U.S.-Based International Nurse Recruitment:

Structure and Practices of a Burgeoning Industry

Report on Year I of the Project International Recruitment of Nurses to the United States: Toward a Consensus on Ethical Standards of Practice

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This report summarizes the results of the first year of the two-year project entitled International Recruitment of Nurses to the United States: Toward a Consensus on Ethical Standards of Practice. It examines the structure and basic practices of the U.S.-based international nurse recruitment industry.

The purpose of the project is to facilitate consensus among stakeholders on how to reduce the harm and increase the benefits of international nurse recruitment for source countries and for migrant nurses themselves. An Advisory Committee composed of representatives from recruiting companies, hospitals, nurse associations, and foreign-educated nurses has guided the project (see Appendix D).

During Year 2 of the project, AcademyHealth will use this report to inform a consensus-building process with recruiters, hospitals, and foreign-educated nurses, culminating in the development of draft "standards of practice" and recommendations on how to institutionalize implementation of the standards.

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Study Highlights

Background

Historically, employers in the United States have viewed international nurse recruitment as a short-term response to nurse shortages, with recruitment operations focused in just a handful of countries. Today, however, nursing is one of the fastest-growing job sectors in the U.S. economy, and the shortage of nurses is expected to reach 800,000 by 2020. As a result, hospitals and nursing and long-term-care homes are increasingly relying on foreign nurses to staff their facilities. The surge in demand for foreign nurses has led to a corresponding growth in the international nurse recruitment industry.

Despite the growing importance of the international nurse recruitment industry, no governmental or nongovernmental organization monitors the industry's size, scope, and operations. This study, based on extensive interviews with recruiters, employers, and foreign nurses, as well as on an analysis of Commission on Graduates of Foreign Nursing Schools (CGFNS) market surveys and recruiter Internet advertising, is a first attempt to describe the industry.

Findings

- Our internet searches identified 267 U.S.-based international nurse recruitment firms, representing a ten-fold increase from what recruiters called "a cozy niche" of about 30 to 40 companies in the late 1990s. Recruiters' Web sites report operations in 74 countries. Most recruiters say that they plan to expand the number of nurses they bring to the United States as well as the number of countries in which they recruit.
- Not all nurses are "actively" recruited from abroad. A 2006 CGFNS survey of recently arrived foreign-educated nurses (FENs) found that 41 percent of such nurses were recruited in their home country, up from 35 percent in a 2003 National Council Licensure Examination (NCSBN) survey. Among those recruited from abroad, the CGFNS survey found that direct recruitment by hospitals was slightly more common than recruitment by third-party firms. Many nurses in our focus groups had found alternative ways to enter the United States, such as on a tourist, student, or dependent visa, and, once here, sought assistance with the licensure and immigration processes. Many focus group participants found employment through local staffing agencies that specialize in FENs.
- Some large health care organizations and systems, such as academic health centers, recruit directly, but most use third-party recruiters. Among recruiters, sources estimate that about 60 percent are "placement" agencies that charge health care organizations a standard fee per nurse: usually $15,000 to $25,000 depending on the state and the nurse's experience. The other approximately 40 percent of recruiters are "staffing" agencies paid on an hourly basis for the nurses they provide. The latter are about four times more lucrative but require significant upfront capital. Some companies operate as both placement and staffing agencies, depending on client preferences and cash flow.
- Contracts with nurses executed by placement and staffing agencies usually require a two- to three-year commitment. Most recruiters and employers require a "buy-out" or breach fee in the event that a nurse wishes or needs to resign before the end of a contract. Fees include not only expenses incurred but damages for lost opportunities. As a result, fees vary widely, ranging from $10,000 to $50,000. It is worth noting that one large company no longer levies a breach fee, indicating that such a fee is not needed when salaries and benefits are competitive.
- While most firms do not charge nurses upfront fees, a CGFNS survey of recruiters revealed that 18 percent of firms do in fact charge nurses an upfront fee, a practice that has been found illegal in connection with the recruitment of temporary farm workers in the United States and prohibited in the U.K. Code of Practice for the International Recruitment of Health Care Professionals.
- Many founders of smaller firms are immigrants themselves. Former information technology recruiting firms have also turned to nursing as the next big wave in trade of professionals.
- We found wide variation in the size of companies, with some bringing in just one nurse and others as many as 800 nurses per year. However, firm consolidation seems to be underway. Large companies are actively seeking to acquire smaller companies while recruiters from other industries are seeking to merge and acquire nurse recruitment firms. Part of the motivation for small companies is that they need more capital to evolve from placement firms into staffing firms.
- Five recruitment firms are publicly traded. Most of the large firms are also involved in domestic nurse recruitment through a subsidiary of the company.
- A CGFNS survey of recruiters revealed that registered nurses (RNs) account for approximately 90 percent of recruiter revenues, with physical therapists (PTs), occupational therapists (OTs), licensed practical nurses (LPNs), speech pathologists, pharmacists, and laboratory technicians representing a small portion of their business.
- An NCSBN survey found that about 64 percent of FENs are employed by hospitals, with the remainder working for nursing home, long-term-care, and home care companies.
- Most recruiters interviewed for the study said that they are careful not to recruit in countries with critical nurse shortages. However, we found 40 firms are recruiting from developing nations other than the Philippines, India and China. These include 25 firms in Africa, 18 firms in Latin America and 11 in the Caribbean.
- Interviews and focus groups with FENs revealed a series of questionable practices., primarily in nursing homes. Questionable practices include:
  - Denying nurses the right to obtain a copy of the contract at the time of signing

- Altering contracts both before nurses' departure from their home country and upon arrival in the United States without their consent
- Imposing excessive demands to work overtime, in some cases with no differential pay, combined with threats that nurses will be reported to immigration authorities if they refuse to comply
- Retention of green cards by employers, delays in processing Social Security numbers and RN permits, and payment of nurses at lower rates until documentation is complete
- Delaying payments and paying for fewer hours than actually worked
- Paying wages below direct-hire counterparts and in some cases other per-diem nurses
- Providing substandard housing
- Offering insufficient clinical orientation
- Requiring excessively high breach fees and refusing to allow nurses to pay buy-outs in installments

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1. Introduction

Since the current nurse shortage began in the late 1990s, the number of private, for-profit international recruiting companies specializing in bringing foreign-educated nurses (FENs) to the United States has grown by almost 10-fold. The expansion came after several decades characterized by what recruiters term "a cozy niche" of about 30 to 40 companies. Today, at least 267 U.S.-based firms specialize in FEN recruitment, ranging from small "mom and pops" that bring in just a few nurses per year to large, publicly traded firms that import as many as 800 nurses per year.

Despite the dramatic growth of the international nurse recruitment industry and the accompanying controversy over recruiting nurses from low-income nations with shortages of trained health professionals, no government agency or nongovernmental organization oversees the industry's size, scope, or activities. This report represents a first attempt to piece together existing data and gather new qualitative and quantitative information on the structure and practices of the international nurse recruitment industry.

The lack of public information has likely contributed to the entrenchment of opposing views on international nurse recruitment. While those concerned about the delivery of health care in low-income nations describe recruiters as "poachers" who lure much-needed nurses away from poor nations, employers of FENs and FENs themselves point to the advancement opportunities offered by international nurse recruiting. Individual recruits and their families benefit from U.S.-based employment as do nurses' home economies through FENS' remittances to family members residing in nurses' native countries. Meanwhile, governments in source countries are divided in their views, with some governments—such as that of the Philippines—actively facilitating the departure of nurses and others—such as that of South Africa—publicly protesting foreign recruitment.

For several reasons, this report focuses on U.S. companies recruiting to the United States. To begin, even though the international nurse recruitment industry could be described as global in scope, U.S.-based companies that supply U.S. health care organizations play a far larger role than recruiters from other nations. The size of our nurse workforce, which comprises approximately one-fifth of the world's supply, the magnitude of our nurse shortage, and the comparatively high salary levels of U.S.-based nurses, make the United States by far the greatest draw on international nurses. The U.S. draw operates not just directly from source countries but also through third and fourth countries, where nurses may migrate first before finding their way to the United States.

In addition, the United States is a special case because of its reticence to engage in international agreements on recruitment practices. The Commonwealth nations have agreed to a set of ethical principles to guide international recruitment, and many European, African, and Asian nations see bilateral agreements that regulate recruitment as an important future strategy to prevent the undermining of source countries' health systems (see Appendix C). The largely private nature of health care provision in the United States, however, makes both international and bilateral agreements an improbable vehicle for regulation. As with other areas of U.S. health policy, a more likely proposition is incremental steps that represent agreements reached by coalitions within the private sector.

This report describes the structure, practices, and future trends of U.S.-based international nurse recruitment from the standpoint of those directly engaged in the process and as documented through in-depth interviews with stakeholders and a review of recruiter advertising and other publicly available documentation. The purpose of the study is not to ascribe a normative value to the practice of international recruitment but rather to provide an empirical basis on which to conduct discussions among stakeholders about ways to increase the benefits and diminish the harm to source countries and nurses.

While not all FENs are recruited, the percent appears to be increasing. A 2003 survey found that 35 percent of respondent FENs had worked with recruiters,[1] and a 2006 survey reported that 41 percent turned to recruiters.[2,3]

Regardless of the percentage of FENs who depend on recruiters, it is reasonable to assume that the growth of the recruitment industry will lead to higher levels of nurse migration to the United States. The one impediment to this phenomenon is the backlog of occupational visas available to FENs.[4] Hospital and recruitment lobbyists, however, believe that the number of occupational visas for FENs will increase. In 2005, in an effort to address the backlog in the Philippines, India, China, and Mexico,[5] Congress reallocated 50,000 visas for Registered Nurses (RN) and their dependents. By November 2006, migrant nurses filled those visa quotas such that lobbyists set their hopes on inclusion of an amendment to the immigration bill that would remove the cap on FENs. Since the defeat of the immigration bill, lobbyists requested 61,000 additional visas for the short term and continue to work for full elimination of the restrictions on FEN occupational visas.

If, as expected, the demand for FENs and the international recruitment industry continue to grow, stakeholders will need to address at least two challenges:

1. How can qualified foreign nurses be recruited in a way that does not disrupt the delivery of vital health services to local populations of source countries, especially those countries with poor health systems and high burdens of disease?

2. How can the rights of FENs be guaranteed throughout the processes of recruitment and integration into the United States?

A first step in addressing these concerns is to understand more about international nurse recruiters and how they operate.

2. Methods and Data

Our research was designed to describe the international nurse recruitment industry in the United States.[6] Specifically, we asked:

- How large is the U.S.-based international nurse recruitment industry?
- How did it emerge?
- How do recruiters describe the industry's current functions?
- What do employers and FENs report about how the industry functions?
- What are the industry's future prospects?

It is important to note that it is beyond the scope of this study to assess the impact of

recruiter activity on source countries. Based on previous work, however, we summarize some of the existing findings and suggest categories of source countries that are affected differentially by international recruitment.

Qualitative data used to describe the industry come from semistructured interviews and focus groups. We derived quantitative data from a review of recruiter advertising on the World Wide Web and unpublished surveys conducted by the Commission on Graduates of Foreign Nursing Schools.

- We conducted interviews with 21 recruiter company executives and purposefully selected informants to represent a range of small and large companies and a range of business models.

- To develop a full understanding of when, why, and how employers decide to use international nurse recruiters, we interviewed 18 chief nursing officers in hospitals. We purposefully selected the hospitals to represent a range of rural, urban, and suburban facilities across the country.[7] We included at least two hospitals in each of the eight regions that compose the United States as defined by the American Hospital Association (AHA).

- In partnership with CGFNS and based on its lists of FENs who had recently moved to the United States, we conducted two focus groups with FENs in New York City[8] and conducted six interviews with FENs from other cities.

- CGFNS gave us access to unpublished data from a market survey of recruiters conducted in February 2006.

- We conducted Internet searches to identify recruiters through their Web sites. Web pages are a fundamental part of most recruiters' marketing strategies. The amount and quality of information posted on the Web by each company varied, but we were able to develop an extensive database with several key variables. We used several combinations of keywords (i.e., international, recruitment, nurses, migration, agencies) to perform the Internet searches and then viewed the agencies' Web sites to verify that the agencies were actively recruiting abroad and to note other statistical informational such as geographic location, nurse benefits, and source countries.

- We reviewed publicly available data from Dow Jones Market Watch on publicly traded recruiting firms.

- We found two publicly available secondary sources particularly useful: the AHA's 2007 survey of hospital leaders and a National Council of State Boards of Nursing (NCSBN) report comparing FEN RNs to U.S. RNs.[9, 10]

When possible, we triangulated information from these above sources to strengthen our findings.

3. Background on the Nurse Shortage

Since 1998, the United States has been experiencing a shortage of nurses. Nursing is one of the fastest-growing job sectors in the United States, and the nursing education system has been unable to keep pace with the demand for nurses. Estimates predict that the nation will need at least 800,000 new nurses by 2020.[11]

Rising demand results from several factors: the physical expansion of hospitals, an aging population and the surge of chronic diseases, physician shortages in primary care, the use of nurses as case managers in disease management companies, and the staffing of new retail and worksite clinics with nurses.

Supply constraints have impaired an adequate response to increased demand. In one study, more than 40 percent of nurses working in hospitals report dissatisfaction with their jobs, and one out of every three hospital nurses under age 30 was planning to leave his or her current job in the next year.[12] Among those who remain, there is a dramatic aging of the workforce, with the total number of nurses predicted to drop for the first time in decades as of 2010.[13]

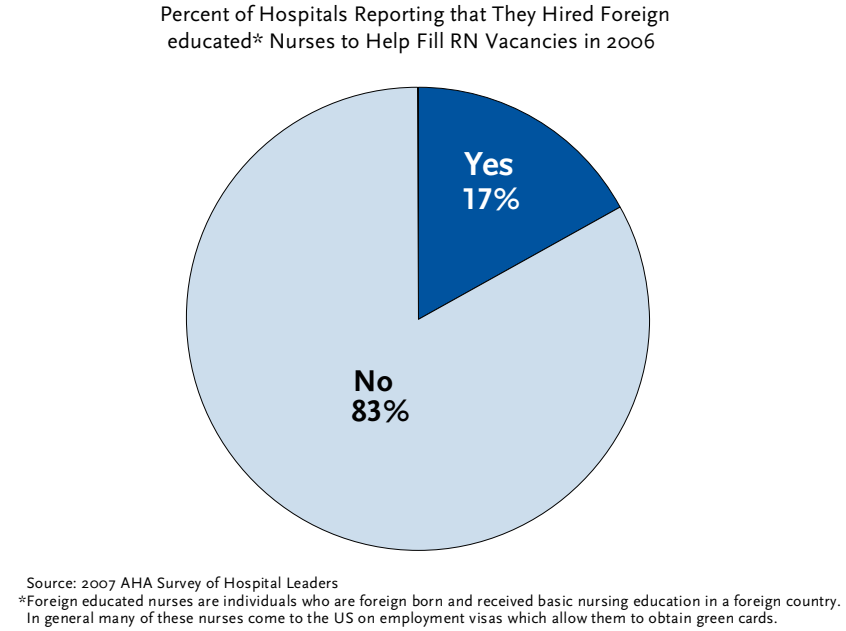
Even more problematic are the financial implications of expanding needed education programs. Unlike medical education, federal nursing education subsidies are low and have been declining in real dollars.[14] As a result, few private universities have shown interest in launching new schools of nursing. State universities and community colleges with nursing schools are turning to partnerships with local health systems and hospitals to help fund expansions, but, even so, salaries in acute care settings are drawing experienced faculty out of the classroom and into various nursing facilities. In short, despite efforts to expand nursing schools, the nursing education establishment has not been able to meet demand; in 2006, nursing schools turned away approximately 32,000 qualified applicants.[15]

As the nurse shortage escalates, the costs of domestic recruitment are also rising as a consequence of the increasing time needed to fill vacant positions. A 2002 study by the HSM Group estimated that the cost of replacing a nurse could be up to two times a nurse's salary, or approximately $92,442, and significantly greater if the nurse is a specialty nurse. A recent PricewaterhouseCoopers Health Research Institute report noted that every 1 percent increase in nurse turnover costs a hospital about $300,000 annually.[16] Replacement costs include human resources expenses for advertising and interviewing, increased use of travel nurses, overtime pay, temporary replacement costs for per-diem nurses, lost productivity, and terminal payouts.[17,18]

4. The Demand and Supply of Foreign Nurses

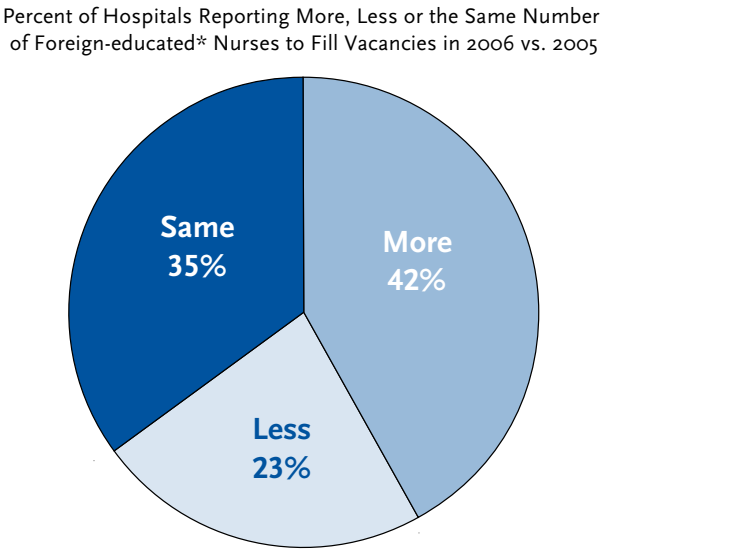
The current and projected nurse shortages have led employers to look abroad to fill vacancies. According to a 2007 AHA survey, 17 percent of hospitals reported that they hired FENs in 2006 to help fill vacancies (Figure 1).[19] Another hospital survey confirmed similar numbers, with 18 percent hiring FENS.[20] The data suggest that approximately 850 of 5,000 community hospitals were conducting some form of international nurse recruitment. It is important to note that these figures do not account for nursing homes, which, according to a 2004 NCSBN survey, employed 22 percent of FENs entering the country and 61 percent of Licensed Practical Nurse (LPN).[21]

Figure 1: 17 Percent of Hospitals Reported Hiring Foreign Educated* Nurses in 2006.



