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City University of New York PH.D. 1985

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MIGRATION OF CARIBBEAN WOMEN IN THE HEALTH CARE FIELD: A CASE STUDY OF JAMAICAN NURSES

by

MARTEEN NICHOLSON

A dissertation submitted to the Graduate Faculty in Sociology in partial fulfillment of the require-ments for the degree of Doctor of Philosophy, The City University of New York.

1985

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This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

MIGRATION OF CARIBBEAN WOMEN
IN THE HEALTH CARE FIELD: A
CASE STUDY OF JAMAICAN NURSES

by

Marteen Nicholson

Adviser: Michael Brown

This dissertation examines the migration of Jamaican nurses to New York City, an issue that involves the migration of women. It has been observed over the past fifteen years that a salient feature of international migration has been the increase in the number of female migrants from the Caribbean--not as dependents of resident immigrants but as independent migrants. These female migrants share at least one characteristic with male migrants: they are part of a transnational migration stream, with skills that can be utilized in the host country. This new development in female migration may reflect certain socioeconomic and political changes that have occurred in both Jamaican and American societies, particularly with regard to the relative proportion of women in the labor force. Yet, because of the fact that many aspects of the lives of female migrants from the Caribbean are not accounted for by these changes, it is expected that this

study will reveal a certain pattern of adaptation which may reflect the changing occupational status of women.

It is the specific purpose of this dissertation to study a sample of Jamaican nurses living and working in New York City, with the expectation of adducing certain adaptation patterns which may be characteristic of this migration. The focus of this study will therefore examine the following issues:

1. The "push-pull", or social demographic, conditions that are characteristic of Jamaican nurses in New York City;
2. The structural conditions that are characteristic of Jamaican nurses in New York City; and
3. The degree of adaptation of these migrants to the United States.

Acknowledgments

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I also wish to express my heartfelt gratitude to my parents, and to my sister and brother, Barbara and John, for their unstinting support and encouragement throughout the long hours of work on this project.

Finally, I dedicate this dissertation project to my late brother, Desmond Nicholson.

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CHAPTER I

INTRODUCTION TO THE STUDY

Background Information

Historically, migration is a phenomenon which is an integral part of the growth and development of the United States. Davis (1974) underscores this fact when he made the following statement:

> Migration is a key variable in the industrial growth of the United States. During the 16th and 17th centuries, the whole world (for the first time) began to be one migratory network. This migration phenomenon was dominated by a single group of technologically advanced States in Europe, which were culturally similar. This resulted in the beginnings of the industrial revolution, which enormously enhanced Europe to the status of world dominance.[1]

This migratory movement from Europe to the United States continued through the eighteenth century until World War II. After the war, mass migration from Europe was checked, and migrants from non-European and Third World countries increased (Keely 1975: 157-169).[2]

The recent large-scale migration of persons from Third World countries or developing countries to the United States exposes the disparities in economic growth between developed and developing countries, emphasizing a shift away from policies formerly restrictive of the demand for

foreign labor. Migration patterns do not occur without reason, neither do they change unless there exist causes that are either political, social, economic, or a combination of all of these factors.

The movement of nurses from the Caribbean island of Jamaica to the United States occurs because of what demographers refer to as "push" factors (low salaries and lack of opportunities in the sending country) and "pull" factors (significantly higher salaries and opportunities for career advancement in the receiving country). Push factors constitute declining conditions that can, under the right circumstances, serve as expelling forces; pull factors are indicated by the attractiveness to a given potential in the host country. Together, "push-pull" factors are part of an account of the selective rather than random character of migration. During the 1970s, the forces expelling migrants were so strong that, despite the difficulties posed by travel across international borders and the worldwide recession, labor migration continued to flow to countries like the United States and other western European countries, areas referred to by Petras (1980) as wage areas, or regions of rapid expansion.[3] This international movement of workers has been given a great deal of attention lately, because of (a) the unprecedented numbers of migrants to New York City and (b) the recent economic contraction in the United States

over the past decade.

As always, New York City is a powerful magnet for groups wishing to improve their economic situation.[4] Bryce LaPorte (1979: 218) suggests that the recent wave of immigrants to New York City is the result of an increase in the volume of legal migrants, a drop in the output from traditional European and Canadian sources, and a marked increase from Asia, the Caribbean, and South America.[3] On the side of the pull factors, this is due to the demand for labor in certain categories of occupations available to immigrants and changes in the United States immigration policies favoring labor migration. Bryce LaPorte refers to this as a "wave" not so much because of a surge in the numbers, although the figures bear out this fact (see table 1), but because of the tremendous increase in a particular sector of the New York economy--the service sector. With regard to the push factors, the movement of migrant labor to New York City can be attributed to changes in the political and socioeconomic conditions in Asia, South America, and the Caribbean.

Jamaica, an integral part of the Caribbean area, has been plagued historically with an underdeveloped economy and political system. During the 1960s this situation worsened because of inflation and increases in the price of oil. The capital-intensive development strategies in Jamaican agriculture and industry failed to generate adequate employment opportunities for the majority of the labor force. This

failure had a ripple effect upon the whole economy, adversely affecting many workers. The unemployment and underemployment rate increased by approximately 30 percent (Kuper 1976), and so the alternative for many of these workers was migration to the United States, where they anticipated greater opportunities for employment.[5]

It was asserted by Sandis (1980: 30) that it was the conventional wisdom to view the United States as the willing, attractive recipient or "pull-force" in world migration.[6] The United States is the dominant country in the capitalist world, capable of attracting workers on a worldwide basis from all the countries of the so-called free world because of the tremendous political and economic influence that the United States has over these other countries, including Europe. With the advent of the twentieth century, the United States has undergone rapid changes in its developmental needs, international role, and structural complexity, all of which have brought about changes in its policies toward immigration and migrants. Many of these changes have manifested themselves most dramatically, perhaps, in New York City.

It was reported by Sassen-Koob (1981: 30-31) that immigration to New York City provided low-wage labor to declining sectors of capital, which is the basic view of the migration literature.[7] Additionally, immigration provides labor for low-wage manufacturing and service sector industries

which are expanding and which maintain the high life style of the executives. Within the immigrant community, immigrants become agents actively engaged in rehabilitating the economic sectors of New York City.

The abovementioned factors show that since the 1960s Third World immigrants have not only contributed to the survival of the declining sectors of capital in New York City but have also been instrumental in the recomposition of the city's economy. From the standpoint of pull factors, Bryce LaPorte (1979: 216) stated that New York City is conceived as the mecca of Caribbean-United States migration and tourism.[8] Even persons who live in other European countries, such as Great Britain, Germany, France and Sweden, are drawn by a special curiosity and determination to enter New York eventually. The ultimate arrival of Caribbean persons to New York City is mainly the result of the following:

1. A much nurtured need to fulfill their dream and curiosity, sense of achievement, and drive for adventure, associated with New York City as a special object in immigrant ethos of the Caribbean

2. An actual desire to establish acquaintances and re-establish linkages with relatives and friends

3. An impulse to emigrate from their less-developed homeland to what they have learned to be the most free, liberal, cosmopolitan, and opportunity-filled metropolis in the world

From these statements by Bryce LaPorte we observe that migration to New York City has a certain appeal to

Caribbean people, even though historically it has been the port of entry for the majority of migrants from Europe. These reasons, however, are very general in nature; therefore, the two main objectives of this study are to attempt to pinpoint more accurately the reasons for the migration of a specific group--Jamaican nurses--to New York City, and to show their adaptation pattern since migration.

STATEMENT OF THE PROBLEM

One of the most problematic questions which concerns scholars of migration, and which is quite difficult to formulate for study, is why people migrate. The difficulties in formulating this study are due to many factors, not the least of which is the fact that migrants themselves cannot state the precise answer to this question. However, from studies that have been done on migrants, it is possible to set out in general terms the reasons that prompt migration and the causes that underlie that choice. These will be discussed later in the section that reviews the literature on migration.

In addition to the reasons for migration, the general theme that is discused in the literature on migration is the variety of structural features of the migration stream, including the relative opportunities in the receiving and sending countries. These issues are usually discussed in the

framework of the organization of the international exchange of labor, which is formulated in terms of the abundance or scarcity of labor. The push-pull or social demographic approach is used to describe the relationship existing among the structural features: the decision to migrate and the adaptation of migrants in the host country. Because of the complexity of the migration process, different methods, such as the push-pull approach and the neo-Marxist approach, are needed to study this phenomenon, these and other approaches are also discussed later.

This dissertation attempts to clarify two aspects that can be adequately studied by means of the survey method: the structurally controlled reasons for migration and the adaptation patterns within the migrant population. The scope of this thesis is a limited one and of an exploratory nature. The sample under study consists of nurses who were trained and educated in Jamaica, distinguished by three levels of technical training in nursing: licensed registered nurses, licensed practical nurses, and nurses' aides. The issues that are of concern to us are as follows:

1. What are the most important factors in the decision to migrate?

2. What factors made it possible for these nurses to leave the country of origin and enter the United States?

3. What are the characteristics of career mobility and economic achievement among the immigrants that account for the various types of adaptation to the host country?

METHODOLOGY

Questionnaires were designed in conjunction with this study in an effort to obtain information about a sample of Jamaican nurses who migrated to the United States between 1950 and 1980, and who are currently working in hospitals, clinics, and nursing homes in New York City. Three hundred questionnaires were distributed to nurses working in Brooklyn, Queens, Manhattan, and the Bronx. About 50 percent of the distribution was carried out through the mail but, because of difficulties respondents experienced in filling out the questionnaires, the remaining 50 percent was distributed by the researcher through personal visits, to ensure that the questionnaires were answered according to specifications. The hospitals and nursing homes were selected on the basis of the greatest concentration of Jamaican nurses. The institutions visited were Kings County Hospital, Downstate Medical Center, Brooklyn Jewish Hospital, Little Neck Nursing Home, Queen of Peace Nursing Home, Jewish Institute for Geriatric Care, Mount Sinai Medical Center, and Montefiore Hospital.

The Jamaican Professional Nursing Group, located at Cadman Plaza, Brooklyn, provided the researcher with the names and addresses of 50 respondents. This organization was instituted to function as a network and support group for Jamaican nurses in New York City. Prior to the mailing

of a questionnaire, or visit to a prospective respondent, a telephone call was made in which the researcher briefly described to the prospective respondent the purpose of the study and requested completion of the questionnaire. The distribution of questionnaires began in September of 1980 and ended in January of 1981, when a total of 140 questionnaires complete enough to be processed for analysis had been received.

THE SAMPLE

The sample under study represents 140 diploma nurses who migrated from Jamaica to New York City between 1950 and 1980 in search of employment. The sample consists of three levels of nursing skills: licensed registered nurses (112), licensed practical nurses (8), and nurses' aides (20). These women were educated and trained in Jamaica, prior to migrating, and the majority of the sample were sponsored on the basis of occupation. Two of the categories in the sample (licensed registered nurses and licensed practical nurses) had to sit the State board examination in the United States to qualify for practice. This, however, was not the case with the nurses' aides who, although they had their diplomas, were not required to be licensed by the State but, instead, had to undergo on-the-job training.

The registered nurses in the sample were mainly employed in municipal hospitals and nursing homes, although some held positions in semi-private hospitals. Most were employed at the entry level category, where they performed bedside nursing in the traditional way. The majority came from blue-collar backgrounds and traditional rural families. Most of them were married. Their ages ranged between 20 and 49 years, and they lived in communities in Brooklyn and Queens that are predominantly occupied by West Indian migrants.

LIMITATIONS OF STUDY

This dissertation project carried out on Jamaican nurses residing and working in New York City does not claim to be representative of the entire migrant group of nurses from Jamaica. However, it attempts to present a profile of the sample in terms of demographic characteristics and adaptation to United States society. The study has other limitations, due in part to the lack of statistical data on foreign nurses in the United States. The researcher contacted the Division of Professional Licensing Services in Albany, New York, and was informed that it was not possible to obtain any accurate count of foreign nurses in New York City, because nurses submitted multi-applications in various states, and it would be a massive project to get any kind of accurate data

for the period the researcher was investigating. To the knowledge of the researcher, there are no well-documented empirical studies carried out on foreign nurses in the United States by the Department of Health, Education and Welfare, or the American Nurses Association.

It was also difficult to obtain any information from the Jamaican government on the issue of migration of nurses from that country, because of the lack of statistical data or studies carried out on this subject. Therefore, because of the sheer lack of information, limited funding, and the unanticipated difficulty in obtaining responses from the respondents, the researcher could only concentrate on a limited aspect of the issue. This project should thus be viewed as an exploratory or pilot study on the topic of foreign nurses, an area that needs more research.

Notes to Chapter I

1. Kingsley Davis, "The Migration of Human Population," in The Human Population: A Scientific American Book (San Francisco: W. H. Freeman, 1974), pp. 55-56.

2. Charles B. Keely, "Effects of United States Immigration Law on Manpower Characteristics of Immigrants," Demography 8 (1975): 157-69.

