COMMENTS ON THE INTERNATIONAL NURSE STAFFING MODEL
SENATE STAFF BRIEFING
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I am a Professor of Health Policy and Management, and the Director of the Fitzhugh Mullan Institute for Health Workforce Equity at George Washington University. My research focuses on the U.S. healthcare workforce and, in particular, a range of nursing policy topics.

One nursing issue that I have studied extensively over the last decade is the international recruitment of nurses to the United States. Interested initially in whether the industry itself was driving our reliance of foreign-educated nurses, I was funded by the MacArthur Foundation to study the industry and, later, to convene stakeholders to discuss my findings.

This work led to a series of peer-reviewed publications, as well as the creation of a multi-stakeholder voluntary code of conduct for the industry and the Alliance for Ethical Recruitment Practices, which manages this voluntary initiative, and currently is directed by my colleague Mukul Bahkshi.

1. BACKGROUND

When I began research on the industry in 2007, the U.S. was just concluding one of the most severe nursing shortages in our history. At the height of this shortage, around 15,000 nurses were being recruited per year from abroad.

Starting in 2008, visa retrogression and then the recession slowed international recruitment. About that time, the number of new U.S. nurse graduates began to increase dramatically. In addition, due to the economic downturn, thousands of U.S. nurses returned to work full time, while others already in the market decided to delay their retirement.

With the economic recovery, small pockets of shortages have returned, largely reflecting distributional problems. The latest projections by the Health Services Resources and Administration (HRSA) does not anticipate of an overall shortage of nurses in the United States, as we shall discus in more detail later.

2. RECRUITMENT MODELS

When I began to study the international nurse recruitment industry in 2007, there were three distinct types of recruiting companies at that time.

1. First, some **large health systems recruited directly.** This is the model preferred by international nurses but required a recruiter on staff with knowledge of source country laws and culture and was therefore only common among very large systems, such as academic medical centers. In 2008, we estimated that just 5 percent of nurses were recruited using this method, and today, that is likely an even smaller segment of the activity.

2. The second model was **placement firms that were paid by U.S. employers for each nurse recruited on behalf of the client hospital.** These companies comprised about 60 percent of the market a decade ago but today are almost extinct.

3. The third international nurse recruitment model is the **staffing agency in which the recruiter hires a nurse, who is then hired out to hospitals.** Staffing agencies were less common in 2008 (estimates were about 35 percent of the market), but today they have become the dominant model. This business model is far more lucrative for recruiters than the placement model but is the least preferred by international nurses, because they tend to be paid less and have less control over where they work and the jobs themselves.

The question of why the staffing agency model has emerged as dominant likely has several answers. There is far less demand for international nurses now, making health care organizations less likely to recruit internationally themselves or hire a placement firm. In addition, as we shall see, staffing agencies offer advantages to hospitals, because they promise to eliminate the high costs of turnover through long contracts that tether international nurses to the agency.

3. MORE ON THE STAFFING AGENCY MODEL

The details of the international staffing agency model are important to understand. While agencies vary somewhat in their practices, there are also many similarities. The core concept is that they engage in a long-term "lease" of international nurses to hospitals and other facilities. They charge hospitals less than a domestic travel nurse agency (which are per diem and 13 week contracts for travel nurses), because they pay international nurses around $18 less per hour than U.S. travel nurses are paid (average hourly wage of travel nurses is over $45).

Nurses from developing countries (mostly the Philippines) sign contracts with staffing agencies while in their home country, where they have little understanding of the U.S. market and often do not understand the complex contracts they are signing. Moreover, nurses in these countries are often facing significant economic, and in some cases security, duress, which further

exacerbates the power imbalance between the international candidate and the U.S. staffing agencies.

International nurse staffing agency contracts are based on a commitment to work for a predetermined amount of time, and they include high breach fees if the nurse chooses to either reject the placements she or he is offered or obtain other employment before the end of the term. The contracts do not limit where the nurse can be placed, nor do they guarantee a minimum length of any placement.