Source: 2007 AHA Survey of Hospital Leaders
*Foreign educated nurses are individuals who are foreign born and received basic nursing education in a foreign country. In general many of these nurses come to the US on employment visas which allow them to obtain green cards.

Figure 2: 42 percent of hospitals reported that they hired more foreign-educated* nurses in 2006 vs 2005.



Source: 2007 AHA Survey of Hospital Leaders
*Foreign educated nurses are individuals who are foreign born and received basic nursing education in a foreign country. In general many of these nurses come to the US on employment visas which allow them to obtain green cards.

The AHA survey also reports that hospitals' demand for FENs is rising, with 42 percent of hospitals indicating that they hired more foreign nurses in 2006 than in 2005 (Figure 2).

The growing interest in FENs is reflected in the data on nurses entering the United States. One proxy for entry of FENs are VisaScreen® certificates, which are issued by CGFNS after reviewing educational and English proficiency credentials. (See Appendix B for an extensive discussion of alternative data sources on FENS.) VisaScreen® certificates are required for all occupational visas, but are not needed for the diversity lottery, student visas, or dependents. Figure 3 presents VisaScreen® data beginning in 1998 when the requirement was enacted.

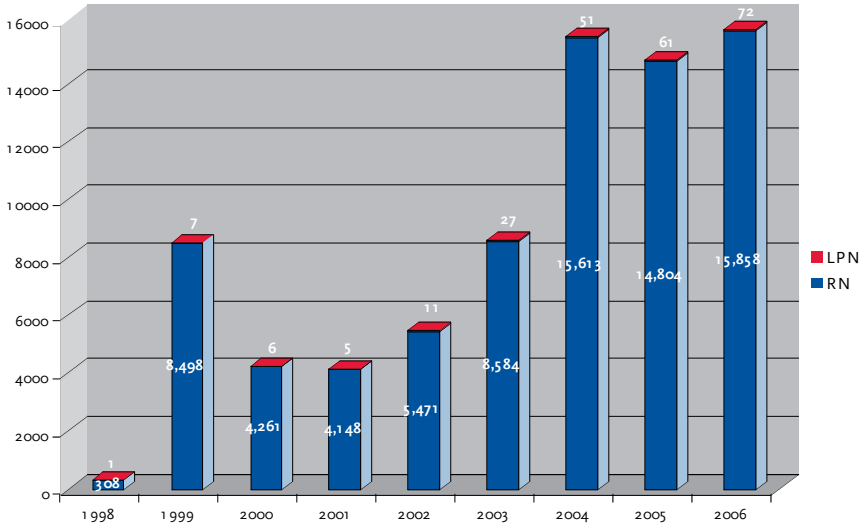
Given that all nurses must pass the National Council Licensure Examination-Registered Nurse (NCLEX) in order to be licensed to practice, the number passing the examination each year is another reasonable proxy for FENs entering the U.S. workforce. Foreign-trained LPNs (as opposed to RNs) constitute a small percentage of the total FEN number: 6 percent in 2006, or 1,378. We include LPNs in the report because they presumably practiced in their source country before applying for licensure in the United States and, as such, are relevant to the discussion.

The NCLEX data confirm the upward trend but show higher figures than the previous measure, in part because it includes FENS in the Unites States that have come in as tourists, students, dependents or through the lottery, and in part because some of those who take the test may remain in their home countries. Figure 4 shows that in 2006, 22,305 FENs (RNs and LPNs) passed the NCLEX, representing 12 percent of all nurses who passed the examination.[22] Based on data from second-quarter 2007, we project that 22,864 FENs will pass the NCLEX in 2007, representing approximately 12.6 percent of all nurses who pass the examination.

Immigration policies have directly affected and continue to determine the flow of FENs.[23] The early 1990s bulge in nurse migration (Figure 4) was the result of a special temporary nurse visa (H-1A) that later was eliminated. As discussed previously, the leveling off of FENs since 2006 is likely a temporary phenomenon linked to the backlog of occupational visas. Congress will probably address the backlog by reallocating new visas and may go so far as to lift the cap on visas for RNs.

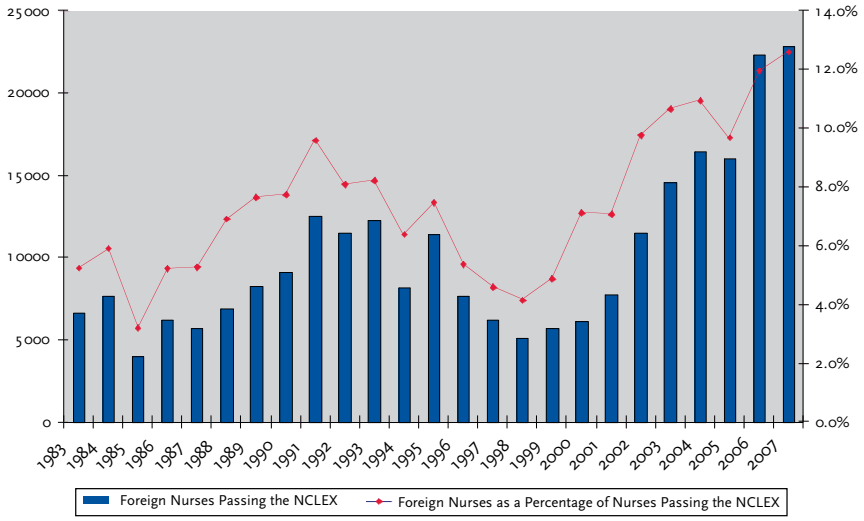
We know from interviews with employers that increased demand for FENs results from a complex set of factors that go into employer decision making. Several sources report that health care organizations (HCOs) view international recruitment as a means to keep hiring costs down and retention up over the long run and that it may cost less than increasing salary and benefits across the board.[24,25] One study estimated that, in two years, an HCO could save $40,000 to $50,000 by hiring an FEN instead of a per-diem or travel nurse.[26]

Figure 3: VisaScreen® Certificates Issued 1998-2006



Source: Authors' elaboration CGFNS VisaScreen® Data

Figure 4: Foreign Educated Nurses Passing the NCLEX 1983-2007*



Source: Authors' elaborations of NCLEX pass rates.

Given that the national average for RN hospital vacancies is approximately 8.5 percent, some hospitals clearly see FENs as a competitive solution to domestic RN recruitment. When asked what factors influenced their decision to hire FENs, one hospital leader said that, while employers would not see a return on their investment in FENs for several years, an equivalent investment in U.S. nurses would not yield the same return. They cited signing bonuses and scholarship programs with local colleges as major cost drivers for domestic recruitment. A few employers, however, reported that they paid as much to recruit domestically as to recruit abroad.

Employers also reported that several factors limit their use of FENs, including problems with English proficiency and cultural affinity with patients, as well as the more principled notion that the United States *should* produce its own nurses. Among the pragmatic reasons cited for avoiding reliance on foreign nurses was the difficulty in managing uncertain timelines. Among interviewed employers, the time elapsed from initial contact to final "delivery" varied from 18 months to more than four years. Much of the delay was attributable to difficulties with the visa process. Respondents also expressed a strong preference for recruiting nurses who had already passed the NCLEX, thereby enabling employers to accelerate the recruitment process.

Large academic centers appeared to be more likely to recruit directly, perhaps because of the volume of nurses they employ. Respondents from large universities said that academic institutions have name recognition in the Philippines, a factor that helps in attracting top nurses. However, for those able to import RNs easily and directly, employers clearly conveyed the sense that they did not want "too many FENs" in the hospital. While such employers were reluctant to talk about the possibility of patient disapproval of a high a percentage of FENs, one chief nurse officer had identified a "tipping point" of about 25 percent beyond which she would not want to increase the number of FENs on staff.

Among those employers using third-party recruiters, they reported mixed experiences, with some employers unsatisfied with services. In one case, a hospital had paid a recruiter $100,000 and had not received a single nurse. In other cases, hospitals were satisfied with recruiters and with the nurses they had hired. Hospital respondents said that they were increasingly careful in choosing recruiters, interviewing several and checking references.

5. Structure of the U.S.-Based International Nurse Recruiting Industry

It is generally accepted that recruiting companies, also called *handlers, facilitators, intermediaries,* or *brokers*, play a significant role in both stimulating and easing the process of international nurse migration.[27] Yet, we know little about the size of the industry or how it operates. This study used interviews, focus groups, a review of Web advertising and a CGFNS survey of recruiters to piece together a coherent picture of U.S.-based firms.

Size

International nurse recruitment is not new, and the oldest companies report that, until the late 1990s, between 30 and 40 companies were active in nurse recruiting, primarily from Ireland, the United Kingdom, Canada, and the Philippines. When, however, the nurse shortage reached severe proportions in 2000, it spawned new nurse recruiter companies and represented a turning point for the recruitment industry.

Table 1: Largest Domestic Health Care Staffing Firms 2004[30]

($ in millions)

Company	2004 Revenue ($ in millions)	Also Recruit Internationally	Separate International Subsidiary	Publicly Traded (stock symbol)
Cross Country HealthCare	$654	✓	Assignment America	(CCRN)
AMN Healthcare	$629	✓	O'Grady Peyton	(AHS)
Medical Staffing Network	$417			(MRN)
CompHealth	$395			
Maxim Healthcare	$306	✓	Maxim Nurses	
Nursefinders	$232			
InteliStaf Healthcare	$227			
MHA Group	$219			
U.S. Nursing Corp.	$184			
Favorite Nurses	$135			
ATC Healthcare Services	$130	✓	ATC Travelers	(AHN)
Medical Doctor Associates	$112			
Supplemental Health Care	$112			
On Assignment	$110	✓		(ASGN)
Interim HealthCare	$100			

Source: MarketWatch from DOWJONES.

The nurse recruitment industry is a largely unregulated industry, thus complicating efforts to track the number of recruitment firms. While recent years have witnessed efforts in Maryland and the District of Columbia to require licensure of nurse staffing agencies in order to ensure that personnel meet minimal quality standards. Both agencies report that it is likely that only the largest international staffing firms in those districts have applied for licensure, but they are unable to distinguish them from domestic staffing firms. Similarly, the Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations), has just implemented a voluntary accreditation program for health care staffing services, but does not distinguish between domestic and international recruitment.

A review of Web-based advertising permitted us to identify 267 U.S.-based international nurse recruiting firms. We suspect that the number of active firms is higher but that, for whatever reason, some firms have not invested in Web pages and/or have not paid for their pages to be listed in search engines. However, given the importance of the Internet to international advertising, the number of nonadvertising firms is probably relatively small, and the firms are likely to be modest in size.

It is important to note that the Web-identified number of firms does not take into account HCOs that recruit directly. A CGFNS survey of recently arrived FENS reveals that direct hospital recruitment is slightly more common than third-party recruitment, suggesting that at least as many HCOs recruit abroad as do third-party companies. Our employer interviews indicate that most direct recruitment by HCOs is targeted at the Philippines and India, while third-party recruiters may be active in less common source countries and be more likely to operate in several countries simultaneously.

Corporate Origins

We noted considerable variation in the corporate origins and personal backgrounds of the founders of the recruiting firms we interviewed. Recruiting firms we interviewed, reflecting a range of attitudes toward international recruitment.

Most commonly, we discovered that many founders are themselves immigrants, in particular Filipino-Americans. As one recruiter explained, in addition to the obvious language and cultural advantages of relying on immigrants to return to their home countries to recruit nurses, many immigrants view their agencies as "helping people realize their dreams." We also spoke with two U.S. executives who had previously lived in source countries from which they now recruit nurses and therefore came to the recruitment industry with language and business ties.

Another group of international recruitment companies was founded and staffed by U.S. nurses who had worked in domestic recruiting. One nurse executive said that she was drawn to the business because she saw important clinical practice differences between U.S.-trained and foreign-trained nurses and was interested in improving the acculturation of FENs in U.S. HCOs.

A third group grew out of international recruiting ventures in other industries. For example, some international recruiting agencies originally involved in the information technology (IT) sector shifted to international nurse recruiting following the late 1990s .com collapse. Many of these agencies already had immigration specialists on staff and had invested in infrastructure in source countries. One recruiter who had started an IT staffing company said that, when the IT industry "fizzled," he began to research the "next wave of need" and found "nursing was huge."

Finally, there is a group of companies that grew out of private health systems and were formed to meet the internal needs of the health system or a parent company. Some companies have become independent while others are still owned by the same parent company that owns hospitals and/or nursing homes. In some cases, they have begun to sell their recruiting services to outside clients. One recruiter described this arrangement as a flexible way to meet the needs of the nurse. The nurse has the option of working either within the health system or for other HCOs outside the parent company.

Geographic Distribution

The international recruiters identified by the study tend to be headquartered on the East Coast and in the South, with concentrations in California, Texas, Georgia, and Florida. Not surprisingly, their headquarters locations closely match the states with the highest concentrations of foreign-born nurses: California, New York, New Jersey, Florida, and Illinois.[28]

Most of the international recruiters identified for the study maintain overseas offices. A few U.S.-based international recruiting companies have gone multinational; for example, one large recruiter reported that it now also recruits on behalf of the United Kingdom and Ireland.

Mergers and Acquisitions

Some evidence suggests that the international nurse recruitment industry is experiencing a "bulge" in the number of companies in the industry. Numerous recruiters reported a flurry of mergers as companies seek to consolidate their capital and expand operations. Some have merged with recruiters from other sectors, e.g., IT and aviation, in order to build market share. Other small firms, unable to move into the staffing model due to lack of capital (see discussion of models below), are exploring the possibility of selling their firms to larger companies. Some of the larger companies' executives interviewed for the study indicated that they were seeking to acquire smaller international firms with country-specific expertise.

Characteristics of the Largest Recruiters

Today, international recruiting is a significant part of the overall health care recruiting industry. Of *Modern Healthcare's* 15 largest domestic health care staffing companies, five have an international recruitment line of business (see Table 1). In order of revenues (including domestic recruitment), the five companies are Cross Country Healthcare, AMN Healthcare, Maxim Healthcare, ATC Healthcare Services, and On Assignment.[29] Most of the largest international recruiting companies also recruit domestically. We are aware of just one large international recruiting firm—HCCA International—that does not operate a domestic arm. This may explain why it is not included in the top 15 U.S. firms.

Five of the 15 largest domestic firms are publicly traded; of these, four are involved in international recruiting, leaving just one top firm that is international but not publicly traded (Maxim Healthcare). As in other industries, the choice to go public brings with it new capital but means public scrutiny and less autonomy for the company's CEO. One CEO indicated he would not go public because he believes his mission goes beyond increasing revenues to include the well-being of the company's nurse clients. Interestingly, Maxim Healthcare is the only one of the large international recruiters that functions as a placement agency as opposed to a staffing agency (see analysis of recruiting models below).

In summary, the rankings suggest that most of the large firms:

a) engage in domestic as well as international recruiting,

b) are publicly traded,

c) separate their international recruiting via a subsidiary so that work conditions can be different than domestic nurses,

d) use the staffing, rather than placement,model.

Planned Expansion

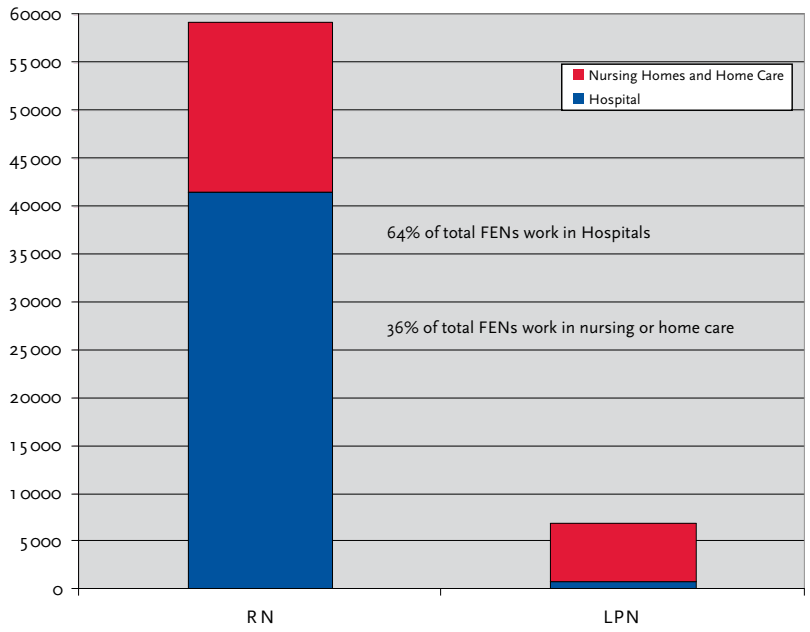
In addition to growth in the number of firms, all of the executives interviewed for the study indicated that they planned to expand their business in the next several years. The executive of one large firm expected to increase the number of nurses imported by the firm from 500 in 2006 to 1,200 in 2007. The 2006 CGFNS market survey of 85 recruiters confirmed the industrywide growth trend, noting that 74 percent of recruiting firms expected their international recruitment activities to increase next year. Of the same group of recruiters, 52 percent indicated that they also planned to expand their businesses into new source countries in the coming year.[31]

Clients

The demand for recruiters is largely driven by U.S. hospitals, although nursing homes, home care services, and other long-term care facilities are important clients. Some large hospitals and health systems—particularly well-known academic health centers—recruit internationally, but do so directly. In view, however, of the complexity of the credentialing, licensure, and immigration processes, most HCOs rely on third-party recruiters.