3. Elizabeth McLean Petras, "Toward a Theory of International Migration: The Division of Labor," in Sourcebook on the New Immigration: Implication for the United States and the International Community, ed. Roy Simon and Bryce LaPorte, assisted by Delores Mortimer and Stephen R. Couch (New Brunswick, New Jersey: Transaction Books, 1980), pp. 439-48.

4. Simon Bryce LaPorte, "New York City and the New Caribbean Immigration: A Contextual Statement," International Migration 13 (1979): 218.

5. Adam Kuper, Changing Jamaica (London: Routledge and Kegal Paul, 1976), pp. 1-50.

6. Eva Sandis, "Alternative Intellectual Frameworks for Studying the New Immigrant," in Sourcebook on the New Immigration: Implications for the United States and the International Community, ed. Roy Simon and Bryce LaPorte, assisted by Delores Mortimer and Stephen R. Couch (New Brunswick, New Jersey: Transaction Books, 1980), p. 30.

7. Saskia Sassen-Koob, "Exporting Capital and Importing Labor: The Role of Caribbean Migration to New York Cuty," Occasional Paper, no. 28 (1981), pp. 30-31.

CHAPTER II

THEORETICAL ORIENTATION

This chapter presents some of the major studies and research carried out on the subject of migration and assimilation which are relevant to the project under study. The migration phenomenon encompasses political, economic, social, and cultural areas. Its study is best understood from an interdisciplinary approach. There are basically two broad approaches to the study: the neo-classical or general formulations of migration and the neo-Marxist approach with emphasis on the economic aspect of migration. Many supplementary, overlapping approaches lie within these two categories. Thus it is very difficult to establish any one theory or typology for the study of all migrant groups.

Migration can be viewed from the standpoint of migrating groups or individuals, as a cycle consisting essentially of three main phases: (a) departure from the country of origin, (b) arrival in the host country or country of destination, and (c) settlement and adaptation. A pattern or distinctive structure of causation identifies each phase of the cycle. The transition itself from phase to phase occurs

through the operation of external, intervening or mediating factors. The studies presented here discuss in detail the cause and effect of migration as a process, and they also offer some explanation of why the phenomenon occurs.

GENERAL THEORIES OF MIGRATION

Migration was characterized by Jansen (1969: 60) in the following way:

> Migration is a demographic problem, because it influences sizes of population at origin and destination. It is an economic problem because the majority of the shifts in population are due to economic imbalances between sending and receiving countries. It may be a political problem, which is particularly the case with international migration where restrictions and conditions apply to those wishing to cross a political boundary.[1]

The movement of population historically has been and remains, as Jansen implies, an important component of economic development, social change, and political organization.

From the observations of Jackson (1969: 1), capital investment in labor resources and the effects of the labor market give rise to far-reaching consequences in the spatial relationships of people to their environment.[2] He argued that the movement of population is related to:

> . . . the growth of cities, the development of new resources, and territories; and the increasing international context of business, leisure, and political experience depends upon settlement of individuals in diverse locations away from their place of birth and upbringing.

The movement of people varies in patterns, depending on local economies and sociocultural patterns of adaptation. From the standpoint of migration, however, the important factors of the migration process are the ways in which migration affects the social relationships of the individuals concerned and the differences in the sociocultural systems between the sending and receiving countries. These are factors which will determine why each group migrates and how migrants adapt to the host country.

Each successive migration process implies an element of disassociation from the usual and familiar environment and the transition and adaptation to a new society. The migrant carries much of the life experience (depending on age, socialization, and circumstances of departure) to the new society. The host country, on the other hand, is not likely to have any knowledge or experience of the background from which the migrant comes. This is usually the case with migrants who are minorities in the host country and thus enjoy only marginal status by virtue of race.

Discrimination and its institutional effects on women and minorities add to the problem associated with the settlement of migrants and further complicates the process of their adaptation to the host country. In view of this, it is difficult to construct a single model that is adequate to study all migrant groups. In fact, Jackson (1969: 3) alluded to

this problem of the remarkably static theoretical development in the study of migration, which demands some more adequate explanation in view of the dynamic quality of migration itself and the extraordinary importance which movements of population assume as both catalyst and ingredient of social change. Jackson continued:

> In spite of the expression of a somewhat general unease with the narrowly materialistic basis of the "push-pull" approach, there have been little serious attempts to grapple with some of the underlying assumptions and the decision-making process which students of migration have often quite unconsciously constructed.[3]

This statement was made a decade and a half ago, but it seems as true today as it was then, for the literature that focused on the decision aspect of migration does not necessarily focus on the demographic and economic aspects as well. Because this thesis examines aspects of _decision_ and its _aftermath_, Jackson's criticism remains a valid point of departure.

In the absence of a formal theory of migration, one can make certain generalizations about the migration process, although these will have to be modified for each migrant group. It was proposed by Bogue (1961: 4-6) that there are certain general principles which may be applicable to most migration to the United States, and they are:

1. There is a series of stages in the development of any migration stream. From the initial invasion it develops into a phase of settlement which at its peak becomes routine, or institutionalized. In the initial stages

men outnumber women, but with the settlement phase, sex selectivity tends to disappear or even favor women. Migration in the initial stages is highly selective of young, but mature, adults, and persons who are single, divorced, or widowed

2. Migration stimulated by economic growth, and technological improvements attracts the better educated, while areas tending to stagnation lose their better educated and skilled persons[4]

These propositions, although general, attempt to formulate, in a rudimentary way, certain observed patterns of migration. We could generalize from these propositions that migration is a necessary element of population redistribution and an arrangement for making the maximum use of available manpower. It could also be said that migration is conditioned by interregional differences in the availability of economic opportunities. In areas of rapid economic growth and expansion, there is usually a demand for skilled labor. This usually leads to the flow of migrants from areas with less economic growth and job opportunities to areas of viable economic growth and development.

Historically, migration is usually associated with self-improvement; however, the circumstances prompting migration may differ with each migrant group. For example, the migration that occurred after World War II consisted mainly of persons who were displaced after the war, for economic or political reasons, and who migrated to the United States to start a new life. For many of these persons, migration was a permanent change of residence which involved a complete

change and adjustment to the new society, both culturally and socially. Migration that occurred during the sixties, however, involved persons who had skills that could be utilized in the host country, which was the main criterion for entrance to the United States. In addition, these migrants were predominantly from Third World countries; therefore the interchange as well as the political and cultural relationships were quite different from those of the host country (Patterson 1978).[5]

Migration from the Third World represents a change in United States immigration policies toward persons in the Third World. For example, the major goal of United States immigration during the period under review was more structured and not as random as migration at the turn of the century. This was noted by Beijer (1969: 25) who stated that migration was no longer the haphazard affair of the past. There was now a more carefully planned program for international migrants entering the United States.[6] The new migration policy of 1965 mandates that only migrants who can serve the national interest of the host country are allowed to enter. This immigration policy gives preference to skilled persons, who are recruited for specific jobs in the United States. The planning of this new immigration program is an example of the initiative in economic affairs that the United States government has taken to ensure that the economic objectives of the country are realized.

International migration over the past two decades differs from earlier migration (i.e. prior to World War II) in a number of important respects. These differences were stated by Richmond (1969: 238-39), who concluded in his study of this new migration the following:

1. This migration is on a smaller scale and subject to political control
2. It is planned and governed by "welfare state" considerations (i.e. persons who migrate must have skills that are needed in the host country)
3. It is educationally and/or occupationally highly selective
4. Each of these differences has important implications for the adaptation of the migrant population[7]

The immigration policies of 1965, as just stated, are in effect in the 1980s. Petras (1980) describes this new pattern of migration as the "global framework of international division of labor."[8] Within this framework, bound together into one capitalist system, the driving tendency toward capital accumulation is realized internationally as one single division of labor within a multiplicity of polities and cultures. This approach to world economy is relevant to the new migration because the migrants can contribute their skills to the host country. Because they are mainly from the Third World, areas of characteristically weak political and economic systems, the migrants feel compelled to travel to countries like the United States that offer better employment situations.

The main theme running through these migration studies is that of mobility of people over space and time. This mobility is seen within a system of structured relationships which makes it difficult to formulate a formal theory or model adequate for the study of all migrant groups. The problem was well expressed by Meadows (1980: 397) as follows:

> Migration literature is not noted for its abundance of postulational statements of relationships, though some notable formulations have been made. Much of the literature is historical, descriptive, evaluative, or reportorial (in some form such as journalistic or case history). Some of the literature has been able to formulate variables and has developed some middle-range theories. Very little of it approaches the stage of formal theory development.[9]

This statement sums up, very accurately, the problems involved with the study of migration. However, we will discuss some of the other approaches that are employed by scholars of migration in their attempt to grapple with this issue.

SOCIAL DEMOGRAPHIC, OR "PUSH-PULL," STUDIES

The social demographic, or push-pull, approach to the study of migration was first formulated by Ravenstein (1980).[10] This approach essentially outlines the demographic and socioeconomic variables that are associated with migration. Ravenstein's study represents the beginnings of an attempt to relate in a systematic way the factors which enter into the migration process, such as the cause and effect factors of migration, and the intervening variables such as age, sex,

marital status, which are related to the migration process. This approach attempts to explain changes in migration rates which may vary with each migration process. It explores the relationship between expectations and opportunities, in both sending and receiving countries, which may vary with successive migrant groups.

In any given group of persons, both male and female, it will be found that economic conditions at home will affect each member of the group differently (Lee 1966: 56).[11] The probability of their migration will depend upon the availability of employment and other opportunities in the country of origin. Lack of these opportunities constitute push factors. On the other hand, gains and advantages in terms of higher salaries, career mobility, and higher standard of living anticipated by those who migrate are the motivational, or pull, factors. The decision to migrate is determined by the circumstances of the particular migrant group and whether or not they are responding primarily to negative factors in the country of origin or positive factors in the receiving country.

According to Lee (1966: 56), the following generalizations help to explain the migration process: Firstly, migration increases when population expectations in the country of origin outstrip economic development and, conversely, when economic opportunities in the receiving country surpass those in the sending country; and, secondly, migration occurs when it is legally and economically possible.[12] The push-pull

approach to the study of migration, therefore, is more empirical, as suggested by Lee, because we can obtain information about immigrants and analyze this information within the framework of the push-pull approach as in the method used in the project under study.

In general, social demographic, or push-pull, studies of migration have been concerned with the characteristics of individual migrants. They tend to view two sets of individual factors as figuring in the migration process. One set of factors has to do with the individual's position in the social structure, life cycle position, socioeconomic status, and kinship and community ties. The other set of factors explores the individual's motives, values, perceptions, and aspirations. In the general demographic framework, individual migration is essentially a product of the cost benefit advantage between sending and receiving countries. Migration thus becomes the play-off between the aggregate of negative factors at origin (push factors) and positive factors at destination (pull factors).

DUAL LABOR MARKET STUDIES

The dual labor market concept is relevant to this study because we are attempting to examine the condition of black female migrants in the predominantly female occupation of nursing. Dual market studies analyze the hierarchical

structure of the labor force, whites vis-a-vis blacks and other minorities. The underlying principle of dual labor market studies is that there are two categories of workers in the labor force: the "primary sector," or upper level, which consists of persons who are professionals and administrators; and the "secondary sector," or lower level, consisting of persons with no professional status and who carry out productive functions. We will discuss some of these studies in relation to the nursing occupation.

Dual labor market studies are a departure from the neo-classical and functionalist theories, which emphasize the individual's abilities and efforts as measures of ultimate occupational achievement (Montagna 1977: 4).[13] They presuppose a "dual" or segmented system of occupations, in which the primary sector has an economic interest in excluding from their domain persons comprising the secondary sector. This phenomenon evidences a high degree of discrimination in each sector and sub-sector, which is carried out on the basis of race, sex, and age. Within this context it was noted by Montagna that the recent gains of blacks are somewhat deceptive, when the specific kinds of jobs they occupy within the broader occupational categories are compared with those occupied by whites. Although there has been an increase of blacks in the professions, proportionate to the increase for whites, most blacks find themselves in the lower-paying or less prestigious jobs.

If we examine the study of Doeringer and Piore (1971: 3), we observe that the concept of the "secondary labor market" is described as the sector with the least amount of status, comprising persons with low-paying jobs and inferior working conditions, little chance of advancement, and a highly personalized relationship between workers and supervisors.[14] This concept leaves a wide latitude for favoritism, which is conducive to harsh and capricious work discipline, considerable job instability, and a high turnover among the labor force. The groups who occupy these positions comprise the following:

1. Persons with stable but low-wage work experience
2. Black females and recent immigrants from Latin America and the Caribbean
3. Teenagers with little or no previous work experience, of which urban blacks are disproportionately represented
4. Persons with clearly defined obstacles to employment--the physically and mentally handicapped, mothers with children, students seeking part-time employment

These are usually the groups which occupy the secondary labor sector. The progress of persons within this category will depend on the ability to adjust to work situations. Obviously, the more qualified persons will find it easier to enter and adjust to work situations.

