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KAROLINE SCHMID

**EMIGRATION OF NURSES FROM THE CARIBBEAN:
CAUSES AND CONSEQUENCES FOR THE SOCIO-ECONOMIC WELFARE
OF THE COUNTRY: TRINIDAD AND TOBAGO – A CASE STUDY**

Table of Contents

INTRODUCTION.....	1
CHAPTER 1: DATA AVAILABILITY AND DATA QUALITY	4
I. EMIGRATION DATA FROM THE SENDING COUNTRY	6
Nurses emigrating: 1960-1980.....	6
II. DATA ON MIGRANTS FROM THE RECEIVING COUNTRIES	8
Data from the United Kingdom	8
The Nursing and Midwifery Council (NMC).....	8
Recent data on foreign nurses registered with the NMC.....	8
Work Permits United Kingdom.....	9
Data on migration from the United States	10
CHAPTER 2: THE NURSING WORKFORCE IN TRINIDAD AND TOBAGO	12
I. EDUCATION AND TRAINING OF NURSES IN TRINIDAD AND TOBAGO	12
Basic Nursing Training.....	12
II. Advanced training for nurses.....	13
Post basic education certification programmes.....	13
Advanced academic education.....	14
Issues of critical concern in teaching.....	14
Supply and demand in nursing.....	14
Future staffing needs.....	16
Implication of the staffing shortage on the performance of the public health system in Trinidad and Tobago.....	17
CHAPTER 3: PAST AND PRESENT GOVERNMENT POLICIES TO ADDRESS THE NURSING CRISIS	19
I. PROBLEMS IDENTIFIED AND POLICIES ADOPTED IN THE 1960S.....	19
II. PROBLEMS IDENTIFIED AND POLICIES ADOPTED IN THE 1970S AND 1980S	19
Ageing of the workforce.....	20
Human resource management.....	20
Education and training	20
Benefits and pay	20
Recognition of the profession	20
Staff motivation and morale	21
III. Recent policies.....	21
IV. Strategic plan for nursing and midwifery 2002 - 2007	22
V. The Health Services Quality Act	24
CHAPTER 4: GLOBAL IMBALANCE OF THE HEALTH WORKFORCE AND INTERNATIONAL RECRUITMENT.....	255
I. Supply and demand of qualified nurses in the United States and the United Kingdom	255
II. National strategies adopted in the United States	266
III. Immigration policies in the United States	266
H-1C visa for nurses in disadvantaged areas	266
Commission on Graduates From Foreign Nursing Schools (CGFNS)	277

IV. National strategies adopted in the United Kingdom	277
V. Immigration Policies in the United Kingdom.....	288
 CHAPTER 5: REGIONAL AND GLOBAL INITIATIVES TO MANAGE MIGRATION OF NURSES	 30
Managed migration	300
Magnet hospital initiative	311
Year of the Caribbean Nurse	322
Commonwealth of Nations Code of Conduct.....	322
International Council of Nurses (ICN) position statement on international recruitment	333
 CHAPTER 6: ECONOMIC IMPLICATIONS: COSTS AND BENEFITS OF NURSE MIGRATION	 344
Measuring the Costs of Out-Migration	344
Remittances	366
 CHAPTER 7: SUMMARY CONCLUSIONS AND OUTLOOK.....	 377
Summary.....	377
Conclusions and recommended policies	388
Policies on the national level	388
Policies on the regional and international level	39
Outlook	40
 REFERENCES	 411

EMIGRATION OF NURSES FROM THE CARIBBEAN: CAUSES AND CONSEQUENCES FOR THE SOCIO-ECONOMIC WELFARE OF THE COUNTRY: TRINIDAD AND TOBAGO – A CASE STUDY

Introduction

Migration in the Caribbean has a long history. The slave trade in the eighteenth and nineteenth centuries caused the first major immigration waves into the region. After Emancipation in the early nineteenth century, agricultural workers from India were brought to Trinidad to fill in the gaps the abolishment of slavery had left in the labour force on the plantations. The end of slavery increased the demand for workers in the entire region and consequently more people began moving within the region in search of employment or better working conditions. In the twentieth century, the movement of labour to destinations outside the region increased, particularly due to close ties with the colonial powers. With the move towards independence in the 1960s and 1970s, chances to easily move to Europe decreased. However, other windows of opportunities to reach “greener pastures” in the developed world opened: the rising demand for highly qualified people in North America and the United Kingdom has been triggering a mass exodus of professionals over the last 50 years.

Based on the most recent estimates provided by the United Nations Population Division (United Nations, 2002) the Caribbean has lost more than five million people over the last 50 years. The present net-migration rate¹ for the Caribbean is one of the highest worldwide, however, with a great variation within the region.

Recent global and regional agreements supporting the free movement of professionals enhance these trends. The entry into force of the General Agreement on Trade in Services (GATS) in 1995 provides the framework for further liberalization of cross-border movements of professionals. The Caribbean Single Market and Economy (CSME) is currently implementing regulations for free cross-border travelling of professionals. Nurses holding a Caribbean Community (CARICOM) license² can practice their profession in virtually any member State desired and are even recognized to register with the Nursing Council in the United Kingdom. The Free Trade Area of the Americas (FTAA) framework also includes a chapter on services which discusses the cross-border movement of the skilled and trained.

Worldwide, large streams of qualified migrants leave their country and are accepting jobs as teachers, social workers or nurses in the United States or in the United Kingdom and other parts of the developed world. The largest numbers of such migrants are drawn from Asia, where

¹ *Net migration*: Net average number of migrants: the annual number of immigrants less the number of emigrants, including both citizens and non-citizens. *Net-migration rate*: The net number of migrants, divided by the average population of the receiving country. It is expressed as the net number of migrants per 1,000 population. Source: Population Division of the United Nations Secretariat, International Migration, Wallchart, 2002, ST/ESA/SER.A/219, Sales No. EO3.XIII.3

² Nurses in the Caribbean write a common final nursing examination referred to as the ‘Regional Nursing Examination’.

the Philippines and India are the main providers of health professionals or of highly qualified IT specialists. With steadily growing demands, the competition over these scarce qualifications is growing. Fast track immigration procedures for those possessing the required credentials are being implemented and immigration rules and regulations are amended to facilitate visa and green-card applications. Many employers and State authorities are paying hefty fees to those willing to move and to internationally operating recruitment agencies to quickly identify and hire the desperately required human resources which the domestic labour market cannot supply.

With the supply and demand gaps widening and the competition for skilled labour growing, increasingly smaller and more vulnerable countries are targeted by the international recruitment machinery. Ads are posted in local newspapers and recruitment drives launched directly targeting new graduates and increasingly the more senior and more experienced professionals in the desired areas of expertise.

The departure of the best affects the sending countries in many ways. For those with a surplus of labor, emigration provides access to employment which could not be offered at home. Moreover the inflow of remittances is often welcomed as a boost to the national economy and the enhancement of skills of return-migrants is considered by many as an important asset of migration.

However, smaller islands and developing countries like the Caribbean Small Island Developing States (SIDS) can barely cope with the negative consequences of the loss of their best. Deprived of their teachers and health professionals, many nations are no longer in a position to improve or even sustain the quantity and quality of public services delivered.

Last but not least, migration affects the individual as well as his immediate family network. Particularly stunning is the impact on the social and psychological well-being of children left behind by migrating parents. These children often suffer the loss of one or even both parents, while being cared for often in a rather unstable environment of older siblings, grandparents or other relatives or a combination of such arrangements³.

The present paper will examine the migration of nurses in the Caribbean SIDS over the last 50 years, focusing on the situation in Trinidad and Tobago. It will make an attempt to assess the scope of nurse migration by drawing on data available in Trinidad and Tobago as well as in the two main destination countries, the United States and the United Kingdom. The main push factors triggering this mass exodus in the homeland and the various counteracting strategies adopted will be presented. To capture the whole picture, the different pull factors in the receiving countries attracting foreign migrants will be analyzed. Since the emigration of the skilled is not a new phenomenon and its implications on the developing countries are becoming increasingly severe, various efforts have been undertaken at the regional, as well as at global level to address this increasing global imbalance and its implications and to find viable solutions for all parties concerned. The economic implications of the emigration of health professionals will be studied using a model currently developed by the World Health Organization (WHO). Last but not least,

³ The University of the West Indies has conducted a study on the impact migration on children: Adele Jones, Jacqueline Sharpe, Sogren Michele; (2003) Children of Migration, A Study of the Care Arrangements and Psycho-social Status of Children of Parents who have Migrated, St. Augustine, Trinidad and Tobago, W.I.

based on the findings of this analysis, policy recommendations will be formulated to be used as a guideline for concerned policy makers at various national and international levels.

Chapter 1

DATA AVAILABILITY AND DATA QUALITY

The collection of data on migration is one of the most difficult and tedious tasks demographic and social research has to accomplish. Even with the existence of immigration rules and regulations to control and track the movement of people, coherent and consistent data on migration is in most instances not available. Global estimates and projections on migration are published every two years by the United Nations Population Division (United Nations, 2002a). These data provide a general overview of migration stocks with no further breakdown for immigration and emigration. Further on, no global statistics are available on recurrent movements, return migration or on the socio-demographic background of those concerned.

People move legally and illegally and migrate from one country to another, quite often via a third country until they reach their final destination. Some move back and forth over a certain period of time until they stabilize their situation while others engage permanently in such a process. Whereas a certain part of the migrants stay over an extended period of time or will settle permanently abroad, others will only spend a couple of months or a few years at their destination before coming back and – possibly – leave again in the not too distant future.