Prior to the 2008 recession, when staffing agencies faced competition from placement firms and large health care organizations hiring directly, these contracts rarely surpassed 18 months, and the highest breach fees reported in surveys at the time were $15,000.

Today, **international nurse staffing firms require contract periods that are often 36 months, and in some cases 48 months, and include breach fees that often exceed $25,000.** We have seen contracts with breach fees in the six-figure range.

While breach fees have increased over the last decade, the costs of recruitment has recently fallen. This is for three reasons:

1. Visa waiting times for Filipino nurses have declined from around six years during the pre-recession period, to less than a year currently.

2. In many cases, recruiters are picking up nurses that were already in the pipeline and were abandoned by prior sponsors. This means that the prior recruiter has already covered many of the costs (test and immigration fees, etc.). (Note that during the recession, the U.S. virtually stopped international recruitment both because of the surge in new nurse graduates, and because older nurses were coming back into the workplace and delaying retirement.)

3. During the U.S. recession and visa retrogression, many Filipino and Indian nurses were recruited to other English-speaking countries, such as the United Kingdom or Canada, making them more experienced and less expensive to recruit.

In 2007, placement firms estimated their costs to recruit an international nurse at around $8,000. Some health systems reported that their costs were as low as $2,000. Estimates of the cost to recruit a U.S. nurse range from $22,000 to $64,000, and, of course, rise when there are shortages.

4. THE PROBLEM WITH EXCESSIVE BREACH FEES

The use of breach fees by international nurse staffing agencies is at the heart of the problem with this business model.

No other developed nations use breach fees in their international recruitment of nurses.
It is also clear that no U.S. nurse would agree to breach fees. In fact, in order to attract U.S. nurses to domestic staffing agencies (some of which also own separate international staffing agencies), they pay U.S. travel nurses about ten dollars more per hour than the mean hourly wage for U.S. nurses.

The problem with the use of high breach fees is that it creates the conditions under which some companies can abuse international nurses and, because of the threat of financial penalty, prevent them from leaving their jobs. In the event that a nurse feels they have been treated unfairly by the agency, the threat of this financial penalty prevents them from challenging the contract and seeking employment elsewhere. When breach fees are used to hold international nurses in a job against their will, they essentially meet the definition of **debt bondage**.

Where nurses have dared to challenge the contract, they are usually sued, and not just for actual damages, but also for lost profits, attorney fees, and interest. Indeed, **hundreds of civil suits have been brought against internationally recruited nurses by staffing agencies.** We know of one agency that has filed over 70 cases against foreign nurses in Florida courts in the past three years alone. Another agency has filed over 50 cases in Ohio.

In most cases, the foreign nurses have simply defaulted and their wages in a new job are being garnished. This is likely a result of either a lack of access to legal representation, or simply not having received notice of the court filing in time to respond.

However, we also are aware of several cases being litigated. In one case that is now public, lawyers from Public Citizen recently defended a Filipino nurse in a suit brought by MedPro in Florida, which resulted in a settlement agreement under which the company agreed to make changes to its practices. Public Citizen has also provided technical assistance to other lawyers that have been hired by international nurses to defend themselves against staffing agencies.
Many more nurses report remaining in their unfair working situations, because they have received threats of financial ruin from staffing agencies, who present them with a bill as soon as they broach the possibility of seeking employment elsewhere.

Information about these cases is difficult to obtain, as staffing companies have included a range of provisions in the contracts designed to make it hard for the public to learn about this litigation tactic, including mandatory arbitration clauses and waivers of the ability to remove cases to federal court or to proceed as a class. But based on the cases of nurses' that have

reached out to us, as well as searches conducted in two key county district courts, a picture of the types of abuses that can occur has become clear. These include:

- **Benching**: In many of the cases in dispute, despite its representation to the government as part of the immigration process, the agency does not actually have immediate work for the international nurses. Nurses arrive and are asked to wait, sometimes for months, until the agency can find them a placement. During this time, they are not paid or are only given an "advance" against future work, and the time that transpires does not count toward their contract period. Yet they are prohibited from seeking employment elsewhere, are required to show up at the agency's office on-demand, and sometimes even prohibited from traveling outside a small geographic area. In some cases, the benching occurs between assignments.