With regard to hospital workers, and nursing in particular, there are some interesting studies and observations worth mentioning here, which appear to support the dual labor

market concept. In a study of hospital workers, Ehrenreich (1973: 15) observed that not only was there a division of roles based on occupational skills but also racial and sex discrimination within the ranking system of hospital employees.[15] This study suggested that 98 percent of the physicians were white; 93 percent were male; and 98 percent of the nurses were female. In the municipal hospitals, between 80 and 90 percent of the service workers (aides, orderlies, licensed practical nurses) were black or Puerto Ricans. The sex-typing of certain occupations (e.g. nurses, secretaries, airline stewardesses) occurs when one sex dominates an occupation in numbers, and there is the expectation that this pattern should be maintained. For example, in nursing, the nurturant and care-taking role of the woman is emphasized because it is assumed, by virtue of their sex, that women are better suited biologically to fill this role than men.

In another study demonstrating this pattern of sex discrimination, Devereux and Werner (1950: 629-634) observed that the medical profession is partly governed by persons who create or control knowledge.[16] For example, nurses are governed by physicians who are presumed to possess superior knowledge. The organistic-scientific approach to medicine does not regard the healing qualities of tender, loving care provided by nurses, which is a nurturant quality, as a scientific attribute. Nurses who are striving for professionalism vis-a-vis medical doctors find themselves in an

insecure position and are often forced to display an excessively professional attitude to attain the recognition they deserve.

Katz (1969: 54-56) pointed out that nurses work in hospitals which are locations where medical doctors are the guardians of knowledge.[17] These doctors integrate with the hospital organization to harness this knowledge and relate it to practical situations. In health care, scientific methods rule supreme, and physicians control the scientific body of knowledge that is applied. The role of the nurse is to overcome the problems that science cannot deal with, which is to supply the nurturant function necessary for the well-being of the patient.

Strauss (1966: 60-108) suggested that nursing is an occupation that is highly hierarchical.[18] At the top of this hierarchy are physicians, followed by the various levels of nursing categories (head nurse for nursing services, nursing supervisors, head nurses, staff nurses, practical nurses, and aides). Hospital administrations generally regard nursing as a low-level occupation. However, this image of the nurse is changing, because university faculties and modern hospital administrators have taken steps to professionalize nursing. University programs have been developed to influence the direction of nursing education and nurses may avail themselves of these programs to secure

certain choice positions; for example, degree nurses hold almost exclusive control of the private nursing market, while diploma nurses work in state and municipal hospitals. Other measures taken toward the professionalizing of nurses make a distinction among the various levels of nursing and control the relationship between nurses and other health occupations through the nursing code of ethics (Strauss 1966: 66-108).[19] Moreover, by developing the body of nursing knowledge and renaming old practices for new expert approaches (for example, total patient care, psychodynamics and interpersonal relations), the image of the profession is further enhanced.

Haberstein and Christ (1955: 29) observed that labels are given to nurses in an attempt to describe their functions.[20] There are the "professionalizers" which constitute degree nurses who occupy the choice positions in nursing; the "utilizers" who carry out the productive functions of nursing; and the "traditionalizers" who are those nurses with a strong belief in the bedside nursing ideal, crystallized around the themes of service, motherliness, and efficient housekeeping, as opposed to more glamorous roles.

We observe from the preceding discussions that the dual labor market concept appears to be applicable to the health care delivery system, which is highly stratified

along the lines of occupational status, race, and sex. In the nursing occupation, for example, the discussions show that there are clearly primary and secondary levels in which those nurses who occupy the primary sector have the choice positions in nursing, while those who occupy the secondary sector are involved in the productive and least interesting, although necessary, aspects of nursing. This will be discussed in greater detail.

STUDIES ON FEMALE MIGRATION

Women in increasing numbers are crossing international boundaries as independent migrants--unaccompanied by their husbands or male relatives. Prior to the 1980s women were thought of as "passive" migrants--in most cases they were reliant upon the sponsorship of their male relatives and spouses. We now know, as supported by the findings of this study, that female migrants are assuming important functions, ranging from the initiation of the migration decision to taking major responsibilities for restructuring the household in the receiving country. One feature that is characteristic of this migration pattern, as pointed out by Chaney (1980), is that whereas, formerly, the modal type in the international migration stream was considered to be the young male (even though this may still be the case in some instances),[21] we are now

aware that the participation of women in the international migration stream is increasing, and in some cases, for example, the Caribbean, female migration has surpassed male migration (Dominguez 1975).[22]

While many women migrate unaccompanied, other categories of migrants include women who are accompanied or who are refugees. The migration process affects each of these categories differently. The structural determinants of migration, as well as the individual characteristics and motivations of migrant women, will play an important role in their settlement and adjustment in the host country. For example, in the sample under study, refugee women would be more likely to be in a less-favored position than women who were sponsored on the basis of their occupation. This is due to the fact that women with skills are in demand in the host country and so more likely to earn higher salaries. These factors have enabled Jamaican nurses to be economically independent and in a position to obtain the material assets for reestablishment.

The findings of Foner (1978), whose sample consisted of unskilled Jamaican women who migrated to Britain, bore out the fact that after migration, these women were economically better off than if they had not migrated.[23] The migration experience fostered greater independence among the women, contrary to the traditional situation that existed in the country of origin.

It was interesting to note that studies carried out on women in societies as different as Ireland and newly independent African nations showed that migration improved the status of women. In his study of Irish migration, Kennedy (1973: 15) observed that the women in his sample were economically better off than if they had remained in Ireland.[24] This was mainly due to educational and career opportunities available in the United States, which subsequently led to greater employment opportunities and higher salaries. This contrasted with the situation they left in Ireland, where opportunities for women were fewer and access to them was difficult to obtain because of the stiff competition and the nonexistence of viable alternatives.

In the case of African women, Little (1973) suggested that urbanization and the efforts to improve the position of women in Africa through education and training were mainly responsible for the changes that were occurring among African nations.[25] This improvement was due to certain developments that were taking place in Africa as a result of new revenues from oil, gold and other mineral resources, which provided the incentive for the training and recruiting of women for jobs in the service sector. Women in the urban areas were breaking out of their traditional mold, because of the modernization of those areas in the fashion of western cities.

This pattern of departure from the traditional way of life was also observed by Kuper (1965) who showed that African women were no longer bound by traditional cultural limitations because of the changes in the economies of many African nations, brought about by the shift from agricultural to industrial production.[26] It appears, therefore, from the findings of these studies that, because of industrialization, more women in African countries are participating in the labor market and are also migrating abroad.

A general theme runs through all of these studies, which indicates that migration improves the status of women regardless of race or level of skills. The fact that these women are migrating to countries like the United States, where opportunities for women are expanding, enhances their situation more favorably than if they had remained in the country of origin to compete for the relatively fewer opportunities. From these studies, and the findings of the sample under study, we observe that through the process of migration, women are able to enhance their status because of economic independence and the opportunities for career advancement.

THEORIES OF ADAPTATION

In a study of European immigrants, Eisenstadt (1954: 6) found that these immigrants were forced to make certain

adjustments so that assimilation could be as harmonious as possible. These adjustments entailed disassociation and transformation of the role, status, image, and sets of values of the indigenous culture because of a shrinkage in the number of roles available to them in the host country. If assimilation is to be successful, it is necessary to establish successful work roles and to develop in-group patterns. This process of adaptation, according to Eisenstadt (1954: 17-21), involves three important aspects:

1. The fulfillment of the immigrant's aspirations and satisfaction with the situation in the host country

2. The degree of accommodation extended by the host country that will influence the immigrant's pattern of adaptation. This accommodation includes participation in the universal roles of the host country, such as participation in the economic, political, educational, and legal institutions.

3. The extent to which the immigrant can retain those aspects of the original culture that are considered important to his or her psychological well-being[27]

From Eisenstadt's study, we can conclude that there may be varying degrees of adaptation, depending on how successful the above factors are applied.

Migrant adaptation was also noted by Gordon (1964: 71-73), who distinguished between two patterns of adaptation or acculturation: behavioral, which is the acquisition of the manners and style of the host society, and the structural, which is the dissolution of differences even at the primary levels.[28] Structural assimilation does not

necessarily follow behavioral assimilation, as is the case with blacks and Puerto Ricans, who have a low assimilation level because of racial as well as cultural differences.

Wirth (1955) suggested that assimilation may not be the desired goal of every immigrant group.[29] He observed that minorities varied widely in their desired form of relationship with the dominant group of the society. The patterns of relationships were pluralistic, in that the various ethnic groups adapted differently to their situation in the American society. For example, Jews, Irish, and Italians were assimilated into the mainstream of American society by virtue of being white, while blacks and Puerto Ricans had only marginal status in the society.

Studies carried out by Glazer and Moynihan (1963) noted that ethnicity is a factor characteristic of American society.[30] They observed that in New York City, the residential, economic, social, and political behavior of the various ethnic groups was manifested in ethnic cleavages throughout the city. The idea that immigrants should eventually deny their indigenous culture in favor of the norms and values of the Anglo-Saxon group, the dominant group in American society, has not been empirically documented. On the other hand, it is shown that because of racial differences minority migrants are likely to retain many aspects of their indigenous culture.

The patterns of adaptation of minorities are very different from those of whites in the United States. This issue has been studied by migration scholars such as Siu (1952: 34) who, in his study of Chinese migration, showed that the pattern of adaptation among this group was one that he referred to as the "sojourner."[31] The term describes the individual or group which maintains the culture of the country of origin, and which is psychologically unwilling to accept permanent residence in the host country, regardless of the years of residence. This sojourner status provides the immigrant with the opportunity to stay as long as he or she desires, since departure is voluntary. Because there is no limit placed on when the sojourner status should end, immigrants can delay indefinitely their departure from the host country. The decision to stay or return can be made consciously, assessing the relative advantages and disadvantages of living in either society. The decision resulting from this assessment may be the individual's realistic relinquishing of the sojourner status in deciding whether to stay or leave.

Minority immigrants, such as blacks and Orientals, come to realize that they have only limited access to the opportunities that exist in American society because of discrimination. It was found from this project under study that, despite years of residence and investment in terms of

property ownership, the respondents still expressed the desire to return to the country of origin. (Table 14) It appears that while discrimination is a potential source of dissatisfaction, migrants who are minorities may derive other measures of satisfaction which may be economic in nature. The migrants' satisfaction and attitude toward the host country may depend on their perception of themselves as being better or worse off than they were prior to migration, rather than on their comparison with other groups which are in a more favored position.

It can be aruged, therefore, that all migrants do not necessarily intend to settle permanently in the host country. Some may have limited short-term goals and plan to return to their homeland when these objectives have been achieved. Frustration may be encountered in the achievement of these objectives, which may be economic or sociopsychological, and which could increase the probability of migrants prolonging their stay in the host country, even when they express the desire to return home.

As has been stated, migratory movements do not necessarily entail the total disregard of old social relationships nor the formation of new ones in the host country. Also, it should not necessarily be assumed that the migrant undergoes a complete change of personality as a consequence of migration. It may be vital for migrants to subscribe to

certain customs, values, and attitudes in the host country. This is accomplished through interaction with persons in the host country and conforming to certain customs, while maintaining different values with fellow migrants, as appears to be the case with West Indian migrants.

The concept of "assimilation" or "adaptation," which terms are used interchangeably in the literature, describes the adjustment of migrants to the host country. It is now evident that this concept in the narrow sense of complete acceptance into the mainstream of the host country, and the adoption of the customs and values of the host country, is not applicable to all migrant groups. This issue was alluded to by Richmond (1969: 275), who stated the following:

> There can be no question of complete assimilation either cultural or structural in an industrial society, because the latter is itself quite heterogeneous, stratified and pluralistic. Unlike traditional societies, there are innumerable groups and associations which the migrant is free to join or ignore as he or she pleases . . . . There are regional and local differences within the receiving society as well as the all-important differences arising from the differential distribution of income and occupational status.[32]

It was further pointed out by Richmond (1969: 266) that the greater the solidarity between the culture and the way of life of the former place of residence and the host country the more likely it will be for migrants to adjust.[33] Contemporary migrants are frequently persons of two worlds,

being able to move easily from one to the other. Subjective problems of adjustment only become serious when successful participation in one social system subjects the individual to penalties and deprivations in the other. They may arise when participation in more than one system is perceived as an act of disloyalty, or when there is discrimination against the migrant in the dominant social system, as is the case with non-European immigrants.

From these studies of adaptation or assimilation, we observe that in contemporary technological societies, like the United States, migration may be related to occupational or career advancement, and thus regarded as a means to an end. However, there may be other population movements, such as those resulting from political persecution or war, that are perhaps the only alternative to large-scale migration.

