keywords: nurse migration, health workforce planning, migrant nurses, nurse workforce planning, nurse, nursing, midwives.

Introduction

International nurse recruitment campaigns were initiated in 2000 to attract migrant nurses from outside the EU into the Irish health system. Non-EU migrant nurses accounted for 35% of newly registered nurses between 2000 and 2010 (1) with 11,481 non-EU migrant nurses issued with working visas from 2000 to 2009. In a relatively short time, migrant nurses became integral to the Irish health system, a fact acknowledged by the Irish Nurses and Midwives Organisation¹ (INMO) who noted in 2008 that Ireland would be forced to close hospital beds without the presence of migrant nurses (2).

The appeal of international nurse recruitment, in Ireland as elsewhere, lay in the fact that it enabled nurses to be 'imported' into the health system at relatively short notice and at a lower cost than training nurses locally. The process of importing rather than training sufficient health workers to meet demand is known internationally as the '*free rider phenomenon*' (3). International nurse recruitment was a convenient method of coping with unforeseen nursing demand, but it should have also served as a warning signal and provided the impetus for improved health workforce planning. Instead, international nurse recruitment became '*the solution of choice*' (4) based on an implicit assumption that migrant nurses were '*essentially available on tap*' (5) and that any future skills shortfalls nationally could similarly be met from a global skills pool (6).

Such was the success of international nurse recruitment campaigns in filling vacant posts within the Irish health system (7) that it enabled underlying nurse workforce planning problems to be obscured (8, 9), specifically issues relating to retention. The past decade saw almost as many nurses recruited internationally as trained locally - 14,546 non-EU and non-Irish EU-trained nurses joined the Irish nursing workforce between 2000 and 2010, alongside 17,264 Irish-trained nurses (10). In terms of international comparisons, since 2004 Ireland has had a greater reliance on international recruits than the UK (see Figure 1) and is more reliant upon foreign trained nurses than traditional immigrant destinations, such as Australia and New Zealand (see Table 1)

¹ The INMO is the largest nursing/midwifery union in Ireland

Figure 1: Percentage of New Entrants to the UK and Irish Nursing Registers from outside the EU
the EU
2002-2008 (11) (12) (10)

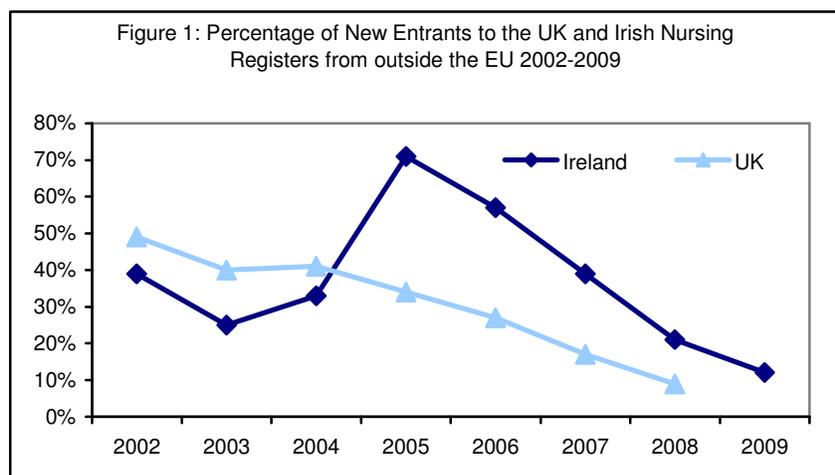


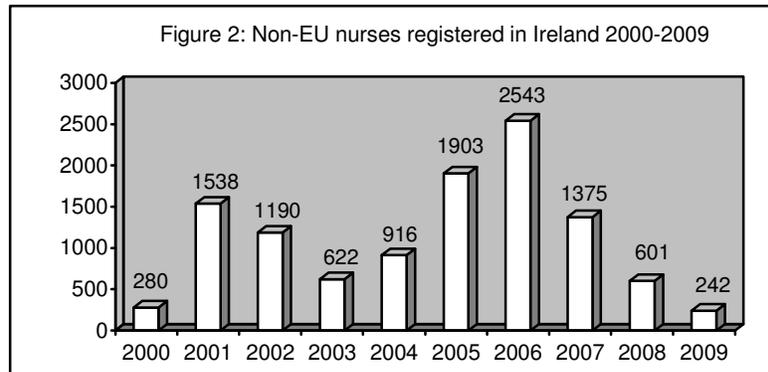
Table 1: Share of foreign-trained or foreign nurses in selected OECD countries, 2008(13)

Country	Foreign Trained Nurses as a Share of Total
Ireland	47.1
Australia	16.4
New Zealand	22.1
United Kingdom	8.0
United States	3.5
Netherlands	1.4

International nurse recruitment appears to have become a major supplier of nurses to the Irish health services by default rather than by design. Within the hospitals, international nurse recruitment was perceived as a stop-gap measure - a short-term solution to the shortage of nurses (14) with the understanding being that Irish-trained nurses would be prioritised for recruitment as soon as more graduates came on stream (14). As a result, the early international recruits were initially issued with two year employment contracts (14), largely to enable the health system to adapt to a 'gap year' in which there were no graduating nurses in Ireland (as a result of the transition from a three year to a four year degree programme)(15) (7). Although the gap year theory helps to explain the 'peak' recruitment of 2005/6 it fails to account for the significant recruitment levels in 2001, 2002 and 2007 (see Figure 2). The Irish situation appears to mirrors that of the UK whereby there was a general openness to health professional mobility

1998-2006, followed by increasing levels of restriction from 2006 onwards (16). In the UK, as in Ireland, an openness to mobility coincided with economic growth and health workforce expansion (16).