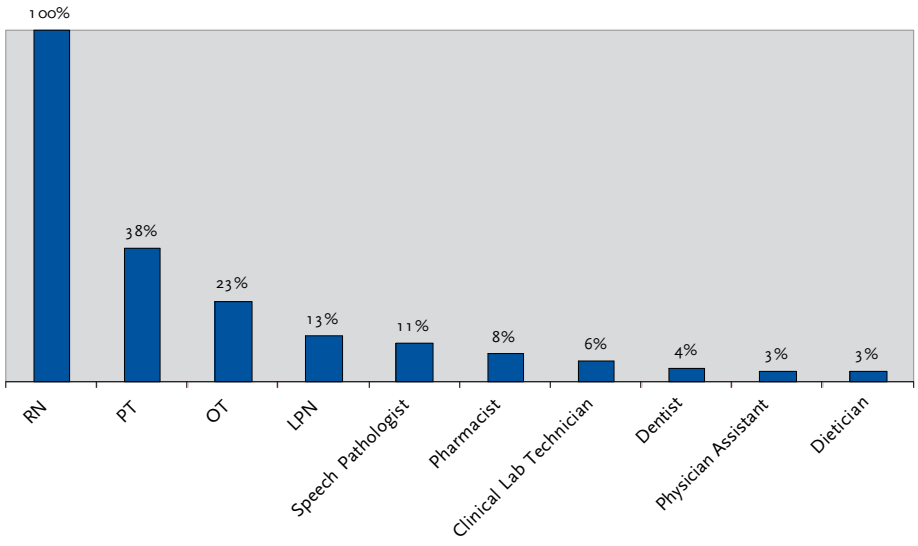
To estimate the relative importance of the hospital and nursing home and home care industries to recruiters, we looked at where FENs are placed. According to the 2004 National Sample Survey of Registered Nurses (NSSRN), approximately 72 percent of FENs (RNs) work in hospitals.[32] A 2003 NCSBN survey reported similar numbers, with just 31 percent employed in nursing homes, other long-term-care, or home care. Eighty-eight percent of LPNs, on the other hand, work in nursing homes or long-term care or home care settings.[33]

Figure 5: Foreign Educated RN and LPN NCLEX Passers 2001-2005 by Work Setting



Source: Authors' elaboration of NCLEX data and NCSBN 2003 Nurse Survey

Figure 6: Percentage of Companies that Recruit Various Professions



Source: Authors' elaboration of CGFNS 2006 Recruiter Survey

Using RN and LPN NCLEX passers from 2001 to 2005 as a proxy for FENs who have recently migrated to the United States and combining the proxy measure with the NCSBN workplace settings data cited above, we estimate that hospitals represent approximately 64 percent of the market for international nurses and that nursing homes and home health care companies represent most of the remaining 36 percent (Figure 5).

Use of Recruiters by FENs

As discussed in the introduction, some limited data are available on FENs' use of recruiters. CGFNS leaders, who work with nurses and recruiters seeking immigration to the United States, report that a minority of nurses entering the United States have historically contracted with recruiters, although the number now appears to be rising. A 2003 NCSBN survey found that 35 percent of 1,000 surveyed FEN RNs and 16 percent of 500 surveyed LPNs had worked with recruiters.[34] An unpublished CGFNS 2006 survey of all VisaScreen® Certificate holders, which includes RNs, LPNs, Physical Therapists (PT), and Occupational Therapists (OT), reports that 41 percent use recruiters.[35] The breakdown of recruitment services within that group in order of importance follows:

- Hospital-based recruiters
- Commercial placement firms
- Staffing agencies
- Immigration lawyers

Basic Practices of the Recruitment Industry

Professions Targeted by Recruiters

According to the same 2006 CGFNS survey of 85 recruiters, approximately half of recruiters seek out professionals other than nurses, particularly PTs and OTs, speech pathologists, pharmacists, and laboratory technicians. Figure 6 presents the results of the CGFNS survey.

The proportion of revenues generated by these professions, however, remains small. Respondents indicated that 90 percent of revenues come from RN recruitment, 3 percent from LPN recruitment, and negligible amounts from the recruitment of other professionals.

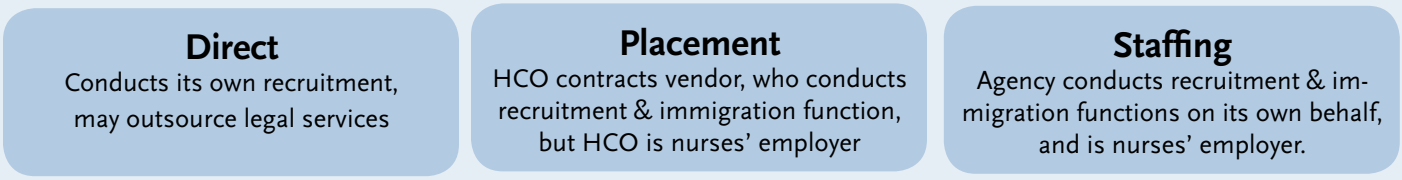
Recruiting Models

Nurse recruitment relies on three primary models in the international sector and several variations on each (Figure 7). The three major models are (1) direct recruitment by HCOs, (2) placement, and (3) staffing.

Prices

Recruiters generally cover a core set of upfront costs for the FEN, including costs associated with testing (CGFNS, NCLEX, and English examinations), visa and immigration processing, credentialing, and the nurse's flight to the United States. Some recruiters may offer additional benefits, such as pretest preparation, signing bonuses, one or two months' housing and/or relocation costs, meal vouchers, training and continuing education once in the United States, cultural acclimation programs, and nursing association memberships. Recruiters

FIGURE 7: BASIC RECRUITING MODELS



Direct

In the direct model, HCOs use their own resources to carry out most recruitment and immigration functions, and FENs work as HCO employees. HCOs that recruit directly tend to be large teaching hospitals and health systems with name recognition abroad. HCO Indirect Management is a variation in which the HCO may hire a recruiter and/or an immigration lawyer but conducts many of the recruitment activities itself.

In another variation of the direct model, a few HCOs not only recruit directly for themselves but also recruit as a placement or staffing agency for other facilities. For example, one New York hospital engaged in direct recruitment recently established a wholly owned, for-profit subsidiary to handle international recruitment for "client" hospitals. Interestingly, the subsidiary charges a far lower rate per nurse than a recruiter: just $2,000, which presumably covers its costs.

Similarly, a Midwestern hospital has partnered with a recruiter to bring in more RNs than needed. The hospital trains the nurses and then "resells" them to another HCO. The recruiter and the partner hospital split the resulting revenue.

Health systems and parent companies that own nursing homes are also likely to recruit directly. Some of these companies have created their own subsidiaries charged with international recruitment. When they satisfy their own staffing needs, they often engage in placement or provide staffing services for HCOs outside their network.

Placement

In the placement model, the HCO contracts with one or more vendors to perform most of the recruitment and immigration functions. These vendors serve as placement agencies and facilitate the process of placing the FENs with HCOs. The agencies usually sign short-term contracts with the FENs they recruit; however, once a FEN is "placed" in an HCO, he or she is under contract with the HCO. HCO involvement in placement activities varies. For example, HCOs may sometimes be directly involved in the interview and selection process.

Placement agencies are often characterized as "mom and pop" or "start-up" operations, and one source described the rapid growth of the agencies as "mushrooming." Compared to the staffing model, the placement model is generally considered less lucrative. One placement agency representative said, "My profits are so low, investors are not interested."

However, from the perspective of the employer and the nurse, the placement model is the preferred model. Chief nurse officers say that they prefer the placement model because they can invest in training and integration from the outset. An American Organization of Nurse Executives (AONE) editorial also recommends the model as long as companies are well capitalized and operate with a guaranteed timeline.[36] Nurses say they favor it because they are more likely to be treated as equals if they are on staff.

Staffing

In the staffing model, sometimes referred to as a "lease" model, the agency carries out most of the recruitment and immigration functions on its own behalf, although, in some cases, it may contract with one or more vendors to perform specific services. FENs work at HCOs as employees of the staffing agency either as agency nurses or traveling nurses. Staffing companies' contracts with FENs tend to be longer than those of placement companies and usually include an opportunity for the HCO to buy out the contract.

As noted, four international staffing companies are publicly traded. One recruiter source estimated that the staffing model is up to four times more lucrative than the placement model. Many placement companies are working toward becoming staffing companies, some through mergers that require significant ramp-up time, risk, and upfront capital investment. To become a staffing company, the company must have assets on hand equivalent to one year of salary, plus benefits, for every nurse it imports. It must also submit an annual report (if publicly traded), a tax return, and an audited financial statement.

From the employer perspective, our interviews suggest that the staffing model is attractive under certain circumstances. When employers need more than a few nurses at a time, they often find that the upfront costs of recruiter fees can be an impediment to using placement agencies. Several employers reported that, as a result, they used the placement model for as many FENs as board approval permitted and then used FEN temporary staffing as a supplement.

Despite the profitability of the staffing model, several recruiters indicated that they consider the model "unethical" and would therefore remain placement agencies. They believed that temporary arrangements delay integration of immigrant nurses and that work conditions and wages tend to be less beneficial to nurses employed by staffing agencies. The FENs in our focus groups voiced the same concerns and preferred direct-hire employment. (See section eight on FEN experiences.)

Both our database and our interviews with recruiters indicate that more than half of recruiting agencies use the placement model. One recruiter source estimated that approximately 60 percent of recruiters use the placement model, with about 35 percent using the staffing model and the remaining 5 percent relying on direct recruitment by the HCO. The CGFNS recruiter survey found that 55 percent were using the placement model and 45 percent the staffing model.[37]

must ensure that FENs' wages meet U.S. Department of Labor prevailing wage requirements by region.

While most recruiters do not charge nurses for the various services listed above, the CGFNS survey revealed that 18 percent still collect fees from nurses in addition to the fees they charge employers.[38] It is important to note the questionable nature of this practice, which the United Kingdom prohibits under the 2004 Code of Practice for International Recruitment of Health Care Professionals (see Appendix C).

The costs of international recruitment services to HCOs vary with the type of recruitment and the benefit package that is offered. The following estimates are based on information provided in interviews with recruiters and employers:

- Among employers, recruitment costs for HCOs involved in direct recruitment range from $5,000 to $12,000 per nurse.
- HCOs typically pay placement agencies a flat negotiated rate of $15,000 to $20,000 per FEN recruited, which includes direct costs (usually $5,000 to $10,000) and agency fees. Placement agency profits can range from approximately $5,000 to $15,000 per nurse. Most recruiters do not offer HCOs a guaranteed placement period. Of those who do guarantee a placement period, they usually guarantee placement within 90 days. Payment is often structured as a contingency fee or a small retainer fee, followed by another fee when the FEN is placed.
- HCOs typically pay staffing agencies about twice the average salary of a nurse. The agencies are paid on an hourly basis, at approximately $60 to $80 per hour. Of that, the FEN is paid about $25 to $35 per hour (varies depending on the prevailing wage for the region). In some cases, the staffing agency may charge the HCO a management fee on top of the hourly rate, but HCOs generally incur no upfront costs. In one staffing agency, potential annual profits were estimated at approximately $50,000 to $55,000 per year per nurse. A large, publicly traded staffing company estimates its profit at 7 percent of pre-tax revenues.

While the interviewed recruiters reported that they pay FENs at the same rate as direct-hire domestic counterparts, almost all of the FENs who participated in focus groups indicated that they were paid less by a staffing agency than were their colleagues employed by a hospital or nursing home.

Under all three scenarios, nurses are usually bound by a contract to work for the same employer for between 18 months and three years. The contract usually stipulates that, in the case of a breach of contract, the employee must pay a fee often described as a "buy-out," breach, or penalty fee. Recruiters reported fees of between $15,000 and $20,000. Nurses reported fees of between $8,000 and $50,000.

It is interesting to note that even though most executives said that the breach fee was essential, an executive of one of the largest firms disagreed and indicated that his firm does not write breach fees into its contracts. He said that his company's salary and benefits are competitive and that the company therefore "prefer[s] to work on an individual basis with the hospital and nurse should this situation [resignation] arise. Thus far, we haven't experienced any major issues or concerns that we are aware of," he said.

As detailed below, employers sometimes abuse breach fees as a means to force FENs to accept work conditions that they may consider unfair or even dangerous to patients. On the other hand, recruiters say that breach fees deter FENs who enter contracts "in bad faith," i.e., with the intent of abandoning the employer as soon as possible despite the employer's significant investment in bringing the FEN to the United States. Employers recognize the tension between good and bad faith, but some say that they would rather use positive incentives—even bonuses—rather than penalties to encourage retention.

7. Recruiter Activity by Source Countries

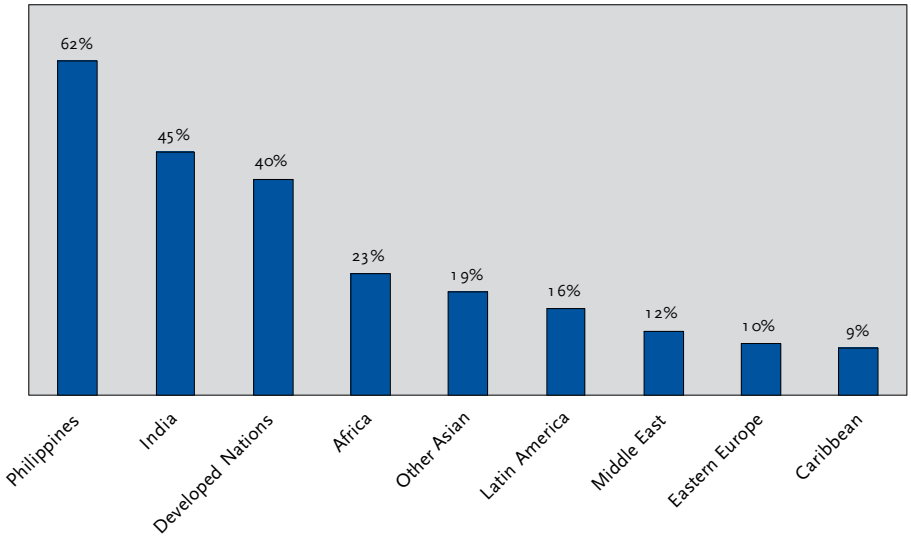
Our study found, in addition to a dramatic increase in the number of recruiting firms, a surge in the number of nations in which such firms recruit. We identified 74 nations in which recruiters say they are active, and most interviewees indicated they plan to continue expanding into new countries in the near future. As mentioned above, the 2006 CGFNS recruiter survey confirms the trend, reporting that 52 percent of recruiters expected to expand their recruiting efforts to other countries in 2006.

One key factor in considering the impact of expanded recruitment is, of course, country size. Small countries are particularly affected by recruitment, even when the absolute number of recruits may be just a few dozen. In any case, some data at the FEN level reflect the expansion of recruitment into new countries. The number of nations from which FENs applied to take the NCLEX grew from 90 in 1983 (the first year that NCSBN online records were disaggregated by country) to 139 in 2005 (the most recent year for records disaggregated by country). Moreover, while the Philippines remains the most important source country for the United States, its relative importance among NCLEX first-time test passers declined from 60 percent in 1983 to 45 percent in 2005.

Countries in which recruiters said they are exploring new business opportunities include the United Kingdom, Israel, India, China, Poland, Russia, Ukraine, Norway, Sweden, Colombia, Brazil, Argentina, Czech Republic, and South Korea.[39]

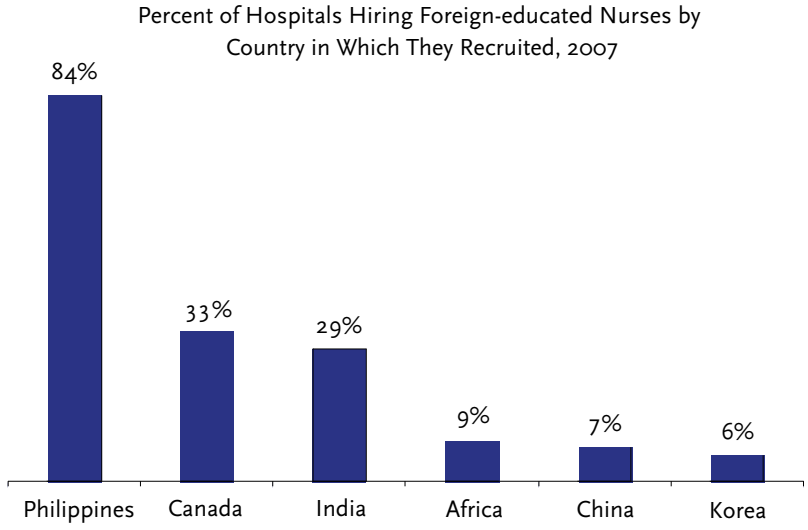
Our database of 267 recruiters provides a snapshot of the source countries in which companies currently indicate they maintain operations. Of the 267 recruiters we identified through the Internet, 124 list the countries in which they actively recruit. Recruiters mentioned source countries in a variety of ways, noting, for example, the location of their own-company offices or "partner" companies, the location of job fairs, or a list of countries from which they have recruited. Figure 8 aggregates the number of firms that self-report activity by region.[40]

Figure 8: Percent of U.S.-Based Recruiters Active by Region



Source: Authors' review of 124 recruiter Web sites August 2007

Figure 9: 84 Percent of hospitals hiring foreign-educated nurses recruited from the Philippines.



