Exporting Nurses: A Global Incentive for Local Change

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The disastrous tsunami on Boxing Day 2004 focused world attention on Indonesia. Humanitarian aid in the form of immediate expert assistance was mobilized and millions of dollars of foreign currency have been pledged to support the overwhelming task of reconstruction. The sheer enormity of the task ahead of the Indonesian people has perhaps highlighted to the world the need for human resource development – a need that is one of the priorities of the Indonesian government and a particular challenge for the Ministry of Health in its critical contribution to the health and welfare of the Indonesian people. This paper explores the tension between quantity and quality of nursing human resources and identifies the potential domestic benefits of a Ministry of Health human resource development focus on preparing nurses for the global workforce that at face value appears counterproductive to improving local health service delivery.

Background

The Republic of Indonesia is located in Southeast Asia and is home to 220 million people inhabiting 6,000 of the 17,000 islands that form an archipelago straddling the equator. The Ministry of Health is responsible for overseeing the nation’s public and private health care system and developing, implementing and monitoring policies to ensure health service delivery. Despite a decrease in the poverty index and improved under-five mortality rate, a rising incidence of tuberculosis, HIV/AIDS, sexually transmitted infections, malaria, dengue hemorrhagic fever, heart disease, and diabetes and a maternal death rate of 307 per 100,000 pregnancies contribute to poor overall performance in health and welfare indices. Accordingly, the Ministry faces significant challenges in providing health care services to the world’s fourth largest population.

Factors Conducive to Nurse Migration

Given the increasing foreign debt in the wake of the Asian financial crisis, the Indonesian Department of Manpower and Transmigration set a target of facilitating the placement of 2,350,000 workers abroad as part of its strategic plan for 2001 – 2004, a figure considerably higher than the 662,460 new employment
opportunities it hoped to create domestically.\textsuperscript{7} In the context of industrialized countries increasingly turning to international recruitment to solve nursing shortages,\textsuperscript{8,9} the Ministry of Health is expected to implement appropriate policies and initiatives for education and training to specifically facilitate international recognition for nurses to migrate to specific destination countries.\textsuperscript{10}

The ethics of exporting nurses from developing to developed countries, however, is an issue that has been subject to considerable debate.\textsuperscript{11,12,13,9} Exporting nurses can contribute significantly to economic development in source countries by reducing domestic unemployment and generating foreign income in the form of remittances from exported workers.\textsuperscript{14} For example, Pacquiao\textsuperscript{15} reports that Filipinos living abroad sent home $7.6 billion in 2003. Another potential benefit to source countries is the positive contribution of enhanced skills and knowledge that returning migrant nurses can make.\textsuperscript{16, 17}

However, this rarely occurs, as permanent migration to developed countries is the norm for migrant nurses from developing countries.\textsuperscript{18} Therefore, one of the most worrying problems relating to migration from developed to developing countries is not just the volume of nurses leaving the country but also the quality of the professionals who leave. Loss of such nurses from developing countries results in even fewer skilled nurses, increases care demands on the nurses who remain, and leads to the further deterioration of already inadequate domestic health care systems.\textsuperscript{19,20,9} In Indonesia, less than 30\% of the population currently accesses public health services,\textsuperscript{21} and only 66\% of births are attended by skilled health personnel.\textsuperscript{1} Therefore the deliberate government policy to export skilled health workers appears opposed to improving the domestic health care system.

Ironically, it is one of the strategies designed to improve the health outcomes of the domestic population that has created the stimulus for Indonesia to consider exporting nurses as a potential income source. With only 34.8 nurses per 100,000 people\textsuperscript{1} in 2000, compared to 870 nurses per 100,000 people in the UK,\textsuperscript{23} increasing the number of nurses is seen as critical to improving health outcomes and improving the quality of health services in Indonesia. To this end the Ministry of Health set a goal of 117 nurses per 100,000 people to be achieved by 2010.\textsuperscript{10} The primary mechanism for achieving this goal was to encourage the participation of private educational providers in delivering pre-service (undergraduate) nursing education.

