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Immigration policy and internationally educated nurses in the United States: A brief history

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ABSTRACT

Since the 1980s, U.S. policy makers have used immigration policy to influence the supply of nurses by allowing or restricting the entry of internationally educated nurses (IENs) into the U.S. workforce. The methods pursued have shifted over time from temporary visa categories in the 1980s and 1990s to permanent immigrant visas in the 2000s. The impact of policy measures adopted during nursing shortages has often been blunted by political and economic events, but the number and representation of IENs in the U.S. nursing workforce has increased substantially since the 1980s. Even as the United States seeks to increase domestic production of nurses, it remains a desirable destination for IENs and a target market for nurse-producing source countries. Hiring organizations and nurse leaders play a critical role in ensuring that the hiring and integration of IENs into U.S. health care organizations is constructive for nurses, source countries, and the U.S. health care system.

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During the past 20 years, the U.S. nursing workforce has experienced significant shifts between shortage and oversupply. Nursing employment trends have been described as "countercyclical" or working in opposition to cycles of economic growth or recession (Buerhaus, Auerach, & Staiger, 2009). In times of shortage (or surplus), U.S. policy makers have sought to use immigration policy to influence the supply of nurses by allowing (or restricting) the entry of internationally educated nurses (IENs) into the U.S. workforce (Glaessel-Brown, 1998). The number of IENs working in the United States has increased from around 50,000 in the mid-1970s (Ea, 2007) to an estimated 165,000 (5.4% of all nurses) in 2008, mostly from the Philippines, Canada, the United Kingdom, and India (Health Resource and Services Administration [HRSA], 2010). These trends have been shaped by immigration policy changes that were as much a function of broader political and economic conditions as of the nursing labor market changes they were intended to address.

The purpose of this article was to provide an overview of immigration policy changes directed toward IENs since the 1980s; to describe the political, economic, and nursing labor market conditions under which they occurred; and to analyze their impact on the U.S. nursing workforce. To accomplish these goals, we review evidence from health care trade publications, Congressional records, government documents, news reports, and academic publications pertaining to immigration policy and nurse migration into the United States from the 1980s to the present.

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Historical Background

The large-scale migration of nurses to the United States began under the Cold War–era Exchange Visitor Program, which was initiated in 1948 and sponsored by the American Nurses Association (Brush, 1993). The rapid growth of the U.S. hospital sector during the 1950s and 1960s created a huge demand for nurses. Many hospitals sponsored exchange nurses for work and study in the United States under the Exchange Visitor Program, first from European countries (Brush, 1993) and later from the Philippines (Choy, 2003).

The U.S. Immigration Act of 1965 ended a national origin quota system that heavily favored immigrants from Europe, enabling skilled workers from Asia, including thousands of nurses from the Philippines, to obtain immigrant visas (Brush, 2010). Migration opportunities for nurses were further extended when the H-1 occupational visa program, originally established to bring foreign workers to the United States in temporary jobs, was amended in 1970 to allow foreign workers to fill permanent positions (Choy, 2003).

1989 to 1993: Expansion and Contraction

The entry of IENs into the United States began to expand in the late 1980s because of a confluence of factors including facility expansion, high acuity, changes in Medicare prospective payment, and declining nursing school enrollments created increased demand for nurses in U.S. health facilities (Glaessel-Brown, 1998), whereas low overall unemployment created a political environment amenable to the expansion of legal immigration in the United States. The 1989 Immigration Nursing Relief Act allowed nurses with H-1 work visas with at least 3 years' residency in the United States to adjust their status to permanent residency, and it exempted nurses and their families from H-1 visa quotas and backlogs (Choy, 2003). The Immigration Nursing Relief Act also created the H-1A visa, the first visa category specifically for nurses. The H-1A visa required prospective employers of IENs to attest to protections for U.S.-educated nurses (USENs) and to document their plans to reduce dependency on IENs.

Most H-1A visas were issued to Filipinos coming to the United States to work in hospitals and nursing homes (Nichols, 1995; Glaessel-Brown, 1998). Because H-1A nurses often worked in undesirable locations and shifts, they were not perceived as taking jobs from USENs, and the program was found to have no adverse effects on U.S. nurses' wages, benefits, or working conditions (Nichols, 1995; Glaessel-Brown, 1998). The Department of Labor loosened the attestation requirements in December 1990 (Tokarski, 1990), allowing thousands of IENs with expired H-1 visas to stay in the United States who otherwise would be sent home (Glaessel-Brown, 1998).

Despite its documented success, the H-1A visa program also created dilemmas; the availability of IENs provided little incentive for the U.S. nursing sector to increase educational capacity in response to the shortage. The program has been described as a "national solution to a New York problem" because its primary outcome was the adjustment of status for Filipino nurses working in New York City (Nichols, 1995; Glaessel-Brown, 1998). It also showed that legislation is a slow way to address nursing shortages; by the time the H-1A visa program went into effect, the shortage it was intended to address was over. Nonetheless, the program was extended by 2 years past its original "sunset" date (from 1995 to 1997) to facilitate the entry of an additional 3,000 to 5,000 IENs in the face of another anticipated nursing shortage (Aston, 1996).

The Immigration Act of 1990 created another pathway for nurses to enter the United States—the H-1B visa, a category for skilled temporary workers. H-1B visa recipients were required to hold bachelor's degrees and to work in positions that required bachelor's degrees (Department of Homeland Security, 2008), so the category was theoretically open to IENs who fit these requirements. However, the visa was not heavily used for IENs because most employers did not require bachelor's degrees for nursing positions even after the Immigration and Naturalization Service revised the guidelines to allow nurses without 4-year degrees to substitute work experience for the educational requirement and sped up processing in the early 2000s (Department of Homeland Security, 2008; Reilly, 2003). Department of Homeland Security (2008) records indicate that only a few hundred nurses have entered the United States on H-1B visas since the category was created. Nonetheless, the opening of a new category was representative of the expansion of migration pathways for IENs and other skilled immigrants during this period of economic growth and optimism. As of 1992, about 74,000 IENs worked in the United States, representing 3% of the nursing workforce (HRSA, 1992).

The nursing shortage of the late 1980s ended in the early 1990s because of the decreased demand for nurses associated with economic recession including the return of some nurses to the workforce, managed care, and cost controls including the use of unlicensed nursing personnel (Glaessel-Brown, 1998; Aiken, 2007). The H-1A program remained in effect, but the number of IENs taking the U.S. nursing licensure examination (NCLEX) declined as the recession reduced legislative interest in and demand for IENs in U.S. hospitals (Figure 1).

1994 to 2001: New Opportunities for IENs

The slowdown in nurse employment and the demand for IENs did not last long; declining nursing school enrollments (Figure 2) and the departure of many