Source: 2007 AHA Survey of Hospital Leaders

A complementary source of data on current source countries is the 2007 AHA survey of hospital leaders (Figure 9).[41] This survey differs from our database in that (1) it includes hospitals that recruit directly and (2) does not include other types of HCOs, such as nursing homes. The results, however, are similar and show the Philippines, Canada, and India as dominant source countries. Other developing nations, particularly African and Caribbean nations, are less prominent in the AHA survey. The difference may reflect the fact that hospitals that recruit directly tend to concentrate on the Philippines and India, whereas large recruiters maintain simultaneous operations in several countries. Of interest to the discussion below on disadvantaged source countries is the 9 percent of hospitals that are hiring from African countries. It is important to note that the survey question concerns hiring, however, not active recruitment abroad.

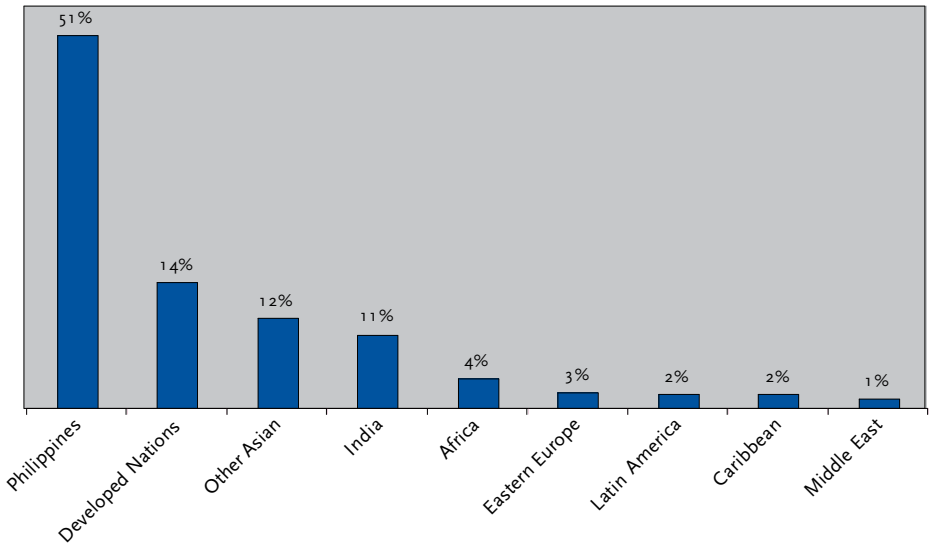
Figure 10 presents a third complementary data source: first-time NCLEX passers by region between 2001 and 2005 (see discussion on NCLEX data, page 8). While there is no limit on the number of times individuals can take the NCLEX, NCSBN does not provide country-level data on those who pass after their first attempt. The numbers in Figure 10 therefore represent a total undercount of approximately 30 percent and may be higher or lower in a given country depending on the likelihood of first time passers.[42] CGFNS has not yet disaggregated its VisaScreen® data by country such that the NCLEX first time passers are the only proxy data available at this time.

"Active" Recruitment and "Natural" Migration

The availability of data on recruiter activity in source countries allows us to carry out a preliminary analysis of the relationship between active recruitment of nurses and migration. While such an association may be self-evident, we know that as many as half of all nurses coming to the United States from abroad do so without the assistance of "active" recruiters (see Use of Recruiters by FENs, page 12). Further complicating the equation is the difficulty in obtaining data on the so-called "carousel effect," whereby nurses migrate to one or even two countries before they are recruited to the United States. It would be important, for example, if CGFNS or the U.S Department of Homeland Security tracked not only a nurse's country of origin but also the country from which a nurse was recruited. Better knowledge of the countries where recruiters are primarily responsible for stimulating migration and where the migration occurs "naturally" are useful inputs into discussions about how best to address the problem of "brain drain" in the least developed nations.

The United Kingdom 2004's Code of Practice for the International Recruitment of Healthcare Professionals, which distinguishes between a nurse who migrates on his or her own versus "active" recruitment of a nurse, stimulated a fierce debate on active recruitment. The United Kingdom prohibits "active" recruitment to the National Health Service from low-income countries in the absence of a signed letter of

Figure 10: First Time Internationally Educated NCLEX Passers by Region: 2001-2005



Source: Authors' elaboration of NCLEX data.

bilateral agreement with the source country government (see Appendix C). In this case, "active" refers to stimulating the inflow of FENs through overseas job fairs and the advertising of nursing opportunities that lead to the employment of qualified applicants.

Based on our interviews with recruiters, it appears that most U.S. companies are involved in both active and non-active recruiting, although some of the larger recruiters said that they do not accept applicants who have not come through their screening process in source countries.

Operationalizing the distinction between "active" and "non-active" recruitment is fraught with difficulties, yet it is no doubt important to understand that distinction for analytic purposes. One question is whether Internet advertising, a primary strategy used by most recruiters, is "active" or "non-active" recruitment A larger issue, however, that must be addressed if active recruitment is to be discouraged in the poorest nations is whether the denial of recruitment services to a nurse because of his or her country of origin constitutes discrimination. This issue raises an unresolved tension between individuals' rights to migrate regardless of the health care situation in their home country and the rights of individuals in source countries to obtain high-quality health care. The search for a balance is central to any public policy on international recruitment.

With these complexities in mind, Table 2 compares NCLEX data on first-time passers from 2001 through 2005 with the number of recruiters active in the given country as self-reported by the same 124 companies in Figure 8. Some companies indicate only the region in which they recruit and therefore are not listed in the table. In addition, it is important to note that, particularly in developed countries and Middle Eastern countries, the nationality of the recruit may differ from the source country, i.e., Filipinos are recruited from Dubai.

The simple correlations in the table are a first attempt to understand how much of international nurse migration results from active recruitment.

India is among the countries demonstrating an inverse relationship between the number of recruiters and the level of migration, although recruiters explained that they were still in the early stages of establishing partnerships and processes on the subcontinent. Latin American nations also showed high levels of recruiters and low levels of migration; again, recruiters reported that they were operating in new territory. It is also possible that Indian and Latin American nurses may be among those less likely to pass the NCLEX the first time (see discussion of NCLEX country level data, page 8).

South Korea exhibits the opposite pattern. There, many nurses are passing the NCLEX despite the absence of recruiters. Our recruiter respondents indicated that firms are not active in that country because they are concerned about poor English. Respondents also said that many Koreans come to the United States on tourist visas to visit family, particularly in the New York area. They are able to self-subsidize test fees and then hire their own Korean American immigration attorneys to process work visas.

Other nations that appear to have no recruiter activity but still exhibit migration patterns are Cuba, Iran, Guyana, Uzbekistan, and Nepal.

Recruiters are active in 28 countries in which there were no first-time NCLEX passers in 2005. It may be that nurses have not yet arrived from those countries or, more likely, that they are among the approximately 30 percent who failed the NCLEX the first time and have taken it again but are not recorded in NCSBN country-specific data.

Identifying Source Countries with Critical Nurse Shortages

Numerous international publications have pointed to a growing pattern of disparity in which nations with the fewest nurses are losing them to wealthy countries with the most nurses.[43,44] Developing nations often publicly fund nurse education, making nurses' migration to wealthy countries in effect a subsidy from the poorest to the richest nations of the world.

While it is beyond the scope of this study to assess whether U.S.-based recruiter activities have impaired the delivery of health care in developing countries, a summary of previous work on the nurse disparity between the developed and developing world, limited as it may be, is important for purposes of this report.

With the notable exception of the Philippines, much of the data on the flow of nurses from source countries is derived from destination countries. The lack of data in many developing nations, the lack of comparable data across countries, and inconsistent definitions of nurses all impede efforts to develop a standard measure of critical nurse shortages and to assess the impact of international migration and active international nurse recruitment.

A further complexity is that the migration of nurses benefits source countries in the form of remittances. Although such remittances do not fully compensate for the loss to the health care system, the net effects of remittances from an economic perspective remain unknown.[45]

Despite the data deficiencies in most source countries, a continuum of situations defines a source country's degree of vulnerability. Key variables to consider include the following:[46]

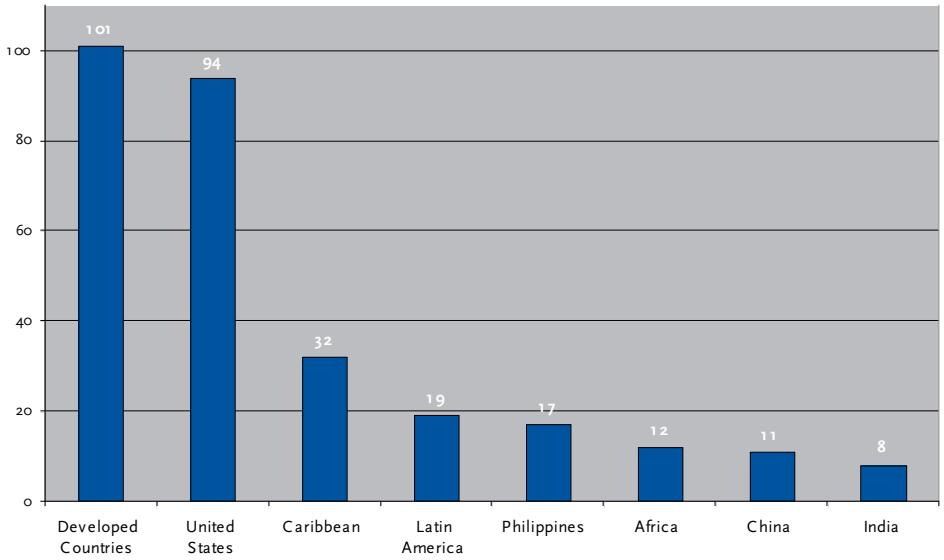
- Total stock of nurses
- Levels of poverty and burden of disease
- Nurse-to-populations ratios
- Nurse vacancy rates (by locality if possible)
- Nurse unemployment rates
- Role of migration in causing local shortages
- Level of education and experience among nurses leaving the country
- Capacity to educate new nurses quickly
- Government and health authorities' reactions to foreign recruitment of nurses
- Government interest in and capacity to implement policies to retain nurses through attractive employment conditions

All of these factors play a role in determining the degree to which a nation can reasonably be expected to participate in the global competition for health professionals. Which variables are most important in a country and the degree that each variable might signal that a country

Table 2: First-Time NCLEX Passers 2001-2005 and Level of Recruiter Activity by Source Countries.

Number of First-Time Passers NCLEX 2001–2005	Number of U.S.- Based Recruiters
Philippines (23,204)	Philippines (77)
Canada (5,405)	Canada (22)
India (4,573)	India (56)
South Korea (3,657)	South Korea (7)
United Kingdom (989)	United Kingdom (34)
China (794)	China (8)
Nigeria (743)	Nigeria (5)
Jamaica (435)	Jamaica (2)
Taiwan (362)	Taiwan (2)
Russian Federation (322)	Russia (2)
Australia (316)	Australia (14)
South Africa (312)	South Africa (9)
Kenya (280)	Kenya (3)
Cuba (279)	
Japan (207)	Japan (1)
Germany (191)	Germany (1)
Poland (189)	Poland (1)
Ukraine (184)	
Israel (181)	Israel (2)
Romania (179)	Romania (3)
Thailand (168)	Thailand (2)
New Zealand (152)	New Zealand (11)
Iran (140)	
Haiti (138)	Haiti (1)
Trinidad & Tobago (137)	Trinidad & Tobago (2)
Guyana (136)	
Ghana (128)	Ghana (3)
Colombia (100)	Colombia (2)
Mexico (98)	Mexico (7)
Lebanon (86)	Lebanon (1)
Ethiopia (80)	Ethiopia (1)
Brazil (65)	Brazil (3)
Singapore (65)	Singapore (6)
Peru (63)	Peru (1)
Zimbabwe (60)	Zimbabwe (1)
Uzbekistan (59)	
Nepal (57)	
France (47)	France (1)
Sweden (45)	Sweden (1)
Jordan (42)	Jordan (1)
Ireland (41)	Ireland (8)
Turkey (33)	Turkey (1)
Norway (31)	Norway (1)
Netherlands (27)	Netherlands (1)
Sierra Leone (25)	Sierra Leone (1)
Lithuania (25)	Lithuania (1)
Czech Republic (23)	Czech Republic (1)
Malaysia (22)	Malaysia (3)
Scotland (22)	Scotland (1)
Dominica (22)	Dominica (1)
Panama (22)	Panama (1)
Cameroon (21)	Cameroon (2)
Switzerland (14)	Switzerland (1)
Spain (14)	Spain (1)
UAE (13)	UAE (5)
Grenada (10)	Grenada (1)
Austria (10)	Austria (1)
Albania (10)	Albania (1)
Kuwait (3)	Kuwait (2)
Sri Lanka (2)	Sri Lanka (2)
Saudi Arabia (1)	Saudi Arabia (2)
Bermuda (1)	Bermuda (1)
Bahrain (1)	Bahrain (1)
	Oman (3)
	Dubai (1)

Figure 11: Average Nurse to Population Ratio Per 10,000 by Region and Country



Source: Authors' elaboration used WHO data from www.who.int/whosis

should not be targeted for recruitment are matters to be addressed by stakeholders.

In reviewing a series of case studies published in a special issue of *Health Services Research* in 2007, we identified five scenarios that could help stimulate stakeholder discussions:[47]

1. Africa. Africa, particularly sub-Saharan Africa, represents the most dire scenario, with nurse-to-population ratios below 1 per 1,000 population in many countries.[48] (See Figure 11.) Health systems in Africa have historically been poorly developed, but now, owing to a combination of the HIV/AIDS epidemic and the shortage of health professionals, many countries are in crisis. Dovlo reports a vicious cycle in these countries: weak health systems stoke the desire to migrate, but migration further burdens and demoralizes those remaining, making their departure more likely in the future. Kingma cites numerous examples of program impairment attributable to nurse shortages.[49] Across the region, governments become indignant when recruiters from wealthier nations "capitalize" on the crisis. Sub-Saharan African governments argue that wealthy governments must reorient foreign aid to help improve work conditions and help retain health professionals in source countries.

2. English-Speaking Caribbean. The English-speaking Caribbean nations have fairly well-developed U.K.-style national health systems and have historically reported nurse-to-population ratios higher than those of many other developing nations, although the ratios remain low by developed country standards. Current nurse-to-population ratios range from 1.65 in Jamaica to 4.7 in Bahamas per 1,000 population (WHO 2006). The region's ties to the United States, Canada, and the United Kingdom have made the Caribbean countries natural targets for recruiters seeking English-speaking nurses. Salmon and colleagues report that vacancy rates for budgeted nurse positions have reached almost 59 percent in Jamaica and 53 percent in Trinidad.[50] The governments of Caribbean countries have responded to the problem of nurse migration with innovative strategies to increase the status of nursing in the region and to manage migration through agreements with recruiters.

3. Philippines. At least among small countries, the sustainability of the "nurse for export" scenario is currently being tested in the Philippines. The government has historically supported the export of nurses, and the private sector has demonstrated an ability to produce more nurses than the Philippines can absorb in major cities, which is where nurses prefer to live and work. Nurse-to-population ratios remain just above 1 per 1,000 population, however, Lorenzo and colleagues report that nurse-to-patient ratios in public sector district hospitals have declined from about 1 nurse per 20 patients to 1 per 60 patients.[51] Lorenzo also reports that more nurses are leaving the country each year than are produced and that health leaders are concerned about distortions in the health workforce resulting from the massive nurse exodus, particularly the exodus of physicians who retrain as nurses in order to migrate. The Philippine Hospital Association claims that 200 hospitals have closed as a result of physician shortages created by physicians' rush to retrain as nurses and leave the country. In response, the government is considering the establishment of a Health and Human Resources Commission and has made recommendations to encourage retention of nurses and reinvestment by foreign recruiters in nurse education in the Philippines.

4. Large Developing Nations (China, India). Large developing nations such as China and India have embraced the departure of human capital as a legitimate and beneficial export. These countries have weak health systems with low levels of funded nursing positions and historically low nurse-to-population ratios of just over 1 nurse per 1,000 population (WHO 2006). Unemployment is high across all professions, and the demand for nurse education is increasingly driven by the notion that a nursing credential is a "ticket" out of the country. The prospect of profiting from partnerships with recruiters has led to a surge in the number of private nursing schools, many of which are viewed locally as less academically rigorous than the major public universities. At least until new nurse positions are funded in China and India, U.S.-based recruitment does not appear to be generating adverse effects.

5. Developed Nations. Other developed nations, such as the United Kingdom and Canada, have long relied on nurses from abroad to respond to cyclical shortages, but they also lose their nurses to the United States and other developed countries. While Canada in particular is concerned about losing nurses to the United States, both nations have both the political will and economic resources to compete to retain

Recruiter Views on the Impact of Nurse Recruitment in the Philippines and India

For the most part, recruiters and employers adamantly believe that they are doing no harm in the Philippines; they cite as evidence government support for their activity and Manila's unemployment figures.