In recognition of the concomitant need to improve the quality of nursing personnel, the Ministry introduced a National Curriculum for standardized diploma level (D3) pre-service nursing education\textsuperscript{13} in 1999. This curriculum replaced School Health Nursing (SPK) training that consisted of some nursing subjects taught within the final two years of high school. D3 nursing education comprises theoretical and practical subjects conducted across six semesters (3 years) for school leavers and over four semesters for SPK nurses to upgrade their qualifications. English language and computer studies are included in the theoretical program. The practical component consists of laboratory experiences and field experiences (in hospitals and primary health settings). Due to the weighing of the theoretical and practical components, graduation is determined by achieving a pass in the theoretical examination alone.

While developed countries have made little headway in addressing the shortfall of nurses,\textsuperscript{13} the same cannot be said of Indonesia. The introduction of private educational providers was a resounding success in terms of overcom-
ing the numbers deficit. By 2002, there were 61,885 student nurses attending programs in 444 educational institutions: 196 (44%) government owned and 248 (56%) privately owned.24 Now in 2005, the number of institutions has increased to 630 producing between 20 and 23,000 graduates per year, a figure that, when compared to the goal for 2010, represents an on-paper surplus of 16,670 graduates per year for the next seven years.25 The real surplus at present is unknown, but with health spending at only 3% of the total development budget (or 1.8% of Gross Domestic Product)1 the resulting zero growth in government employment bodes poorly for graduates, so much so that employment prospects for graduates are thought to be as low as 10% in some regions.26 Not surprisingly, the combined problems of unemployment and servicing an ever increasing foreign debt are strong motivators for the manpower division within the Indonesian Ministry of Health to increasingly look towards the option of assisted migration for employing surplus graduates of the diploma level nursing programs.10

Factors Limiting Participation in the Global Workforce

For exporting nurses to be a viable option, however, three important conditions need to be met. Firstly, there needs to be a market; secondly, there needs to be a willing workforce to export; and thirdly, the quality of the willing workforce needs to meet the demands of the destination country. There is ample evidence that there is a market for foreign born graduates in the UK, the US and Canada.13 Moreover, in the current political climate, Indonesia with its predominantly Muslim population may be particularly attractive to the Arab states as a source country.27 Similarly, the generic “push factors” for migration, including poor employment prospects, low standards of living and high risks of occupationally acquired infectious diseases,28,29 all exist in Indonesia. However, the current driving forces leading to the surplus of nurses do not necessarily suggest that nursing graduates are of the required quality for export.

While the goal of improving the number of nurses has been overwhelmingly achieved, desired improvements in the quality of the graduates have not followed.24,30 In particular, graduates of the D3 program struggle to meet minimum standards of clinical competence grounded in evidence-based frameworks.26,31,32 This paper reports on a collaborative initiative between the WHO and the National Ministry of Health that occurred in 2004. The aim of the initiative was firstly to identify the factors that have contributed to deficits in clinical competence, and secondly to develop a strategic action plan to address the identified problems and improve the clinical component of D3 education.

Phase 1– Identifying Local Factors Limiting Participation in the Global Workforce

Empirical data for the first phase of the project was collected and analyzed by the author, who has worked on capacity building projects with the Indonesian Central and Provincial Ministries of Health over the past five years. Workforce and education statistics and evaluation reports relating to educational outcomes and clinical performance indicators were reviewed then interviews with 31 key stakeholders were conducted. The interview process began with a focus group contain-
ing representatives from five different divisions within the Ministry of Health involved in nursing education and health workforce planning, the national nursing and midwifery professional organization, and local and international coordinators of national nursing capacity building projects. The head and three sub-heads of Pusdiknakas (the pre-service education division within the Ministry of Health) who had participated in the focus group then participated in individual interviews to probe and clarify the focus group data. The author’s bilingual capacity and knowledge of the local context were augmented during data collection and analysis by a research advisory group consisting of five senior lecturers from Ministry of Health D3 academies.

Four critical interdependent problems relating to the clinical component of D3 nursing education were identified from the data: an overwhelming number of students competing for field practice experiences; laboratory experiences failing to compensate for the lack of context specific learning; clinical experiences (when available) focusing on skill acquisition, as opposed to the integration of theoretical knowledge and evidence-based practice; and the few consequences facing providers who fail to facilitate technical proficiency in a framework of evidence-based practice. Each of these problems is described below.