- **Forced reassignments:** Prior to the 2008 recession, industry norms made it unusual for international nurse staffing agencies to oblige nurses to change locations for a new assignment. That is because they recognized the difficulty immigrants face assimilating, and they believed only long-term assignments were "fair." Today, some staffing agencies require nurses to move to new cities several times during their contract period. Because this represents hardships for families with children, some nurses have decided to breach their contracts to avoid moving.

- **No payment during orientation:** Some staffing agencies require that nurses participate in a month-long training program once they are in the U.S., but they provide no payment for this period and do not count it towards the contract period. Of course, U.S. nurses are paid during their orientation periods.

- **Non-compete clauses:** Some contracts have non-compete clauses that prohibit nurses from working for another employer within 50 miles of the current assignment, even for a period after completing their contract period.

- **Waiving rights:** We have seen contracts that waive international nurses' rights to a jury trial, and many include non-disclosure clauses.

We are currently launching a new study to document these cases around the country, so that we can better understand the nature and magnitude of this phenomenon.

5. THE CURRENT U.S. NURSING LANDSCAPE

Despite the continued use of Schedule A (the Department of Labor certification of an ongoing national shortage which obviates the need for recruiters to prove that no domestic candidates can be found for a job), **HRSA reports that the overall supply of nurses in the United States will**

be adequate through 2030. They also note a problem of maldistribution, with some states likely experiencing a surplus, while others may experience a shortage. Six states in particular could have shortages in the future.[i] In addition, nurse leaders report that jobs in some specialty areas could face shortages of experienced nurses.

It is important to remember that the Bureau of Labor Statistics' (BLS) Employment Projections only estimates the demand side of the workforce, i.e., projected jobs. While international recruiters often cite a BLS' estimate of 1 million new nursing jobs by 2024, it is not, as they claim "proof of a massive nursing shortage…." To project a shortage, the supply side must also be accounted for.

Between 2001 and 2014, the number of U.S. first-time takers of the NCLEX (the nurse licensure exam) grew by 130 percent. This massive growth occurred around the time of the last recession, creating a temporary problem of oversupply for new graduates seeking jobs. It is this surge in new graduates that led HRSA to conclude that, at this increased pace of nurse production, there would not be an overall shortage.

However, demand is also expected to increase, and it is not easy to project changes in demand, even by the BLS. Leading nurse organizations, such as the American Association of Colleges of Nursing (AACN), continue to call for an expansion of nursing school capacity.

Young Americans continue to be eager to go to nursing school; it is one of the best paying jobs for the level of education required and has historically provided a pathway out of poverty for disadvantaged women and now increasingly men. AACN reports that in 2018 U.S. nursing schools turned away more than 75,000 qualified applicants because of a limited faculty and/or clinical preceptors.

The recruitment of international nurses certainly has a place in our health system, but clearly it does not address the structural challenge of expanding nurse education opportunities.

6. THE EFFECT OF THE STAFFING AGENCY MODEL ON THE NURSE LABOR MARKET

Given the cyclical nature of U.S. nurse shortages and the ongoing challenge of identifying structural solutions to the problems of high nurse turnover, as well as the pockets of nurse shortages, the question we should ask is: **how do we ensure that international nurse recruitment is matched to those areas and those specialties where there are real shortages, and does not undercut the domestic nurse labor market dynamics in areas where there is no shortage?**

The decline of the direct hire and placement models of international recruitment complicates this challenge, since under those models, it was more likely that international nurses would be matched to real jobs, where there are real shortages.