THE NEO-MARXIST APPROACH

The neo-Marxist approach to the study of migration is concerned with essentially three basic issues: (a) the role of migration or migrant labor in advanced capitalist societies; (b) the out-migration or "brain drain" as it relates to the development in less industrialized societies; and (c) international migration as a phenomenon of the world economy. The studies which have been concerned with the role of migrant labor in advanced capitalist societies utilize the

neo-Marxist approach, which explores the problems international migration poses for both sending and receiving societies. The basic argument presented by scholars using this approach is that advanced capitalist societies are in the position by virtue of their political, military, and economic strength to dominate other societies that are less powerful (Castels and Kosack 1973 and Piore 1979).[34]

Piore argues that the centrality of migrant labor in advanced capitalist economies results in a dual economy, characterized by a primary and secondary labor market. Castels and Kosack and Gorz, on the other hand, assert that the reliance on immigrant labor to do the so-called manual tasks allows for the upward mobility of the middle stratum in the host country.[35] Immigrants are therefore involved in job activities that are less desirable, as opposed to administrative or professional positions, which are prestigious and high in status.

THE DEPENDENCY APPROACH

The dependency approach to the study of migration is concerned with the economic inequality between developed and developing countries. The argument presented by studies such as those done by Myrdal (1957) and Frank (1972) relates to the cumulative draining of surplus from the underdeveloped nations by the developed nations.[36] This surplus may take the

form of migrant labor or mineral resources (such as oil, bauxite, gold, diamonds) from countries that are less technologically advanced and politically, economically, and militarily weaker. Therefore, the countries that are less powerful are dominated by the more powerful countries and become dependent upon these powerful countries economically. Western industrialized nations control the world economy, and these nations are thus in a position to dictate policies to the less-developed ones. The dependency of underdeveloped countries has resulted in their stagnation because of the lack of capital to carry out industrialization.

The issue of migration also involves the drain of skilled personnel from the developing nations to the developed nations, where salaries are higher and opportunities abound. Developing nations not only lose skilled persons who are important to their country's development but they have no control over monetary policies or the market price of their mineral resources. This dependency eventually becomes a way of life for these countries, which subsequently have very little hope of controlling their destinies.

WEST INDIAN MIGRATION: CORE/PERIPHERY

The essential argument set forth in the literature on West Indian societies is that the economies of these countries are dependent economically and financially on the United States and other western industrialized countries. As pointed out by Palmer (1979: 106):

> The migration of human resources from the Caribbean to the United States; the growing financial indebtedness of Caribbean countries to the United States; and the dominance of growth points of the Caribbean economy by the United States direct investment; all underscore the economic and by implication the political role of the United States in the Caribbean . . . . The United States is now the major supplier of foreign capital and food to the Caribbean, and the Caribbean is now the major supplier of labor and raw materials to the United States. This relationship between the Caribbean and the United States has existed since the 1960s when many of these countries became politically independent from Britain.[37]

The decade of the 1960s marked a period of large-scale economic expansion by the United States in the Caribbean area. Watson (1976) noted that United States international firms began investing in the Caribbean where there was a cheap and stable supply of raw materials, such as bauxite, and cheap labor supply.[38] The subsequent expansion of mineral output in these islands was largely responsible for the dramatic growth of Caribbean trade with the United States, which led to the establishment of the United States as the most important trade partner of the region. Although trade with the United States grew rapidly, Caribbean development strategy of industrialization failed to develop a viable

manufacturing sector that would create adequate employment opportunities for an expanding work force.

This issue has also been studied by other scholars, such as Lewis (1950), who asserted that foreign capital was indispensable for development because poor countries could not generate enough savings to finance their capital needs.[39] However, long after the foreign investments were instituted, salaries continued to be relatively low and unemployment remained high, while substantial savings in the form of repatriated profits went to metropolitan countries. According to Singham (1968), these developing countries perceived the international trade relationship with the United States, Britain, and other western industrialized countries to be operating in favor of the advanced countries, whose disproportionate market power influenced the outcome of prices.[40]

The exchange relationship is the essence of the market mechanism between developed and developing countries (Palmer 1979: 107).[41] With the exception of some of the oil-producing countries, many Third World countries feel that the existing rules of the game offer little prospect of achieving what they regard as a more equitable distribution of the gains from world trade. Many developing countries depend heavily on the export of raw materials to the advanced countries, and because the prices of these commodities have

historically been unstable, the focus of the call for a new international economic order has been on stability in commodity markets. The new international economic order can only provide a general framework within which specific policies for Caribbean development must be formulated.

Over and above the general question of a redistribution of the gains from world trade is the question of the collective viability of the small Caribbean economies. The long historical and cultural relationship between the Caribbean and the United States mandates a serious United States commitment toward the development of this region.

The position of the United States toward the Caribbean since the 1970s has been a preference for a regional approach to the development of the area. As was asserted by the United States Assistant Secretary for Inter-American Affairs, Terrence A. Todman:

> We are committed to support strengthened cooperation among Caribbean states themselves. In the Caribbean, the whole is more than the sum of its parts. So long as its peoples remain isolated from each other, instability and dependency on others are likely to persist. The resources of the area will be used inefficiently, and political and social energies will be dissipated.[42]

The advocacy of the United States for regional cooperation is contingent upon the private sector or multinational corporations, and not the United States government, playing an important role in the development of the area.

Todman (1978: 10) further states that the volume of investment required and the need for functional long-term relationships and institutions in the development process both point to the indispensable role of private sector activity:

> The individual decisions of American businessmen and companies to become involved in industry or tourism in one of the Caribbean nations; to engage in import or export trade; to open a plant; to invest in local enterprises; to arrange financing; to cooperate with a Caribbean government or company in a joint-venture; these are the kinds of activities which, as a whole, will affect the economic future of the Caribbean far more than the official transactions of the United States government.[43]

This new policy of economic development formulated by the United States for the Caribbean region offers no planned program for development except the reliance on multinational corporations to provide capital for the region, which is subject to the fluctuations of the financial marketplace. In view of this, the Caribbean area continues to be a dependency of United States economic and political policies, without any viable program for internal development. These conditions are not in keeping with internal economic growth and expansion, and will subsequently lead to high rates of unemployment and deficit balance of trade payments.

The flow of migrants from the Caribbean to the United States is a function of the economic differential between the two areas. Palmer (1979: 137) noted that the wide disparity in income and opportunities between the Caribbean and the

United States, the proximity of the two areas, and the propensity of the Caribbean worker to migrate to developed urban metropolitan areas have contributed to the large-scale migration to the United States.[44] In most cases, the supply of Caribbean labor is greater than United States demand for this labor power. In other words, more workers are willing to migrate to the United States than the number of immigrant visas that country is willing to issue. These reasons cover a wide range of push-pull factors which will be discussed later.

The most important reason for large-scale migration, alluded to in the literature on the Caribbean, is the wide income differential between that area and the United States. This income differential is well known to the potential migrant because it has been widely demonstrated through the tourist industry and the presence of United States multinational corporations and banks. The flexibility of the rate of emigration with respect to wage differentials is well documented by Palmer (1979: 137-39), who argues that the rate of emigration from the Caribbean at any point in time will be influenced by the availability of employment opportunities in the United States and the flexibility of the immigration policies of the United States.[45]

Notes to Chapter II

1. Clifford Jansen, "Some Sociological Aspects of Migration," in Migration, ed. J. A. Jackson (New York: Cambridge University Press, 1969), p. 60.

2. J. Jackson, Migration (London: Cambridge University Press, 1969), p. 1.

3. Ibid., p. 3.

4. Donald J. Bogue, "Techniques and Hypotheses for the Study of Differential Migration," International Population Conference Paper 114 (1961): 4-6.

5. Orlando Patterson, "Migration in Caribbean Societies," in Human Migration: Patterns and Policies, ed. William H. McNeil and Ruth Adams (London: Indiana University Press, 1978), pp. 106-145.

6. G. Beijer, "Modern Patterns of International Migratory Movements," in Migration, ed. J. A. Jackson (New York: Cambridge University Press, 1969), p. 25.

7. Anthony Richmond, "Sociology of Migration in Industrial and Post-Industrial Societies," in Migration, ed. J. A. Jackson (New York: Cambridge University Press, 1969), pp. 238-39.

8. Elizabeth McLean Petras, "Toward a Theory of International Migration: The Division of Labor," in Sourcebook on the New Immigration: Implication for the United States and the International Community, ed. Roy Simon and Bryce LaPorte, assisted by Delores Mortimer and Stephen R. Couch (New Brunswick, New Jersey: Transaction Books, 1980), pp. 439-48.

9. Paul Meadows, "Immigration Theory: A Review of Thematic Strategies," in Sourcebook on the New Migration: Implication for the United States and the International Community, ed. Simon Bryce LaPorte, assisted by Delores Mortimer and Stephen R. Couch (New Brunswick, New Jersey, 1980), p. 397.

10. E. G. Ravenstein, "The Laws of Migration," *Journal of the Statistical Society* 48 (1880): 167-277.

11. Everett S. Lee, "A Theory of Migration," *Demography* 3 (1966): 56.

12. *Ibid*.

13. Paul D. Montagna, *Occupations and Society: Toward a Sociology of the Labor Market* (New York: John Wiley & Sons, 1977), p. 4.

14. Peter Doeringer and Michael Piore, *Internal Labor Market and Manpower Analyses* (Lexington, Mass.: Heath & Co., 1971), p. 3.

15. Barbara Ehrenreich and John Ehrenreich, "Hospital Workers: A Case Study on the New Working Class," *Monthly Review* 24 (January 1973): 15.

16. George Devereux and Florence R. Werner, "The Occupational Status of Nurses," *American Sociological Review* 15 (October 1950): 629-34.

17. Fred E. Katz, "Nurses," in *The Semi-Professions and their Organization*, ed. Amitai Etzioni (New York: The Free Press, 1969), pp. 54-56.

18. Anselm Strauss, "The Structure of Ideology of American Nursing: An Interpretation," in *The Nursing Profession: Five Sociological Essays*, ed. Fred Davis (New York: John Wiley & Sons, 1966), pp. 60-108.

19. *Ibid*.

20. Robert Haberstein and Edwin A. Christ, *Professionalizer, Traditionalizer, and Utilizer* (New York: University of Missouri Press, 1955), p. 29.

21. Elsa M. Chaney, "Women in International Migration." A report prepared for the Office of Women in Development, United States Agency for International Development, Washington, D.C., 1980.

22. Virginia Dominguez, *From Neighbor to Stranger: The Dilemma of Caribbean Peoples in the United States* (New Haven: Antilles Research Program, Yale University, Richmond, 1975), p. 50.

23. Nancy Foner, Jamaica Farewell: Jamaican Migrants in London (Berkeley: University of California Press, 1978), p. 63.

24. R. Kennedy, The Irish Immigration, Marriage, and Fertility (New York: University of California Press, 1973), p. 15.

25. Kenneth Little, African Women in Towns (London: Cambridge University Press, 1973), p. 180.

26. Hilda Kuper, Urbanization and Migration in West Africa (New York: University of California Press, 1965), pp. 1-5.

27. Samuel N. Eisenstadt, Absorption of Immigrants, (London: Routledge and Kegan Paul Ltd., 1954), pp. 6-21.

28. Milton Gordon, Assimilation in American Life: The Role of Race, Religion, and National Origin (New York: Oxford University Press, 1964), pp. 71-73.

29. Louis Wirth, "The Problem of Minority Groups," in The Science of Man in the World Crisis, ed. Ralph Linton (New York: Columbia University Press, 1955), pp. 10-25.

30. Nathan Glazer and Patrick D. Moynihan, Beyond the Melting Pot: The Negroes, Puerto Ricans, Jews, Italians and Irish (Cambridge, Mass.: M.I.T. Press and Harvard University, 1963), pp. 50-55.

31. Paul Siu, "The Sojourner," American Journal of Sociology (July 1952), p. 34.

32. Anthony Richmond, "Sociology of Migration in Industrial and Post-Industrial Societies," in Migration, ed. J. A. Jackson (New York: Cambridge University Press, 1969), p. 275.

33. Ibid., p. 266.

34. Stephen Castels and Godula Kosack, "Immigrant Workers and Class Struggle in Advanced Capitalism: The Western European Experience," Politics and Society 5 (1973): 33-36; and Michael Piore, Birds of Passage: Migrant Labor and Industrial Societies (New York: Cambridge University Press, 1979), pp. 10-15.

35. *Ibid.*; and Andre Gorz, "Immigrant Labor," *New Left Review* 61 (1970): 28-31.

36. Gunnar Myrdal, *The International Economy* (New York: Harper & Row, 1957), pp. 1-25; and Andre G. Frank, "Economic Dependence, Class Structure, and Underdevelopment Policy," in *Dependence and Underdevelopment: Latin America Political Economy*, ed. James D. Crockcroft; Andre G. Frank; and Dale Johnson (New York: Doubleday & Co., 1972), pp. 20-25.

37. Ransford Palmer, *Caribbean Dependence on the United States* Economy (New York: Praeger Press, 1979), p. 106.

38. Hilbourne Watson, "Migration and the Political Economy of Underdevelopment: Notes on the Commonwealth Situation," presented to the Panel of International Migration as a Policy issue; the Western Hemisphere, at the International Studies Association Conference held in Toronto, Canada (February 25-28, 1976).