The burgeoning number of educational institutions providing D3 education means that an overwhelming number of students require clinical experience at any one time. In the context of a limited number of clinical sites with low bed occupancy rates, this situation has resulted in student-patient ratios that are not conducive to students gaining “hands on” experience during clinical placements. For example, in the academic year of 2002/2003 there were 61,885 nursing students competing for experience in 1,020 public and private hospitals. Participants reported that having fifty students in a ward with twenty patients was not uncommon. Moreover, the number of students requiring clinical experience at any one time far exceeds the supervision available by experienced clinicians. Participants reported that it is not uncommon for there to be as few as three graduate nurses available to provide supervision on the same ward with fifty students. Therefore, in addition to the student-patient ratio not being conducive to “hands on” clinical practice, the student-supervisor ratio does not permit levels of supervision appropriate for skill acquisition. Accordingly, there is little opportunity for the majority of students to engage in direct patient care to develop clinical competence.

Laboratory-based hands on experience included in the D3 program, however, does not compensate for the lack of context-specific clinical learning for development of practical skills. According to participants, the laboratories located in academies have little resemblance to clinical sites. The teacher-centered learning style precludes interactive skill development opportunities for students, and the teaching staff have limited clinical experiences, some having never practiced following graduation. Therefore, while laboratory experiences may afford students opportunities to undertake “hands on practice,” the instruction that they are receiving is at best outdated, and at worst taught by someone with no more experience than the students themselves.

The alternatives of conducting such experiences in laboratories in the hospital or of clinical personnel contributing to the laboratory sessions in the academies are severely hampered by the shortage of appropriately qualified clinical personnel. Approximately 75% of nurses providing clinical care and student supervision
are still SPK qualified\textsuperscript{24,25} and therefore lack the theoretical knowledge to place clinical skills developed by students within the appropriate evidence-based framework to achieve the desired competency attributes for diploma level graduates. This same problem affects the nature of the clinical competence gained in the clinical practice setting. In those instances where student numbers are manageable, the focus is on skills acquisition and not integration of theoretical knowledge and evidence-based practice into clinical interventions.

The final problem arising from the data is one of governance. Currently, there is no system in place that guarantees that either clinical experiences gained in the field or clinical experiences gained in the laboratories are suitable for achieving the desired levels of clinical competence. This deficit means that new institutions can be approved to conduct nursing programs and existing institutions can continue to enroll nursing students, despite their inability to provide the practical experiences necessary for competency achievement in either the clinical or laboratory settings. Similarly, there are no guidelines that prohibit clinical institutions from taking on students when they cannot ensure adequate student-patient ratios, student-clinical supervisor ratios, or suitably qualified clinicians to provide clinical supervision.

Importantly, there are few consequences when these requirements are not met. In particular, the data reveal that current requirements for graduation from the D3 program place the majority of emphasis upon achievement of theoretical objectives and do not assess clinical skill achievement within a competency framework. Therefore, students can still graduate from these programs, despite it being highly unlikely that they will have achieved competency in delivering good quality patient care. Moreover, consumer pressure is unlikely to be placed on the academics to rectify this deficit. Given the present oversupply of graduates, there is little reason for clinical institutions to place pressure on the academic institutions to improve graduate outcomes.

Consumer pressure from students is also unlikely. In an environment of widespread general unemployment, where the majority of students enroll under instructions from their parents and not necessarily because they intend to become nurses, the English language and computer skills gained during the theoretical component of the course are valuable enough for attracting future students to the program.\textsuperscript{26} Both skills provide valuable employment opportunities in the civil service, business, and tourism, all of which have higher status and reportedly better working conditions than nursing. In other words, without high failure rates in the theoretical component of the D3 curriculum, there is no motivation for the academic institution to improve the clinical component of the program.

Moreover, there is no licensing system in place to prevent graduates who do not meet clinical competency requirements from entering practice. Employment as a “nurse” is contingent only upon completing the theoretical requirements of the D3 program.