The use of intermediary staffing agencies, with their current business practices, makes this challenge particularly difficult.

An analysis of one agency's sales materials for hospitals reveals some of the ways in which this model creates perverse incentives that could affect the U.S. nurse market dynamics.

This firm describes itself as *"the leading provider of internationally-trained RNs to U.S. healthcare institutions"*.[ii]

- The agency claims that they *"Provide better continuity of patient care with long-term nurses and low 5% turnover rate."* Indeed, this is likely the case because of the long contract periods and use of breach fees. Average turnover rates for U.S. hospitals is now at about 18 percent, and the costs of a single nurse turnover can range between $37,700 to $58,400. This amounts to, on average, between $5.2 million to $8.1 million annually for a hospital.

- The agency also states that they can *"Reduce costly nurse overtime staffing… (and) Properly staff hard-to-fill shifts such as nights, weekends, and holidays"*. Again, international nurses are not "at will" employees, which means that there is little risk in giving them the worst shifts or obligating them to work more overtime hours than their direct hire U.S. nurse counterparts.

- The company affirms that they save hospitals *"$11.00/hour versus travel RNs"*. This differential appears to come at the expense of the international nurses' wages. While contracts we have reviewed show that international staffing agencies are paying the prevailing wage (varies by state) for an entry level job, or about $27 dollars an hour, U.S. travel nurses are paid on average about $45 an hour and also receive a housing stipend. U.S. nurses on average earn $37.50 an hour. This is the case despite the fact that many international nurses have significant experience and may have worked in another English speaking country such as Canada.

- In an extraordinary statement, they explicitly offer themselves to hospitals as an alternative to raising wages and educational incentives to improve retention of nurses. They state: *"Many companies are adopting additional pay and education incentives to attract healthcare professionals. Although this may solve the short-term problem, it is unsustainable in the long-term."*

- Lastly, the use of breach fees under U.S. law is generally only acceptable in the case of individuals of extraordinary ability who are deemed irreplaceable. Examples might include a famous movie star or a sports hero. This agency openly touts that international candidates are abundant and easily replaceable. They state: *We can provide your healthcare organization with RNs, PTs, OTs, SLPs, and Medical Technologists and have hundreds of candidates that are ready for interview and selection.*"

The growth of the international staffing agency recruitment model, therefore, potentially represents a significant disruption to the U.S. nurse labor market.

On the one hand, hospitals perceive these problems (high turnover costs, hard to fill shifts, high cost of U.S. travel nurses, etc.), and international staffing agencies have stepped in to fill the gap. On the other hand, many of them do so in ways that are not consistent with the principles in our U.S. labor and contract laws. This undercuts the process of addressing legitimate demands by U.S. nurses for marketplace solutions to these same problems.

Essentially, allowing bad actors within the international staffing industry to flourish threatens to worsen, rather than alleviate, the nursing shortages in our country. If the sales pitch to U.S. hospitals is that the international nurse staffing agencies provide cheaper labor that will reduce the high turnover rates, their impact is likely to be broader than shortage areas. While we have no data on where these placements are occurring, the concern is that they may not be going where there are actually real nurse shortages. To the extent that hospitals can reduce turnover by using these international staffing firms, the impetus to improve working conditions and wages for U.S. nurses is lessoned.

7. THE NEED FOR A POLICY SOLUTION

There is a legitimate role for the recruitment of international nurses to the U.S. However, **it must be conducted in a manner that is fair to the international nurses themselves, targets real shortage areas, and does not disrupt the U.S. nurse marketplace.** It is critical that the U.S. nurse labor market continue to adjust and find more structural solutions to high turnover and shortages where they exist.