Figure 2: Non-EU Nurses Registered in Ireland 2000-2009 (10)



Health workforce planning is about *'getting the right staff with the right skills in the right place at the right time'* (17, 18). In an ideal world, it would; *'continually and robustly'* identify *'risks and trends, and . . . trigger flexible responses'* (17); *'reduce staff wastage'* (18); *'ensure that current members of staff have the right skills to meet future demands'*(17); anticipate future needs for different skills in time for action to be taken (18, 19); be integrated with financial planning and control (18) and with *'the broader objectives of service planning'* (20) and be a continuous rather than a *'one-off exercise'*(18). Ireland has only recently begun to grapple with health workforce planning concerns, perhaps prompted by European initiatives, such as the European Working Time Directive (EWTd) and the Green Paper on the European Workforce for Health (21) and international initiatives such as the Global Code of Practice on the International Recruitment of Health Personnel (22). The first integrated workforce planning strategy for the Irish health system was published in 2009 (23) as was the first attempt to develop a quantitative health workforce planning tool (24).

Despite the significance of international nurse recruitment in terms of nursing supply, data collection on this component of the nursing workforce has been virtually non-existent. In Ireland, as in many other countries, *'reliable and relevant data upon which good workforce policy depends are simply unavailable'* (25). This is a common complaint internationally (16, 25) and yet data are essential for

incorporating nurse migration into *'the overall workforce planning approach'* (26). While nurse workforce profiling is occasionally conducted (27) these are one-off occurrences rather than regular exercises. Although non-EU migrant nurses accounted for 35% of new entrants to the Irish Nursing Register between 2000 and 2010 (10), little or nothing is known about this section of the nursing workforce. Although useful, immigration and registration data record only their *arrival* to Ireland, there is no available data to track their subsequent progress within the Irish health system (7). Beyond secondary immigration and registration data, no information is routinely gathered about the migrant nurse workforce. Even baseline information on the number of migrant nurses employed nationally, their nursing specialities or geographic location is lacking (7). Buchan explains that an evidence base which includes information on inflow, countries of origin and whether migration is temporary or permanent in nature, are necessary to enable destination countries, such as Ireland, to assess whether international recruitment is cost effective, sustainable and/or justifiable (28) (29), a point echoed by Wismar et al (30).

Although Ireland's *'reliance on migrant nurses indicated a failure to produce and retain sufficient nurses to meet the growing demand'* (7), notable in its absence has been a national analysis of the weaknesses in nurse workforce planning that necessitated such large-scale international nurse recruitment. This article reflects on a decade of international nurse recruitment to ascertain what lessons have been learnt and how these will facilitate the development of a secure nursing workforce going forward. Although drawing on examples from the Irish context, the analysis is relevant to an international audience eager to understand the dynamics of nurse migration. Drawing on data from our 2009 survey of non-EU migrant nurses (N=337) in Ireland, we present a profile of respondent non-EU nurses in Ireland and some insight into their experiences within the Irish health system, alongside information on migrant nurses' and key stakeholder perspectives on the role of non-EU nurses within the Irish health system. In so doing, the paper will offer insight into the contribution made by non-EU migrant nurses to the Irish health system.

The Study

Key Stakeholder Interviews

Approval for the key stakeholder interviews was granted by the institutional Research Ethics Committee. In-depth interviews (N=12) were conducted between September 2009 and January 2010. Stakeholders were selected for interview on the basis of their knowledge and/or experience of international nurse recruitment and health workforce planning, either at a policy or service

level. Relatively few organisations are involved in health workforce planning in the Irish context and all were interviewed for this project. Stakeholders were invited to reflect on a decade of international nurse recruitment and its implications for health workforce planning, particularly in the context of an economic recession and recruitment moratorium. Three policy briefs presenting findings from the Nurse Migration Project (31) (32) (33), were circulated prior to interview to stimulate discussions. All interviews were conducted by NH, were audio recorded and transcribed verbatim. Data management was facilitated by using MaxQDA qualitative analysis software.

Migrant Nurse Interviews

Ethical approval for the qualitative and quantitative elements of Nurse Migration Project was granted by the institutional Research Ethics Committee. The initial fieldwork, in 2007, involved qualitative in-depth interviewing of non-EU migrant nurses in Ireland (N=21). Potential respondents were contacted in several ways – firstly the INMO circulated 250 letters to a random sample of nurses affiliated with their ‘Overseas Nurses’ section, inviting them to participate in the research; secondly, adverts were placed in migrant newspapers/newsletters inviting participation and thirdly, snowball sampling was used whereby respondents were asked to refer the researchers to other potential respondents (34). All respondents were given a €20 gift voucher to thank them for their participation in the research. Interviews were conducted by NH, a postdoctoral researcher with significant experience in qualitative interviewing. Theme sheets were assessed and approved by co-authors (RB and HMG) and by a non-EU migrant nurse prior to the interview phase. Interviews were audio recorded and transcribed verbatim by NH. Data management and analysis were facilitated by the use of MaxQDA software. Conducting the qualitative interviews with non-EU migrant nurses ahead of the quantitative survey allowed the qualitative findings to inform the development of the survey. This worked as a strategy as specific survey questions included those relating to remittances (35) and bullying/discrimination (36) which were not considered priority areas by the research team ahead of the qualitative phase. Other topics, such as adaptation and orientation, received less priority in the survey as qualitative findings suggested that they were less important to respondent migrant nurses than the research team had envisaged.

Migrant Nurse Survey

A quantitative survey of migrant nurses was conducted in early 2009. The Irish Nursing Board² forwarded postal surveys to a random sample of 1536 non-EU migrant nurses on behalf of the research team. A number of strategies recommended by Edwards et al (37) were used to maximize survey response rate – incentives were used³, coloured ink was used in the survey and freepost envelopes were distributed with each survey. As the survey was circulated by the Irish Nursing Board on behalf of the research team, follow-up contact was not possible, instead 1536 postcards were circulated to potential respondents ahead of the postal survey, a strategy also considered to increase response rates (37). However, a low response rate of 25% was anticipated, in line with previous migrant surveys in the Irish context (38). The postal survey achieved a response rate of 20%; a sample size of 309. A parallel sampling strategy, involving the recruitment of non-EU migrant nurses via their hospital employers, was also used. Three large Dublin hospitals were selected as research sites; ethics approval was received from each. This recruitment strategy resulted in the recruitment of only 28 non-EU migrant nurses. The questionnaire asked respondents for details on their nursing background, the recruitment process, their experiences of orientation, their employment experiences, other details about living in Ireland and their future plans. Quantitative data (N = 337) were input and analysed in SPSS software; the analysis of open-ended survey responses was facilitated by using MaxQDA software.