**Phase 2 – Identifying Barriers to Addressing Factors Limiting Participation in the Global Workforce**

In Phase 2 of the WHO/Ministry of Health project, the author first worked with the advisory group to develop a national strategic action plan for addressing the problems identified in Phase 1 as contributing to poor graduate out-
comes. The recommendations included reducing the number of students requiring “hands on” experiences at any one time, upgrading the qualifications of experienced clinical nurses to facilitate better clinical supervision and clinician participation in laboratory experiences, and improving the governance system to ensure graduates are clinically competent. These recommendations were then promulgated to the thirty-one participants of Phase 1 via a repeat focus group and individual interviews for feedback on the likelihood of success. Further validation of the findings and feedback on the likely efficacy of recommendations was provided by twenty-seven Polytechnic directors who are responsible for the decentralized governance for the D3 programs in all twenty-seven provinces that comprise the Republic of Indonesia. The data from these interviews and consultations are presented below.

The central theme that emerged is that attempts to initiate such strategies in the past have largely been unsuccessful and that they have been rejected because they undermine the current organization of nursing education that makes it a very lucrative business.

For example, the single most important initiative to improve access to “hands on” patient care is to limit the number of students requiring practical experiences at any one time by reducing the number of school leaver programs. The participants reported that this is an extremely unpopular initiative for three powerful stakeholder groups who derive important financial benefits directly relating to the number of students enrolled in school leaver programs. The owners of the academies receive their income from tuition fees. Because the success in increasing the number of nurses has largely resulted from a burgeoning number of small private providers (rather than a few large providers), the viability of many academies would be threatened by even a small reduction in student numbers.

Nursing education also has significant financial benefits to the owners of clinical facilities, who receive income for providing student clinical placements, and for the academics who work across both private and government sectors and receive supplementary incomes from supervising field placements. Accordingly, all three stakeholder groups have much to lose. Unless such losses are offset by some benefit from improvements to quality, they will strongly resist a reduction in numbers of students.

Replacing some of the school leaver programs with re-developed SPK to D3 conversion programs is another initiative that was included in the strategic action plan. The benefit to the clinical field and education system from such an initiative would be significant. A critical mass of D3 nurses prepared with evidence-based knowledge should improve the quality of service delivery over and above that provided by a workforce with predominantly SPK level qualifications and should improve the ability of clinicians to assist subsequent students in integrating theoretical knowledge into clinical practice and acquiring competency rather than simply acquiring skills. Having clinically experienced academic staff is also crucial to improving laboratory experiences for students and, once D3 qualified, these upgraded SPK nurses also become eligible for academic positions. However, despite these promising career progression prospects and potential financial benefits, the interviews revealed that SPK nurses demonstrate little interest in undertaking a program that requires completion of the same amount of theoretical and clinical content as school leavers. Accordingly, a re-developed conversion course that includes a better system of recognition for prior learning would be necessary. Once again, the participants report that
this initiative would reduce the income generated from fees, threaten the job security of academics, and require release from service; it has also encountered resistance from key stakeholder groups.

The interviews also revealed that implementing a governance system that overcomes the current situation in which students can graduate and practice without gaining a minimum standard of clinical competence is also subject to opposition. Such a governance system would need to include an accreditation system for academies that links enrollment capacity to accreditation. That is, academies would have student numbers limited as a penalty for not implementing measures to ensure that they provide good quality clinical experiences in both the clinical field and in the laboratory setting. Similarly, strengthened governance would also need to involve the auditing of clinical facilities and the instituting of consequences that deprive them of receiving students if they cannot provide appropriate student-patient and student-clinical supervisor ratios and appropriately qualified supervisors. As described above, the data reveal that such penalties have significant financial implications for both groups.

A final step would be to combine such a strengthened quality assurance system with a system of national nursing registration that incorporates demonstration of minimum standards of competency as a prerequisite for the title of registered/licensed nurse. The interviews revealed that, despite strong support from the nursing professional organization, there is no domestic consumer demand for licensed nurses. However, the international market does demand professional regulation and licensure.