However, the Filipino-American recruiters we interviewed for the study expressed unease about their home country's situation. They were well informed about the "nurse-medic" phenomenon, i.e., physicians retraining as nurses in order to migrate to the United States, and had heard that many hospitals had closed as a result of the physician shortage. They blamed the Filipino government for underinvesting in health care but expressed the view that U.S. recruiters should do more to "pay back" the Philippines.

Because of its size, India is an important source country for the future. Employers point to the increased social status of nursing as a positive effect of migration. One recruiter said, "After two years of nurses coming to the U.S., there was a huge cultural shift. Nursing was no longer considered 'hand-maidenly' and low on the social scale. Nurses became much more respected."

Some resistance is apparent, however. "The majority of nurses from India are produced in Kerala, and there was the most resistance (to recruiters)," said one recruiter. "Early on, the nursing councils did not want the nurses to go and were very slow to provide the necessary documents," indicated a hospital officer who recruits directly from India. Another informant described the impact on hospitals. "Some hospitals, especially specialty hospitals, have been hard hit [by international recruiters]. Some have experienced 20 to 50 percent turnover."

their nurses and to increase the production of nurses over the short term, as recently demonstrated by the increase in domestic nurse supply in the United Kingdom.[52]

Nurse to population ratios are, of course the most universal accessible metric. Figure 11 provides averages for the countries and regions as grouped in the discussion above.

These five scenarios are in no way exhaustive. Many developing countries have only recently become of interest to recruiters. The impact of recruitment on countries such as Mexico, Colombia, and Brazil has yet to be studied. Similarly, Eastern European nations, with current nurse-to-population ratios as high as those of Western Europe, may find that accelerated recruitment activities in their countries will not permit them to retain their best nurses at current salary levels.

For now, however, this preliminary system of classification, which includes the countries in which recruiters are currently most active, may provide a reference on how best to minimize harm and maximize the benefits of recruitment in source countris.

Recruiter Activity in the Most Disadvantaged Source Countries

Recruiters and employers are acutely aware of the controversy over targeting countries with severe nurse shortages. Several indicated that they had decided not to recruit in countries with severe nurse shortages, particularly in Africa and the Caribbean. One recruiter said, "There needs to be more of a social consciousness in terms of stealing from other countries' resources. . ." Two recruiters expressed the view that Africa should be on a "no touch list."

Nevertheless, we found that, among the 124 companies that provide information on the source countries in which they are active, about 35 percent, or 40 firms, are recruiting from regions that may be considered disadvantaged in terms of their ability to compete in the global market for nurses. They are nations with some combination of the variables presented above but, at a minimum, have high burdens of disease and low nurse-to-population ratios. We exclude from the list of 124 companies the Philippines, India, and China and developed countries.

We found that 25 firms recruit from Africa, 18 from Latin America, 11 from the Caribbean, and 3 from other possible shortage areas (Pakistan, Malaysia, and Sri Lanka). Table 3 lists the firms.

As mentioned above, several recruiting firms were interested in and willing to explore the question of active recruitment being discouraged in certain countries. One recruiter called for better information about international nurse shortages. "There is a need for [a better] understanding of where we should go and recruit; [there's] not enough good information."

Indeed, technical consensus on what combinations of measures should be considered in assessing severe nurse shortages would provide an important first step in establishing an empirical basis for agreements among stakeholders as to where recruitment is most destructive.

Efforts to "Give Back" to Source Countries

Aware of the ethical issues inherent in recruiting from less developed nations, many recruiters have begun to explore ways to assist with training nurses in the source countries in which they are active. The executive of one large company said, "It is essential to work with a source country to create partnerships. It is a matter of sustainability."

Table 3: Nurse Recruitment Companies Active in Regions with Critical Nurse Shortages as of July 2007

Recruiting Company	Source Countries with Critical Nurse Shortages	Satellite Offices
1. 1st Health Staffing	Nigeria	
2. Acirt USA	Caribbean, Nigeria	Ghana, West Indies, Nigeria
3. Advanced Health Alliance	Africa	
4. ALDA Solutions	Caribbean, South Africa	
5. Amerecares	Africa, Caribbean, Latin America	
6. American Staff Exchange	Cameroon	Cameroon
7. Assignment America	Bermuda, Jamaica, South Africa, Trinidad	
8. Avant Healthcare Professionals	Malaysia, Puerto Rico	
9. Cambridge Healthcare	Brazil	
10. Cebu Nursing Resource and Referral Services	Malaysia	
11. Concept Healthcare Resources, Inc.		South Africa
12. CORPOCARIBE	Colombia	
13. CSI HealthCare	Mexico	Mexico
14. D'Jobs International	Mexico, Puerto Rico	
15. Florida Nurse Program	Mexico, South America	
16. Global Healthcare Group	South Africa	
17. Global Healthcare Resources	Cameroon, Ghana, Kenya, Mexico, Nigeria, Peru	
18. Global Nursing International	Brazil, Caribbean, Mexico	
19. Global Scholarship Alliance	Zimbabwe	
20. Have Nurses, Inc.	Malaysia, Pakistan	Pakistan
21. HCCA International	Colombia	Colombia
22. Health Careers of America LLC	Ghana, Mexico	
23. International Nurses Alliance	South Africa	
24. Jasneek Medical Staffing	Panama	
25. Kennedy Healthcare Recruiting	Ghana, Grenada, Kenya, Haiti, Nigeria	
26. Liberty Nurse Recruiting	Africa	
27. M3 Medical Management Services	South Africa	
28. Madison Healthcare	Africa, Caribbean, Latin America	
29. Nurse Immigration Services		Ghana, Mexico, South Africa
30. Nurse Immigration USA	Argentina, Jamaica, Trinidad	
31. Nurses Network International	Kenya, Nigeria, Sri Lanka	
32. Nurses 'R' Special	Africa	
33. Nursing Resources Services	Mexico	
34. O'Grady Peyton/ AMN	South Africa	South Africa
35. Open Hearts Global Professional Placements		Colombia
36. Premier Healthcare Professionals	South Africa	
37. Professional Healthcare Resources International	Ethiopia, Nigeria, Sierra Leone	
38. Professional Placement Resources	South Africa	
39. South Nassau Community Hospital	Puerto Rico	
40. World Health Resources	Dominica, Nigeria	

Some of the ideas already in use include the following:

Source-Country Scholarships. HCCA International has established partnerships with nursing schools in which a school identifies the top five or so entry-level students. The recruiter pays the tuition for those students in exchange for a commitment to immigrate to the United States after a two-year period of practice in their home countries.

U.S. Scholarships and Return Programs. All About Staffing, O'Grady Peyton, and Global Scholarship Alliance offer opportunities for nurses to gain advanced training while they work in the United States. Training periods vary from six months to three years. After the completion of training, nurses may be required to return home for a period. The programs are popular during periods of "retrogression" when permanent work visas have been depleted.

Partnerships with Hospitals to "Manage" the Flow. GlobalCare selects the best nurses from universities and places them in local hospitals in their home country for two to three years so that they will gain needed experience while serving their own country. GlobalCare then moves the nurses to positions in the United States but not before helping local hospitals plan for the turnover and recruit new nurses. In so doing, GlobalCare "build[s] a relationship of trust with the hospitals." One recruiter (RN India) has signed agreements with several hospitals in India, committing to take no more than a certain number of nurses per year from a specific unit and from the hospital as a whole.

Sending U.S. Faculty Abroad. Global Scholarship Alliance sends U.S. faculty to Filipino nursing schools both to ensure that the quality of recruits is adequate and to provide training for students who remain in the country.

Twinning. O'Grady Peyton reports that it facilitates relationships between source and recipient hospitals in order to provide technical assistance and to operate exchange programs.

Open Training Programs. HCCA International holds training programs for its own recruits to assist them in preparing for U.S. licensure. The programs are open to the public "in order to leave behind better trained nurses."

Some of the above efforts simultaneously support recruiters' own interests:

- Scholarships in the source country allow for the early identification of the best and brightest nursing students.
- Scholarships in the United States facilitate the entry of nurses as students when permanent visas are depleted.
- Partnerships with nursing schools and hospitals build relationships of trust, which over time are important to maintaining the flow of nurses.

Recruiters indicated that they were interested in exploring collective efforts that would go beyond individual company arrangements. One informant proposed the following:

"For example, when NCLEX is initiated in a country, that's an opportunity to educate and form partnerships. We need to start giving something back, helping schools through scholarships, setting up financial aid funds. . .We have to agree on how to do that."

8. Foreign Educated Nurses' Experiences

Interviews and focus groups with immigrant nurses revealed wide variation in the conditions under which recently arrived FENs enter the United States and are employed. In some cases, patterns of abuse are evident. It is important to note that all of the questionable practices that were reported to us occurred in relation to nursing homes.

The types of reported practices were consistent with recruiters' and HCO officers' accounts of "fly-by-night" recruiters. One recruiter was aware of recruiters "not following through on their contractual obligations and inappropriately charging nurses." Another said, "Some [recruiters] are treating nurses like cattle." However, one HCO officer noted improvement and said, "Nurses are more aware now of the many choices they have, but many have been taken advantage of in the past." At the same time, recruiters and HCO officers were uniformly adamant that their own company or facility treated FENs fairly and provided them with an adequate clinical and cultural orientation.

It is beyond the scope of this study to measure how frequently abuses occur. Our qualitative findings would, however, help to inform a quantitative survey that could systematically assess the situation. They would also help inform discussions among stakeholders about how best to prevent abuses.

Experiences with Recruiters in Home Country

For those recruited in their home country, problems can begin there. In the case of the Philippines, a host of U.S. companies is interviewing nurses and urging them to sign contracts. The Philippines government requires foreign recruiters to register with the government, demonstrate a minimum level of capital, and agree to work through local recruitment companies.

Nevertheless, nurses report that the Philippine government oversight is insufficient and abuses do occur. Nurses are invited to job fairs where they are often asked to sign contracts on the spot. In some instances, nurses are uncertain as to what they have signed and are often denied copies of the contract.

"At the time I wanted to get a copy of the contract, but they didn't want it taken out and be photocopied. So I just left it there. They said over time they would send us papers. There were lots of papers that we signed, and I just couldn't keep track of what they were about."

For those recruited while still in their country of origin, recruiters must submit contracts to the U.S. embassy at the time of application for a work visa. In the Philippines, a central office called the Philippine Overseas Employment Agency (POEA), also registers contracts, although nurses in the study reported that the contracts submitted to each entity were sometimes different.

"The first one that I signed was for [X] facility, but when I signed the other one it was like a different name. In all, I remember signing three contracts. They also made me sign another one before I went for Embassy review."

Nurses also report that contracts commit them to an exclusive relationship with one recruiter, even if that recruiter does not honor his or her promises or disappears after collecting money for test fees. For one nurse who had already resigned from his job and sold his belongings in preparation for a promised departure to the United States, he felt that his only choice—after a recruiter failed to honor a signed contract—was to work in Saudi Arabia for several years to earn enough money to return to the Philippines and try again to emigrate to the United States.

In addition, nurses describe situations in which nurse colleagues tried to break their contracts in their home countries so that they could seek out better/faster recruiters. They said that such a breach of contract can result in a lawsuit brought by the first recruiter, who may have required collateral in the form of family land deeds or checks written on depleted bank accounts. Nurses point out that if the recruiter tries to cash the check and it bounces, the recruiter can press charges against the nurse for fraud.

It is important to note that while a recruiter's failure to perform its obligations under a signed contract is generally illegal, some of the abuses described above do not technically violate contract law, even if practices are unethical. When nurses have signed contracts agreeing to seemingly unfair terms, those contracts—despite potential exploitation—may nonetheless be deemed enforceable by U.S. courts, even if the nurse never fully read or understood the obligations. U.S. laws do provide some obligation for employers to reimburse foreign workers for their travel and visa costs, although case law in this area primarily involves "guestworkers."[53]

Seeking Recruiters in the United States

Among focus group participants in New York City, many had made their way to the United States on tourist or student visas, which they converted into work visas with the assistance of local staffing agencies. Even among those who entered the United States with the assistance of a recruiter, several found the recruitment agency through the Internet; the agency had no local representative in the FENs' home country, and none of the immigrants took advantage of job fairs or advertisements. Such was the case of two African nurses, both of whom were employed by a Filipino American–owned staffing agency that specializes in FENs but maintains no offices abroad. The nurses learned of the agency through relatives in the United States.

While most of the issues faced by immigrant nurses already in the United States were similar to those faced by individuals recruited in source countries, this finding is important for another reason: international recruitment is usually assumed to be active only in a source country. Guidelines therefore have focused only on overseas activities (see discussion in Section 6 under Recruiter Activity by Country). It is apparent, however, that any oversight or self-regulation of the industry should also include recruiters operating with FENs that are already in the United States on student or tourist visas.[54]

Contracts and Breach Fees

Consistent with reports from the recruiters and hospital leaders interviewed for the study, the nurses described contracts that usually involved a two- to three-year year commitment and "buy out" or "breakage" clause, sometimes also described by recruiters as a "breach" fee, that ranged from $8,000 to $50,000.

In theory, breach fees are commensurate with the investment made by the recruiter for bringing a nurse to the United States and for facilitating the visa and licensure processes. Recruiters, nurses, and employers see breach fees as a fair arrangement, so long as (1) the fee is commensurate with the above costs and (2) payment is pro-rated in accordance with the period of work actually delivered.

Several types of problems, however, were reported by FENs. In some cases, the fee amount did not appear to be commensurate with the investment, arguably invalidating the relevant contract terms that would otherwise bind the FEN charged with excessive fees. The costs of recruitment reported by hospitals that recruit directly from the Philippines, for example, range from $5,000 to $12,000, while placement agencies reported costs of $5,000 to $10,000. However, one nurse in our focus group had a contract with $50,000 breach fees. Even among nurses who had entered the United States as tourists and subsequently found recruiters specializing in FENs, most signed contracts obligating them to pay the breach fee. Only one nurse, already in the United States, found an FEN staffing agency that did not require a buy-out penalty.

Another issue arose in relation to the pro-rating of the breach fees. In two cases, nurses reported that their employers were unwilling to pro-rate the fee and their employers demanded that nurses pay the penalty in a lump sum at the time of resignation instead of permitting them to pay in installments. Most nurses who send a large portion of their salaries home to families in their country of origin are unable to pay the full penalty in a lump sum.

"I talked to my agent last Friday (who is Filipino) because I wanted to buy out my contract. My agent told me that buying out my contract would ruin his relationship with the mother company, which is one of his biggest clients. He also told me that my buying out my contract might result in revocation of my immigrant visa since it was [that company] who petitioned it. Also, if I opted to buy out, I will need to pay the whole amount in one-time payment only, which is $13,650. . . For now, I can only pay them one-fourth of the buy-out price."

All recruiters and employers acknowledged that a nurse will occasionally "flee." The District of Columbia Board of Nursing reported that employers file complaints when FENs terminate contracts, but the board has declined to rule on these cases because its mandate is restricted to protecting patient safety.

Forced Change of Employment

A separate contractual issue that arose in our focus groups and review of documents was the change in place of employment. In some of the cases reported to us, nurses were coerced into changing their place of employment in what might be considered a bait-and-switch scheme. The change left them dissatisfied because they had family and friends in the city where they were hired to work and did not want to live in another location. For example, two nurses in the focus groups arrived in New York City only to be told that they would be deployed

to a new employer in a new city. In both cases, the nurses hired lawyers to negotiate reduced payment of the breach fee and they were able to remain in the New York area.

In another bait-and-switch technique, recruiters offered employment to nurses as direct hires. Upon their arrival in the United States, however, the nurses learned that they would be working for a different company, which was a staffing agency. We learned of four companies that regularly take this approach to recruiting in the Philippines. It is important to note that most FENs seeking employment in the United States, especially Filipinos, believe that work conditions are likely to be better when they are directly employed by a health care facility rather than by a staffing agency.[55] The four companies we identified misrepresenting nurses' employer types were all linked to the nursing home industry.

Under occupational visas, the above transfer of nurses as described in interviews would constitute a violation of federal visa requirements that "for a reasonable period of time" prohibit the employment of a FEN at any worksite other than a worksite controlled by the petitioning facility. That period of time is usually interpreted to be about a year, although the law allows for exceptions to be made when circumstances are beyond the control of the employee, e.g., a death in the family.

Greater awareness among FENs about the value of written terms versus oral promises may help prevent future bait-and-switch schemes. It is also possible that education about mutual obligations could benefit recruiters and employers concerned that, without a breach fee, nurses will be tempted to seek employment in a facility offering more generous salaries, benefits, or bonuses.

Working Conditions

Many FENs working for staffing agencies reported that they are paid as much as $10 less per hour, or about 25 percent less, than direct-hire nurses and, in some cases, FENs from other agencies who work in the same facility. In New York City, the prevailing wage for level I nurses (the lowest) is $25.43 per hour. Most of the nurses interviewed for this study earned between $20 and $28 per hour while direct hires at the same level earned $30 to $38 per hour. One Filipino nurse had been promoted to supervisor but was still paid less than the U.S. nurses he supervised.

"The contract was like $22.50 per hour, but the American LPNs that I work with, I know one of them gets around $30 to $32. As an RN, we should be paid higher. Like me, I'm a supervisor of the unit, but my wages are lower than my staffing helper who's an American!"

Several nurses reported more restricted health benefits than direct-hire employees and, in some cases, no health benefits for the first year of employment. One nurse reported that she discovered she was pregnant when she arrived in the United States and had to go on Medicaid.