To differentiate between the various data cited in this paper, input from the key stakeholder interviews will be reported as (Key Stakeholder, X), data from qualitative interviews with non-EU migrant nurses will be reported as (Migrant Nurse Interviewee X). Survey data will be clearly identified as such and accompanied by a 'N' and open ended input from the survey will be reported as (Migrant Nurse Survey X).

Results

1. Profile of non-EU migrant nurses within the Irish health system

In terms of country of origin, 51% (173) of respondent migrant nurses were from the Philippines, 33% (112) from India and the remainder were from one of 16 other countries. The vast majority of respondents, 85% (287), were women and most respondents 77% (261) were also married. Respondents ranged in age from 25 to 63, with an average age of 38. This brief profile already poses a challenge to the stereotype of the young, single migrant nurse. As their age profile

² The Irish Nursing Board (An Bord Altranaís) is the regulatory body for the nursing profession in Ireland. It maintains a Register of all nurses licensed to practice in Ireland.

³ Survey respondents were invited to take part in a draw for one of three €500 travel vouchers

suggests, respondent migrant nurses brought a wealth of nursing experience to Ireland. Prior to their arrival, 44% (182) of respondents had between 6 and 15 years of nursing experience and 13% (45) had over 16 years of nursing experience. Respondents had not acquired all of their nursing experience in their home countries, however, a significant number of respondents worked in other destination countries before migrating to Ireland. For instance, of those respondent nurses who had trained in the Philippines, one third (58) worked in the Middle East before coming to Ireland, as did 21% (23) of respondent nurses who had trained in India. Respondent nurses had worked at a variety of grades - 49% (164) had worked as staff nurses or midwives, 28% (96) had held senior staff posts, 11% (36) had held nurse/midwife manager posts and 4% (15) of respondents had worked as lecturers.

The majority of survey respondents, 83% (278) reported that a recruitment agency facilitated their migration to Ireland. Interview panels, consisting of private and public sector employers and nurse recruitment agencies travelled to countries such as India and the Philippines to recruit non-EU migrant nurses into posts in the Irish health system. Both Irish based and local recruitment agencies were involved in the recruitment process - 54% (181) of respondents used one of two main Irish recruitment agencies, and a further 32 recruitment agencies were named by respondents, highlighting the role played by brokers in international nurse recruitment (39).

On arrival, 62% (208) of respondents took up nursing posts in public hospitals and 21% (71) began their Irish nursing careers in private nursing homes. The specialism that attracted the greatest proportion of newly arrived respondents - 29% (98) - was geriatric/care of the elderly nursing. Bornat et al (40) found that South-Asian trained doctors in the UK established a niche in geriatric medicine as a result of it being an unpopular specialism with UK trained doctors and similar factors may be at work in the concentration of respondent non-EU migrant nurses in the geriatric/care of the elderly sector in the Irish context. One respondent explained the transition to geriatric nursing *'Before I came to Ireland I was working in an acute hospital handling various cases of medical, surgical, paediatric and maternity but never geriatric cases. It's a huge transition/transformation on my part but somehow I managed to adapt and handle it well'* (Migrant Nurse Survey 178). Other specialities to which new arrivals were recruited included intensive care, surgery, general medicine and intellectual disability nursing.

70% (235) of respondent migrant nurses worked at staff nurse/midwife grade in the Irish health system at the time of the survey, with 20% (67) working at senior

staff level and 7% (25) working as nurse/midwife managers. Evidence internationally suggests that migrant health workers frequently occupy less desirable posts (3, 9) within the health systems of their host countries and that they struggle to achieve career progression (41). Survey respondents gave both positive and negative findings in relation to their career progression within the Irish health system, for instance, although only 19% (63) of respondents had applied for promotions at the time of the survey, those who had applied have been largely successful, with 71% (45) achieving promotion. The main reasons for not applying for promotion included being content in their current posts, believing that a promotion would involve too much extra work and stress and a feeling that Irish people would be preferred for promotion, '*opportunities are mostly offered to Irish nurses even though they are newly qualified and less experienced*' (Migrant Nurse Survey 162). Despite this, 81% (274) of respondents felt that their skills and qualifications were accepted by their Irish medical and nursing colleagues. Respondents were asked whether they had ever experienced bullying or discrimination while working as a nurse in Ireland and 55% (184) noted that they had, as this respondent explained:

'... some of our colleagues . . . we are welcome, but I think some of them were not so, I suffered loads of things which I don't really suffered back home. Em, really honestly, I was also bullied, I was being harassed' (Migrant Nurse Interviewee 12)

The response to bullying was varied, but the most popular course of action among respondents who had experienced bullying or discrimination was to discuss it with colleagues. Only 16% (54) of those who had experienced bullying or discrimination, raised the issue with management.

In terms of professional qualifications, 70% (238) of respondents held Nursing Degrees and 15% (52) held Higher Diploma and/or Masters Degrees. Surprisingly, 71% (240) of respondents had received no state funding for their nursing education in their country of origin. It would seem that respondents and/or their families had invested significant financial resources in their nursing education, presumably in the hope that the acquisition of an '*internationally tradable occupation*' (42) would facilitate emigration and ultimately a remittance flow (35).

Most respondents were relatively secure in their employment posts, with 80% (269) holding permanent posts within the health system. In terms of geography, respondent migrant nurses were concentrated primarily in Dublin with 80% (271)

based in the capital. As the first national survey of non-EU migrant nurses in Ireland, this profile offers health workforce planners an insight into the migrant nurse population, their location and roles within the health system. As such, it provides an important starting point in the quest to assess the current contribution of non-EU migrant nurses to the nurse workforce in Ireland, although more accurate data on the health workforce is required to enable health workforce planning to be conducted with precision (24).