39. Arthur Lewis, "The Industrialization of the British West Indies," *Caribbean Economic Review* (May 1950): 18.

40. Archibald Singham, *The Hero and the Crowd in a Colonial Polity* (New Haven: Yale University Press, 1968), pp. 1-10.

41. Palmer, *Caribbean Dependence*, p. 107.

42. Terrence A. Todman, address on Inter-American Affairs, at the 2nd Caribbean Conference on Trade, Investment, and Development, Miami, January 18, 1978. (Mimeographed.)

43. *Ibid.*

44. Palmer, *Caribbean Dependence*, p. 137.

45. *Ibid.*, pp. 137-39.

CHAPTER III

THE JAMAICAN SOCIETY: THE PUSH FACTOR

In Chapter I we discussed various approaches and formulations to the study of migration. We observed from these studies that the reasons why people migrate (push factors) are embedded in the differences (positive in terms of the host country, and negative in terms of the country of origin) in the political and socioeconomic structure of both sending and receiving countries.

Many Third World scholars (Singham 1968, Palmer 1974, and Watson 1976) have argued that inequalities between rich and poor nations are the major contributing factors of migration to the United States.[1] They view migration from the West Indies to the United States as the result of failed economic systems, which are not viable enough to compete on the world market. These economic systems have worsened as a result of worldwide inflation, which dealt a severe blow to their already weak economic systems. The result of this inflation was stagnation and lack of economic growth because of inadequate capital to stimulate the economy of Jamaica and other West Indian islands, which led to borrowing from the United States.

The monetary and political policies of the developed nations vis-a-vis the developing nations have resulted in a very unfavorable balance of trade, unemployment, and economic stagnation for most of these nations. These negative consequences usually lead to dissatisfaction among persons in the labor force who are skilled and who subsequently migrate to the United States to seek higher salaries and greater opportunities for advancement.

HISTORICAL PERSPECTIVE ON JAMAICA

The study of colonial societies such as Jamaica raises a number of questions that are unique and peculiar to these areas. Most societies which have endured long periods of colonial rule tend to carry forward into the post-independence period features of the colonial experience. This tendency is reinforced by the economic dependence which continues even after political independence is achieved.

Economic dependence is woven into the historical development of colonial societies and is further strengthened by the contemporary structure of world capitalism (to which Jamaica is subordinated) and the economic, political, and social policies generated by the resulting class structure, especially the class interest of the dominant class. Furthermore, "dependency" lies not only in the external relations that exist between these nations and the advanced

capitalist countries but equally in the internal conditions of the societies themselves.[2] It is reflected in their international and domestic policies and becomes the source of the most profound far-reaching ideological and psychological manifestations of the assimilation of metropolitan ideology and capitalist theory. At the same time, this dependency generates reactions visible through nationalism, the growing class struggle against the capitalist system, and the development of political ideologies contrary to the capitalist system.

Jamaica underwent a slave period from 1517 to 1834, which was the period of the emergence of the expansionist industrial powers of Europe and the search for raw materials and trade. Out of this system emerged a group of territories whose sole purpose was to supply raw materials for the market demands of Europe. Incorporation of a raw-material producing colony had far-reaching consequences for the Jamaican economy. Sugar emerged as the principal crop on the island and resulted in the entire island becoming a predominantly agrarian society. The typical economic unit on the island was the plantation estate. The principal factors of the estate were capital investment from Great Britain and slave labor from Africa. The system derived external stimulus, finance, and enterprise from Britain. Based on these characteristics and on the development of an export economy, the plantation system was fundamentally international and became

closely associated with most political and international development of modern times: mercantilism and free trade, slavery and independence, capitalism and industrialism.

British economists often described Jamaica and the other Caribbean islands as places where Britain found it convenient to carry on the production of sugar, coffee, and a few tropical commodities, and the trade between them was similar to the town and country trade at home (Beckford 1969). The capital generated from the profits of sugar and other commodities did not remain on the island, unless it was to maintain existing plantation facilities. Instead, the capital accumulation actually took place in Britain, where many fortunes were made from sugar to develop Britain's industrial base and world dominance. Slavery ended in 1834 but Jamaica continued under British control until 1962 when the island gained its independence.

Political freedom for Jamaica meant little in the way of reducing its economic, social, and psychological dependence on Britain. The influence of the British was strong in the formulation of the Jamaican parliamentary system of government and educational system. British common law and practice still formed the basis of the legal and judicial systems, with little modification for local situations. By maintaining many of the British political and legal forms, the new government likewise inherited, to some

extent, the purpose of that structure, which was to maintain a dependency status vis-a-vis Britain and the United States. The lack of change in the political and economic structure of the island led the former prime minister Michael Manley, in 1975, to state the following:

> Between 1938 and 1972, a considerable assault was mounted against the worst material consequences of our colonial experience. I do not sell short a country like Jamaica, brought by nationalism to perception of the need for, and the ability to take, independence. The trade union movement laid the foundation of material wealth and some measure of class confidence among workers. Organized political parties secured considerable amelioration of the national condition in the form of economic growth, increasing education, and the first outlines of social security. But we found even as late as 1972 that, apart from the fact of independence, the fact of the modern political parties, the things that were happening were not so much change as modification. The system that we had been bequeathed by colonialism was not changing. The effects of the system were being modified substantially, but that is not the same thing as change.[3]

From the preceding account on Jamaican history, which was summarized to give some perspective on the socioeconomic and political problems which are still evident today, we observe that areas with dependency status, like Jamaica, are characterized by the emergence of a resident commercial class which directs this process and shares its benefits in economic and political alliance with Britain and the United States. Furthermore, because of the unequal exchange of raw materials for manufactured goods and remittances of profit and interest, the flow of capital from Jamaica to the United

States and Britain has continued to increase. The colonial structure has created a high profitability of production for export, and an unequal distribution of income at home, and the consequent class struggle has deprived the majority of Jamaicans of adequate purchasing power and rendered production for domestic market ultimately unprofitable.

Another characteristic of dependency is the utilization of the indigenous population for the production of raw materials for export at extremely low remuneration. Furthermore, Jamaica's close ties with Britain produced a system of development which was rigid and effectively eliminated opportunities to channel development in a way that was constructive to the economy. Unlike the capitalist class in advanced countries like the United States, Jamaica did not invest in a productive system, or create a social organization capable of generating self-sustained economic development. Therefore, the way was paved for the new forms of capitalist expansion by multinational corporations and, thus, the dependency is perpetuated.

The government of Jamaica opened its doors to trade with the United States and Europe under similar circumstances as existed under colonialism. Consequently, the conditions which led to the migration of Jamaican nurses to New York City cannot be fully understood without a background of the negative political and socioeconomic conditions which form the background for the present conditions.

FACTORS CONTRIBUTING TO MIGRATION

The factors prompting migration from Jamaica to the United States can be further specified within the framework of the socioeconomic relations between developed and developing nations. The availability of foreign workers organized as a distinct portion of the labor force in the United States has introduced new competitive and functional dynamics into the economy of production.

The allure for migrants to leave their country and migrate to the United States is based on the premise that the United States, in its position as the leading capitalist country in the world, can offer better employment opportunities and a higher standard of living than many of the sending countries with less developed socioeconomic systems. Therefore, it would appear that even though most migrants from Third World countries, like Jamaica, comprise what is labeled the "secondary" labor force in the United States, the salaries in the United States are higher and they are economically better off than if they had not migrated.

It was asserted by Lee (1966: 56) that the decision to migrate is determined by the circumstances of the particular migrant group, and whether or not that group is responding primarily to negative factors in the sending country or positive factors in the receiving country.[4] These factors

are weighed against the advantages accruing with the migration (i.e., perceived opportunities in the host country).

The single most important factor that facilitated the migration of nurses to the United States was the passage of the Immigration Act of 1965. An examination of table 1 shows that between 1962 and 1965 a total of 7,052 immigrants came to the United States. In the subsequent four-year period the number increased to 47,643. The increase of approximately 95 percent between 1966 and 1976 is significantly higher than the general rate of immigration to the United States prior to 1965. The Immigration Act of 1965 gave preference to skilled persons to migrate to the United States in consideration of the general needs of the American economy.

UNITED STATES IMMIGRATION POLICIES

The granting of visas to nurses who petition to enter the United States for employment presupposes that the nurse is prepared to function as a fully qualified nurse. The only indication of such readiness available at this time to officials responsible for issuing visas is a diploma or certificate granted by the country of origin where the nursing education was received.

TABLE 1

JAMAICAN MIGRATION TO THE UNITED STATES 1962-1976

Year	Number of Migrants
1962	1,573
1963	1,880
1964	1,762
1965	1,837
1966	2,743
1967	10,483
1968	17,470
1969	16,947
1970	15,033
1971	14,571
1972	13,427
1973	9,963
1974	12,408
1975	11,076
1976	9,026
Total	140,199

SOURCE: U.S. Immigration and Naturalization Service, Annual Reports, 1962-1976.

According to a report issued by the Department of Health, Education and Welfare (HEW) (1975), the principal agencies formulating immigration statutes and regulations are:

1. The Congress of the United States, which has the authority for legislation on the basic requirements for immigration.

2. The Immigration and Naturalization Service of the Department of Justice, which develops the regulations and procedures for determining the admissibility of persons wishing to enter the United States, and has the responsibility for enforcing immigration laws and regulations. Included in this function is the adjudication of visa petitions seeking to confer preference classifications upon certain intending immigrants or classifying certain temporary visas.

3. The Department of Labor, which is responsible for the issuance of labor certifications for alien employment. Under the Immigration and Nationality Act, the Department of Labor must determine and certify to the Department of State and to the Immigration and Naturalization Service that qualified United States workers are not available, and that alien employment will not adversely affect wages and conditions of workers in the United States similarly employed.

4. The Department of Health, Education and Welfare, which maintains an interest and responsibility for providing the numbers and kinds of health manpower needed to provide health care for the people.[5]

There are a variety of provisions under which nurses may enter the United States as temporary or permanent workers. The HEW report states that the "H" visa granted to an alien accounts for the recent rapid increase in the number of nurses entering the United States for employment. This type of visa provides for nonpermanent admission to the United States of aliens of "distinguished merit and ability

to perform services of an exceptional nature." This provision has gradually become utilized to admit greater numbers of aliens who fill needed categories of workers. One reason for this expansion is the fact that the statute, originally a provision for temporary admission, was amended by Congress in 1970 to delete the word "temporary" from the description of employment, so that aliens admitted under this provision can obtain work in positions which are permanent.

Prospective employers are required to prepare and submit to the Immigration and Naturalization Service the petitions for "H" visa eligibility for persons they have contracted to employ. An employer may include more than one individual in the petition if the beneficiaries of the petition are to be employed in a single institution and will be doing the same kind of work. Aliens admitted under this provision are required to take employment with the employer who petitioned for their admission. If they change employment, a new petition must be submitted, and they may apply to the immigration authorities to have their status adjusted to that of lawful permanent resident aliens. In these circumstances, a permanent visa may be granted on the immigrant's ability to perform services of an exceptional nature, requiring such merit and ability, and if employed persons capable of performing such services or labor cannot be found in the country.

Because of these changes in United States immigration policies since 1965, increasing numbers of nurses are entering the United States from countries where language, education and culture are quite different from those of the host country.

SOCIAL AND ECONOMIC FACTORS

The conditions that expel migrants from Jamaica to the United States can be attributed to the negative socio-economic conditions that have existed in Jamaica over the past two decades. These conditions include a weak industrial base, economic stagnation, and high interest rates. Jamaica has to borrow money from the United States to carry out capital investments and expand the industrial base. These loans are secured at high interest rates, which leads to further borrowing to pay the interest on the loans.

Since 1981, it was reported in the New York Times (Kaufman 1982), the surge of imports from the United States to Jamaica has increased the island's foreign debt.[6] The International Monetary Fund (IMF) has again been giving balance of payment support and loans are forthcoming from the Reagan administration. Since the election of 1981, loans of almost $1 billion have been negotiated, and the foreign debt was expected to reach $3 billion by the end of 1982. These facts show that Jamaica continues to be tied

to and governed by the monetary policies of the United States. The inevitable result will be increased foreign debt since, with the island's stagnant economy, it is almost impossible to raise the capital internally to pay off this loan. Also contributing to the island's economic plight is foreign ownership of key industries and corporations which control the resources of the country because Jamaica lacks the technology to develop and market these resources.

Kuper (1976: 18) pointed out that the internal structural imbalances of Jamaica's economy are related to its dependence on foreign investment.[7] Jamaica's politicians have been able to nudge the economy, but the direction of the economic development has been shaped by the investment decisions of foreign companies. The extent of this foreign control may be seen in the fact that outside companies own 40 percent of sugar and its by-products; 40 percent of transport, communications, and public utilities combined; about 60 percent of financial services; 55 percent of hotel capacity in the tourist industry; and about 100 percent investment in bauxite alumina production, which is the primary source of revenue for the island.