Similarly, there were reports of no vacation or sick leave provided by some staffing agencies. One nurse reported, *"There was a time I called them [to say] I was sick and I need to be out of job for one-and-a-half days. My recruiter told me that to try as hard as possible to make sure I put in 40 hours a week. They don't give us any sick days. Nothing."*

Several nurses described situations in which they were obliged to work overtime, often during weekends, on holidays, or on night shifts. *". . .[A]ll the new recruits will be placed in a night duty. . ."* said one participant. "*They assume Filipinos don't have lives. . .*" said another. *"We were paid less [than the other agency nurses] and were not as expensive, so we were always mandated to stay, even if we didn't want to. They call us if we are on our off days. They would still call us and make us go to work."*

Some nurses felt that they received the least desirable assignments because they were foreign-trained and often employed by staffing agencies rather than by the facility itself. *"What happens (is that) whenever they need to float for a while you're always the one to float, "* said one nurse. *"They give you the worst patients on the floor because you are an agency nurse*," said another.

Most of the FENs with whom we spoke for the study said that recruiters did not recognize the nurses' experience in their home country when determining pay levels. Our interviews with employers, some of whom indicated that they did not recognize foreign experience as the same as U.S. experience, corroborated the nurses' reports. One nurse stated, *"The experience back home was really like, no big deal (not counted), because when it came to the hospital and nursing home that I am working at now, I met my instructor (from the Philippines) there. So we are both in orientation; we're both starting at the bottom."*

Most of the blatant discrimination practices described by FENs we interviewed could be considered illegal under U.S. statutory law (i.e., the Fair Labor Standards Act). In addition, the practices contravene international conventions (i.e., the International Labour Organization's Core Labor Standards) and run contrary to the Declaration on Fundamental Principles and Rights at Work. In most cases, employers' responsibilities under federal visa requirements include equal payment of wages to FENs and similarly employed nurses.

Other abuses described by FENs likely violate the minimum terms and conditions in their employers' labor certifications, but federal law sometimes fails to provide a remedy when these conditions are not satisfied. Moreover, government enforcement of basic labor protections has steadily decreased even as the number of U.S. workers covered by the Fair Labor Standards Act has dramatically increased. Some have observed that the government is not capable of ensuring that employers comply with the most basic workplace laws.[56] The impact may be significant for FENs, who may be particularly vulnerable to exploitation and manipulation and may require greater government protection.

The United Nations International Labour Organization (ILO) has described norms requiring the equal treatment of domestic and migrant workers in areas relating to recruitment, working conditions and Social Security and guarantees general rights to migrant workers (e.g., freedom of association, freedom from discrimination, the right to a safe work environment, equal pay for work of equal value, easy access to grievance procedures). While the United States has yet to adopt all applicable UN conventions, its own statutes and case law may be applied to protect each of these rights.

Threats

Several nurses described threats relating to their immigrant status. Three nurses said that their employers had initially retained their green cards (which the U.S. Department of Homeland Security sends to the U.S. employer/petitioner). Though told that their green cards had not yet arrived, the nurses later learned that their cards had in fact arrived. In some instances, nurses were told that they would be reported to the Immigration and Naturalization Service (INS) and deported if they did not honor their contracts. One nurse said, *"I couldn't fight because I was still waiting for the petition to go through. So because they have this weapon to grab you, they can just stop everything."* In another case, a nurse reported, *"There was one weekend they were lacking nurses and so the supervisors were calling the nurses. The ones that were off didn't want to go to work because we were always tired. Then they said, 'If you're not gonna go to work, then the INS will call and see you and they're gonna talk to you.'"*

The exploitation described here is not exclusive to FENs. The U.S. Government Accountability Office,[57] Human Rights Watch,[58] and the Southern Law Poverty Center,[59] among other groups, have detailed the widespread use of both implicit and overt threats and intimidation targeted to immigrant workers. While certain international conventions and U.S. law protect general rights to freedom of association, freedom from discrimination, the right to a safe work environment, and equal pay for work of equal value, the power imbalance between employers and immigrant workers and the consequences of deportation substantially thwart challenges to illegal practices.

Members of professional organizations and labor unions enjoy much stronger protections under U.S. and international law regardless of citizenship status and are often better informed about their rights. Even under those circumstances, however, the consequences of losing one's visa—even as a result of illegal intimidation—is enough to sustain persistent exploitation, particularly given that legal services organizations are barred from representing undocumented workers.

Insufficient Training and Clinical Orientation

Several nurses pointed to insufficient training and clinical orientation as yet another concern. *"The facility knows that I have no hospital experience in the Philippines and during my orientation they only. . .trained me twice, then they left me on my own,"* said one nurse. Another said, *"I was afraid to go to work, because I was afraid that I would do more harm than good to my patients, because I am unfamiliar with these procedures. I felt like I needed more orientation, but they wouldn't give it because they needed people on the floor."*

The training and clinical orientation of FENs continues to evade regulation. The Joint Commission, an independent, not-for-profit organization, accredits and certifies nearly 15,000 health care organizations and programs in the United States that have met the commission's guidelines for safety and quality of patient care. The Joint Commission has moved into long-term-care accreditation and has developed standards relating to quality in nursing homes. It also operates a program of accreditation for supplemental staffing firms. It is only through the assessment of safety and quality of patient care, however, that FEN training and clinical orientation (or lack thereof) may fall under the purview of the Joint Commission's certification process.

Medicare also sets requirements for patient care and safety that, if not met, delay or prevent reimbursement. To date, Medicare requirements have not addressed the clinical orientation of FENs.

Poor Housing

Some nurses reported poor living conditions in the free housing provided during FENs' first two months of work. One nurse recounted, *"They [other FENs] didn't have comforters, they didn't have pillows. The stuff that was inside was what their neighbors threw out and they thought it was still usable, so they took it with them and put it inside the house. They had like 3 or 4 people in the rooms, like a small room. And then they had to fix the doors, they had to role up newspapers to put it in the sides of the windows."*

Employer Perspectives

Hospital leaders' accounts of FENs' treatment in their facilities differed markedly from the nurses' accounts. Hospital interviewees said that they paid the same salary to FENs as to locally recruited nurses. Some hospitals gave one year of credit for one year of work experience, and other hospitals gave one year of credit for two years of work experience. The length and content of clinical orientation varied by hospital and unit.

Hospitals also reported that, in most cases, the recruitment package included some form of housing, which varied from temporary housing in apartments to long-term subsidized housing. In a couple of cases, hospitals purchased housing units for the express purpose of temporarily housing nurses working in the hospital. In some cases, the housing was limited to occupancy by FENs only; in other cases, the housing was available to any nurse working in the hospital.

Some hospital leaders reported that they worked hard to integrate FENs into their communities. In some cases, individuals "adopted" nurses to help them acclimate to their new surroundings. Such outreach was especially important when there were few Filipinos in a community. In some of those cases hospitals reported that FENs' would leave as soon as their contract was complete which in turn made officers less interested in using foreign recruitment as a staffing strategy.

Discussion

Gaps in oversight are presumably the exception; nevertheless, they clearly do exist. The stories reported by nurses vary considerably but seem to represent at least four different types of situations that make FENs vulnerable to abuse:

1) Lack of information about the market. FENs are often unaware of recruiting companies that do not charge nurses a fee and do not require contracts.

2) Common contractual arrangements. Some contractual terms place FENs in a vulnerable situation vis-à-vis their new employers. In particular, high buy-out fees can pose a problem when resignation is the ultimate defense against workplace abuses such as coerced overtime, delayed pay, and excessive work loads.

The Case of Sentosa 27+

One case, now known as the Sentosa 27, has gained visibility among the Filipino American community. We interviewed several of the affected nurses as well as their lawyer.

The story began in the New York City Filipino consulate, where nurses often come to complain about their jobs and seek legal advice. Given the high number of complaints, the consulate sought out the pro bono assistance of a Filipino American lawyer named Felix Vinluan. Like many immigration lawyers, Vinluan had a range of clients that included nurse recruiters as well as individuals seeking work visas. When Vinluan began interviewing the nurses, he realized that a large number of them (originally 27 and now 36) were working for a network of nursing homes owned by a single company. He also learned that the New York Nurse Association and the Labor Attaché in the Philippines Embassy in Washington, D.C., were receiving similar complaints about the company.

The Sentosa Recruiting Agency, which billed itself as a placement agency on its Web site, had recruited the Filipino nurses. Various facilities associated with the agency sponsored the nurses for their U.S. visas and were listed with the U.S. Embassy and the Philippine Overseas Employment Agency. Upon their arrival in New York, however, the nurses learned that they would be employed by Prompt Nursing Employment Agency, a staffing agency. Their contracts required them to work for three years, with a $25,000 buy-out penalty.

The nurses believed that they had no choice but to work for Prompt Nursing, given that they had given up their jobs at home and urgently needed housing and a job. The agency provided the nurses with housing for two months, although the housing was less than desirable. The nurses also learned that other elements of the contracts were altered, leaving the FENs with a less generous health plan, no dental insurance, and no differential pay for holidays or weekends.

The nurses were also displeased with the work conditions in the nursing homes. In addition to receiving insufficient clinical orientation to care for patients recovering from a range of acute illnesses and interventions, the nurses said that they were charged with caring for 60 to 100 patients each. They also complained that their wage hours were reduced to 35 hours per week despite a promise of 37.5 hours.

Vinluan advised his clients that Sentosa had violated the original legal contract under which they had obtained their green cards and that, as such, they were working "at will," i.e., they had no legal obligation to remain on the job. On April 6, 2006, he filed a complaint on behalf of 26 nurses and one physical therapist before the U.S. Office of Special Counsel in the U.S. Department of Labor.

One week later, Bent Philipson, Sentosa's owner, filed a series of complaints against the nurses and their lawyer claiming breach of contract. The first complaint took the form of an administrative request to the New York Board of Nursing to suspend the nurses' licenses for abandonment of patients. After several months, the complaint was resolved in favor of the nurses, although the nurses were unable to work during the proceedings. In addition to the complaint, the company brought a civil case against the nurses who had terminated their contracts, and one year later, the Suffolk County district attorney brought criminal charges against 10 of the nurses and their lawyer, accusing them of patient abandonment. Both the civil and the criminal cases are still pending; while the defense contends that health care organizations never directly employed them such that the nurses should be absolved of responsibility, the nurses fear that Philipson's significant political influence could affect the ruling.

The National Alliance for Filipino Concerns has rallied to defend the group. In June 2007, the American Nurses Association and New York State Nurses Association issued a press statement bringing attention to the case and condemning the exploitation of FENs.

3) Lack of recourse. When confronted with illegal practices such as alteration of contracts or retention of green cards, FENS find themselves isolated and rarely have a relationship with local unions.

4) Insufficient clinical orientation and excessive workloads. Without experience in the U.S. workplace, FENs tend to be unsure about the content and extent of clinical orientation and what they should expect from employers.

Part of the challenge in addressing these issues is that the issues touch on several areas of law and professional practice, e.g., immigration, licensure, and labor contracts. As such, no single entity is responsible for the well-being of nurses. If the Sentosa case is any indication of the responsiveness of the U.S. Department of Labor, there appear to be problems of responsiveness. Unions have a complex relationship with immigrants, but are beginning to set clear policies and programs to organize and defend them. State Boards of Nursing, charged primarily with protecting quality of care, have been reluctant to become involved in disputes over nurses' work conditions and contracts.

Any systematic effort to prevent abuses requires a deep understanding of the interrelationship of all of factors affecting the employment of FENs as well as a commitment to encouraging action on several fronts simultaneously.

9. Discussion

Limitations

While the data sources used for this study limit the scope of findings, the resulting information gaps are clear and can be used to identify priority areas for new research.

FENs' reluctance to participate in focus group in cities except New York limited the number of focus groups to two. While the reasons for FENs' reluctance are unclear, hindsight suggests that focus groups may not have been the best data collection technique. Individual interviews may be a more appropriate data collection approach in that they (1) might be more convenient in terms of nurses' schedules and mutually acceptable meeting places and (2) might be

Summary of Problems Reported by Foreign Nurses Interviewed

- Some nurses say that they were not allowed to keep copies of the contract they signed and that they were not clear on the terms of their contract.
- Nurses sign contracts to work exclusively with a recruiter. If the recruiter is unable to obtain a visa or place the nurse with an employer, the nurse may find him- or herself in financial difficulty if he or she has already left a local job and has sold his or her belongings in preparation for departure.
- In some cases, nurses try to break their contract in favor of hiring faster recruiters. The original recruiter may sue nurses who break contracts and may pursue them for family land deeds put up as collateral. When a recruiter cashes a check for a fee backed by insufficient funds, the recruiter can press charges against the nurse for fraud.
- In other cases, agencies collect payments from nurses for testing or travel and then never reappear to follow through on commitments.
- According to a CGFNS survey, 18 percent of recruiters charge nurses a fee for their services, a questionable practice given that such recruiters also receive payment from employers.
- Some nurses sign contracts to work with a particular employer and, upon arrival, learn that they must work for another employer.
- Some nurses are told that they will work as direct hires and, upon arrival, learn that they are assigned to a staffing agency.
- Contracts are sometimes "sold" to another agency; nurses are then forced to work in the new agencies' hospital or nursing home.
- Upon arrival, nurses may be asked to sign a new contract with new conditions. They believe that they have no choice.
- The jobs that nurses are asked to perform often are not the same jobs they agreed to in the contract.
- Some nurses who have been promised reimbursement of test fees and travel expenses never receive the funds.
- Breach fees are sometimes far greater than the damages recruiters would incur in bringing nurses to the United States. A high fee leaves nurses vulnerable to abuse.
- Nurses are told that they must pay the breach fee in full upon departure rather than in installments.
- Some employers have withheld green cards, telling nurses that the cards have not yet arrived.
- Nurses have been told that they would be deported if they broke their contract.
- Nurses told that their temporary permit and Social Security number (SSN) would be ready upon their arrival in the United States have sometimes found that the documents were not yet available. As a result, payment for work was delayed until issuance of the SSN, leaving the nurses with no option but to work as clerks for $12 an hour until permit issuance. In one case, a nurse had to work as a nanny for the agency owner until licensure approval.
- Some staffing agencies pay substandard wages (sometimes $10 less per hour).
- In some cases, nurses report that, despite promises of an increase, their pay remains the same for a period after obtaining licensure.
- At least one agency bases pay differentials on nationality and paid Koreans more than Filipinos.
- Agencies do not always provide health insurance, especially in the first year. In several cases, nurses who were pregnant when they arrived in the United States had no health insurance coverage and were not paid for maternity leave.
- Some FENs do not receive differential pay for nights and holidays.
- FENs are sometimes assigned to less desirable units with more patients and asked to work shifts that domestic nurses will not work.
- Some have complained of substandard housing (overcrowding, poor heating, lack of furniture) and transportation difficulties.
- While larger hospitals tend to take into account experience and advanced degrees when determining pay, many agencies and nursing homes consider all FENs to be entry-level nurses, arguing that they have no experience in the United States.
- Some nurses feel that, upon arrival, they did not receive sufficient clinical preparation for their assignments.

perceived by nurses as private encounters and therefore safer than focus groups.

Even with more focus groups, however, the qualitative nature of the data would not allow us to ascertain the frequency of abuses committed against FENs. Our preliminary findings of what may be isolated abuses is limited to informing discussions on how best to prevent such practices and how to design a comprehensive survey of FEN experiences with U.S.-based recruiters for purposes of assessing the magnitude of the problem.

The focus groups and interviews with FENs also pointed to the need to take a closer look at nursing homes' use of staffing agencies to employ FENS. Given that our research plan did not anticipate uncovering such practices among nursing homes, we did not interview managers or employees in these facilities and did not review data on the quality of care provided in facilities that treated FENS unfairly. Both lines of inquiry are worth pursuing in the future.

Finally, it was beyond the scope of the study to assess the extent to which U.S.-based recruiters adversely affect local health care services. Similarly, the study was not designed to evaluate the extent to which some of the efforts to "give back" have benefited nations. Even a qualitative assessment based on interviews with hospital and primary care leaders in source countries would help provide useful information for stakeholders interested in reducing harm and increasing benefits to source countries.

Final Reflections

Despite the study's various limitations, our analysis of the U.S.-based international nurse recruitment industry provides new information on the magnitude and nature of this growing business. We were able to estimate the size, structure, and many of the business practices of the industry. Findings suggest rapid growth in both the number of recruiters and size of companies. The study also reveals recruiter operations in far more countries than was the case just a decade ago.

Assuming that the United States lifts the immigration barriers imposed by a limited number of visas, it is evident that the industry will continue to grow. Hospitals and recruiters alike say that they plan to expand the recruitment of FENs in the coming years.

Our findings suggest that growth will likely mean more companies but, at the same time, a consolidation of capital and an expanding role for staffing agencies. All three phenomena will lead to the recruitment of more FENs to the United States, subject to the availability of visas. The trend toward larger companies may result in some benefits by increasing the opportunities for establishing standards and monitoring companies' activities. Only the largest firms have expressed interest in and can afford to undergo the Joint Commission accreditation process. On the other hand, the trend toward an increased number of staffing companies may be less beneficial. Domestic per-diem and travel nurse companies provide far better conditions for U.S. nurses as a way to compensate for the lack of integration in the workplace. International staffing agencies, however, do not pay at the same level as these agencies and sometimes provide lesser benefits.

Our research also documents the activity among a subset of companies in disadvantaged source countries with critical nurse shortages. While important data limitations undermine the precision of the measure of nurse shortages, few among those interviewed for the study would dispute that recruiting from African nations with high burdens of HIV/AIDS or countries, such as Jamaica, with nurse vacancy rates of over 50 percent has no ethical implications. Many recruiters express an interest in coming to some agreement on which countries should be "no hit" countries. The challenge is to reach an agreement on the criteria to be used to identify these nations and to establish programs through which employers and recruiters in the United States can compensate interested source countries in ways that strengthen their health services.