Information on whether nurse migration is temporary or permanent in nature is, as Buchan explains, essential to any evaluation of its contribution to the health workforce (28). Survey respondents were asked how long they had originally intended to stay in Ireland for. 34% (116) of respondents had come to Ireland unsure of how long they intended to stay, 15% (51) intended to stay for less than 2 years, 18% (62) for 2-5 years and 15% (50) stated that when they came to Ireland, they had intended to stay for 5-10 years. Only 9% (33) had, on arrival, intended to remain in Ireland on a permanent basis. Respondents were also asked to indicate their future plans and these plans revealed that less than one fifth of respondents 19% (65) were intent on remaining in Ireland while 49% (166) intended to return home and 23% (79) planned to migrate another country. Therefore close to three quarters (72%) expressed an intention to leave Ireland.

2. Impact of Economic Recession

Insight into how respondent migrant nurses perceived their current role within the Irish health system and the impact that the economic recession were having were evident in the 'free text' answers provided by survey respondents. A specific focus of these comments was the economic recession. Respondents appeared to associate economic recession with increased vulnerability and insecurity, despite the fact that they were predominantly employed on permanent contracts:

'Though we are permanent we are uncertain of our jobs' (Migrant Nurse Survey 142).

The recession seemed to have raised awareness of their status as migrant workers, at the mercy of short-term immigration status and the ever-changing requirements of the health system:

'The 'recession' has made us question ourselves: how long is the country going to need us? Being on a working visa only renewable every 2 years we are unsure of (our) security and stability here' (Migrant Nurse Survey 222).

Underlying these comments appears to be the fact that unforeseen circumstances, such as the deteriorating economic situation, could pose a threat to their place within the Irish health system. Although migrant nurses in Ireland, as in the UK, have been subjected to less hostility than other migrant groups (43) due to the essential nature of their work and the shortage of nursing staff locally, there was a sense among respondents that this acceptance might evaporate in the face of an economic recession. Recent surveys have compounded these fears in revealing a significant cooling of enthusiasm for immigration since the onset of the economic recession(44).

'It makes the Irish people think more 'racism' (because they think economic downturn is because of overseas people). We can feel that tension in the workplace more nowadays' (Migrant Nurse Survey 138).

The question for health workforce planners is how the insecurity and uncertainty expressed by respondents might translate into action by Ireland's non-EU migrant nurses. Will they remain in Ireland despite less favourable conditions (wage reductions, tax increases, poor employment prospects for spouses). Their decisions in this regard could have significant repercussions for the stability of the nursing workforce and for the wider health system.

3. Nurse Emigration

Support to the findings on the intentions of Ireland's non-EU migrant nurses to emigrate can be gleaned from an analysis of the verification requests⁴ lodged with the Irish Nursing Board. Verification data are generally considered an indication of *intent* to migrate (7) and in terms of nurse workforce planning, '*can give an indication of the demand created for replacement*' (27). Between 2008 and 2010, verification requests were processed on behalf of approximately 4202 non-EU migrant nurses (1), equating to 29% of those recruited since 2000. Despite a decrease in verification requests by non-EU migrant nurses in 2010, this represents a significant proportion of the migrant nurse workforce. If these nurses were to emigrate - as is their intent - it would represent a significant loss to the Irish health system.

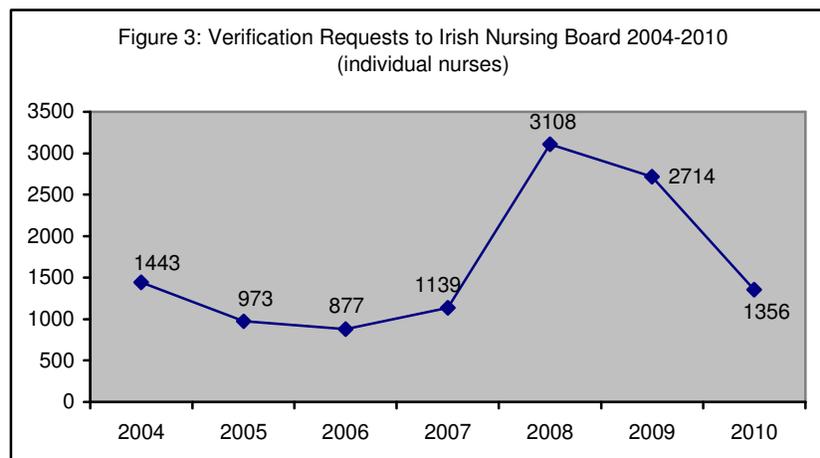
Non-EU migrant nurses are not alone in their desire to emigrate from Ireland. Newly graduated Irish nurses are also seeking to emigrate in search of

⁴ The number of nurses who have sought to have their Irish registration verified by the nursing board of another country.

employment as a result of the Irish public sector recruitment embargo (45, 46). In 2008, verification requests were received on behalf of 805 Irish nurses, with a further 909 received in 2009 and 967 in 2010 (1). Stakeholders felt that Ireland was letting these Irish trained nurses ‘drift away’ (Key Stakeholder 9) and warned that their emigration would bring Ireland ‘full circle’ in terms of nursing shortages and bed closures (Key Stakeholder 9). There was a sense that the emigration of nursing graduates would store up health workforce planning problems for the future and that in years to come, Ireland would ‘be going out recruiting them to come back’ (Key Stakeholder 8).

Overall, the number of verification requests received from both non-EU migrant and Irish nurses and the scale of emigration of which they are indicative, pose a significant health workforce planning challenge. The numbers intent on emigration in 2008 and 2009 (see Figure 3) far exceeded Ireland’s annual nurse training capacity of 1570. It would appear that Ireland, which has been an international recruiter of nurses since 2000, has now become a source country for nurses, with its nursing staff seeking to emigrate, primarily to Australia and the UK (10). Recruitment agencies are now actively recruiting nurses from Ireland (47), facilitating their emigration from Ireland rather than the more recent facilitation of nurse immigration into Ireland.