At the global level, there is growing consensus of the principle that "workers shouldn't have to pay to work." Under this principle, workers should not have to pay recruitment and related fees for their jobs. Breach fees essentially represent a back-end way for recruiters to keep nurses liable for recruitment fees until they have paid those costs back by completing a multi-year contract. **New guidance issued by the International Labour Organization (ILO) explicitly includes contract breach fees among the types of fees that governments should prohibit.**

Many of these issues have also been explicitly addressed in the U.S. in a recently updated voluntary code of conduct for the healthcare recruitment industry. The Alliance for Ethical International Recruitment Practices is a multi-stakeholder initiative that includes the American Hospital Association, several large recruiters, as well as nurse associations, labor unions and international nurses themselves. The Code is an indispensable reference in thinking about ethical norms; it includes a monitoring and enforcement mechanism, but, unfortunately, only a few companies have agreed to abide by it.

Instead, most of the staffing agencies have chosen to go the route of the American Association of International Healthcare Recruitment (AAIHR), which has its own Code that makes overarching commitments to ethics. While it mimics the Alliance's Code, it does not include specifics, such as restricting the amount of breach fees and the importance of having a job for nurses when they arrive, and it has no monitoring or enforcement mechanism other than reporting abuses to the agency leaders themselves. Indeed, the leaders of this organization are the most active in the courts suing nurses that have fled.

With international nurse recruitment returning to its pre-recession highs, it appears that voluntary codes are insufficient, and that legislative options are needed.

EB green cards are intended to be issued to U.S. sponsors that have a specific job, in a specific place available immediately. This basic principle, however, has not been enforced with respect to these agencies; many international nurse staffing agencies do not have assignments for nurses when they arrive in the U.S.

Therefore, two areas of reform are needed:

1. **The government must ensure that staffing agencies list a specific job assignment in a specific place in the contract they present to U.S. consulates.** In addition:
    a. If that job location changes, nurses should have a right to terminate the contract if they do not agree.
    b. Similarly, staffing agencies that sponsor nurses as their employees must actually pay nurses from the time they arrive in the U.S. until they complete a contract.
    c. This should include the time used to train the nurses.

2. To avoid the use of breach fees as debt bondage, **ideally no breach fee should be used in a contract, so that retention is based purely on positive incentives, not threats of a penalty.** However, a more moderate option that is consistent with the Alliance Code, would be to **restrict fees to the actual expenses incurred** by the staffing agency in the recruitment process that go beyond the kinds of expenses a U.S. recruiter would incur in the hiring process.
    a. These might include test preparation in their home county, immigration related fees, test fees, and international travel. Contracts should list those expenses explicitly in the contract and the agency should be prepared to provide documentation of payments.
    b. In no case should breach fees include hypothetical future lost profits or "liquidated damages" – which have no relationship to any expenses actually incurred by the agencies.
    c. Further, repayment of expenses should be pro-rated and reduced based on the time served in the contract and, after 18 months of service, should be voided. At

that point, the staffing agency has more than recovered the costs of international recruitment.

The American Hospital Association and several international staffing agencies have already agreed to the principles in the Alliance's Voluntary Code. A range of nurse stakeholder groups, including labor, also support them. They are opposed by the trade organization for the staffing agencies, AAIHR.

8. CONCLUSION

Current contracts in use by many of the largest international staffing agencies clearly represent discrimination in terms of wages and the conditions of the contracts. No American nurse would agree to such conditions.

It is the responsibility of all U.S. employers, including international staffing agencies, to enhance employee retention through positive incentives. It is unconscionable that in the 21st century a staffing agency would use the threat of a financial penalty or debt bondage to force retention.

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[i] HRSA estimates that is the current demand for nurses is maintained, seven states are projected to have a shortage of RNs in 2030. California was initially one of those states, but recent state based estimates do not anticipate a shortage there. Three remaining states may have a deficit of 10,000 or more: Texas, New Jersey and South Carolina. States that HRSA estimates will have the largest surpluses of nurses in 2030 are (53,700 FTEs) followed by Ohio (49,100 FTEs), Virginia (22,700 FTEs) and New York (18,200 FTEs).

[ii] Accessed 4-16-19