Since no country has an established system to monitor in- and out-migrant flows coherently, various public administrative organs dealing with immigration are the primary source for such data. Since in most countries immigration is much more controlled and monitored than emigration, better and more accurate data are available on immigration than on emigration. Generally information on migration can be drawn from various registers, such as the national census bureaux, labour-force offices and other official sources dealing with visa applications, work-permits and professional registration. Other valuable data sources are population censuses, household surveys, for example, labour-force surveys and surveys of living conditions and special studies on the theme. Censuses and household surveys provide data on the migrant stock in a given country. Recurrent migration as well as out-migration of whole families or individuals with no further ties to the country of origin are not covered by censuses conducted in the country of origin. Censuses administered at the destination country do not capture the full picture either, since only those surveyed are captured, but not those who are illegally in the country. Only occasionally is information collected on the country of origin, the time spent in the host country, years worked in the profession and other related information. Data collection for a specific subgroup within the migrant population, such as nurses, is even more difficult since their absolute number (particularly when they come from small countries) is rather small and therefore quite often data at the country level are not provided. In addition, many data based on census as well as registration data often do not list nurses as a separate professional group, but they are included in the larger group of health professionals or ‘service providers’.

Additional sources need to be tapped to estimate migration data in the source country. For example, past and present nursing vacancy rates in hospitals, community health centers and other health facilities could serve as proxy-indicators for missing staff who might have left the country. However, these data may be inaccurate as well, since vacant posts can either be held by temporary employees, or, due to the lack of financial resources may not be intended to be filled

at all. At the destination country, professional bodies collect data on entrance exams to qualify for working visas or residence. Such registers are useful sources for data on selected professions. In the case of nurses and midwives, nursing and midwife councils are a reliable source for this type of information. However, various sources collect data for different administrative purposes and are therefore usually not compatible. For example, registration data cover only the qualified workforce that has registered, but do not provide any information on actual arrival in the country or if the person has actually taken up a position. Work-permit data or data on working visas or green-cards issued only provide information on those who became legally eligible for work and do not state if the person has actually moved to the country and started work. Various registers refer to different periods of time, for example, a calendar year versus an administrative year referring to a different 12-month time-span.

A growing share of aspirants who do not have the necessary credentials to qualify for legal access to the desired labour market abroad are pursuing other ways to enter. The increased demand for unskilled and semi-skilled labour will attract more undocumented and illegal migrants seeking access to the labour markets of the more developed world and thus an increase of the unskilled and quite often illegal workforce can be expected. Many un- or under-qualified health workers enter their destination country legally on a visitor's visa, overstay and seek employment in the private sector as caretakers of the elderly or children. Others overcome legal immigration hurdles by using the services of illegal immigration agencies and traffickers. Not much apart from anecdotal and individual case studies is known about the trafficking of health personnel. The movements of such migrants are much more difficult to monitor, since they are nowhere comprehensively captured and data available rely heavily on estimates based on case studies and data provided by border controls or the police.

Apart from the lack of adequate data, access to census and registration data at the sending as well as at the receiving country is often restricted either because of lack of resources to process the required data further or as a result of legal restrictions prohibiting the release of certain information.

Attempts to coordinate and streamline research on migration have been hampered by inconsistent concepts to define international migration (United Nations, 2002b). Basic criteria used to identify migrants are citizenship, residence, time or duration of stay, purpose of stay and place of birth. The most widely, but rather loosely defined, concept is that of residency; but also legal nationality is used as an identifying factor. However, data based only on the citizenship of a person will not capture naturalized migrants, which will lead to an undercount of the actual number of immigrants in any given country.

Given the outlined constraints and limitations in the availability of data, any assessment of the scope of migration as well as its impact on the sending as well as receiving countries will remain a challenge for all parties involved.

In the case of Trinidad and Tobago, as well as in most countries in the Caribbean, national data collection machineries are rather weak and thus the general lack of sound and timely demographic data has been a matter of serious concern over the last decades. Therefore

most national Central Statistical Offices (CSO) or any other governmental institutions will not be in a position to collect, analyze and disseminate coherent migration data in the near future.

I. Emigration data from the sending country

Nurses emigrating: 1960-1980

The earliest data available are drawn from a study conducted by the United Nations Institute for Training and Research (UNITAR) under the auspices of the Central Statistical Office in Trinidad and Tobago (CSO 1970). This study was conducted at a crucial point in the history of Trinidad and Tobago. Until the 1960s, Trinidad and Tobago was an immigration country with more people entering than leaving. In the 1960s, for the first time, the trend reversed and an increase in the emigration of its more qualified population mainly to the United Kingdom, but increasingly to the United States and Canada, became obvious.

The study states that, in spite of the requirement to serve a two-year compulsory period after graduation many nurses left the country right away. Of all students who had graduated over the five-year period 1960 – 1964, by 1969 almost 60% had emigrated, 73% had gone to the United States, 8% to the United Kingdom, 13% to Canada and 6% to other countries.

The following table provides a summary of the findings of the report:

Table 1
Distribution of resigned nurses by country of present residence (August 1969) and year of graduation

Year of graduation	Number of graduates	Emigrants (total)	Emigrants (%)	Destination					
				Abroad				Trinidad & Tobago	
				U.S.	U.K.	Can.	Other	Priv. and other.	Pract.
1960	64	39	61	32	3	4	-		3
1961	86	51	59	39	7	5	-		3
1962	107	66	62	49	1	14	2		2
1963	83	47	57	34	7	6	-		
1964	119	66	55	43	2	6	15		2
Total	459	269	59	197	20	35	17		10

Source: Central Statistical Office (1970), The Emigration of Professional, Supervisory, Middle-level and Skilled Manpower from Trinidad and Tobago 1962 – 1968 – Brain-Drain; Port of Spain, Trinidad and Tobago; page 28

Data drawn from a survey (Ministry of Health and Environment, 1980) conducted in the 1970s concluded that during the observed period 1976 - 1980 fewer nurses had left the country. Still, in total about one third of all graduates had actually resigned from their duties in the public health sector to take up a position abroad.

Table 2
Annual loss and gain of nurses
1976-1980

Year	Resignation	Emigration (as part of Resignation)	Retirement	Death	Total loss	No. Graduated	Net Gain
1976	15	2	1	0	16	100	84
1977	13	0	8	0	21	63	42
1978	8	0	9	1	18	92	74
1979	27	5	10	1	38	120	82
1980	34	2	20	6	60	113	53
Total	97	9	48	8	154	488	335

Source: Report on the Second Quantitative and Qualitative Survey of Nursing Needs and Resources 1980, Table 20, p.38

The simple mathematical exercise applied in the table above to calculate loss and gains by adding graduates and subtracting migrants does not provide the information necessary. An analysis based on a simple 'head-count' does not take into consideration the real loss of skills and expertise. An in-depth analysis of available skills and evident gaps would have been crucial to assess the magnitude of the loss of skills and to design special measures to address the problem at the very early stages of its emergence.

A look at the main factors depleting the nursing workforce clearly singles out retirement and resignation as the main causes. Both draw on the older and thus more experienced nurses. The increment in numbers of retiring nurses over the period observed is a clear hint at another emerging issue: ageing of the workforce. However, according to the data presented, resignation from the public health system in order to follow job opportunities abroad has been the major contributor to the emerging nursing crises. Since the rather realistic chance of finding more attractive and rewarding work abroad had been a major reason for resignation in the 1970s, it is assumed that the provided estimates for emigrating nurses are too low and most probably more nurses than accounted for have left the country in search of a better life abroad.

No data on the emigration of nurses are available for Trinidad and Tobago for the last 20 years. The most recent figures provided by the Ministry of Health indicate that 120 nurses had resigned or retired and a total of 179 nurses were recruited in 2002. However, more information about recent migration trends can be derived from data published in the United Kingdom and in the United States.

II. Data on migrants from the receiving countries

Data from the United Kingdom

Two major sources in the United Kingdom provide data on foreign nurses: The United Kingdom Nursing and Midwifery Council (NMC) and the Work Permits United Kingdom Office in the United Kingdom Home Office Immigration and Nationality Directorate.

The Nursing and Midwifery Council (NMC)

The NMC is the regulatory body for the nursing profession in the United Kingdom. Prior to working as a registered nurse or midwife in the country, registration with the NMC is mandatory⁴.

This register only accounts for qualified and licensed registered nurses and does not cover the unregistered unqualified workforce that is employed as nursing assistants or auxiliaries. The following data are recorded:

- New admissions to the register: the number of nurses from non-United Kingdom sources entering the register, recorded annually;
- Successful applications: the number of successful applications from non-United Kingdom countries to practise nursing in the United Kingdom;
- Total number of decisions made on applications: by the NMC.

However, there are limitations in using these data to monitor inflows into the United Kingdom, since the data record the registration, but do not provide any information whether the nurse has actually entered the United Kingdom and if she in fact has taken up employment as a nurse. Some double-counting is possible, since nurses might apply to more than one part of the register (a nurse who is also a qualified midwife may apply for registration as a midwife at the NMC register). Information concerning the country of initial training is collected, but this does not necessarily provide the information on the nationality of the nurse, which possibly causes some underreporting of nurses of certain nationalities if the country where the training was provided is not the country of origin. Those countries that provided training to foreign nurses will be over-reported.