The abuses reported by FENs were of concern to some recruiters. While it is likely that only a small group of recruiters and nursing homes engages in abusive practices, the very existence of such practices is indicative of oversight problems. Efforts to educate FENs are urgently needed, along with clear industry standards that recruiters may adopt to demonstrate fair treatment of FENs. Certain practices, such as charging nurses fees and including in contracts high buy-out penalties that far surpass the original investment in the FEN, are among the practices that recruiters need to review.

Finally, some recruiters and health care organizations have already launched a set of isolated initiatives to attempt to "give back to countries" from which they recruit. Discussion and agreement on the most beneficial initiatives would be useful to all parties, including a systematic effort to assess which strategies are most effective from the source countries' perspectives.

Appendix A: Alternative Data Sources for Foreign Educated Nurses Entering the United States

There are no exact counts of foreign-educated nurses currently working in the United States. The explanation for the lack of precise data lies in the fact that (1) nurse licensing is handled by more than 50 state and territorial boards of nursing and (2) the National Council of State Boards of Nursing (NCSBN) does not have a complete list of newly licensed foreign-trained nurses from every state. To complicate matters further, up to 15 percent of nurses are licensed in more than one state. Nevertheless, several data sources,may serve as potential proxies for estimating the number of FENs in the United States. Each has its own strengths and weaknesses as discussed below.

National Council Licensure Examination (NCLEX)

The NCLEX data embody both over- and undercount biases. Potential overcount bias is revealed by an NCSBN 2003 survey of 1,000 FENs in which 76 percent of respondents indicated that nurses in their country take the examination only if they want to practice in the United States. Other functions of the examination include the demonstration of knowledge, skills, and requirements for jobs. However, the survey instructed respondents to select "all that apply," making it unclear whether any nurse who takes the test has no intention of practicing in the United States. Moreover, in order to take the test, nurses must first apply to practice in a specific state, making it less likely that they would take the test simply to verify knowledge.

On the potential undercount side, the same survey revealed that many FENs in the United States are working either as aides or students and have not yet taken the examination, with 46 percent of RNs and 63 percent of LPNs residing in the United States at the time of taking the test. These figures suggest a delay in tracking time of entry, but presumably most of the nurses will eventually pass the test and appear as immigrants in later years (Smith, J., and Crawford, L. Report of Findings from the Practice and Professional Issues Survey Winter 2003. NCSBN Research Brief, 2004).

Total numbers of passers of the NCLEX are reported in aggregate form. Country-level data are available, but only for first-time passers.

VisaScreen®

The Commission on Graduates of Foreign Nursing schools (CGFNS) certifies foreign nurses' credentials, including education and English proficiency, through what it calls a VisaScreen®. Such certification is required for an occupational visa. CGFNS began issuing certificates in 1998 and maintains publicly available data on the total count of certificates issued every year since then. CGFNS publishes the top five countries of origin but does not provide data disaggregated by country. The data represent another proxy measure for the number of FENs entering the Unites States, although CGFNS's numbers tend to be several thousand fewer than the number of NCLEX passers. Not counted in VisaScreen® are nurses who entered through the diversity lottery (as opposed to on occupational visas) and nurses on student visas, undocumented nurses, or nurses in the United States as dependents.

Health Resources and Services Administration (HRSA) National Sample Survey of Registered Nurses

Another source of information on FENs is the U.S. Department of Health and Human Services's Health Resources and Services Administration (HRSA) National Sample Survey of Registered Nurses (NSSRN). Conducted in 2000 and 2004, the NSSRN estimated that approximately 100,000 RNs are foreign-trained (representing 3.5 to 3.7 percent of the total RN workforce). The survey was based on a probability sample of 35,724 nurses from all 50 states and Washington, D.C.

While the NSSRN provides the greatest demographic detail on FENs, the survey results were outdated by the time they were published. In addition, the survey's sampling methodology may result in an undercount of FENs by not accounting for the large concentration of FENs in a handful of states. One indication of undercounting is the fact that the survey finds little change in the number of FENs between 2000 and 2004 despite significant growth in the number of FENs passing the NCLEX over the same period (discussed below).

U.S. Census Data

An even older data source is the U.S. Population Census, conducted every 10 years, which counted approximately 300,000 foreign-born RNs in the United States in 2000. Of these, an estimated 218,000 (or 8 percent of all RNs) were foreign-born RNs who immigrated to the United States as adults (age 21 and over). In a recent *Health Services Research* paper, Aiken suggests that the estimate of 218,000 foreign-born RNs can be used as the best proxy for the number of foreign-trained nurses residing in the United States as of 2000.

U.S. Department of Homeland Security Immigration Statistics

Still another data source is the U.S. Department of Homeland Security's (DHS) immigration data. While DHS counts immigrants by occupational visas, the published data do not break out health occupations into specific professions (RN, physician, therapist, and so forth); therefore, it is difficult to estimate exactly how many nurses immigrated as a portion of total health workers. In addition, many nurses enter the United States on other types of visas not represented in the DHS data. Thus, the data probably represent an underestimate of the total number of FENs immigrating to the United States.

Appendix B: Recruiter and Employer Suggestions for Improving the International Nurse Recruitment Process

The following is a list of ideas expressed during interviews with recruiters and employers that may stimulate discussions.

Development and Implementation of Guidelines

- If recruiters pledge to abide by certain agreed-upon rules, they will be listed in a central registry managed by a not-for-profit group such as the CGFNS or NCSBN, both of which have the capability to survey FENs to monitor recruiter compliance. Companies found to be in violation of the pledge will be removed from the list. Recruiters would pay a fee to be listed. Employers could consult the list when considering the use of recruiters.
- Develop a model contract for use by accredited agencies.
- Establish guidelines for compensation to

source country nursing schools and/or employers for loss of nurses.

- Form a professional association of recruiters, e.g., American Staffing Association.
- Include measures that relate to emplyment and work conditions of FENs in the instrument for the Joint Commission's accreditation of staffing agencies.

Return Migration

- Establish J1 visas for nurses.
- Create a fund that will allow nurses to return to their home countries to teach for a few months every couple of years.

Educational Exchange

- Provide online training services for source country universities.
- Develop and operate fellowship exchanges.
- Twin a U.S. hospital with a source country hospital to faciliaet technical leanring exchanges.
- Establish a maximum number of nurses that can be recruited from a graduating class or hospital.

Protecting FENs' Rights

- Develop an online template for a nurse contract, specifying rights, obligations, and areas of caution.
- Develop an educational brochure for nurses, specifying rights, obligations, and areas of caution, for distribution by the U.S. Department of State when nurses apply for visas. Other entities, such as trade unions, NCSBN, and the CGFNS, could also distribute the brochure.
- Better labor laws.
- Better enforcement.

Appendix C: Efforts to Guide International Nurse Recruitment[60]

This section includes a brief review of the limited evidence and current debate on the usefulness of ethical guidelines and codes of practice for the international recruitment of health care professionals. It also includes a glossary with a short description of (1) international initiatives and (2) U.S. initiatives. A bibliography with links to original guidelines and codes follows.

The Impact Debate

Debate continues over the usefulness of nonbinding ethical recruitment instruments. Some believe that the instruments highlight the international workforce migration situation and increase awareness of both the positive and negative impacts of health workforce migration (Commonwealth 2003; World Health Organization 2006). Evidence of the instruments' impact is, however, scarce owing to limited data on patterns of nurse migration and methodologic challenges in attributing changes to the instruments (Merchants of Labor 2006).

At the core of the critiques are concerns about enforceability. The United Kingdom's Code of Practice is the only existing document with any legal ramifications (Bach 2003), but critics argue that even the United Kingdom's (UK) 2004 code has limited impact. Obviously, the private sector can still recruit from banned countries while the global diffusion of technology provides individuals interested in immigration with increased access to employment opportunities (Save the Children 2004). The inclusion of countries on a list of banned countries may have the effect of simply shifting source countries and not reducing international recruitment (Royal College of Nursing 2002).

According to Martineau, "Since the introduction of the first ethical guidelines by the Department of Health in England in 1999 the outflow from sub-Saharan Africa to the UK has increased significantly and in the case of South Africa this figure has more than quadrupled" (Martineau 2004). In 2005, Martineau asserted that, unless the inherent limitations built into the existing voluntary codes are addressed, including but not limited to (1) source countries' development of data collection systems on migratory patterns of their health care workers and (2) increased external and internal monitoring pressure on health care systems to ensure compliance with codes, ". . .it would probably be better not to introduce the instruments at all."

Maybud points out that, with rising numbers of foreign workers already present in destination countries, health care workers from source countries now have more solid support networks and information systems to facilitate the migration process, regardless of the activities of recruiters (Maybud 2006).

Many position statements have set forth recommendations calling for recipient countries to make reparations to developing and source countries to compensate for the countries' educational investments in their health care workers. However, to date, recipients have not made such reparations, and most observers would argue that reparations are not politically feasible given developed countries' resistance (Bach 2003). In addition, establishing the monetary amount of reparations would pose a significant challenge, along with identifying the source country to which compensation is owed.

Proponents of ethical guidelines, on the other hand, argue that the instruments educate health care employers as to what constitutes ethical and unethical practices. Health care organizations as well as associations for health care workers are beginning to distribute information to their stakeholders to raise their awareness about the nature of the recruitment process and thus reduce the chances of recruits' vulnerability to questionable contracting practices (Merchants of Labor 2006; World Health Report 2006).

It is noteworthy that, even among those skeptical of the impact of instruments on the volume of recruitment, there seems to be agreement that such instruments can potentially benefit individual recruits. A recent trend in Europe has seen the negotiation of bilateral agreements and memoranda of understanding (MOUs) between countries. While experience with such instruments is still limited, some believe that government-to-government agreements may be more effective than guidelines and codes of practice in managing the international recruitment of health care workers. Bach asserts that bilateral agreements would reduce dependency on commercial recruitment agencies, promote transparency between parties, and lend themselves to modification to address country-specific concerns.

Further analysis of voluntary agreements and bilateral agreements between governments is warranted in order to understand which instruments prove effective in protecting international health care workers and their source countries.

Glossary of International Initiatives

United Kingdom 1999 Guidance on International Nursing Recruitment

In 1999, the United Kingdom became the first country to develop a set of guidelines for international health care worker recruitment. The purpose of the guidelines is to (1) mitigate the negative aspects of international health care worker migration, (2) decrease the difficulty and confusion associated with the international recruitment process, and (3) support the rights of individual health care workers (U.K. Department of Health 1999).

- As a nonlegal document, the guidelines provide information to National Health Service (NHS) employers about the recruitment of international health care professionals and introduce ethical considerations for both the individual health worker and the source country.
- The guidelines apply only to the NHS and exclude the United Kingdom's independent health care sector.
- The guidelines state that international nurse recruitment is to be considered only "when its professional and service value can be clearly demonstrated and when it will have no adverse effects upon the recruit's home health care system."
- While the guidelines prohibit active recruitment from the Caribbean and South Africa, they do note the right of the individual to migrate and permit consideration of individual applications regardless of source country.

United Kingdom 2001 Code of Practice for the International Recruitment of Health Care Professionals

In 2001, the U.K. developed a more formal Code of Practice for the International Recruitment of Health Care Professionals to "promote high standards of practice in international recruitment." The code stipulates that NHS employers may "actively" recruit health care workers only from countries without health care worker shortages, unless formal government-to-government bilateral agreements are in existence, "and strongly commend[s] all employers to adhere to the Code of Practice."

United Kingdom 2004 Code of Practice for the International Recruitment of Health Care Professionals

In December 2004, the U.K. updated the 2001 Code of Practice and included an official list of the 150 "at risk" countries in which active recruitment of health care workers was prohibited unless a government-to-government agreement was in place. The update also strengthened the 2001 Code of Practice by expanding its domain to include all health care professionals, such as permanent, locum (temporary substitutes), temporary, and part-time health care workers. In addition, it invited the independent health care system to sign on to the code voluntarily.

Ireland 2001 Guidance for Best Practice on the Recruitment of Overseas Nurses and Midwives

Closely related to the 2001 U.K. Code of Practice, Ireland's guidelines do not carry the regulatory authority of the U.K. guidelines. In addition, Ireland's guidelines recommend that "Irish employers only actively recruit in countries where the national government supports the process" (Department of Health and Children 2001).

Scotland 2006 Code of Practice

In 2006, NHS Scotland replicated the U.K.'s 2004 Code of Practice. As with the U.K. guidelines, any commercial recruitment agency that wishes to supply health care workers to the NHS must comply with the Code of Practice. The NHS employer Web site maintains a list of all agencies in good standing that are permitted to recruit to the NHS. Scotland's only addition to the U.K. model calls for compliance monitoring by the recruitment agencies and NHS employers. The Scottish Executive Committee asked the NHS Scotland Boards to provide information semiannually on "recruitment trends including agencies used and countries targeted" (NHS Scotland 2006).

Sigma Theta Tau International 2005 Position Statement on International Nurse Migration

The statement supports research on international nurse migration and the education of stakeholders so that they may assist in sustainable policy formation.. The statement also endorses both the Commonwealth Code of Practice and the International Counicl of Nurses (ICN) position statements on international health worker migration (**Sigma Theta Tau International** 2005).

Commonwealth 2003 Code of Practice for the International Recruitment of Health Workers

The code is a set of guidelines for international recruitment by all Commonwealth countries. The voluntary guidelines are more general than the NHS Code of Practice (Commonwealth 2003).

European Union (EU) Directives

The directives are a form of multilateral agreement that allows qualified nurses from one EU country to move to and work for another EU country, provided that they meet EU training standards. The recent accession of many countries to the EU facilitates nurse migration within Europe, particularly from Eastern to Western Europe.

General Agreement for Trade in Services (GATS)

The agreement is a legally enforceable World Trade Organization (WTO) agreement created in 1995 to establish a multilateral system for trade in services. All 150 members of the WTO have signed on to GATS. Mode Four of GATS applies to the movement of people across international borders. With respect to trade in health services, GATS focuses on the temporary movement of health workers but does not define "temporary movement," perhaps giving source countries the advantage in establishing limitations on the duration of visas for health workers. The future impact of GATS on international nurse migration remains unclear, although some hypothesize that GATS may stimulate additional migration through bilateral agreements and harmonization of nurse qualifications across nations.[61,62]

International Council of Nurses (ICN) 2001 Position Statement on Ethical Nurse Recruitment

The statement provides detailed guidelines and methods to improve the ethical treatment of individual health care workers and to improve developing nations' health systems (ICN 2001).

International Labour Organization (ILO)

As a United Nations (UN) agency, the ILO is committed to establishing basic international labor standards and promoting opportunities for individuals to obtain decent and productive work. The ILO adopts conventions and recommendations that must be ratified by its member states. Several ILO Conventions address the treatment of migrant workers and issues related to international nurse recruitment.[63]

MOU between South Africa and the United Kingdom

Signed in October 2003, the MOU is a bilateral agreement that established a reciprocal educational exchange, allowing South African health care workers to spend a specified period of time on education and practice in the NHS and permitting clinical staff from England to work in South Africa, particularly in rural areas. The MOU grew out of a concern about the migration of health care workers from South Africa to the United Kingdom. Sources in South Africa believe that the MOU has had a positive impact on workforce migration issues.

Nordic Passport Free Area

The arrangement facilitates the movement of workers between/among Denmark, Finland, Norway, Iceland, and Sweden.

North American Free Trade Agreement (NAFTA)

NAFTA governs migration between North American countries. In the late 1990s, NAFTA provided the impetus for Canada, Mexico, and the United States to compare their nursing education systems and move toward licensing and certification reciprocity.[64] Before changes in U.S. visa requirements, NAFTA allowed Canadian nurses to migrate to the United States without a visa and/or without passing the NCLEX.

Standing Committee of Nurses of the European Union (PCN) 2005 Good Practice Guidance for International Nurse Recruitment

The guidance provides useful information for health care employers on the international recruitment process and on ethical recruitment issues (PCN 2005).

Trans-Tasman Agreement

The agreement allows free movement of nurses between Australia and New Zealand.

World Federation of Public Health Associations (WFPHA) 2005 Ethical Restrictions on International Recruitment of Health Professionals from Low-Income Countries

The restrictions seek to mitigate the underlying causes of global health care worker shortages by negating the push/pull factors that result in massive migration of health care workers to developed nations (WFPHA 2005).

World Health Organization (WHO) Resolution

In 2004, WHO issued a resolution urging member states to develop strategies to mitigate the adverse effects of international health workforce migration.[65] The resolution encourages government-to-government agreements to manage migration by setting up health personnel exchange programs and emphasizes efforts to strengthen health systems in developing countries. The resolution also requests the Director-General to establish means to monitor the movement of the health workforce, conduct research on international migration, and develop an international code of practice.

- The **1997 Private Employment Agencies Convention (C181)** states that workers must be treated without discrimination and cannot be denied the right to freedom of association and collective bargaining. In addition, the convention prohibits private employment agencies from charging any fees to workers except in the case of authorized exceptions for certain categories of workers. C181 also calls for adequate protection against and prevention of abuses of migrant workers and asks member states to consider addressing migrant rights through bilateral agreements.
- The **1977 Nursing Personnel Convention (C149)** broadly addresses the employment and treatment of nurses. Article Six states that nurses' working conditions should be at least equivalent to those of other workers in the destination country (e.g., hours, holidays, leave time, social security). It is important to note that the United States did not ratify C149. An accompanying 1977 Nursing Personnel Recommendation, a nonbinding instrument, includes more detailed guidance for nurse labor practices and states, for example, that FENs with equivalent qualifications have a right to employment conditions as favorable as those of national personnel in the same posts. In addition, the 1977 recommendation states that the recruitment of FENs should be authorized only in the case of a shortage of qualified personnel in the destination country and no nurse shortage in the source country.