Figure 3: Verification Requests to Irish Nursing Board 2004-2010 (individual nurses)(10)



Stakeholders disagreed as to the significance of the verification data as it related to non-EU migrant nurse emigration with several noting that they had yet to see evidence of this emigration at hospital level. Nine of twelve stakeholders acknowledged that the emigration of non-EU migrant nurses in significant numbers would have an impact on health service delivery either because it would involve a loss of specialist skills and experience and/or simply because

migrant nurses make up a significant proportion of the nursing workforce in Ireland. It was felt that certain specialist areas reliant upon migrant nurses, were particularly at risk. Respondent stakeholders made specific mention of; Intensive Care Units (ICU); High Dependency Units (HDU); Operating Theatres (OT) and Neonatal Units, particularly in the larger Dublin hospitals. Some key stakeholders felt that migrant nurse emigration posed a particular threat to the continued operation of these units:

'Well I think it would be a huge loss of expertise and experience and it would have . . . significant implications when it comes down to a skill mix and a grade . . . if you're replacing somebody with 10, 12 years experience in a speciality with somebody that's relatively newly qualified, obviously there are implications there' (Key Stakeholder 9).

An important aspect of health workforce planning is ensuring that *'current members of staff have the right skills to meet future demands'* (17). Two key stakeholders argued that Ireland's migrant nurses were not highly specialised and, if they emigrated, could be replaced relatively easily by Irish nurses:

'the bulk of that recruitment (was) . . . into, basic, you know, staff nurse kind of jobs . . . not highly specialised nurses. . . . So if we had to deal with a situation whereby people left and we have our own people . . . we would have to manage it until they basically got themselves up to speed' (Key Stakeholder 10).

However, other stakeholders expressed concern that experienced, specialised migrant nurses could not immediately be replaced by freshly graduated nurses: *'you can't replace an ICU specialist with a new graduate, it's just not feasible'* (Key Stakeholder 5).

That the emigration of migrant nurses would pose no challenge to the Irish health system was a theme of two stakeholder interviews. These sentiments were expressed with confidence, despite (or perhaps because of) a lack of available data on the migrant nurse workforce and the precise jobs or specialties in which they practiced in Ireland. In terms of emigration of migrant nurses from Ireland, both of these stakeholders felt that emigration could somehow be managed in such a way that only non-specialist migrant nurses would elect to emigrate.

'I think what you'd want to do is do it selectively. If people want to leave and you can replace them and you'd be happy to replace them . . . But if

they're in a more specialized area, you need them, well then you'd probably have to be a bit more selective about it' (Key Stakeholder 10).

Quite how this might be achieved was not explained, but the underlying assumption appeared to be that a 'laissez-faire' approach to both nurse migration and to health workforce planning was justified. Even if nurse emigration were to increase, somehow only the migrant nurses in non-specialist, non-essential posts would elect to emigrate onwards and the vacancies left in their wake would then automatically 'match' the skill sets of the newly qualified Irish nurses seeking employment:

'If the migrant nurses are in situ, then the Irish nurses can't get those jobs. But obviously if they left . . . they would create spaces that some Irish people who can't get jobs would obviously stay and take' (Key Stakeholder 6).

Another suggestion from stakeholders, eager to downplay the potential negative impact of migrant nurse emigration on the Irish health system, was a solution to migrant nurse emigration might be found closer to home as part-time nurses increased their working hours.

'even a 25% increase in the number of hours that all part-time nurses work, would generate a massive number of a millions of man hours per annum. . . without additional people. So there's scope there' (Key Stakeholder 6).

Buchan and Seccombe specifically warn against the presumption that an economic recession will resolve all workforce planning difficulties. Instead, they advise that *'the next few years will be the most difficult for decades for the planners and policy makers who have the responsibility to sustain an adequate, productive and motivated nursing workforce'* (48).

2. Health Workforce Planning

Stakeholders agreed that health workforce planning in Ireland was in its infancy and that, to date, there had been *'no overarching planning strategy'* (Key Stakeholder 6). Despite this, there was recognition of its fundamental importance to the health system: *'If we don't plan we'll only be running from one crisis to another and that's what we seem to be doing at the moment'* (Key Stakeholder 9). In a sense, the recession has brought health workforce planning concerns to the fore in the Irish context. This has arisen because of the challenge of addressing the conflicting fiscal and service needs of the health system. These

dilemmas are by no means unique to Ireland - Dussault and Dubois discuss the tendency of Governments to focus attention on the size of the workforce and the wage bill while overlooking other important issues relating to health workforce planning (49).

Most stakeholders were keenly aware of the contribution that non-EU migrant nurses make to the Irish health system: *'46% of my workforce are from overseas . . . that wouldn't be dissimilar to other hospitals of the same size, particularly . . . in Dublin'* (Key Stakeholder 8). They were aware of the extent to which the Irish health system had come to rely on migrant nurses and were apprehensive about the prospect of managing without them: *'we couldn't possibly have kept the services running without them . . . we couldn't do it now either'* (Key Stakeholder 9). Stakeholders however, appeared to have little faith in Ireland's ability to achieve self sufficiency:

'It's unlikely, the way we're currently structured, that we would be self sufficient in nurses' (Key Stakeholder 10).

'I can't see us ever having to manage without migrant nurses in the future. Across the whole health services, I just can't see that happening' (Key Stakeholder 9).

Discussion

In the Irish context, International nurse recruitment campaigns were initiated in response to vacancies in the health system, rather than in response to a comprehensive health workforce strategy. The distinction is significant because while international nurse recruitment was a successful method of coping with a growing demand for nurses, few lessons appear to have been learnt from a decade of active international nurse recruitment. Learning from the experience and strengthening health workforce practice could have prevented Ireland from experiencing similar difficulties with regard to the medical workforce. Active overseas recruitment of doctors was instigated in 2011 to fill vacancies within the Irish health system (50). The lesson to be learnt is that active health worker recruitment and health worker migration should not be divorced from health workforce planning.