Recent data on foreign nurses registered with the NMC

Statistics provided by the NMC (NMC, 2002) point to an enormous increase in the number of overseas-trained nurses and midwives registered over the last years. The 'top 20' list of the leading countries where nurses and midwives are being recruited is led by the Philippines, South Africa and Australia. On this list, the West Indies region is the eighth largest provider with 248 nurses for the year 2001/2002. Applicants from Trinidad and Tobago have been among those with the highest proportion of first-time acceptances in recent years.

⁴ Re-registration is mandatory every three years.

The following table gives an overview over the number of nurses from the Caribbean that has been registered with the NMC from 1998 - 2002.

Table 3
Nursing and Midwife Council (NMC) registration

West Indies			
1998/1999	1999/2000	2000/2001	2001/2002
221	425	261	248

Source: The Nursing and Midwifery Council (2002); Statistical Analysis of the Register
1 April 2001 to 31 March 2002; United Kingdom

Work Permits United Kingdom

All applicants from outside the United Kingdom who wish to take up employment in the country are required to obtain a work permit. Applications for a work permit need to be filed with the Work Permits United Kingdom Office in the Home Office Immigration and Nationality Directorate.

The following table presents an overview of the number of nurses and midwives from Trinidad and Tobago who have applied for work permits from 1995 to 2002.

Table 4
Work permit applications in the United Kingdom for nurses and midwives from Trinidad and Tobago between 1995 - 2002

Year	Nurses	Midwife
1995	233	30
1996	268	31
1997	239	36
1998	313	31
1999	498	38
2000	427	40
2001	362	31
2002	335	25

Source: Unpublished data, Work Permits United Kingdom, e-mail received on 14 April 2003

As is the case for registration data, until the year 2000 a clear upward trend in the numbers of work permit applications for nurses and midwives can be observed. After 2000,

fewer but constant numbers of nurses have applied for work-permits. The applications for the year 1999 to the year 2000 and from the year 2000 to 2001 decreased by 14% and 15%, respectively, which might be due to the impact of the adoption of the Code of Conduct by the Commonwealth of Nations (see chapter 5).

Data from both sources (the Council for Nursing and Midwifery (CNM) and Work Permit) are not fully compatible since permit data cover a calendar year whereas CNM data report on an annual cycle beginning 1 April and ending on 31 March. Also, permit data refer to the date when the individual became eligible to work in the United Kingdom whereas CNM data only indicate the year of registration. None of these data provide any information regarding if and when a person has actually started to work.

Data on migration from the United States

Capturing data on migration of nurses and midwives to the United States is a complex task since there is no central register to keep track of foreign nurses employed in the country. The main sources for data on foreign nurses in the United States are the registers of the Commission on Graduates of Foreign Nursing Schools (CGFNS) and the National Council of State Boards of Nursing (NCSBN). The CGFNS exam is a mandatory requirement to file an application for a working visa or a green card. It basically verifies a candidate's credentials to judge whether a foreign qualification is equivalent to what a United States nursing graduate has received. Most States require a nurse to pass the NCSBN licensure exam (NCLEX) in order to obtain a license to practice nursing in that State⁵.

Data collected by CGFNS and NCLEX provide information on how many foreign nurses took the exam, but no conclusion can be drawn if and when a successful candidate has taken up a job in the United States. However, the data can be used as indicators for the purpose of seeking work overseas. However, since it may take one to two years to actually complete the formal procedures required, even the intention to migrate can hardly be used as a proxy indicator to assess migration over a certain period of time.

The following table provides data on Registered Nurses (RN) and Licensed Practical or Vocational Nurses (LPN) who have taken the NCLEX exam in the years 1997 – 2000. Over the four years covered, 84 nurses from Trinidad and Tobago have taken the licensing exam and more than 50% of the candidates have passed the test at their first attempt.

⁵ For more information on CGFNS and NCSBN see chapter 5.

Table 5
Number of first-time candidates from Trinidad and Tobago taking the
NCLEX-RN or NCLEX-LPN exam

Candi- dates	1997		1998		1999		2000		1997-2000		1997- 2000	2000- 2001
	LPN	RN	LPN	RN	LPN	RN	LP N	RN	LPN	RN	Total	Total*
Examined	3	18	3	15	2	15	6	32	14	80	84	166
Passed	2	8	2	6	2	7	4	17	10	38	48	77
Passed %	67	44	67	40	100	47	67	53	71	48	57	46

Source: National Council of State Boards of Nursing Licensure and Examination Statistics, Annual Reports for the years 1997 – 2000 accessed on the internet <http://www.ncsbn.org> May 15, 2003

* Data provided by CGFNS e-mail communication 15 May 2003

According to figures provided by the Commission on Graduates of Foreign Nursing Schools, 17 nurses from Trinidad and Tobago have sat the CGFNS exam in the five years from 1998 to 2002 and 40% per cent (7) have actually passed the test.⁶

⁶ Unpublished data received from CGFNS by e-mail on 15 May 2003

Chapter 2

THE NURSING WORKFORCE IN TRINIDAD AND TOBAGO

I. Education and training of nurses in Trinidad and Tobago

Basic nursing training

Since 1919 the Ministry of Health and the Nursing Council have been offering apprenticeship programmes to provide basic nursing training.

In the mid-1980s it was found that the country had more trained nurses than the system could absorb and consequently the government decided to suspend basic nursing training in 1986. Already a few years later, in response to shifting health care needs and changing local and international trends, the development of a coherent and more formal and academic nursing education programme became a priority. This led to the establishment of the College of Nursing in 1990, which presently is a member institution within the College of Science and Technology and Applied Arts of Trinidad and Tobago (COSTAATT). The facility presently has the capacity to take in 90 students annually. This institute offers general as well as psychiatric nursing training at three locations in the country. These are the General Hospital in Port of Spain, the South Learning Center in San Fernando and the St. Ann's Learning Center at St. Ann's Hospital in Port of Spain. On successful completion of either of these programmes the graduate is awarded an Associate Degree in Science in General or Psychiatric Nursing.

In order to fill in the gaps resulting from the strong emigration flows of qualified nurses, the Ministry of Health in 2000 decided to resume the three-year apprenticeship programme.

The following tables present estimates on present and future nursing students (Table 1) and graduates (Table 2) trained at COSTAATT and through the apprenticeship programme from 1999 until 2008. Based on figures from the Ministry of Health, an estimated 1695 nursing students will have been enrolled in both programmes between 1999 and 2005 and an estimated total of 1779 students will have graduated between 2000 - 2008.

Table 6
Basic nursing student population 1999 – 2005

Institution	Year of Entry							Total
	1999	2000	2001	2002	2003	2004	2005	
College of Nursing, COSTAAT	158	126	90	100	150	300	300	1224
School of Nursing, MoH	-	120 (-9*)	-	180 50**	130 40***	-	-	471
Total	158	237	90	330	280	300	300	1695

Source: Ministry of Health, and Environment Nursing Division (2002a), An Analysis of Human Resources in Nursing/Midwifery 2000 – 2005, p.18, Port of Spain, Trinidad and Tobago

** Psychiatric nursing students

*** Certified Midwives

Table 7
Projected graduates 2000 – 2008

Institution	2001	2002	2003	2004	2005	2006	2007	2008	Total
College of Nursing, COSTAAT	84	158	126	90	100	150	300	300	1308
School of Nursing, MoH			111		230	130			471
<i>Total RN+RM</i>	84	158	237	90	330	280	300	300	1779

Source: Ministry of Health, Nursing Division (2002a), An Analysis of Human Resources in Nursing/ Midwifery 2000 – 2005, p.19, Port of Spain, Trinidad and Tobago

II. Advanced training for nurses

Post basic education certification programmes

In addition to administering the basic nursing education programme, the Ministry of Health also bears responsibility for conducting post-basic nursing education. These programmes are administered by the School of Advanced Nursing Education at the three major hospitals in the country.

The School of Advanced Nursing Education provides various post-basic certification programmes for registered nurses, which are district nursing, neonatal nursing, operating theatre nursing, community mental health, dialysis, midwifery, pediatric nursing, intensive-care nursing and trauma and emergency care. Two programmes are available for Enrolled Nursing Assistants

(ENA), which are training for scrub technician and home care nursing. ENAs can also participate in a midwife certification programme.

Advanced academic education

The University of the West Indies, Faculty of Education, offers a Certificate of Nursing Education/Administration and a Community Health Visitors training programme.

The establishment of a BSc Nursing Programme at the St. Augustine Campus at the University of the West Indies in Trinidad is currently being discussed. The degree is aimed at building on the foundation provided by the basic education programme to enhance and develop skills and knowledge applicable to present nursing practice, nursing education and nursing management. The programme intends to train 30 students per year as nurse practitioners/clinical nurse specialists, nurse educators and nurse managers.

Issues of critical concern in teaching

According to information provided by the Chief Nursing Officer at the Ministry of Health the current shortage of qualified teaching staff impacts on the quality of the training provided as well as on the number of students to be admitted. Out of 34 positions for nursing instructors, half were vacant in 2002 and the remaining posts were partly filled with temporary assignments. The situation for clinical instructors is even worse, since 80% out of 22 positions were vacant in 2002. As a result of a teaching staff shortage and inadequate classroom accommodation, less students than actually planned could register for nurse education in the years 1999 and in 2001.

Other critical constraints experienced by the teaching staff were:

- The slow appointments/promotions for teaching staff in the public service system;
- Continued low recognition and remuneration;
- Poor conditions of the teaching facilities and inadequate supplies and equipment;
- Limited library facilities and audiovisual aids;
- Limited opportunities for educational advancement of teaching staff.