The negative impact that foreign control of key industries has on the Jamaican economy is that the locus of domestic policy is shifted from the internal economy to the

external centers of power. Internal economic growth continues to operate with a margin capacity in the key producing areas such as bauxite, construction, and tourism, all of which are mainly foreign owned and controlled industries. It is understood that in order to develop the internal economy, the controlling interests have to be owned by investors within the country, so that the economy can grow, local people can be employed, and the government can benefit from tax revenues. The Jamaican economy suffers from a lack of capital internally with which to build a viable economic base to offset increasing deficits.

Kuper (1976: 19) also points out that imports to Jamaica totaled J$483.2 million in 1976, while exports were J$300.3 million, showing a deficit of J$192.9 million. Food imports alone rose in value from J$45.9 million in 1969 to J$71.3 million in 1972. The shortfall of the balance of payments is partly met by receipts from tourism, capital flow, and receipts from Jamaicans abroad. However, inflows of capital are partly counterbalanced by freight and insurance expenditures, payment of dividends, and the repayment of loans. These economic conditions were evident prior to the 1970s when fuel costs rose and inflation was rampant, and they have since worsened. All of these factors adversely affected a large segment of the Jamaican labor force, causing severe hardships and the loss of jobs.[8]

At the end of 1974, it was reported that the population of Jamaica was approximately 2,025,000, an increase of 1.7 percent from the previous year (Economic and Social Survey 1974: 8).[9] The rate of unemployment at that time was a staggering 22 percent, not including the seasonal and marginal labor figures. These conditions impacted negatively upon the public sector, because cuts were made in an already lean budget to carry out services in health, education, and welfare.

The government of Jamaica has always been the primary sponsor of health services, which include the construction of hospitals and medical centers, and the staffing of these institutions. The health care delivery system is the joint responsibility of the Ministry of Health and the Ministry of Local Government. The total expenditure of health care services, relative to other public sector expenditures, amounted to an estimated $120 million in 1989, and $135 million in 1980, an increase of $15 million.[10]

Although the health care system has been improving over the past decade in terms of modernization (e.g. the purchase of technological equipment and availability of health programs to the public), there are still major improvements that have to be made. For example, the health care system suffers from a deficiency in the number of reputable institutions for the treatment of mental illness, inadequate

facilities for the elderly, and the lack of clinics throughout the island which provide birth control programs, pediatric and emergency care. Also, the unsatisfactory salaries paid to health personnel, especially nurses, has led to the loss of nurses to the United States, where conditions are far superior to those existing in Jamaica, because of the vast differences between the two economies. Jamaica therefore continues to lose skilled personnel because of all of these negative socioeconomic conditions.

Notes to Chapter III

1. Archibald Singham, The Hero and the Crowd in a Colonial Polity (New Haven: Yale University Press, 1968), pp. 1-10; Ransford Palmer, "A Decade of West Indian Migration to the United States: An Economic Analysis," Social and Economic Studies 23 (1974): 571-87; and "West Indians in the United States: Why So Many?" Amsterdam News, 2 October 1976.

2. George L. Beckford, "The Economics of Agriculture Resource and Development in Plantation Economics," Social and Economic Studies 18 (December 1969): 322-24.

3. Michael Manley, Government Policies at Home and Abroad (Kingston, Jamaica: Agency for Information, 1975), p. 5.

4. Everett S. Lee, "A Theory of Migration," Demography 3 (1966): 56.

5. U.S. Department of Health, Education, and Welfare, Health Resources Administration, Bureau of Health Manpower, Division of Nursing, Bethesda, Maryland, Immigration of Graduates of Foreign Nursing Schools, 1975, pp. 1-33.

6. "Jamaica Still Isn't Making It." New York Times, June 1982, p. 18.

7. Adam Kuper, Changing Jamaica (London: Routledge and Kegan Paul Ltd., 1976), p. 18.

8. Ibid., p. 19.

9. U.S. Department of Justice, Immigration and Naturalization Service, Economic and Social Survey, Jamaica 1974 (Kingston: The Government Printer, 1975).

10. Ibid.

CHAPTER IV

THE AMERICAN SOCIETY: THE PULL FACTOR

In Chapter II we briefly discussed some of the changes that have occurred in nursing within the context of the dual labor market concept. In this chapter we will discuss in greater detail some of the historical developments influencing the changes in nursing service, starting with the early period of the twentieth century, which created a demand for nurses and subsequently led to the migration of Jamaican nurses to the United States. The most important of these developments were the large-scale involvement of the United States federal government in financing the delivery of health care to the disadvantaged and the elderly; federal subsidies for nursing education; scientific and technological advancements in medicine and the treatment of illnesses; and the effects of the women's movement on nursing. All of these factors contributed to the changing role of the nurse and the organizational structure of the modern hospital.

Since the majority of nursing care takes place in the hospital, changes in the structure of the hospital affect nursing services. The changes that have been taking

place in the modern hospital are directly related to the advancement in scientific methods and technology for the treatment of diseases, which did not exist prior to the twentieth century. For instance, the introduction of computers to monitor patient care and the development of artificial organs have revolutionized the medical field. The new methods of caring for the sick required a staff that was trained to handle the specialized equipment and evaluate the effects of these methods. Therefore, all medical personnel, including nurses, had to be reeducated to assume the new roles of the technological age. However, the need for nurses to carry out patient care remains an integral part of nursing service, and an area of nursing which continues to suffer from a shortage of personnel to meet the growing demand.

HISTORICAL PERSPECTIVE ON NURSING

Nursing has been the object of much study and analysis over the past two decades because of certain scientific and technological developments and the involvement of the federal government in financing the improvement and expansion of the American health care system. The antecedents of modern nursing are rooted in Florence Nightingale's activities, which attempted to establish standards for nursing and

to organize the delivery of nursing care into a responsible institutionalized system. The history of modern nursing, therefore, is inextricably interwoven with women. This link to the female image in nursing has persisted from the early part of the twentieth century to the present time, even though male nurses have been involved in the performance of nursing.

It was noted by Maukch (1966) that in western culture, those who care for the sick are identified with labels which are primarily female; for example, the term "sister" is not only applied to the religious functionary but in many European languages generally identifies the nurse.[1] In western context, "nursing" implies the essence of the mother's relationship to her offspring, and the natural tendency of a mother to care for her family without having formal boundaries to her area of competence. This includes the ability to manage her home. Thus, the image of the mother underlies the expectations still held today about the appropriate role of the nurse.

In linking these historical antecedents to modern nursing in the United States, one must consider the different cultural influences that bear upon nursing in the United States, at the beginning of this century, with nursing in Europe. The generally more open society and traditional approach to the division of labor (compared to Europe) and

the American belief in credentializing affected the structure of nursing here. The institutionalizing of educational requirements and prerequisites for nursing were closely linked to the attempts to formalize the nursing occupation, which is again associated with the Florence Nightingale movement.

THE APPRENTICESHIP SYSTEM

Although modern nursing is an outgrowth of scientific and technological developments in part, apprenticeship in the field of nursing was an essential method of educating nurses while they carried out their nursing functions in the hospital. This method of nursing, which was very exploitative of nurses, was the primary method used during the early twenties and through the forties in the hospitals. Therefore, the social and ideological forces that perpetuated the apprenticeship system of nursing also served as the basis for the formation of the modern hospital and the development of nursing, until questions and debates about the system in the late 1940s subsequently led to changes in the role and image of the nurse in the sixties.

Prior to 1965, organized nursing tolerated hospital schools and the public fully accepted the apprenticeship system of training nurses as the major means of educating

them to perform their duties in the hospital (Ashley 1976).[2] The policies and procedures formulated as a guide for management were fashioned on the "household" model, which embraced production, efficiency, and the preservation of the institution's reputation. The role of the nurse at this time was conceived as that of caring for the "hospital family." The function of the nurse was to provide efficient, economical production in the form of patient care, through service and self-sacrifice. Like mothers in the household, they were responsible for meeting the needs of patients, and they were also handmaidens to the physicians.

Although the relationship between the "nurse apprentice" and the hospital was a contractual one, a legal vacuum existed within the apprenticeship system, because practices were carried out according to custom rather than law. The nurse apprentice received a small wage, thus the relationship to the hospital was similar to that of employer and employee, though not in the formal sense. By the late 1940s and 1950s, however, most hospitals had stopped making any kind of payment to apprentices, and nursing students had to pay the hospitals for the opportunity of carrying on their training in those institutions. Hospital management, therefore, grew accustomed to the exploitation of apprentice nurses as a source of labor, until the nurses themselves began to protest the deplorable conditions.

The increasing interest of nurses in obtaining a shorter working day was in part an outgrowth of similar interests of the labor movement of that time, although a shorter day was also considered desirable for the improvement of their education. The apprenticeship system could be characterized as a suitable method for instilling in nurses a dependency on their superiors, a desire to cooperate, and a tendency to deny oneself for the good of others. Although the nurses were dissatisfied with the system, it was not until 1965 that organized nursing came out with a policy statement which revealed the extent to which the apprenticeship system was viewed as an ineffective and exploitative method. During the same period, a proposal to set minimum standards and preparation for upgrading and improving nursing service was introduced.

GOVERNMENT INVOLVEMENT IN THE HEALTH CARE SYSTEM

An interesting feature of the American health care delivery system over the past two decades has been the involvement of the government in every aspect of the health care industry. Government regulates medical and dental practice, construction of hospitals and medical centers, the marketing of drugs, and research and development in medicine and medical technology. All of these areas are

subsidized and regulated by the government--from the education of health professionals to the provision of health care to the poor and the elderly. This extensive involvement of the government in the health care industry has radically changed the way in which medical institutions mediate the various interest groups such as medical, dental, nursing, and other professionals that work for the health care industry. There is continuous competition among these groups to influence the legislature in their favor, at the expense of the less powerful groups in the industry.

Historically, physicians are known to have the greatest success in influencing legislation because of the powerful lobby they have in Washington. However, in the 1960s, the government sought to make certain changes in the health care industry through legislation, despite resistance from the medical lobby. Many doctors and hospital administrators perceived this legislation, though designed to relieve the needs of the poor and the elderly, as a threat to their independence.

The Medicare and Medicaid legislation, passed in 1965, has now far exceeded the early estimated expenditure. The total health care expenditures increased enormously from $10.8 billion in 1950 to $43 billion in 1967, and more than $300 billion in 1982 (Feldman 1984: 336).[3] Because of the rapidly rising cost of medical care since the 1960s, the

government is now seeking to propose controls on health expenditures. Nevertheless, the dominant health interest groups who benefit from the existing system are putting forth a strong resistance.

The expansion of the health care industry as a result of federal legislation and allocation of funding has brought about an increased supply of health professionals and workers and the inflow of migrant medical personnel (i.e., nurses, doctors, technicians) into areas that were once occupied by the indigenous medical personnel. This opened up the opportunity for many indigenous qualified medical personnel to move up into areas of new career opportunities that were created because of the expansion of the health care system. Improved technology at this time also contributed to a change in the organizational structure of the various medical facilities. All of these reforms brought about changes in the role of the nurse.

We observe that, because of the passage of the Medicare and Medicaid legislation of 1965, billions of dollars were allotted to take care of the health needs of the poor and the elderly. This funding effected the expansion of health facilities, such as clinics and nursing homes, and created new job opportunities in the health field, an extensive increase in the employment of health professionals, and the recruitment of medical personnel such as

nurses, physicians and technicians to fill positions, especially at the entry level.

THE FEDERAL GOVERNMENT AND THE FINANCING OF NURSING EDUCATION

The passage of the Nurses Training Act of 1964 provided substantial funding for financing and upgrading nursing in the United States. This was the first comprehensive federal legislation, although the first direct federal support for nursing education approved by the Congress lasted from July 1, 1941 to June 30, 1943.

The Nurses Training Act of 1964 provided refresher courses for inactive nurses, grants for nursing personnel to prepare for advanced positions in nursing, and funds for increased enrollment in nursing schools. The Act allowed hospital training programs and schools of nursing to raise the educational standards of nursing, expand the facilities, and reorganize faculties and curricula. The Health Manpower Act passed in 1968 also provided aid to nursing students, and the Nurses Training Act of 1971 provided additional aid to nursing education, which lasted until June 1974.

According to Gunter (1976), specific improvements resulted from these acts, the most important one being the increase in the ratio of the nurse population, which had decreased during the fifties, from 306 per 100,000 in 1964

to 361 per 100,000 in 1972.[4] In addition to the number of nurses, suitable facilities for nursing education were established by expanding and modernizing existing facilities, as well as building new ones. Student aid in the form of loans and scholarships was provided, and continuing education was developed to qualify nurses for the more technical functions they now had to assume.

Probably one of the most significant outcomes of the legislation passed to further nursing education was the development of an expanded role for the nurse. The grants provided for other improvements such as (a) regional planning to expand and share resources for critical areas and continuing nursing education; (b) initiating twenty new baccalaureate and associate degree programs; (c) providing remedial services for disadvantaged students for the preparation of practical nurses and aides and others interested in second careers in nursing; (d) developing career ladder curricula that enabled students to enjoy greater career mobility; and (e) initiating pilot programs to train nurse practitioners for expanded roles in primary care, and in teaching and management of patients.