Developments in the United States

In response to the U.K. Code of Practice and recognition of the magnitude of the global health worker shortage, several U.S. organizations have developed documents relating to international health care worker migration. None of these instruments carries legal authority, but the sponsoring groups strongly encourage applicable government agencies and policymakers to adopt the instruments' recommendations. In addition, recent efforts to regulate or certify health care staffing agencies (domestic and international) have affected some international recruiters, though on a limited basis.

Nurse Staffing Agency Licensure

requirements have recently been developed in Washington, DC, and Maryland to review and license health care staffing agencies operating in each jurisdiction. In Washington, DC, the law stipulates that "nurse staffing agency" licensure will be the responsibility of the District of Columbia Department of Health.[66] "Nurse staffing agency" is defined as an entity providing or referring nursing personnel to a health care facility or agency for the purpose of rendering temporary nursing services. The definition excludes nurse staffing programs operated by health care facilities (health care organization (HCO) direct recruiting). The District of Columbia Board of Nursing is responsible for implementing the law. Initial licensure fees have been set at $1,000 with a $500 annual renewal thereafter. In Maryland, the state's quasi-independent Office of Health Care Quality conducts licensing review of "nurse referral agencies" at a cost of $1,000 per license. "Nurse referral agencies" are defined as entities that screen and refer licensed health care professionals and care providers to clients for the provision of nursing and home health services.[67] The Secretary of the Maryland Department of Health and Mental Hygiene issues three-year licenses.

American Organization of Nurse Executives (AONE) Policy Statement on Foreign Nurse Recruitment was approved in 2003 and supports the freedom of movement for individual health care workers but expresses concerns regarding recruitment of nurses from areas already experiencing shortages. It encourages increased public and private funding to address the root causes of the global nursing shortage (AONE 2003).

American Public Health Association (APHA) Ethical Restrictions on International Recruitment of Health Professionals to the United States

The restrictions are based on WFPHA 's 2005 resolution. Unlike, WFPHA, however, APHA states that health care organizations may consider "unsolicited applications directly from an applicant." In addition, APHA does not address the need for destination and source countries to mitigate the causes behind global health worker shortages or the factors that cause health care workers to migrate to more affluent countries. APHA recommends that the government contract only with health care organizations that signed its code of ethics and were in compliance with its directives (APHA 2005).

American Staffing Association (ASA) Code of Ethics and Good Practices

The code, a set of guidelines with which all member staffing agencies must comply, includes general language about maintaining high standards of ethical conduct in all business operations and treating all employees with dignity and respect. It also states that agencies must explicitly explain to their employees all conditions of employment (e.g., wages, hours, benefits) before their assignment. ASA's Health Care Section has undertaken preliminary efforts to promulgate template regulations governing health care staffing practices and, as part of that effort, later began participating in the Joint Commission's certification process (described below).

The **Joint Commission** (formerly the Joint Commission on Accreditation of Health Care Organizations, or JCAHO) evaluates and certifies or accredits health care organizations in order to improve patient safety and quality of care. In 2005, the commission began certifying health care staffing services both, domestic and international. The voluntary certification process involves a comprehensive review of staffing companies' key business processes, including verification of staff credentials and qualifications. Staffing companies seeking certification undergo an initial announced review and then unannounced on-site reviews every two years thereafter. As of June 2007, 171 staffing companies were Joint Commission–certified. Of those companies, approximately 12 conduct international recruitment, based on a cross-check of our recruiter database and the list of Joint Commission–certified companies. Four of the 20 companies we interviewed for the study had obtained certification and one was in the review process. Recruiters say that they are motivated to become certified as a way to improve their own performance and gain a competitive edge. However, the Joint Commission certification process seems to have limited usefulness for improving the practices of international nurse recruitment because only the most well-established companies choose to apply for certification. In addition, the certification process does not address nurses' rights or specific international recruitment considerations.

National Council of State Boards of Nursing (NCSBN) Position Statement on the Ethical Recruitment of Nurses for Licensure

NCSBN issued its statement in January 2007 and defines "ethical recruitment" as a "hiring process free from intimidation, misleading information, or exploitation." NCSBN supports the right of individual nurses to migrate, as allowed by law. The position statement recommends that state and federal policymakers consider ethical recruitment policies when addressing the nurse shortage (NCSBN 2007).

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Appendix D: Advisory Council Members

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Appendix E: Acronyms

American Hospital Association (AHA)
The American Hospital Association is the national organization that represents and serves all types of hospitals, health care networks, and their patients and communities. Close to 5,000 hospitals, health care systems, networks, and other providers of care and 37,000 individual members form the AHA.

American Organization of Nurse Executives (AONE)
Founded in 1967, the American Organization of Nurse Executives, a subsidiary of the American Hospital Association, is a national organization of over 5,000 nurse leaders who design, facilitate, and manage care.

Commission on Graduates of Foreign Nursing Schools (CGFNS)
CGFNS is an internationally recognized authority on credentials evaluation and verification pertaining to the education, registration, and licensure of nurses and health care professionals worldwide.

H1-B Visa
The H-1B visa enables professionals in "specialty occupations" to make a valuable contribution to the U.S. economy. The H-1B non-immigrant work visa may be issued to applicants seeking temporary work in a "specialty occupation" that requires the skills of a professional. "Specialty occupations" include, for example, accountant, computer analyst, programmer, database administrator, Web designer, engineer, financial analyst, doctor, nurse, scientist, architect, and lawyer.

Health Care Organization (HCO)
A health care organization is any public or private institution involved in any aspect of delivering health care services (i.e., hospitals, nursing homes, and so forth).

Licensed Practical Nurse (LPN)
A person who is specifically prepared in the techniques of nursing, who is a graduate of an accredited school of practical nursing, whose qualifications have been examined by a state board of nursing, and who has been legally authorized to practice as a licensed practical nurse.

National Council Licensure Examination (NCLEX)
The National Council Licensure Examination is a test that nurses must pass in order to become a licensed registered nurse in the United States.

National Council of State Boards of Nursing (NCSBN)
The National Council of State Boards of Nursing, Inc., is a not-for-profit organization whose membership makes up the boards of nursing in the 50 states, the District of Columbia, and four U.S.. territories--American Samoa, Guam, Northern Mariana Islands, and the Virgin Islands. NCSBN is an organization through which boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety, and welfare, including the development of licensing examinations in nursing.

Registered Nurse (RN)
A registered nurse has graduated from a formal program of nursing education (diploma school, associate degree, or baccalaureate program) and is licensed by the appropriate state authority.

TN Visa
TN Visas are temporary work visas available only to citizens of Mexico and Canada. Under the North American Free Trade Agreement (NAFTA), a citizen of a NAFTA country may work in a professional occupation in another NAFTA country as long as the applicant meets certain requirements.

Appendix F: Recruiter Activity in Disadvantaged Source Countries

COMPANY	AFRICA								
	Cameroon	Ethiopia	Ghana	Kenya	Nigeria	Sierra Leone	South Africa	Zimbabwe	General
Nurse-to-Population Ratio (per 10,000)	16	2	7.4	11.8	10.3	2.3	40.8	7.2	N/A
1st Health Staffing					X				
Acirt USA			Office		Office				
Advanced Health Alliance									X
ALDA Solutions							X		
Amerecares									X
American Staff Exchange	Office								
Assignment America							X		
Avant Healthcare Professionals									
Cambridge Healthcare									
Cebu Nursing Resource and Referral Services									
Concept Healthcare Resources, Inc.							Office		
CORPOCARIBE									
CSI Healthcare									
D'Jobs International									
Florida Nurse Program									
Global Healthcare Group							X		
Global Healthcare Resources	X		X	X	X				
Global Nursing International									
Global Scholarship Alliance								X	
Have Nurse, Inc.									
HCCA International									
Health Careers of America, LLC			X						
International Nurses Alliance							X		
Jasneek Medical Staffing									
Kennedy Healthcare Recruiting			X	X	X				
Liberty Nurse Recruiting									X
M3 Medical Management Services							X		
Madison Healthcare									X
Nurse Immigration Services			Office				Office		
Nurse Immigration USA									
Nurses Network International				X	X				
Nurses 'R' Special									X
Nursing Resource Services									
O'Grady Peyton							Office		
Open Hearts Global Professional Placements									
Premier Healthcare Professionals							X		
Professional Healthcare Resources International		X			X	X			
Professional Placement Resources							X		
South Nassau Community Hospital									
World Health Resource					X			X	
TOTAL	**2**	**1**	**5**	**3**	**7**	**1**	**12**	**2**	**6**

COMPANY	LATIN AMERICA							
		Brazil	Colombia	Mexico	Panama	Peru	Puerto Rico	General
Nurse-to-Population Ratio (per 10,000)	5.9	5.2	5.7	10.8	10.8	6.7	42.5	N/A
1st Health Staffing								
Acirt USA								
Advanced Health Alliance								
ALDA Solutions								
Amerecares								X
American Staff Exchange								
Assignment America								
Avant Healthcare Professionals							X	
Cambridge Healthcare		X						
Cebu Nursing Resource and Referral Services								
Concept Healthcare Resources, Inc.								
CORPOCARIBE			X					
CSI Healthcare				Office				
D'Jobs International				X			X	
Florida Nurse Program				X				X
Global Healthcare Group								
Global Healthcare Resources				X		X		
Global Nursing International		X		X				
Global Scholarship Alliance								
Have Nurse, Inc.								
HCCA International			Office					
Health Careers of America, LLC				X				
International Nurses Alliance								
Jasneek Medical Staffing					X			
Kennedy Healthcare Recruiting								
Liberty Nurse Recruiting								
M3 Medical Management Services								
Madison Healthcare								X
Nurse Immigration Services				Office				
Nurse Immigration USA	X							
Nurses Network International								
Nurses 'R' Special								
Nursing Resource Services				X				
O'Grady Peyton								
Open Hearts Global ProfessionalPlacements			Office					
Premier Healthcare Professionals								
Professional Healthcare Resources International								
Professional Placement Resources								
South Nassau Community Hospital							X	
World Health Resource								
TOTAL	1	2	3	8	1	1	3	3

COMPANY	CARIBBEAN							
		Dominica	Grenada		Jamaica	Trinidad	West Indies	General
Nurse-to-Population Ratio (per 10,000)	?	41.7	37	1.1	16.5	28.7	?	N/A
1st Health Staffing								
Acirt USA							Office	X
Advanced Health Alliance								
ALDA Solutions								X
Amerecares								X
American Staff Exchange								
Assignment America	X				X	X		
Avant Healthcare Professionals								
Cambridge Healthcare								
Cebu Nursing Resource and Referral Services								
Concept Healthcare Resources, Inc.								
CORPOCARIBE								
CSI Healthcare								
D'Jobs International								
Florida Nurse Program								
Global Healthcare Group								
Global Healthcare Resources								X
Global Nursing International								X
Global Scholarship Alliance								
Have Nurse, Inc.								
HCCA International								
Health Careers of America, LLC								
International Nurses Alliance								
Jasneek Medical Staffing								
Kennedy Healthcare Recruiting			X	X				
Liberty Nurse Recruiting								
M3 Medical Management Services								
Madison Healthcare								X
Nurse Immigration Services								
Nurse Immigration USA					X	X		
Nurses Network International								
Nurses 'R' Special								
Nursing Resource Services								
O'Grady Peyton								X
Open Hearts Global Professional Placements								
Premier Healthcare Professionals								
Professional Healthcare Resources International								
Professional Placement Resources								
South Nassau Community Hospital								
World Health Resource		X						
TOTAL	**1**	**1**	**1**	**1**	**2**	**2**	**1**	**7**

COMPANY	MISCELLANEOUS		
	Malaysia	Pakistan	Sri Lanka
Nurse-to-Population Ratio (per 10,000)	13.5	3.1	12
1st Health Staffing			
Acirt USA			
Advanced Health Alliance			
ALDA Solutions			
Amerecares			
American Staff Exchange			
Assignment America			
Avant Healthcare Professionals	X		
Cambridge Healthcare			
Cebu Nursing Resource and Referral Services	X		
Concept Healthcare Resources, Inc.			
CORPOCARIBE			
CSI Healthcare			
D'Jobs International			
Florida Nurse Program			
Global Healthcare Group			
Global Healthcare Resources			
Global Nursing International			
Global Scholarship Alliance			
Have Nurse, Inc.	X	Office	
HCCA International			
Health Careers of America LLC			
International Nurses Alliance			
Jasneek Medical Staffing			
Kennedy Healthcare Recruiting			
Liberty Nurse Recruiting			
M3 Medical Management Services			
Madison Healthcare			
Nurse Immigration Services			
Nurse Immigration USA			
Nurses Network International		X	X
Nurses 'R' Special			
Nursing Resource Services			
O'Grady Peyton			
Open Hearts Global Professional Placements			
Premier Healthcare Professionals			
Professional Healthcare Resources International			
Professional Placement Resources			
South Nassau Community Hospital			
World Health Resource			
TOTAL	3	2	1

Source: Internet Web sites, recruiter interviews, and WHO (www.who.int).

Endnotes

1 CGFNS 2006 Market Survey with Recruiters.

2 2006 unpublished CGFNS Survey of VisaScreen Certificate Holders 2003–2005.

3 CGFNS is the organization charged with verifying educational, licensure, and language credentials and administering a predictor test for the licensure examination (NCLEX) that can be substituted for the NCLEX in the visa application process.

4 Most RNs enter with Employment Based (EB) immigrant visas under Schedule A and become lawful permanent residents. Schedule A is a U.S. Department of Labor designation of shortage professions for which individual "labor certifications" are not required. Such certifications are designed to demonstrate that no U.S. citizen is available for a job. Currently, RNs and PTs are the only Schedule A professions, aside from an obsolete category of "exceptional" aliens. LPNs are not designated under Schedule A. To sponsor an LPN, an employer must prove that no U.S. citizen LPN is available, usually an impossible burden of proof. More than 90 percent of Schedule A visas in this category go to RNs and their families, with the remainder going to PTs. About 55 percent of available visas go to the spouses and minor children of these health care workers. While there is an equal annual quota of visas for each country, most countries do not use their allotment. As a result, the Philippines, India, and China are able to exceed their quotas each year. Approximately 70 percent of all EB immigrants come from these three countries.

The Diversity Visa (DV) Lottery is an additional way to obtain immigrant visas. The United States issues 50,000 visas each year to citizens of countries other than those with the highest rates of immigration to the United States. Africans and Eastern Europeans compose a majority of immigrants under the DV category each year. Health care workers with DVs do not require the CGFNS VisaScreen because their selection is not based on their profession. Although a relatively small number of nurses may enter through the DV Lottery, such nurses are probably not recruited before entry because the lottery selection method allows recruiters to identify them before time of entry.

Some RNs enter with temporary ("nonimmigrant") occupational visas. TNs can be used for RNs from Canada and Mexico, although Canadian nurses primarily use this category. H-1Bs can include RNs, although availability is highly constrained by overall numbers, and the category covers many occupations, especially in the high-tech sector. In addition, the category requires the nurse to hold a BSN and the to-be-filled job to specify a BSN as a minimum requirement, which is not true of most U.S. nursing positions. In health care, TNs are primarily used for physical therapists, medical technicians, and pharmacists. H-1Cs are available for up to 500 RNs per year (limited to 25 to 50 per state) to work in only one of 14 hospitals in severely underserved areas across the country.

5 Approximately 55 percent of these visas went to dependents.

6 The Georgetown University Institutional Review Board approved the research protocol, and all informants were assured of confidentiality and anonymity.

7 Kathryn Leonhardy conducted employer interviews.

8 While we attempted to hold focus groups in Chicago, Los Angeles, Houston, and Miami, FENs were reluctant to participate, and we were unable to identify a sufficient number of participants for the focus groups. We do not know whether time constraints, fear of reprisals, or the controversies surrounding the recruitment of FENs had any bearing on decisions to decline.

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38 CGFNS 2006 Market Survey with Recruiters.

39 CGFNS 2006 Market Survey with Recruiters.

40 An important limitation of the data on recruiter activity by source country is that our database does not include HCOs that recruit directly. Given that most HCOs that recruit directly tend to focus on the Philippines and India, those countries probably represent a large undercount. However, for the other source countries, the undercount may be smaller and similar across countries.

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54 In the late 1990s, a 33-month investigation conducted by the South Plains Texas Visa Fraud Task Force uncovered a nurse smuggling ring that had unlawfully obtained legitimate temporary H-1A visas (which had been withdrawn during a perceived nursing "surplus" in the mid-1990s). Over 500 FENs were brought to the United States illegally and employed by hospitals, nursing homes, and clinics in 35 states. The FENs earned substandard wages and lived in crowded and unsanitary conditions.

55 Canadian nurses are the only foreign nationals with access to the highly lucrative traveling nurse contracts enjoyed by many U.S. nurses. Large travel nurse companies that recruit from other countries tend to do so under a separate corporate entity that specializes in the many complex services required to clear immigration and licensure and to ensure clinical and cultural adaptation to the new location. Even the best foreign nurse staffing agencies pay far less to foreign nurses than they pay U.S. travel nurses, even when the staffing agency is owned by the parent corporation that owns the travel nurse company. As a result, nurses interested in coming to the United States are usually searching for jobs in hospitals that will act directly as their sponsor.

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