The provision of qualified teachers in sufficient numbers as well as ensuring the supply of the material resources for teaching are prerequisites for achieving and maintaining high standards in education. Generally understaffed schools as well as the often observed lack of leadership and guidance provided to the students will further decrease the actual number of students trained and will negatively impact on the quality of the education provided.

Supply and demand in nursing

Data on vacancy rates in hospitals and health care centers for the year 2000 indicate an acute shortage of nurses since on average only every second nursing post is held by a professional nurse. The other half of the posts is either vacant or filled with retirees who came back to work on a part-time basis or with less qualified support staff. Important to note is that not all health care facilities in Trinidad and Tobago are affected in the same way. Generally, the

community health care facilities and the hospitals in San Fernando and in Scarborough are less strained than other facilities.

According to information furnished by the Ministry of Health, half to two thirds of all head nurses posts in the country were vacant in 2000, with the most severely affected hospitals being the Port of Spain General Hospital (68%), San Fernando General Hospital (64%) and the Caura Hospital with only less than a quarter of its head nurses posts actually filled (23%) in 2000.

Not much better is the situation regarding general nursing staff. The situation has been most acute in the North Western Regional Health Authority (NWRHA) region, where in the year 2000 on average about two thirds of all staff nursing posts were vacant. Of particular concern is the situation in the Caura Hospital, which experiences the most severe shortage of nurses with only a quarter of all nursing posts currently filled. According to the Ministry of Health, this is possibly due to the increased incidence of Tuberculosis (TB) and HIV/AIDS-related care needs in that region.

The overall situation at the community level seems to be less dramatic than in the hospitals. However, the overall 30% shortage is severely impacting the service delivery capacity in the district health facilities. With a third of all health visitor posts unfilled, services are mainly provided at community health facilities and only limited health visits to schools and to private homes can be undertaken. The factors mainly contributing to the shortage in the Community Health Service facilities are the severe shortage of nurses and midwives at the hospitals who can not be released for services in the communities, and the high attrition of staff as a result of retirement, emigration and death.

More recent data (Ministry of Health and Environment, 2002a) for the year 2002 indicate a slight improvement in the general staffing situation in hospitals, however, with an overall vacancy rate for all hospitals of approximately 40%.

The report suggests the following explanations for these slight improvements:

- Availability of College of Nursing graduates;
- Increased numbers of nursing assistants employed;
- Reassignment of certified midwives from maternity units to hospitals;
- Reduction of foreign recruitment of nurses as a result of international policies (Code of Conduct in the United Kingdom⁷) and the policy changes in the United States as a consequence of the events of 11 September 2001;
- Employment of additional PCAs (Patient Care Assistants);
- To a limited extent, employment of returnees and retirees;
- Payment of a retention allowance and an increase in salaries.

⁷ For more information on the Code of Conduct and other global strategies to curb nurse migration from the regions see chapter 5

The conditions of staff supply at the community level however did not improve. Trained community health staff were not released from the hospitals and an increasing numbers of nurses have been retiring.

To fully grasp the staffing needs in the public health sector, more detailed information on the staffing resources in the various departments and units of each facility is needed. Presently only data at the institutional level are collected and do not provide enough insight into the staffing needs at the micro-level of the various departments and units. The introduction of a modern human resources management system would make provision for enhanced and more efficient personnel planning and would allow for crisis prevention at earlier stages than simply ad hoc crisis management.

Future staffing needs

Efficient provision of qualitative health care services is dependent on the availability of qualified health care professionals. To this effect, the Chief Nursing Officer at the Ministry of Health projected the future staffing needs based on present vacancy rates and estimated future retirement and attrition rates. Present vacancies as well as projected retirement rates can be easier estimated whereas resignations (mostly due to migration) from the public service sector are more uncertain and thus difficult to project.

The following assumptions were made to forecast the future needs:

(a) About one sixth of the nursing personnel workforce (as of December 2001) at hospitals will have retired by 2005; and

(b) Ten per cent of the present nursing staff (as of December 2001) will have left the public health sector prior to retirement by 2005.

Based on these assumptions the following needs are projected for the year 2005.

Table 8
Projected demand for nursing personnel projected for 2005

Category of Staff	Total Staff (estimated)	Retirement	Vacancies Dec. 2001	10% Attrition	Total posts	Total Demand	Demand as % of total posts
Reg. Nurses/ Midwives	1450	234	1093	145	2543	1472	58
Certified Midwives	50	26	65	5	115	96	83
Health Visitors	100	41	53	10	63	104	68
District Nurses	80	9	17	8	25	34	35
Nurses Educators	50	7	20	5	25	32	46
Enrolled Nursing Ass.	1380	175	326	138	464	639	37
Nurses Aids	190	19	7	19	26	45	23
TOTAL	3300	511	1581	330	4881	2,422	50

Source: Ministry of Health, Nursing Division (2002a), An Analysis of Human Resources in Nursing/ Midwifery 2000-2005, Trinidad and Tobago, p. 17

Based on these assumptions, the table above gives an overview of the present staffing situation and the projected future needs. As indicated earlier thorough human resources planning demands, apart from a mere quantitative "head-count" a solid quantitative and qualitative assessment of the resources available. Based on such analyses, present and future staffing needs can be addressed and possible and sustainable solutions elaborated. Consequently the mathematical exercise to fill the 1472 vacant posts mainly with graduates from the national nursing schools, as suggested in the report, will not solve the problem, since the majority of the posts are vacant due to retirement and emigration, which both draw on more senior and experienced nurses. New graduates from basic training programmes cannot be expected to have the same capacities as nurses who have practised their profession over an extended period of time.

Implication of the staffing shortage on the performance of the public health system in Trinidad and Tobago

In spite of the fact that no systematic analysis of the impact of the staffing shortage of qualified nurses in the provision of primary health care has been conducted in Trinidad and Tobago, there is evidence that the loss of skilled health professionals has tremendous consequences:

(a) At the General Hospital in Port of Spain two wards in the Maternity and the Ophthalmology Department had to be merged recently.

(b) The Hospital in Sangre Grande is currently utilizing part-time staff to assist full-time staff in performing their duties. Young nurses who are currently undergoing operation-theater training will be used to support certified operation theatre nurses.

(c) The public health sector will increasingly draw on students from basic as well as advanced training to fill in the gaps.

(d) Various community maternity units which became operational in the 1980s had to be closed over the last five years due to staffing-shortages.

Chapter 3

PAST AND PRESENT GOVERNMENT POLICIES TO ADDRESS THE NURSING CRISIS

I. Problems identified and policies adopted in the 1960s

The UNITAR study (CSO, 1970) on the emerging brain-drain already identified the changing patterns in migration and the transition of the country from an immigration to an emigration country. For most of its history Trinidad and Tobago had been an immigration country. This changed in the early 1960s, when for the first time there were more departures than arrivals in the island. There was increased emigration among the more skilled sections of the population and the ensuing brain-drain in certain sectors had been recognized. Emigration of teachers, nurses and other professionals had been recognized as a major loss for the country. To understand the evolution of the present crisis in the nursing profession in Trinidad and Tobago, it is important to reflect on these events. The main findings of this survey conducted more than 30 years ago already identified the major problems in nursing in the public health system which are now culminating in the present nursing crisis.

Based on the findings of the study, the main arguments in favour of working abroad were higher salaries, better working conditions and generally more favourable conditions for further education and professional advancement. Also growing racial tensions and increased political instability at home in the 1960s supported such a decision.

Since the government opposed any idea of restricting the free movement of its people in search for a better life abroad, policies targeted to improve the overall work-environment were adopted. Salaries were increased and more advanced training institutionalized and efforts were made to retain nurses by enforcing the mandatory three-year compulsory service period. In order to provide immediate relief to the already overworked nurses, a number of foreign nurses were recruited.

The report states that these measures could not stop the long-term mass exodus of nurses and other health practitioners. It appeared that any actions, short of repressive measures would not suffice to counter the strong pull factors attracting people to the large rich countries in the North.

II. Problems identified and policies adopted in the 1970s and 1980s

The already quoted survey on nursing needs (Ministry of Health, 1980) conducted in the 1970s could identify areas where improvements had been made. More advanced education had been institutionalized and better pay and entitlement packages were offered. Based on The International Labour Organisation (ILO) recommendations, in 1974 the work-week was regulated and sick and compensatory leave for nightshifts had been introduced. To relieve nurses in hospitals and health centers, more nursing assistants were hired.

In spite of the achievements in selected areas, major weaknesses persisted and new problems, particularly the ageing of the workforce, had begun to emerge.

Ageing of the workforce

An alarming disproportion in the age-composition had been found. To prevent a crisis, it was recommended that the annual intake and output of nursing schools needed to be increased: while in 1965, 36% of the nurses were under 36 years of age, the percentage went down to less than 20% in the 1970s.

Human resource management

The increase in the numbers of staff has not been met with a similar increase in management positions. Thus supervision and monitoring of staff could not be provided as needed to ensure effective and quality services. Senior posts to absorb higher qualified nurses either from the country or nurses returning home had not been created as needed. Nurses who possessed advanced skills were appointed to posts and locations where their special skills were of little or no use.

Education and training

The improved student/teacher ratio over the years observed was due to the decreased intake of students and not due to increased resources allotted. More resources would have been needed to improve the overall teaching conditions to maintain the scheduled intake rates of new students and to guarantee continued provision of new nurses. The report further suggests that the inadequate teaching conditions could be cited as a reason for the relatively high student dropout rate of around 10%.

Benefits and pay

Although pay and benefit arrangements had been somewhat improved, generally the salary range of professional nurses was still rather low. It was recommended that salary ranges be established reflecting experience and skills and the actual work responsibilities.