Ethical Considerations

The ongoing reliance on migrant health workers, coupled with the reluctance to strive for self-sufficiency, raises important ethical issues for destination countries. In

the Irish case, the reluctance to commit to self-sufficiency is stated within the national health workforce planning strategy, which notes that *'while self sufficiency is often the ideal objective, there are a number of circumstances where it may be neither possible nor practical'* (23), a statement seemingly at odds with Ireland's obligations under the WHO Global Code to strive towards the creation of a sustainable health workforce (22). The underlying assumption appears to be that there is a global pool of nurses from which Ireland can draw on at any stage to resolve local nursing shortages. Over the past decade, Ireland has been reliant on non-EU migrant nurses to staff its health system. This poses a number of ethical dilemmas for Ireland.

Relying on non-EU countries to supply nurses to staff Ireland's health system has implications for source 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 staff to emigration (7, 51, 52). From an ethical perspective, there is a need for destination countries to identify and attempt to mitigate any negative effects of health worker migration on the health systems of source countries by way of circular migration programmes, bilateral agreements, skills and knowledge sharing (22); and not assume that countries that produce large numbers of nurses and doctors will not experience negative effects from their emigration.

The Irish health workforce has been transformed by international nurse recruitment and health worker migration and yet the fundamental challenge – to retain nurses in the health system- remains (6). Having actively recruited migrant nurses from countries such as India and the Philippines, no efforts were made to retain them in the Irish health system. Ireland is by no means unique in this regard - the OECD notes that most countries don't have specific retention policies for migrant health workers even when they represent a large share of the workforce (3). For many respondent nurses, Ireland was one of several countries in which they would work as migrant nurses – some had worked in other destination countries prior to their arrival and some intended to migrate onwards to another destination country after Ireland. Ireland instigated the migration of non-EU migrant nurses to Ireland, failed to put in place appropriate protections for them in terms of immigration legislation (6) and as a result many appear intent on onwards migration. This demonstrates a disregard for the individual migrant and for the fact that *'uprooting oneself, leaving one's family, community and country of origin, and establishing oneself in a new country are all taxing events'* (4). This study revealed that respondent nurses themselves and/or their families frequently funded their nurse education. Although this means that the

source country did not cover the costs of nurse education, families and individuals within the source country did. Put simply, *'different 'pockets' are involved in covering the costs'* (4) of training non-EU migrant nurses to work in the Irish health system. Surely this underscores the importance of destination countries such as Ireland to strive to train sufficient health workers to meet demand.

Data Requirements

There is a need for the Irish health service to significantly strengthen its health workforce planning capacity and to better understand the impact of migration flows because *'health professional mobility can undermine attempts to forecast workforce needs if inflows and outflows are not well understood and factored into the planning'* (53). Ireland is not alone in having limited data available in relation to health worker migration or in using data which does not directly measure migration (53, 54). A recent book on health worker migration found limited data availability in 13/17 countries, including destination countries such as Belgium, France, Germany, Italy, Spain and the UK (55). Without strong data collection and analysis of health worker migration, the development of *'evidenced base workforce plan'* (22) and the creation of *'a sustainable health workforce'* (22) will be hampered.

In the Irish context, minimal attention has been paid to where in the health system these actively recruited nurses work, which makes it difficult to ascertain *'the impact that nurse migration is having on specific sectors of the health system'* (7). There is little evidence that analysis was undertaken of the weaknesses in health workforce planning that necessitated large-scale international nurse recruitment. For instance, if all of the midwives or Intensive Care Unit (ICU) nurses in a country are migrant nurses, this indicates serious flaws in the country's training and retention strategy in these specialities and should prompt changes to address these deficits. A skills shortage of specialised nurses (theatre, intensive care, dialysis, geriatric and midwives) was recently identified in a national skills bulletin (54) which identified the skills shortage by analysing the number of work permits issued to non-EU workers. The absence of timely, comprehensive data on the migrant nurse workforce is a serious impediment to nurse workforce planning. The availability of baseline information - the grades, employers and nursing specialism of the migrant nurse workforce - would greatly facilitate the move towards evidence- rather than opinion- based policy, which is of fundamental importance to the Irish health system. Without even a basic profile of the migrant nurse workforce, it is difficult to see how migrant nurses can

be properly incorporated into Irish workforce planning strategies, or how their retention might be measured let alone improved (6)

With regard to the nursing workforce, there is need to profile the nursing workforce in order to assess its strengths and identify/address weaknesses. This paper has identified migration as a phenomenon in urgent need of quantification. Other factors determining nurse numbers which need to be taken into consideration include the ageing workforce and the impact of redundancies and retirements (56) (50) on the health workforce. Better data collection and analysis is necessary in order to adequately plan the health workforce, reduce reliance on non-EU migrant nurses and move towards self-sufficiency.

Health Workforce Planning

Importing non-EU migrant nurses to staff the Irish health system rather than training sufficient nurses to meet demand, as happened in the early and mid 2000s, implies a failure of health workforce planning, i.e. a mismatch between the demand for and supply of nurses in the Irish context. Key stakeholders had very different perspectives on this, with some very confident that migration would always work for Ireland – that Ireland could replace any emigrating nurses, that emigrating Irish nurses would return when required by the Irish health system. This attitude justifies inaction. Other stakeholders who were more concerned about the risk to the health system posed by the emigration of nurses were not confident in Ireland’s ability to achieve self-sufficiency.

It is difficult to see how Ireland will manage to maintain an adequate nursing workforce while training fewer nurses⁵, recruiting fewer nurses from overseas, losing domestically trained nurses, and encouraging large numbers to retire early. The impact on frontline health services is already apparent with reports of overcrowded Emergency Departments alongside hospital ward and bed closures and recruitment difficulties within the nursing home sector (57). Unforeseen events, such as the economic recession and a recruitment moratorium underscore the need for ongoing health workforce planning which can adapt the workforce to meet changing circumstances. If destination countries that are heavily reliant on recruiting migrant health workers are to ensure a stable health workforce appropriate to their needs, they must begin to pay far more attention to long-term health workforce planning – *‘proper human resource management is long overdue’* (4).