As a result of the legislative developments in nursing education, 60,000 nurses have received traineeship aid for long-term full-time study, and short term intensive

courses that prepared them for teaching, supervision, administration, and clinical specialization. In addition to these effects, there have been other, more subtle results of federal funding for nursing programs. It appears quite likely that universities in general are impressed or affected by the fact that federal funds are available for nursing programs.

The availability of federal funding showed recognition for the professionalization of nursing within the university and made the programs more significant. Such funding demonstrated to the university community that nursing programs were not completely dependent on university resources. Because of these reasons, it would appear that some universities and colleges associated with the state and federal government have become interested in establishing nursing programs simply because of the federal financing that is available. If such funds were not available, it is unlikely that these institutions could afford to develop programs for nursing education. Therefore, federal funding has influenced the academic community in a tangible way, so that nursing now carries with it a certain amount of political power demanding recognition by the society that it is worthy of professional status by virtue of its contribution to health care.

THE EFFECTS OF SCIENCE AND TECHNOLOGY ON NURSING PRACTICE

The scientific innovations in medical treatment and the technology now applied in the health care industry have vastly changed the organizational structure of hospital and nursing practice. With the advent of post-World War II technology, the nurse began to acquire greater medical and technological skills. The period since World War II to the present has been characterized as a period of rapid growth in knowledge within the health sciences concerning people and diseases. This increase in knowledge has led to technological developments which have refined the quality of care that is provided to people in medical institutions.

A revolutionary change has taken place in the diagnosis and treatment of illnesses, resulting from the scientific discoveries, outside the medical field, in biochemistry, technological equipment, and the psychosocial aspects of medicine. This is particularly noticeable with the availability of an abundant supply of various drugs beginning with the discovery of penicillin. A wide range of equipment employed in the treatment of illnesses, such as remedial dialysis, heart-lung machines, various monitoring devices such as closed circuit television, computers, and radioactive isotopes are only a sampling of the complex treatment

and equipment invented for use in present-day hospitals and medical institutions.

The provision of health services has changed dramatically as a result of increased knowledge and use of technological devices. Knowledge and management of these new devices require special training of responsible health personnel. There are now five basic specialties in the average modern hospital: (a) urologic; (b) emergency care; (c) pediatric; (d) cardiac; and (e) intensive care. Paralleling these developments in the health care delivery system are: the growth of specialty training program for nurses, professional journals, new credentials, and updated standards for practice. Since the 1960s and onward, there have been basic changes in the way Americans view health care. This new outlook has exerted a profound demand on the health professionals who perform these services. Health care became a right, rather than a privilege, and the government had to assume the obligation to provide these health care services to citizens.

In the United States, the passage of Medicare and Medicaid legislation of 1965 provided funding for the provision of health care to the disadvantaged and the elderly. Other forms of medical insurance, such as Blue Cross and Blue Shield and major medical, cover citizens with quality and expensive health care, which resulted from these

scientific and technological advancements in the treatment of illnesses. Both the technological changes and the federal legislation changed nursing services from a relatively simple occupation, which usually involved taking care of patients' hygienic needs and nutrition, to one that has become more complex, as nurses assume such functions as the administration of staffing and patient care, and participation in the performance of complicated diagnostic tests, as well as therapeutic procedures, all of which require increased vigilance and careful observation of the patient. As nurses moved into these expanded areas of nursing service, a shortage of nurses at the productive level to carry out the functions of patient care and the traditional bedside nursing became inevitable. It was necessary, therefore, to recruit foreign nurses to fill this role, because the demand far exceeded the available personnel in the United States.

DEMAND FOR NURSES IN THE UNITED STATES

The demand for nurses in the United States can be summarized from the literature on nursing (Flanagan 1976, Williamson 1976, Millman 1978), as follows: There are basically four major factors which influenced policies, services and the organizational structure of nursing, which results in the demand for the recruitment of foreign nurses:

1. The passage of the Medicare and Medicaid legislation in 1965, which allowed for the allocation of substantial amounts of money for the improvement and expansion of the health care system to provide services for the elderly and the disadvantaged

2. Increased educational requirements for entry into nursing practice as a result of the Nurses Act of 1964, which allotted federal funding for nursing education

3. Scientific and technological advancement in medicine and the treatment of illnesses, which changed the organizational structure of the modern hospital and nursing

4. As a result of these structural changes, more elaborate stratification in nursing, the introduction of new categories in nursing, and changes in the functional relationships among nurses[5]

Since the passage of Medicare and Medicaid, it was shown from the Statistical Abstract (1980-1984) that government expenditure for health care rose from $6.6 billion in 1970 to $122 billion in 1981. The same source also noted that nursing homes increased from 18,165 in 1968 to 22,004 in 1971. These figures indicate the rapid escalation of federal expenditure for the improvement and expansion of health care facilities and services for the poor and the elderly. As a result of this legislation and the expansion of the health care delivery system, there was a great demand for nurses, especially at the productive level. This was due to the fact that health programs were instituted to provide care for the elderly on a larger scale than existed prior to the 1965 legislation. These health programs instituted for the elderly are very labor intensive. For example,

in a nursing home unit, most of the patients are unable to care for themselves and require ongoing care, which is furnished by diploma nurses who carry the workload of all the patients' physical needs, including nutrition, personal hygiene, physical therapy, and the administration of medication. The demand in this area of nursing was more than the available supply in the United States; therefore, foreign nurses were recruited to carry out these functions.

The sixties was also a period of the evaluation and upgrading of nursing services and education. The scope for nursing services increased and the nurse's influence upon the patient and physician broadened. More nurses began to move into the administrative and clinical specializations of nursing service, which further created the need for more nurses at the productive level. The other factor that contributed to the change in nursing service was the technological advancements over the past fifty years which gradually altered the function of the nurse and the organizational structure of nursing. Nurses are now required to be more scientific in the care of patients. These changes have brought about a distinct division in nursing practice--the administrative and professional level and the productive level of nursing.

We observe from the literature on nursing (Altman 1971: 66) that hospitals employ over 60 percent of all

trained registered nurses, practical nurses, and aides.[6] The hospital is the main institution for the provision of health care, and nursing is the main service provided by the hospitals for the care of the sick. The demand for nurses has grown from 50,000 registered nurses in practice in 1910 to 700,000 in 1970. These numbers represent 55 nurses per 100,000 of population in 1970, compared to 34 per 100,000 in 1910. Of all health workers, 16 percent are nurses; and of professionally trained workers, approximately 40 percent are nurses.

Since the Medicare and Medicaid legislation, the demand for nurses (i.e., registered nurses, practical nurses, and aides) has increased.[7] From 1966, the year following the passage of the legislation, to 1972, the number of active registered nurses in hospitals and nursing homes across the country rose by 111,747, or 28 percent. According to the National Institute for Health, the demand for registered nurses increased to 895,000 from 1950 to 1980; the demand for practical nurses increased to 675,000 from 1950 to 1980; and the demand for aides increased to 1,150,000 between 1950 and 1980. From these figures we observe that the demand for nurses at the productive level is increasing at a rapid rate. Nursing services continue to expand as a result of the expansion in the health care delivery system. This has brought about efforts to intensify the recruitment of

nurses, while looking for ways to utilize the present supply of nurses more effectively and efficiently.

THE EFFECTS OF THE WOMEN'S MOVEMENT ON NURSING IN THE UNITED STATES

The period since World War II characterizes a time of social and political upheaval, in which demands were made for racial and sexual equality. The demand for sex equality is an issue that has been popularized by women in highly industrialized countries like the United States and other western countries, where the unequal status of women vis-a-vis men is being questioned, and changes are being implemented to correct these inequalities. To grasp an understanding of this problem, it is important to review the social attitudes toward women in western societies, in order to determine to what extent these attitudes have limited their progress.

It appears that the process by which the society identifies its male and female members is the main cause of the emphasis on biological difference. Sexual identity is the image of the self as a male or female and the convictions about what membership in either group implies. The individual's sexual identity is the sex-typed image which gradually develops from infancy. It is the result of learned conceptions about how one ought to think, act, and feel by virtue

of being male or female. This process also includes learned ideals of masculine and feminine behavior and the proper authority relationships between the sexes. These ideals provide standards for judging emotions and behavior, privileges and limitations, and the evaluation of the self as inferior or superior, desirable or undesirable. If the society defines the characteristics of beauty as feminine, and intelligence as masculine, then the assumption is that a woman who is intelligent is displaying a masculine trait (Acker 1973: 173).[8]

It was noted by Epstein (1971) that the conceptions of masculinity and femininity are incorporated in the values, ideologies, and images which form much of the context in which the socialization process shapes occupational and family life.[9] In western societies women are considered emotional rather than practical, a trait which is considered undesirable for certain categories of employment requiring rational decision-making processes. The personality of a woman should be warm, nurturant, yielding, lovable, and willing to accept the guidance and dominance of the male. Conversely, the typical male characteristics such as aggressiveness, assertiveness, and persistence should not be emphasized in women. It is against this background that one has to examine the occupation of nursing.

Nursing is an occupation which evolved around feminine themes, such as responsibility to aid the sick, good housekeeping, patience, self-sacrifice, and yielding. Historically, within the health care system, nurses occupy a subordinate position to that held by men who control the health industry. However, against this background of subordination, the situation of women in the United States health care system today is unique for the following reasons: Firstly, the majority of the health work force are women and, secondly, when compared with the majority of women in female-dominated occupations, such as airline stewardesses, secretaries, and clerks, nurses are a more highly skilled and trained group.

From the standpoint of feminist philosophy, there seem to be certain characteristics about the health industry which attracts a large concentration of women in various categories, from nurse's aides to physicians and administrators. Of course, the medical system reflects the sexism prevalent in the society at large, but the condition of nurses has vastly improved over the past two decades. These changes are in part a result of the feminist movement of the nineteenth and twentieth centuries and its efforts to improve the status of women. However, there seems to be a more direct relationship between the changing role of the

nurse in the United States and what Ehrenreich (1984: 187-95) refers to as the industrialization of medicine, which began in the 1930s and gained momentum after World War II.[10]

The transformation of the health care industry since World War II has been characterized as the growing institutionalization of the health care delivery system, with hospitals, clinics, and nursing homes replacing solo practitioners' offices as major centers of health care resources. In addition, there is a trend toward the centralization of power over local institutions in the hands of a small number of major medical centers. In this respect, the health industry is developing in the direction of other sectors of United States industries--health care is no longer dominated by individual practitioners but is operated like a corporation. The important unit of the health care delivery system--the major medical center with its network and affiliated facilities--has come to be more like the operations of multinational corporate structures. However, the center is categorized as a "non-profit" enterprise, which nevertheless does seek to generate a financial surplus for institutional expansion and lucrative payments to top administrators and medical staff. The nurses who were in a position to promote their interests (whether on the banner of the feminist movement or through political activities) now enjoy more positive

status as professionals in contrast to the prior status of "handmaiden" to the physician.

For other female health workers, however--aides, kitchen workers, diploma nurses--improvements in their sitution have not materialized. This category of workers, consisting mainly of immigrants and minorities, does not appear to have been positively affected by the feminist movement. They are still concerned with survival issues, such as trying to get by with the salary they make. These workers are employed chiefly in hospitals, nursing homes, and medical centers, carrying out the traditional female role of the motherly repetitive tasks of taking care of the needs of the patients.

The changes that have occurred in the health care delivery system over the past two decades is a progressive replacement of the traditional functions of the nurse by immigrant labor and minorities, who are generally less skilled workers. For example, many of the original functions of the nurse have now been delegated to ward clerks, diploma nurses, and technicians. Thus, professional nursing, stripped of many of its original functions, has become an occupation in transition, with diploma nurses aspiring for higher positions in the nursing hierarchy, and barred from moving up into higher categories without increased education

and training, which results in a redefinition of nursing education. Therefore, the traditional concept of the woman, perpetuated by sexist ideology to be indecisive, emotional, and suited only for motherly tasks, is changing because of the pressures of the feminist movement.

We find that in the health care delivery system today, there is a class of female professionals (nurse practitioners, clinicians, and physicians) who are administrators and co-managers of the so-called ancillary personnel (e.g., diploma nurses, practical nurses, and aides). In this context, the new class of health professionals now occupy positions that were held by males, with the authority of the physician being reduced to one of colleague rather than superior. This change in female attitudes is in part due to the feminist consciousness, where female health workers have been demonstrating increased assertiveness around their own needs vis-a-vis those of patients and physicians. Nurses as well as other health workers are more willing to organize themselves as workers and strike when necessary to attain their demands.

With the growing number of women in medicine and the health field, sex differences may cease to be a rationale for occupational stratification. Ehrenreich (1984) suggested that we may be entering a stage where women health workers may find that the greatest barrier to change may not be

sexism as it is the hierarchical division among women workers themselves.[11] Replacing costly labor with cheaper labor has led to these divisions and could generate deep resentments and anxieties. However, the prevailing hope is that there will be a growing consciousness among women in the health field, against using the banner of feminism to advance the status of a particular occupational group.