Recognition of the profession

The report states the need to give nursing the 'long overdue' recognition for its role in health and to provide the national nursing bodies with direct access to the policy decision-making level. This would ensure that nursing will be able to contribute more effectively to the establishment of health policies and to improve the work relationships with other health professionals and policy makers at various levels.

Staff motivation and morale

In spite of improvements in selected aspects of nursing, it was found that the identified weaknesses of the system had continuously lowered the overall staff morale over the years. In some cases good intentions resulted in additional problems as, for example, the enhanced entitlements for leave introduced. More nurses on leave meant a decrease in the number of nurses available for patient care and consequently a heavier workload for the fewer nurses in the wards. Lack of career-opportunities and the failure to recognize experience and qualification as a basis for promotion contributed further to the frustration of nursing staff. Another negative aspect identified was a weak administrative system with no clearly defined accountability.

In spite of the continuing problems in management and supervision, it seems that in the early 1980s the working conditions had somewhat improved and the better payment schemes and revised benefits package became increasingly attractive to nurses in the country as well as abroad. The global economic recession in the 1980s and the decreased resources available for the public health sector in the developed countries possibly decreased the chances for nurses to find work abroad and thus made staying in the home country or even coming back an attractive alternative. This led to a situation where in the 1980s more nurses were available than the public health system could absorb. Consequently the government decided to suspend training of nurses in 1986.

III. Recent policies

Following a global initiative to reform the public health sector in many developing countries and to decentralize the administration of health care, Trinidad and Tobago embarked in 1994 on a comprehensive health sector reform programme. This resulted in the creation of five Regional Health Authorities (RHAs) as self-governing bodies accountable to the Ministry of Health. The new roles of the Ministry of Health now included guidance, policy formulation, planning, financing, monitoring and evaluation, while the RHAs were made directly responsible for health service delivery.

As a result of the health sector reform⁸, a new structure for the Ministry of Health was approved in 1999, and in the following year, the number of regional health authorities was reduced to four. The loss of qualified health professionals was identified as a major concern which needed to be addressed with utmost priority in the following areas:

- (a) Development of modern management systems within a decentralized model of health services;
- (b) Overhaul of the national training programme and addressing the need to retrain qualified staff;
- (c) Upgrading of the primary health care facilities countrywide to increase the range, quality and quantity of services offered.

⁸ More on health sector reform in: Health sector reform and reproductive health in Latin America and the Caribbean: Strengthening the links, Bulletin of the WHO, 2000, 78 (5))

IV. Strategic plan for nursing and midwifery 2002 - 2007

In line with the Health Sector Reform, the Strategic Plan for Nursing and Midwifery designed in 2002 by the Ministry of Health (Ministry of Health and Environment, 2002b) aims to address the main weaknesses in nursing and suggests strategies to improve the nursing environment in the country.

The main areas of concern outlined in the report are:

- Lack of infrastructure;
- Absence of autonomy in the management of nursing affairs;
- Lack of retention policies and programmes;
- Lack of professionalism;
- Need to improve quality in nursing education and practice;
- Staff loss due to external recruitment

To efficiently and effectively address the current staffing crisis in the public health sector and to improve the services rendered by public health facilities, the report suggests that the following critical areas need to be addressed and the outlined corrective measures put into place:

(a) The five-year strategic plan for nursing and midwifery adopted in 2002 aims to improve human resource management by establishing a system for identifying, monitoring and forecasting of the nursing and midwifery workforce. In particular, a nursing and midwifery human resources database and an automated workload management system is planned for 2004. It aims at further improving public service human resource management by establishing performance-based appraisal review systems and career development schemes.

(b) The plan promotes the development of national policies and plans to strengthen the nursing and midwifery profession by promoting the participation of nurses and midwives in the policy formulation, implementation and monitoring process and to advocate public-private partnerships in the formulation of national health policies.

(c) In order to provide adequate numbers of nurses, midwives and other nursing personnel with the competencies to meet the health care needs, the following initiatives are envisioned:

- (i) Restructuring of the nursing education system;
- (ii) Establishment of a post-basic academic education programme for nurses in collaboration with the University of the West Indies (Bachelor of Science Degree in Nursing);
- (iii) Strengthening educational institutional capacity through south-south cooperation and student exchange programmes;
- (iv) Increased funding for nursing/midwifery education;

- by:
- (v) Development of policies on recruitment of foreign nurses.
 - (d) Working conditions in hospitals and other health care facilities may be improved
 - (i) Ensuring the adequate and timely provision of basic equipment and supplies;
 - (ii) Institutionalization of the magnet hospital concept⁹.
 - (e) Improvement of remuneration and benefits for staff nurses by:
 - (i) Upgrading the remuneration package for nurses and midwives in the public health sector;
 - (ii) Providing additional remuneration for advanced education;
 - (iii) Providing allowances for evening and night shifts;
 - (iv) Introducing flexible working hours;
 - (v) Providing medical plans for nurses and midwives.
 - (f) Overhaul the nursing care delivery system at primary, secondary and tertiary levels based on the health sector reform. The main aspects targeted are:
 - (i) The development and enhancement of the leadership skills of nurses;
 - (ii) Assuring quality in the delivery of nursing and midwifery services;
 - (iii) Introducing new categories of staff to relieve nurses and midwives from allied duties (for example, dieticians to support meal preparation);
 - (iii) Promoting research to improve nursing and midwifery practice and influence health care policy;
 - (g) Develop strategies in nursing to facilitate the implementation of national plans on HIV/AIDS, Non-Communicable Chronic Diseases and mental health by:
 - (i) Providing information and education to nurses who are required to serve in these specific areas of health care;
 - (ii) Advocating the provision of supportive mechanisms for nursing staff affected by these diseases.

⁹ More on the magnet hospital initiative see Chapter 5

Apart from the strategies outlined in the Strategic Plan for Nursing and Midwifery two initiatives to address some of the difficulties under which nurses are currently performing their duties are currently being developed by the Chief Nursing Officer. The provision of professional counseling services to nurses in crisis situations is one of the ideas. A mentor system to provide guidance, particularly to younger nurses in the wards, is the second initiative currently explored.

V. The Health Services Quality Act

The draft version of the Health Services Quality Act (Ministry of Health and Environment, 2003), is currently being discussed by national policy makers and health professionals. Suggestions to improve the present human resources management system in the public health sector are being outlined in the chapter on ‘Model Regional Health Authority By-Laws, Part 7’:

(a) It is suggested that the Chief Executive Officer maintain a personnel management system to ensure personnel are competent to perform their respective duties. Written policies, procedures and performance standards need to be introduced.

(b) Grievance procedures need to be established to ensure good working relationships of an efficient and content workforce. Further it is suggested that a formal grievance procedure for health professionals be established, which should also include the provision of counselling services.

(c) There is a need for formal disciplinary policies and mechanisms for its implementation.

(d) To enhance staff participation in policy formulation and decision making, a structure is to be set up to allow members of staff to participate in the authorities planning, policy setting and decision making.

(e) To improve patient/client care, a quality improvement programme is to be designed, which should include an incident reporting system to identify problems, concerns, and opportunities for improvement of patient care. Each RHA should appoint a Quality Manager who will then be in charge of the quality improvement programme.

(f) Establishment of an Occupational Health and Safety Programme to ensure the provision of a healthy and safe working environment.

These are selected aspects identified to improve the quality of the health services currently rendered by the public health system. The implementation of the suggested policies and programmes however depends largely on the commitment of the policy makers and the key stakeholders at the implementation level. In addition to the commitment of the various layers of the health care machinery, the availability of the necessary resources, human and material, is crucial to successfully translate the suggested policies into strategic action plans.

Chapter 4

GLOBAL IMBALANCE OF THE HEALTH WORKFORCE AND INTERNATIONAL RECRUITMENT

I. Supply and demand of qualified nurses in the United States and the United Kingdom

The ageing of the workforce, declining enrolment ratios in nursing schools, concerns about working conditions and growing numbers of “burnt-out” senior nurses resigning from the job are contributing to the inability to meet the demands of staff in the public health sector in the developed and, increasingly, in the developing world. Low pay and little recognition of the profession as well as steadily increasing workloads for those remaining make it difficult to attract new staff to the profession and to retain those already on board. Consequently, high nurse turnover and increasing vacancy rates are affecting access to health care services. Many hospitals are in the process of merging units and understaffed units are being closed down. Certain treatments cannot be provided and waiting times for others increase considerably. Changing demographic and epidemiological conditions even further expand the demand for nursing services and thus increase the stress on those who are currently in the system. Nursing is becoming less attractive since more rewarding career opportunities have become available for women which, apart from better pay and better status, also make it easier to combine work and family life.

Supply and demand projections for nursing personnel in North America and in the United Kingdom show wide gaps which cannot be filled with the domestic supply of nurses available. For example, the Human Resources and Services Administration (HRSA) of the United States Department for Health and Human Services estimated the supply of registered nurses in the United States at 1.89 million while the demand was estimated at 2 million,¹⁰ a shortage of 110,000 or 6%. Present trends in the supply of registered nurses will not meet the anticipated demand, thus the shortage is expected to grow considerably over the next 10 – 20 years and will, if current trends continue, reach about 30% by the year 2020. The same report suggests that presently 30 States in the United States are estimated to experience a severe shortage of registered nurses. This shortage is projected to intensify over the next two decades with 44 States expected to lack the nursing resources needed by the year 2020.