⁵ The number of nurse training places was reduced to 1570 in 2009 from 1880 places in 2008.

Overall, the Irish experience, 2000 to 2010, provides lessons to those who rely mainly on migration, through active and passive recruitment of health workers, to solve health workforce planning challenges. As a result of the success of Ireland's international nurse recruitment campaigns, the health system became over-reliant on migration and neglected more sustainable, long-term health workforce planning strategies. Ireland actively recruited significant numbers of nurses internationally, from 2000 to 2008. This trend was reversed with the onset of an economic recession and recruitment moratorium which halted international recruitment and appears to have contributed to nurse emigration (of Irish and non-EU nurses). An incentivised early retirement scheme initiated in 2011 will further deplete the nursing stock in 2012 (56).

Conclusion

During the economic boom, Ireland relied on active nurse recruitment to staff an expanding health sector. Migration offered a quick fix solution, but it did not *'resolve the underlying causes of workforce problems'* (30). Although international nurse recruitment obviated the need for health workforce planning in the short-term, a longer term perspective, analysing trends over a 10 year period, reveals the need for a strategic approach. The lesson from this experience is that active international recruitment must be incorporated into a health workforce plan, and that reliable and valid data are a pre-requisite. Nursing and medical registration data, on which we and other have relied to demonstrate workforce migration trends, need to be enhanced or replaced by employment-based data sources. This paper has illustrated some of the challenges faced in relation to nurse migration in an international context. Other significant international challenges lie ahead - such as an ageing workforce. Responding to these and other health workforce planning issues will require improved data collection and analysis, and an increasingly global, as distinct from local and national, perspective on these challenging issues.

Acknowledgements

The authors would like to thank the migrant nurses and key stakeholders who participated in this research. They would also like to thank the Irish Nurses and Midwives Organisation for their assistance in contacting qualitative respondents. Thanks to the Irish Nursing Board and the Employment Permits Section of the Irish Department of Enterprise, Trade and Employment for providing statistics. Thanks to the Irish Health Research Board for funding the Nurse Migration Project: Research Project Grant RP/2006/222. Finally, the authors would like to thank the Health Policy reviewers who provided three excellent reviews.

References

1. Irish Nursing Board, *Unpublished Statistics*.
2. Coonan, C., *Nursing the Western World*, in *Irish Times* 2008: Dublin
3. OECD, *The Looming Crisis in the Health Workforce. How Can OECD Countries Respond?*, in *OECD Health Policy Studies* 2008, OECD: Paris.
4. Kingma, M., *Nurses on the Move: Migration and the Global Health Care Economy* 2006, London: ILR Press.
5. NESCC, *Report on Migration* 2006, National Economic and Social Council: Dublin
6. Humphries, N., R. Brugha, and H. McGee, 'I Won't Be Staying Here for Long'. A Qualitative Study on the Retention of Migrant Nurses in Ireland. *Human Resources for Health* 2009. **7**(66).
7. Humphries, N., R. Brugha, and H. McGee, *Overseas Nurse Recruitment: Ireland as an illustration of the Dynamic Nature of Nurse Migration*. *Health Policy*, 2008. **87**(2).
8. Aiken, L.H., et al., *Trends in international nurse migration*. *Health Affairs*, 2004. **23**(3).
9. Padarath, A., et al., *Health Personnel In Southern Africa: Confronting Maldistribution and Brain Drain in Equinet Discussion Paper Number 3* 2004, Regional Network for Equity in Health in Southern Africa (EQUINET) Health Systems Trust (South Africa) and MEDACT (UK).
10. Irish Nursing Board, *Unpublished Statistics*, 2011.
11. Nursing and Midwifery Council (UK), *Statistical Analysis of Registration*, various years, Nursing and Midwifery Council
12. Nursing and Midwifery Council. *Statistical Analysis of the Register 1 April 2007 to 31 March 2008*. Available from: www.nmc-uk.org
13. OECD & WHO, *International Migration of Health Workers. Improving International Co-operation to Address the Global Health Workforce Crisis*, 2010, Organisation for Economic Co-operation and Development (OECD) & World Health Organisation (WHO).
14. Holmquist, K., *From Manila to the Mater*, in *Irish Times* 2000.
15. Quinn, E., *Managed Migration and the Labour Market - The Health Sector in Ireland*, 2006, Economic and Social Research Institute (ESRI): Dublin.
16. Young, R., *A Major Destination Country: The United Kingdom and its Changing Recruitment Policies*, in *Health Professional Mobility and Health Systems Evidence from 17 European Countries*, M. Wismar, et al., Editors. 2011, World Health Organisation on behalf of European Observatory on Health Systems and Policies: United Kingdom.
17. Imison, C., J. Buchan, and S. Xavier, *NHS Workforce Planning. Limitations and Possibilities*, 2009, The King's Fund: London.
18. Curson, J.A., et al., *Who does workforce planning well? Workforce Review Team Rapid Review Summary*. *International Journal of Health Care Quality Assurance*, 2010. **23**(1).
19. Mullins, L.J., *Management and Organisational Behaviour*. 4th Edition ed 1996, London: Pitman
20. Buchan, J., *Nurse Workforce Planning in the UK. A Report for the Royal College of Nursing* 2007, Royal College of Nursing London.