**Discussion – “Collateral” Local Benefits of Potential Participation in the Global Workforce**

The paper will now discuss how the desire to increase participation in the global nursing marketplace may provide the impetus to overcome the resistance to addressing the inherent problems in the organization and delivery of D3 education described above. The link between local and international regulation provides the first example of a potential “collateral” benefit of the desire to participate in the global nursing workforce. Registration in the destination country is essential for nurses to gain overseas employment, and the process of recognition is significantly streamlined by the source country having an equally robust registration system. Therefore, any initiative to improve export opportunities must address the need to introduce domestic licensure based on the achievement of minimum standards of competency.

The desire to reap financial rewards from exporting graduates may also provide the much needed incentive for implementing radical reductions in the number of school leaver D3 programs. The same stakeholders who own academies and teach in the academic programs also stand to gain much from conducting education programs that prepare graduates to a level compatible with international standards. If they can achieve this aim, then there is the promise of becoming preferred providers, as well as attracting students sponsored by the government and by parents keen on improving the employment prospects of their offspring.

Similarly, if clinical agencies can provide high quality clinical experiences for students studying at these “preferred” academic institutions, then the decrease in numbers of students undertaking experience at any one time...
will be offset by guaranteed student flows from providers who require guaranteed “hands on” experiences for students. The promise of participation in the global workforce following graduation would also be a significant incentive for SPK nurses.

Finally, the promise of resolving the domestic nursing surplus while at the same time reaping the economic benefits arising from preparing graduates to participate in the global nursing workforce may both strengthen the government’s resolve to ensure compliance with an improved governance system and overcome temptation on the part of key stakeholders to continue non-compliant behaviors. Improving the existing system would seem more sensible than embarking upon a parallel education system for preparing graduates for the export market that will be expensive, small in scale and of little benefit to the domestic health care system. As a close neighbor, the Philippines has been somewhat of a role model to Indonesia in relation to exporting nurses. The example of its success in this area on a large scale is a strong recommendation for adopting a strategy that is incorporated within domestic education and training rather than conducted as a small cohort for the specific purposes of export.  

Similarly, the fact that 85% of employed Filipino nurses are working internationally is a powerful motivator for those stakeholders for whom nursing education is a lucrative business and who have previously resisted attempts to regulate quality. Hence, the alignment of initiatives to improve the quality of domestic graduates within the broader human resource plan of finding alternative employment for the surplus of D3 graduates bodes well for these stakeholders compromising short-term financial agendas for the sake of realizing long-term economic benefits of training Indonesian nurses for the global workforce.

**Conclusion**

In conclusion, this paper provides a new perspective on the issue of global nursing workforce trends. While there is nothing unusual about the “push” factors that make nurse migration attractive to the individual, what is unusual are the conditions that have severely limited the individual nurse’s ability to migrate. At the same time as paving the way for a potential export market, the system of nursing education has led to an oversupply in graduates that significantly limits potential exportability.

The oversupply of nurses, while part of a human resource strategy to improve health and human welfare, is also the result of the deeply rooted economic agendas of powerful stakeholders who have vested interests in ensuring that nursing remains a lucrative business proposition. Government initiatives to increase the number of nursing graduates may not have been so successful without such support and, similarly, initiatives to improve export opportunities for nurses may not succeed unless these same stakeholders stand to benefit. Hence, this paper poses some healthy skepticism about the seemingly straightforward nature of “push” factors and about the discourse relating to the balance of positive and negative effects of migration from developing to developed countries.

At face value, it would seem more ethical to employ the surplus graduates locally to improve domestic health and facilitate achievement of improved health and welfare indices, rather than exporting excess nurses to resolve nursing shortages and support health care systems in industrialized countries that do not have as high levels of morbidity, mortality and poverty-related diseases as Indonesia. However, this paper has revealed that inherent problems in the clinical component of D3 nursing edu-
cation compromise the quality of graduates and constitute significant barriers to both migration and improvement of the domestic situation. Accordingly, it raises the possibility of the potential to improve the quality of domestic nurses as a collateral benefit arising from a human resource strategy to export nurses to developed countries.

Acknowledgements

The author wishes to acknowledge her involvement in the World Health Organization, South East Asian Regional Office (WHO SEARO) human resource development project conducted in Jakarta Indonesia that provided the research data to support this work. The views expressed in this article are not necessarily endorsed by WHO SEARO.

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