Other data point into the same direction: According to American Hospital Association’s figures¹¹, 75% of all hospital personnel vacancies are for nurses and 126,000 nurses would have been needed in 2001 to fill the present vacancies in the United States hospitals. Figures released by the National Council of State Boards of Nursing clearly show that the number of first-time United.States-educated nursing school graduates who sat the National Council Licensing Examination for Registered Nurses (NCLEX-RN¹²) for all entry-level registered nurses,

¹⁰ US Department of Health and Human Services, (HRSA), July 2002, Projected Supply, Demand, and Shortages of Registered Nurses: 2002-2020, Washington

¹¹ TrendWatch, American Hospital Association, June 2001

¹² For more information on the NCLEX-RN exam see chapter 5.

decreased by 28.7% in the six years from 1995 to 2001. A total of 27,679 fewer candidates took this test in 2001 as compared with 1995. Projections from the United States Bureau of Labor Statistics published in November 2001 in its Monthly Labor Review show that more than one million new nurses will be needed by the year 2010.

Data from the United Kingdom suggest similar shortages. A survey¹³ conducted by the Office of Manpower in the United Kingdom in 2001 reported that employers in England and Wales had serious difficulties with the recruitment and retention of qualified nurses and midwives. International recruitment is considered a rather successful and cost-effective solution to these pressing shortages.

II. National strategies adopted in the United States

Numerous efforts have been undertaken to increase the attractiveness of the nursing profession. Various advocacy initiatives have been launched by different health care groups in the public and private sector to promote the nursing profession¹⁴.

Apart from strategies adopted to mobilize the national workforce, various policies are currently under review to attract foreign nurses to the United States labour market. Since the early 1990s the United States public health system has been depending on the recruitment of foreign nurses to solve the acute domestic nurse shortage and to be in a position to continue to provide efficient and reliable public health services. With the growing gap between domestic supply and demand, various efforts have been undertaken to draw on foreign-trained health professionals.

The following section explains specific immigration procedures for nurses. There are mainly two ways for a registered nurse to gain access to the United States labour market, either by applying for a temporary visa to work as a registered nurse in a disadvantaged area (H-1C Visa) or to sit exams to qualify for long-term or permanent residency.

III. Immigration policies in the United States

H-1C visa for nurses in disadvantaged areas

The Nursing Relief for Disadvantaged Areas Act of 1999 (NRDAA) allows qualifying hospitals to temporarily employ foreign workers (non-immigrants) as registered nurses for up to

¹³ Office of Manpower Economics annual survey (2001). Published in Review Body for Nursing Staff, Midwives, Health Visitors and Professionals Allied to Medicine Nineteenth Report, December, London.

¹⁴ One major initiative is the 'Campaign for Nursing's Future', a multimedia initiative to promote careers in nursing that includes paid TV commercials, a recruitment video, Web-sites and brochures launched by Johnson & Johnson in February 2002. The Government of the United States has introduced legislation to address the nursing shortage. The Nurse Reinvestment Act (HR 3487 and S 1864), was passed in December 2001 with the aim to attract more students to nursing by providing funding for scholarships and student loan programmes as well as offering grants for internships.

three years under H-1C visas. Only 500 H-1C visas can be issued each year during the four-year period of the H-1C program (2000-2004).

Commission on graduates from foreign nursing schools (CGFNS)

The CGFNS has been established in the United States in 1960 to assess graduates who received their nursing education outside the United States. The CGFNS analyses the education and licensure of an applicant earned outside the United States in terms of comparability to United States standards and expectations. Each applicant will have to pass the CGFNS Qualifying Exam of nursing knowledge to receive a certificate, which is accepted by United States immigration officials to qualify for certain occupational visas and for green-card applications.

In order to work in the public health system in the United States, almost all States require candidates for licensure to pass another test that measures the competencies needed to practice nursing in a given state. For this purpose, the NCSBN developed the NCLEX-RN as a tool to test candidates accordingly. This exam is based on a similar framework as the CGFNS, i.e. to assess competencies across all settings and their compatibility with domestic education programmes.

The nursing licensing exam is currently only administered in the United States and its overseas territories, which forces nurses to make costly trips to take this exam. In order to facilitate participation at the licensing exam, the NCSBN has recently decided to start offering the exam at overseas sites by October 2004.

As of 1 July 2002, Trinidad and Tobago has been granted 'Provisional Eligibility' for a period of 18 months. The quality of nursing education and the English language proficiency justify the country's preliminary designation with the consequence that a nurse who has graduated from a nursing programme in Trinidad and Tobago and has been licensed by the Nursing Council of Trinidad and Tobago, is eligible for expedited screening of her professional credentials and thus exempted from the formal certification process¹⁵. The CGFNS is currently reviewing the nursing training provided in Trinidad and Tobago and is expected to make a final decision as to whether the country should remain on the list of designated countries by the end of 2003.

IV. National strategies adopted in the United Kingdom

Since the early 1990s the Royal College of Nursing (RCN) has raised the issue of the nursing shortage in the country. However, faced with the dramatic consequences of this manpower shortage, the Government of the United Kingdom has launched a series of initiatives to increase the incentive for nursing and to retain qualified staff in the profession. The national health authorities have identified various areas for interventions, such as attracting more

¹⁵ Section 212 (a) (1) of the Immigration and Nationality Act, as added by Section 4 of Public Law 106-95 (Nov. 12, 1999) allows certain registered nurses from certain designated countries to avoid the formal certification process established by the law and instead obtain from CGFNS a 'certified statement' of their qualification (CGFNS Website accessed on 5 May 2003).

applicants to nursing education, encouraging returnees and improved career structures. Programmes to improve staff training and development as well as flexible working hours to allow nurses to combine work and family life have also been introduced.

However, national strategies alone seem do not seem to be adequate to reverse the current negative trend. None of these programmes has been successful in attracting and retaining a sufficient number of qualified nurses to maintain the national standard of public health services. Thus searching for nurses abroad has been seen as a reasonable and efficient solution to these pressing problems.

V. Immigration policies in the United Kingdom

The United Kingdom has been and still is an attractive country to live and to work. This is evidenced by the fact that at the end of the 1990s every sixth nurse who registered for work for the first time came from overseas. To enhance the inflow of foreign nurses, the United Kingdom has introduced facilitated immigration procedures. Generally all applicants from outside the United Kingdom (including the European Union/European Economic Area (EU/EEA) who wish to take up employment in the United Kingdom are required to obtain a work permit. However, the shortage of qualified and skilled resident workers in certain occupations has led to the adoption of a 'shortage category list' (which includes nurses and midwives). For all applicants with such a background simplified procedures to obtain a work permit have been put in place¹⁶. Caribbean nurses holding a CARICOM nursing license are generally accepted for registration without the need to undertake further training or supervised practice.

The Department of Health recognizes that international recruitment is a small, but essential and significant part of the various initiatives undertaken to build and maintain the national workforce to ensure that continuous high standards of health care can be provided. However, government officials are well aware of the negative impact outflows from developing countries can have on their already drained healthcare systems. Therefore the Department of Health and the Department for International Development work closely with developing countries to ensure that United Kingdom recruitment policies follow best practice¹⁷:

(a) There should be no National Health Services (NHS) advertising in or targeting of a developing country unless the government of that country formally agrees to such initiatives;

¹⁶ To qualify for a nursing work permit an individual is expected to have the following qualifications:

(a) A United Kingdom equivalent degree level qualification;

(b) For certain professions where the person has to be registered with a United Kingdom professional organisation, for example, doctors, dentists and nurses the person's registration number instead of statements from previous employers will be accepted. The Nursing and Midwifery Council (NMC) is the regulatory body for the nursing profession in the United Kingdom. Prior to start working as a registered nurse or midwife in the United Kingdom, registration with the NMC is mandatory.

Source: www.workpermits.gov.uk as accessed on 7 May 2003

¹⁷ Department of Health, (2001), Code of Practice for NHS Employers involved in International Recruitment, London,

(b) Recruitment from developing countries should only be undertaken as part of an intergovernmental cooperation agreement based on a 'Memorandum of Understanding' encouraging the exchange of health care personnel, healthcare information and guidelines.

(c) There is an understanding that employment in the NHS is likely to be in the form of a secondment for a specified period of education and training and clinical experience;

(d) Individual healthcare professionals volunteer themselves by personal application to be considered for employment in the United Kingdom;

(e) All international candidates should be fully informed of the requirements of the post for which they are applying and the exact geographical location of the workplace;

(f) NHS employers should ensure a fair selection and recruitment process.

The present situation and the future outlook do not suggest that either the United States or the United Kingdom will be able to provide the supply of nursing professional needed with the available domestic human resources. Being attractive destinations, both countries have various options to attract qualified health workers to supplement their national workforce. Facilitating immigration procedures for temporary and permanent residency to those interested is a rather attractive option for many desperate to escape dire working conditions, low salaries, political instability and poverty at home. Projected demand for qualified nurses and the forecasted gap between domestic supply and demand allows us to conclude that the United States and the United Kingdom will continue to recruit nurses from abroad and further facilitate easy immigration procedures for qualified health professionals.

Chapter 5

REGIONAL AND GLOBAL INITIATIVES TO MANAGE MIGRATION OF NURSES

The global imbalance in the health workforce is a major challenge for policy makers at the national, regional and global level. A balance needs to be established between an individual's right to free movement and the recognition of the great value in sharing of ideas and cultures and the negative impact the brain-drain has on the countries, which lose their qualified human resources to foreign recruitment.