21. Commission of the European Communities, *Green Paper on the European Workforce for Health* 2008.
22. World Health Organisation, *The WHO Global Code of Practice on the International Recruitment of Health Personnel* 2010, World Health Organisation.
23. Health Service Executive and Department of Health and Children, *An Integrated Workforce Planning Strategy for the Health Services 2009-2012*, 2009, HSE & DOHC: Dublin
24. FAS, *A Quantitative Tool for Workforce Planning in Healthcare: Example Simulations*, 2009, FAS & Expert Group on Future Skills Needs: Dublin
25. Kingma, M., *Nurses on the Move: A Global Overview*. Health Services Research 2007. **42**(3 Part II): p. 1281-1298.
26. Buchan, J., S. Baldwin, and M. Munro, *Migration of Health Workers: The UK Perspective to 2006*, in *OECD Health Working Papers* 2008, OECD.
27. Department of Health and Children, *The Nursing and Midwifery Resource Final Report of the Steering Group. Towards Workforce Planning* 2002, Department of Health and Children: Dublin
28. Prime Time, *Growing Resentment Towards Immigrants*, in *Prime Time* 2009, RTE: Ireland
29. Buchan, J. *How can the migration of health service professionals be managed so as to reduce any negative effects on supply?* in *WHO European Ministerial Conference on Health Systems 'Health Systems. Health and Wealth'*. 2008. Tallinn, Estonia: WHO Europe.
30. Wismar, M., et al., *Health Professional Mobility and Health Systems Evidence from 17 European countries* 2011, United Kingdom: World Health Organisation on behalf of the European Observatory on Health Systems and Policies
31. Humphries, N., R. Brugha, and H. McGee, *Retaining Migrant Nurses in Ireland II*, 2009, RCSI.
32. Humphries, N., R. Brugha, and H. McGee, *A Profile of Migrant Nurses in Ireland in Nurse Migration Project Policy Brief 4* 2009, RCSI.
33. Humphries, N., R. Brugha, and H. McGee, *Career Progression of Migrant Nurses in Ireland in Nurse Migration Project Policy Brief 5* 2009, RCSI.
34. Atkinson, R. and J. Flint, *Accessing Hidden and Hard-to-Reach Populations: Snowball Research Strategies*, in *Social Research Update* 2001, Department of Sociology, University of Surrey.
35. Humphries, N., R. Brugha, and H. McGee, *Sending money home: a mixed-methods study of remittances sent by migrant nurses in Ireland* Human Resources for Health, 2009. **7**(68).
36. Humphries, N., R. Brugha, and H. McGee, *Career Progression of Migrant Nurses in Ireland in Nurse Migration Project Policy Brief 5* 2009, RCSI.
37. Edwards, P., et al., *Increasing Response Rates to Postal Questionnaires: A Systematic Review*. BMJ, 2002. **324**.
38. McGinnity, et al., *Migrants Experience of Racism and Discrimination in Ireland*, 2006, Economic and Social Research Institute: Dublin
39. Brush, B., J. Sochalski, and A.M. Berger, *Imported Care: Recruiting Foreign Nurses to U.S Health Care Facilities* Health Affairs, 2004. **23**(3).

40. Bornat, J., L. Henry, and P. Raghuran, *The making of careers, the making of a discipline: Luck and chance in migrant careers in geriatric medicine*. *Journal of Vocational Behaviour* 2011. **78**: p. 342-350.
41. Smith, P.A., et al., *Valuing and Recognising the Talents of a Diverse Healthcare Workforce. Report from the REOH Study: Researching Equal Opportunities for Overseas-trained Nurses and other Healthcare Professionals, 2006*, Royal College of Nursing: London.
42. Brown, R.P.C. and J. Connell, *Occupation-Specific Analysis of Migration and Remittance Behaviour: Pacific Island Nurses in Australia and New Zealand*. *Asia Pacific Viewpoint*, 2006. **47**(1).
43. Winkelmann-Gleed, A., *Migrant Nurses Motivation, Integration and Contribution 2006*, Oxford: Ratcliffe Publishing.
44. O'Brien, C., *Lack of Jobs Brings Change in Attitude to Migration*, in *Irish Times*2009: Dublin
45. McGreevy, R., *Brain Drain as nurses seek work overseas*, in *Irish Times*2009: Dublin
46. McGreevy, R., *Nurses for Sale*, in *Irish Times*2009: Dublin
47. McGreevy, R., *Health Briefing: New South Wales Tries to Recruit 200 Irish Nurses*, in *Irish Times*2011: Dublin
48. Buchan, J. and I. Seccombe, *Difficult Times, Difficult Choices. The UK Nursing Labour Market Review 2009*, in *RCN Labour Market Review 2009*, Royal College of Nursing
49. Dussault, G. and C.-A. Dubois, *Human Resources for Health policies: a critical component in health policies*. *Human Resources for Health*, 2003. **1**(1).
50. RTE News. *Reilly defends recruitment of foreign doctors*. 2011 (cited 2012 13.02.12); Available from: <http://www.rte.ie/news/2011/1003/doctors.html>.
51. Lorenzo, F.M.E., et al., *Nurse Migration from a Source Country Perspective: Philippine Country Case Study*. *Health Services Research*, 2007. **42**(3, Part 2): p. 1406-1418.
52. Khadria, B., *International Nurse Recruitment in India*. *Health Services Research*, 2007. **42**(3, Part II.): p. 1429-1436.
53. Wismar, M., et al., *Health Professional Mobility and Health Systems in Europe: An Introduction in Health Professional Mobility and Health Systems Evidence from 17 European Countries*, M. Wismar, et al., Editors. 2011, World Health Organisation on behalf of European Observatory on Health Systems and Policies: United Kingdom.
54. FAS Expert Group on Future Skills Needs, *National Skills Bulletin 2011. A Study by the Skills and Labour Market Research Unit (SLMRU) in FÁS for the Expert Group on Future Skills Needs, 2011*, FAS: Dublin
55. Glinos, I., et al., *Health Professional Mobility and Health Systems in Europe: Conclusions from the Case Studies*, in *Health Professional Mobility and Health Systems Evidence from 17 European Countries*, M. Wismar, et al., Editors. 2011, World Health Organisation on behalf of European Observatory on Health Systems and Policies: United Kingdom.
56. Hunter, N. *40% of retiring nurses managers/specialists* 2011 10/2/12); Available from: <http://www.irishhealth.com/article.html?id=20355>.

57. RTE News. *500 Vacant Posts in Irish Nursing homes*. 2011 (23rd August 2011); Available from: <http://www.rte.ie/news/2011/0823/nursinghome.html>.