The need to develop policies and strategies to manage international recruitment, to retain qualified health workers and to make the profession an attractive choice has been recognized and a number of initiatives have been launched. 'Managed migration' is the key word for efforts to retain nurses in the Caribbean, whereas countries overseas have been adopting ethical 'Codes of Conduct', which have been initiated by the Commonwealth Secretariat to refrain from recruiting from countries which already suffer a severe shortage of health professionals. However, the success of these various initiatives depends entirely on the continued commitment and sustainable partnerships of all stakeholders concerned at the national, regional and global level.

Managed migration

Experience in other sectors of the economy¹⁸ in responding to labour shortages in the United States and Canada show that properly managed migrant worker movements contribute to the economic and social development in both the sending and the receiving countries.

Based on the fact that the subregion has been losing its doctors and nurses, it was recognized that it would be better to manage migration than to simply allow recruiters to come in and to find the public health system with fewer nurses and other health professionals. In 2001 nursing leaders, national professional nursing associations, training institutions, government agencies and regional institutions in the Caribbean drew up a concept to retain competent nurses in the region and, at the same time, respect the right of professionals to choose where they wanted to live and work. 'Managed migration' was recommended as an approach to comprehensively address the nursing shortage in the subregion in the areas of recruitment, utilization, retention and succession planning. The following critical areas have been identified as needing immediate attention and improvement:

- Terms and conditions of recruitment;
- Education and training;
- Value of nursing;
- Utilization and deployment;
- Good governance;

¹⁸ Organized movement of labour, predominantly in the agricultural and service sectors to the United States and Canada, has provided mostly unskilled workers from Mexico and the Caribbean to meet the seasonal needs of employers in agriculture and in tourism when shortages of domestic workers have occurred.

- Policy on population
- Public health sector reform.

In April 2002 the Regional Nursing Body¹⁹ forwarded this proposal to the CARICOM Council of Human and Social Development (COHSOD) Ministers, which supported, endorsed and approved it. National health authorities endorsed the need for a strategy to plan for the emigration of a certain percentage of their health professionals. Innovative ways to allow migration on a rotating basis, where professionals would go away for a certain period of time and return to their country of origin should be explored.

It was noted that training is a very expensive component in human resources development and that the brain-drain represented a further drain on public finances. Therefore COHSOD strongly recommended the establishment of bilateral agreements with the countries, which recruit Caribbean professionals to seek financial support to train nurses for export.

At present the governments of the CARICOM member States are working on the translation and implementation of this endeavor at the national level.

Magnet hospital initiative

Worldwide efforts are undertaken to retain qualified nurses and other health professionals in the national health service institutions. One such endeavor is the 'Magnet Recognition Programme',²⁰ which was developed by the American Nurses Credentialing Center in 1994 to recognize health care centers that provide the very best in nursing care. This concept is now being adopted by other countries in the developed, as well as in the developing, world. In the framework of the Managed Migration programme in the Caribbean, the Pan American Health Organization Caribbean Programme Coordination Office (PAHO/CPC) has taken the lead to initiate similar activities in the subregion. At present, PAHO/CPC is exploring possibilities to establish partnerships between Magnet Hospitals in the United States and hospitals in the Caribbean. These partnerships could provide the framework for staff exchange programmes to provide opportunities for continuous learning, skills development and enhancement of professional nursing management.

The overall objectives of the Magnet Recognition Programme are:

- (a) To recognize nursing services that utilize the national standards to build programmes of nursing excellence;

¹⁹ The Regional Nursing Body (RNB) comprises Chief Nursing Officers from each CARICOM country and is accountable to the Caribbean Health Ministers Conference. The RNB is attached to the Health Section of the CARICOM Secretariat in Guyana. One of the key aims of the RNB is to set and maintain standards of nursing education in each country through regional cooperation. It also aims to ensure that each country has a sufficient number of adequately trained and educated nursing personnel, to meet the needs of the national health care system.

²⁰ The Magnet Recognition Programme is a formal appraisal process for which the applicant hospital provides documentation and evidence that support and verify the implementation of the global standards for nursing administrators. The applying hospital must meet a set of selection criteria to become eligible for the evaluation process.

- (b) To promote quality in a milieu that supports professional nursing practice;
- (c) To provide a vehicle for the dissemination of successful nursing practices and strategies among health care organizations utilizing the services of registered professional nurses;
- (d) To promote positive patient outcomes.

Research has shown that magnet designation enhances the quality of nursing care, increases staff morale, attracts high quality physicians and specialists, reinforces positive collaborative relationships and improves patient quality outcome. Further on, 'magnet hospitals' benefit from reduced costs associated with higher retention and lower staff turn-over rates. However, since this is a rather expensive and time-consuming assessment process it might be an obstacle for developing countries which are already drained of their scarce resources.

Owing to the lack of resources, only three countries and territories in the Caribbean (Jamaica, St. Kitts and Nevis and the British Virgin Islands) have so far expressed an interest in such an assessment process.

Year of the Caribbean Nurse

The Year of the Caribbean Nurse 'Nurses Lighting the Way' has been launched as a collaborative effort by the Regional Nursing Body (RNB), Lillian Carter Center for International Nursing and the PAHO/CPC Office in May 2003 in Saint Vincent and the Grenadines. Over the next 12 months all islands in the Caribbean are expected to participate in this effort by organizing various national activities to support and market nursing in the region. To support this campaign, Johnson and Johnson has financed the production of a video on nursing in the Caribbean which will be used as a tool to promote the profession. Trinidad and Tobago plans to conduct several events in the National Nursing Week scheduled for the end of October 2003.

Commonwealth of Nations Code of Conduct

While it is crucial to acknowledge an individual's right to move freely and to work anywhere he or she likes to, it is also important to protect the interest of the public health systems in the poorer countries. A number of internationally recruiting countries has therefore put forward strategies to limit recruitment of health professionals from countries that are the most severely affected by this shortage.

In 1999 the Department of Health in the United Kingdom issued guidelines on 'ethical' international recruitment practices, which provide an outline for the international recruitment of health workers taking into account the potential impact of such recruitment on services in the source country. These guidelines, referred to as "The Commonwealth Code of Practice for the International Recruitment of Health Workers" were prepared by the Commonwealth Secretariat at the specific request of the Ministers of Health of its member countries. However, they do not advocate limiting or hindering the freedom of individual health professionals to choose where they wish to work but intend to discourage recruitment of health workers from countries which

are themselves experiencing severe shortages, such as South Africa and the Caribbean. The 'Code of Conduct' promotes transparency, fairness and mutuality among the member States as well as between recruits and recruiters. However, one main limitation of these guidelines is the fact that they do not cover private sector recruitment agencies and employers. Global data published by the Nursing and Midwifery Council (NMC) for the years 1998-2001 suggest that this initiative might have had some temporary effect in reducing recruitment from these countries, but that enforced recruitment took place in other developing countries. More recent figures show that this impact was only transitory since these countries have again been targeted for recruitment in the years after.

International Council of Nurses (ICN) position statement on international recruitment

At the global level, the International Council of Nurses²¹ (ICN) has adopted a position statement calling for a "regulated recruitment process based on ethical principles that guide informed decision-making and reinforce sound employment policies on the part of governments, employers and nurses, thus supporting fair and cost-effective recruitment and retention practices"²². While the ICN recognizes the right of an individual nurse to migrate and work anywhere she/he chooses, it also acknowledges the adverse impact of a mass-exodus on the domestic healthcare service provision of that country. The ICN supports calls for an ethical framework for nurse recruitment providing guiding principals for international recruitment of nurses. To develop such a framework, the following aspects need to be taken into consideration by all parties involved:

- Effective human resources planning and development;
- Credible nursing regulation;
- Access to full employment;
- Freedom of movement;
- Freedom from discrimination;
- Good faith contracting;
- Equal pay for work of equal value;
- Access to grievance procedures;
- Safe work environment;
- Effective orientation/mentoring/supervision;
- Employment trial periods;
- Freedom of association;
- Regulation of recruitment.

The ICN advocates the development and systematic application of such a regulatory framework which will benefit all parties concerned.

²¹ The ICN is a federation of 124 national nurses' associations representing millions of nurses worldwide. Since 1899 the ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally. Website: www.inn.ch

²² ICN, 2001: Position Statement – Ethical Nurse Recruitment, accessed on the internet: www.icn.ch/psrecruit01.htm as of 8. May 2003.

Chapter 6

ECONOMIC IMPLICATIONS: COSTS AND BENEFITS OF NURSE MIGRATION

Measuring the costs of out-migration

To assess the exact impact of the loss of nurses on the national budget is extremely difficult, since various costs need to be taken into consideration and data available are weak. Further no set of indicators to monitor these losses has as yet been established. The costs vary from direct losses such as training expenses to indirect costs, like the decrease of the quantity and quality of services delivered to patients and consequently the loss of productivity for the national economy.

In an effort to assess costs of out-migration of health care professionals the WHO is currently supporting a study in Ghana²³. It is hoped that the findings of this research will provide a model to be used by other countries in the future.

²³ Project Proposal: Measuring the costs of out-migration of health care personnel in Ghana. Received via e-mail from WHO on 9 May 9, 2003

The following aspects need to be taken into consideration when developing such a model:

Table 9
Summary of costs of out-migration as they are experienced

Investment or Benefits Side	Where	Cost or Benefit	Indicators
Investment cost	Government	Budgetary cost of training	Training cost by category of staff for reference year
	Trainee/ Family	Fees and support cost	Reported payments by families
Benefits lost/current costs	Remaining staff	Overload and exhaustion	Reported probability of leaving
		Frustration and loss of morale	Sickness rates, decline in probity
	Health care system	Loss of outputs	Lower service levels: e.g. routine surgery, supervised deliveries
		Loss of quality	Higher levels of complications, higher fatality rates, loss of preventive activity e.g. immunization
	Patients and Community	Loss of Access	Rising exclusion when ill
		Loss of time	Higher waiting times
		Higher mortality	Higher death rates from lack of service delivery or delay
		Higher morbidity	Higher morbidity from untreated complaints and loss of prevention
Benefits gained	Doctor or nurse/ family	Remittances	Level of remittances
		Skills and networking	Reported skills of returners
	Health care system	Professional upgrading	Reported skills of returners compared to leavers

Source: Biritwum, R., Mackintosh, M.; (2003), Project Proposal: Measuring the costs of out-migration of health care personnel, Geneva, p.5

The model attempts to integrate various dimensions of direct as well as indirect costs and benefits can be of monetary as well as of non-monetary nature. The main aspects to be integrated into the model are:

- The monetary value of loss of training and leadership;
- The monetary value of job experience and seniority;
- The financial impact of higher morbidity and mortality rates due to understaffing on the domestic economy in terms of lost productivity and investments;
- Search and recruitment cost for foreign nurses to fill in the gaps;
- Higher costs encountered by patients who seek to buy services from the private sector;
- Increased efficiency of the health care system due to professional upgrading of returning migrants.

Not much is known about the financial implications of the brain drain on the health sector in Trinidad and Tobago. The only estimates available are data from the Ministry of Human Development and Planning and the regional PAHO office. According to the Ministry of Human Development and Planning currently a monthly stipend is granted to all enrolled students, which is at present (2003) TT\$800 for the first and second year and TT\$1,200 for students in the third year of their studies. PAHO estimates the total loss of government investments to educate nurses to the basic level for the whole subregion to be about US\$16.7 million per year.

Remittances

Remittances play a vital role in most countries with a considerable proportion of their population living overseas. Contributions from family members abroad provide vital support to families and whole communities and are quite often an essential contribution to local community development. Apart from the direct impact on the wellbeing of left behind family members' remittances constitute a considerable share of a country's national Gross Domestic Product (GDP). This is particularly the case for Haiti, Jamaica and the Dominican Republic, the three countries in the region, which receive some of the highest worldwide remittance transfers in relation to their national GDP. Thus remittances constitute 25% in Haiti, , 15% in Jamaica and 10% of the annual GDP (2001 GDP)²⁴ in the case of the Dominican Republic. Remittance flows to Trinidad and Tobago are considerably lower than those received by several other countries in the region as mentioned above.

Although data on remittances are available for most countries, they are rarely broken down by country of origin nor do they provide additional information on the remitter. More research is necessary to assess the scope of remittances to better understand their role as a possible incentive for emigration. Remittances can be monetary and in kind, which makes a complete assessment of the flows even more difficult. Quite often they are not transferred through the regular banking system, but sent in cash and kind through family members and friends traveling home.

²⁴ Source: International Monetary Fund (IMF) Balance of Payment Statistics (2001)

Chapter 7

SUMMARY, CONCLUSIONS AND OUTLOOK

Summary

The analysis of the nursing situation in Trinidad and Tobago has shown that the present nursing crisis has been caused over several decades by a variety of push and pull-factors which originate inside and outside the country. Although no coherent analysis of the departure of nurses from Trinidad and Tobago since its beginning is available, this study can identify a number of critical aspects which have been contributing to the present crisis of nursing in the public health system.

A general weakness in the Caribbean is the lack of timely and reliable data. Particularly difficult has been the task of gathering information on migrating nurses from various sources in the home and destination country. Data collection systems are weak and the available data do not allow for further in-depth analysis of the current nursing crises. No systematic monitoring of the in- and outflow of migrants has been established and only scattered information is available on emigration of nurses. No data are available on return migration, which would be essential to systematically trace return and recurrent migrant flows. Also no data have been collected to analyze the outflow of nurses over the past 20 years. The lack of a monitoring tool is a significant weakness for human resources planners, since, without the knowledge of the qualifications lost, sound human resources planning is almost an impossible task to accomplish.

Data from the early 1970s already point at the main weaknesses of the public health system, which would have needed immediate coherent policy responses and critical political commitment to avert the future crisis. Over the years some efforts were initiated to improve the situation. It is assumed that the implementation of selected policies along with the worldwide economic recession in the 1980s seems to have slowed down global international recruitment. The world-wide economic boom in the 1990s, with growing funds available to public administrations in the North, along with the growing awareness of the growing shortage of nurses in the developed countries possibly created an increasingly favorable environment for enhanced international recruitment of nurses. International initiatives to control recruitment from already drained countries seem to have had only a temporary impact, since international recruitment also from already brain-drained countries has resumed and fast track immigration procedures have been put in place in the United States and the United Kingdom.

In summary, the main push-factors consistently listed in all studies and analysis conducted over the last 50 years are:

- Inadequate remuneration and benefits;
- Unfavorable working conditions;
- Lack of management and leadership;
- Insufficient training and professional development;
- Insufficient career-perspectives;

- Under-utilization of acquired skills;
- Burn-out due to increased workload as a consequence of resignations;
- Lack of recognition of profession

Similarly, with the growing nurse shortage in the United States and in the United Kingdom, the pull factors already identified in the early 1960 have become stronger over the past decades:

- Attractive payments and benefits;
- Modern human resources management;
- Professional work-environment;
- Possibility of permanent residency in the receiving country (Green-card in the United States);
- Financial support for registration and immigration procedures provided by foreign employers;
- Supportive network of family and friends;
- Opportunities for professional development and career advancement;
- Professional Recognition;
- Improved quality of life for self and family.

Conclusions and recommended policies

Policies at the national level

The main policy recommendations to be considered by the national government are based on a set of recommendations designed by WHO (2001) to address the current global nursing crisis:

- Strengthen national health policies, plans and systems;
- Establish comprehensive health workforce planning that will ensure that the nursing and midwifery human resources can meet the actual demands for services;
- Engaging in dialogue with internal and external entities to seek solutions to the low levels of remuneration and strengthen the incentives for effective recruitment, development and retention;
- Identify priority areas in which solid evidence is needed to inform national health policy makers and invest in systematic data collection, analysis and dissemination systems for best practices;
- Increase the opportunities to build leadership for nurses and midwives and strengthen their involvement in management of the health system and in health policy development and the decision-making process;
- Set up a national steering committee of crucial stakeholders, such as national nursing representatives, to develop a comprehensive strategic plan;
- Provide opportunities for professional growth and development supportive work environments and compensation commensurate with roles and responsibilities;
- Enforce bonding, also for graduates from higher-level programmes;

- Protection of particularly young and desperate nurses from unscrupulous recruitment agencies that take advantage of uninformed nurses. A national clearing house for international recruiters needs to be set up and a body that regulates and/or monitors the contents of contracts offered needs to be designated;
- Develop a national action plan in collaboration with all important stakeholders in the public and private sector as well as with the support of international and regional organizations;
- Since nurses play a crucial role in caring for our beneficiaries, the issue of nurse staffing needs to be dealt with the utmost priority by concerned governmental authorities.

Policies on the regional and international recruitment level

More collaboration and coordination is needed with the main absorbing countries and their national machineries. A properly structured partnership approach between the developed and the developing world could result in increased staffing for developing countries' health systems while at the same time facilitating subsequent recruitment of paramedical personnel to the developed world.

- Increased collaboration of the countries within the subregion and the region is necessary to further implement already existing mechanisms, such as 'Managed Migration' in the Caribbean.
- More collaboration is needed between the recruiting and the source country to cover the costs of basic and advanced nursing training. Bilateral agreements on cost-sharing arrangements need to be put into place. Industrialized countries must recognize their responsibility to provide financial assistance to developing countries to train nursing staff, since many will ultimately work in the more developed world.
- More awareness of the impact of the brain drain on the well-being of SIDS caused by the departure of even small numbers of health professionals is needed on the part of the recruiting countries.
- Global initiatives to guide international recruitment of nurses, such as the 'Code of Conduct' adopted by the Commonwealth of Nations provide ethical guidance for international recruitment. These guidelines should be applied more strictly and should also address private sector recruitment activities.

To address this eminent shortage of nurses and to improve the capacity to deliver health services throughout the public health system, the interests of various stakeholders at the national, regional and international level need to be taken into consideration. The international recruitment and placement of nurses and other health professionals is a fairly economic process, which inflicts costs on the sending as well as the receiving countries. Presumably only such approaches which integrate the differing interests of all stakeholders will create a win-win situation for all parties concerned and will be sustainable in the long term. However, various measures could be adopted at the national level in both the sending and receiving countries to address the scarcity of health workers at home. Other initiatives, for example the collaborative design of a framework

for a structured partnership approach involving both developed and developing countries equally, could be laid out in discussions between a sending and receiving country. International agreements involving multiple stakeholders, including the various international organizations and negotiation-machineries, could provide the framework for regional and bilateral agreements. The credibility of these approaches, their strength and universality will directly depend on the political will of health sector stakeholders at all levels.

Outlook

The need to address the present nursing crisis is crucial since with the ageing of the population and emerging HIV/AIDS crisis the demand for more nursing care will increase considerably in the near future. Today every tenth person in Trinidad and Tobago is 60 years and older and in about 20 years according to projections every fifth person will belong to this age group. The projected infection rates for HIV/AIDS are soaring. Based on estimates from UNAIDS (UNAIDS/WHO, 2002) currently about 3% of the population of Trinidad and Tobago is HIV/AIDS positive with rapidly growing infection rates projected.

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