THE CHANGING ROLE OF THE NURSE

The terms "nurse" and "nursing" traditionally apply to a variety of health care activities carried on in different institutional settings and under various institutional control. These activities involve the least educated nurses, such as practical nurses and aides, and some of the most educated, such as registered nurses with advanced degrees in administration and clinical specialties. However, this image of the nurse is changing in order to give it a more professional status, because of certain historical developments in nursing service. From the studies of Brown (1948), Altman (1971), and Cannings and Lazonich (1975),[12] it was shown how the image of the nurse as the handmaiden to the physician has changed to one that has more professional status because of increased education and training.

For the first three decades of this century, the registered nurse functioned primarily as a private duty nurse under the direction of a physician. The nurse's relationship with the patients and their families at this time was social and personal, unpressured by the bureaucratic system that exists today. The numbers of private duty nurses began to decrease during the Depression years of the 1930s when hospitals discovered that it was cheaper to employ the nurses to work as staff nurses, rather than to operate a school of nursing to admit large groups of students. Prior to this period, nursing students provided almost all the direct patient care in hospitals as apprentices or nursing students. With the onset of World War II, this system began to change as large numbers of nurses were needed for military service, which resulted in a serious shortage of nurses. This led to a rapid increase of students in schools of nursing, as hospitals again depended upon students to carry out patient care for civilian needs. There was also a marked increase in the emphasis on preparation and employment of practical nurses and aides, who received on-the-job training.

After World War II, registered nurses did not return to civilian health care in the numbers that were expected, so again there was a shortage of nurses. It became quite evident to hospital administrators that nurses were no longer prepared to accept the deplorable and exploitative conditions

they had endured prior to World War II; therefore practical nurses and aides were trained to replace the registered nurses in the hospitals where they performed direct patient care. The registered nurse then emerged to assume the role of primary team leader or head nurse. This event had a profound effect on the leadership role of nursing.

Rapid developments in the social and behavioral sciences of the 1950s impacted upon nursing, and it became apparent to the nursing leadership that there had to be improvements in the educational requirements and practice of nursing. These concerns were expressed by nursing leaders, such as Brown (1948), who stated that, in the latter half of the twentieth century, the professional nurse would be one who recognized and understood the fundamental health needs of a patient, and who knew how these needs could best be met.[13] The professional nurse would possess a body of scientific nursing knowledge which was based on and in keeping with general scientific advancement, and would be able to apply this knowledge in meeting the nursing needs of patients. Brown further stated that the professional nurse must be able to exert leadership in at least four different ways:

1. In making her/his unique contribution to the prevention and remedial aspects of illness

2. In improving those nursing skills already in existence and developing new nursing skills

3. In teaching and supervising other nurses and auxiliary workers

4. In cooperating with other health professionals in planing for a positive health community, on national and international levels

From the preceding statements, we observe that the stagnating situations that existed prior to World War II in the nursing occupation had to be eliminated. Nursing leaders and nurses themselves were prepared to lobby in Washington for these changes in order to raise the standard of nursing through advanced training and education. The professional nurse of the 1960s had to be prepared to function on a higher level in the health care system, in order to assume responsibilities involving behavior in the hospital setting, recognition of physical symptoms of illness that commonly are identified with organic changes, and providing continuous care for the individual's total health needs, which would include the maintenance of oxygen, nutrition, elimination, and prevention of infections. The professional nurse would also be responsible for the provision of care and relief of pain and discomfort through the administration of medication, physical hygiene of the patient, and the referral to other members of the health team or other agencies of the patients that need specialized care. In general, the nurse should have the specialized ability to respond intelligently and

efficiently in any of the numerous situations which may signify a medical emergency. As time progressed, therefore, the role of the nurse evolved from that of a static entity to one that challenged and debated the old system and brought about dramatic changes.

The decade of the sixties was important for nursing, because it was a period of politicizing the plight of nurses and lobbying for change in nursing practice and service. It was also a period of expansion and evaluation of the health care delivery system, which subsequently resulted in changes in the recruitment and training of nurses. As the health care system underwent rapid changes, so did the functions of the nurse. The number, variety, and status of nurses began to change and there was a great demand for entry level nurses to carry out bedside nursing, as the nursing occupation expanded into administrative and specialized areas of nursing, which would qualify them for professional status. This was achieved through advanced education and training of nursing personnel to assume the responsibilities and positions of leadership that were necessary to fulfill this new role. With these changes now in effect, the nurse in the present-day work situation will have to adjust to the developments that are occurring and have occurred in the field of nursing. The advantages to be reaped from these changes are

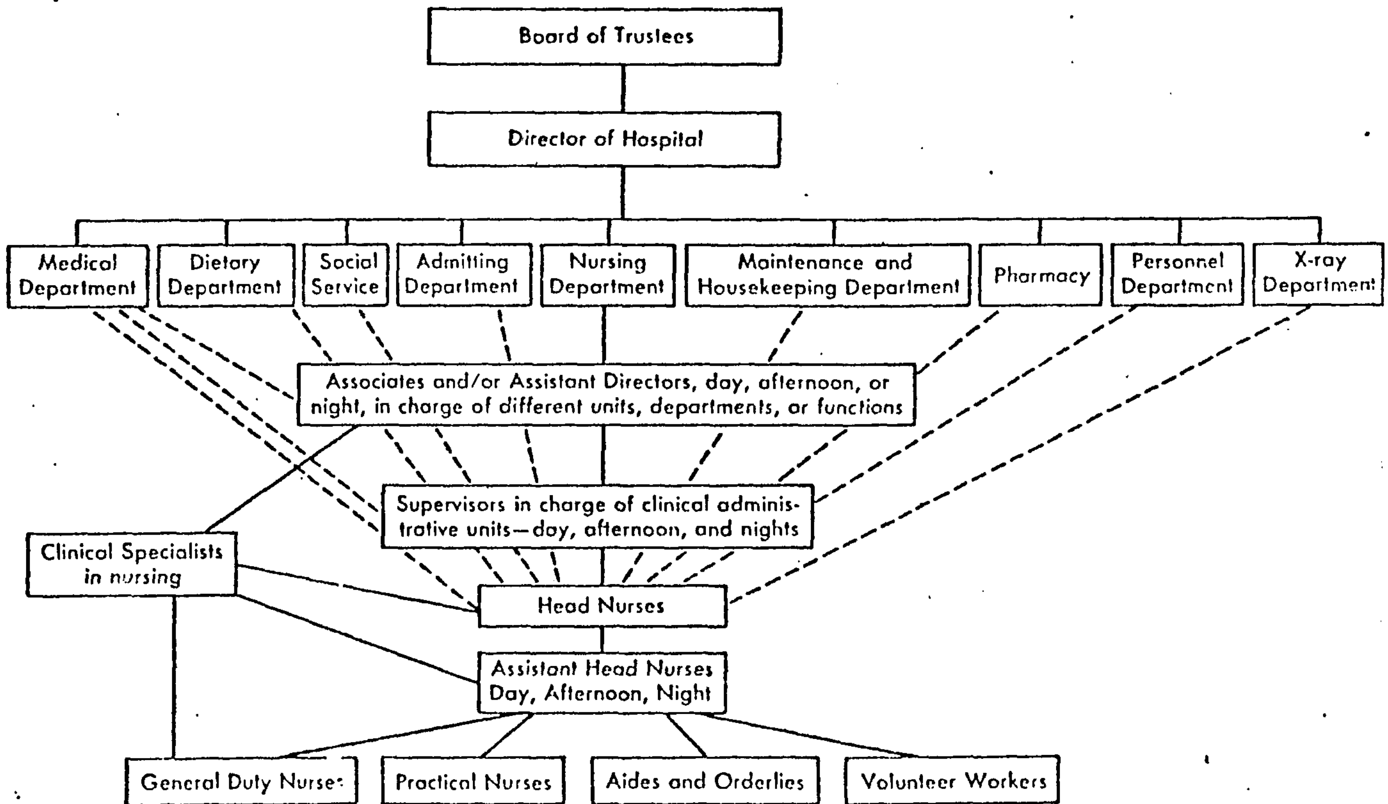
better working conditions, higher salaries, and opportunities for professional advancement that are commensurate with the professional schooling and on-the-job responsibilities.

THE ORGANIZATIONAL STRUCTURE OF NURSING IN THE UNITED STATES

The organizational structure of nursing in the United States is interwoven with the organizational structure of the modern hospital. The modern hospital is reliant upon doctors and nurses working as a team. As medical training became more complicated because of the introduction of technology into the hospital system, the demands of the hospital grew to accommodate these new developments. The modern hospital has the facilities to carry out investigative procedures that would otherwise be impossible even a decade ago.

The evolution of the hospital over the past eighty years has impacted upon nursing services both qualitatively and quantitatively. The organizational structure of the modern hospital, shown on the following page, will be discussed, particularly in relation to the position of Jamaican nurses in this hierarchical structure. The issues of relevance to this discussion are (a) what is nursing; (b) who performs it, and (c) the scope of nursing services. Firstly, nursing can be defined as a human relationship between an individual who is sick, or in need of health

ORGANIZATIONAL CHART OF THE MODERN HOSPITAL



SOURCE: History and Trends of Professional Nursing, p. 206.

services, and a nurse who is trained to recognize and respond to the need for help (Peplau 1952).[14] Nurses today perform various functions within the health care system. Some are skilled members of a team of surgical procedures, serving on the faculties of colleges; others are administrators, consultants, and researchers.

From the organizational chart we observe the following: At the head of the modern hospital is the board of trustees, followed by the director of the hospital, positions that are generally held by doctors. The nursing department, which is the subject of discussion, is a highly hierarchical department. The heads of the nursing department (i.e., associate and assistant directors) are in charge of different units and functions. This level of nurses represents persons with advanced degrees and training in nursing administration. Then there are the clinical specialists in nursing, of which the nurse practitioner is one such category. These clinical nursing specialists have advanced degrees and training in some specialized area of nursing (e.g., pediatric, orthopedic, or surgical nursing).

The nurse practitioner has been defined as a licensed registered nurse with advanced degrees and specialized training, who engages in independent decision-making about nursing needs to consumers and collaborates with other health

professionals in making these decisions (Griffin 1973).[15] The nurse practitioner may contract with a group, agency, or corporation to provide nursing care in a variety of institutional settings. This new category of nursing is part of the expansion of nursing services, which was established to increase the accessibility and availability of preventive and health maintenance services at a reduced cost to the consumer. The nurse practitioner has the responsibility for the implementation and supervision of various programs, some of which are under the auspices of the physician.

On the supervisory level, nursing supervisors assist the directors. Below this level are the head nurses who are in charge of the staffing on a particular unit in the hospital or nursing home, and the assistant head nurse who assists in carrying out these functions. The head nurse and the assistant head nurse are licensed registered nurses, defined by Levine (1978) as graduates of a college or hospital-operated school, with an associate or baccalaureate degree, licensed by the state to practice nursing.[16] The head nurse is the primary nurse of a team of nurses who perform activities related to the needs of the patient. Below this level is the productive level of nursing service, consisting of general duty nurses (i.e., registered nurses, practical nurses, and aides) classified as diploma nurses. The

licensed registered nurse usually supervises the functions of the practical nurses and aides, who are involved in direct patient care.

The effective utilization of nursing personnel and the projections of levels and patterns of staffing are influenced by certain factors. These factors, as stated by Flanagan (1976), are dependent upon the organizational complexity of the modern hospital and its administrative structure, and also upon the degree of specialization of the professional staff and the technical competence of the health practitioners (i.e., doctors, nurses, and other health personnel).[17]

Specialization of nursing is advancing at a rapid rate; therefore, nurses are now required to work toward the attainment of advanced degrees and training. It was pointed out by Williamson (1976) that nurses today are faced with the reality that they have to be qualified to carry out this expanded role in nursing service.[18] The nurses that are operating at the top level are now required to develop knowledge and practice in communication skills, health maintenance, and medical pathology. These changes in nursing service have resulted in the increase of authority on the administrative and professional levels of nursing, vis-a-vis the productive level, because of the differences in competencies and specialties of practice.

The trends occurring in the nursing service have organized it into two distinct levels: the professional level, which encompasses the administrative and clinical aspects of nursing; and the productive level, consisting of persons who carry out direct patient care, of which migrant nurses are overwhelmingly represented. As can be observed from the organizational chart, all persons in the field of nursing are expected to contribute their talents and skills on a wide range of functions on both the professional and productive levels.

Notes to Chapter IV

1. Hans O. Maukch, "The Organizational Context of Nursing Practice," in The Nursing Profession: Five Sociological Essays, ed. Fred Davis, (New York: John Wiley & Sons, 1966), p. 109.

2. Joann Ashley, Hospitals, Paternalism and the Role of the Nurse (New York: Teachers College Press, Columbia University, 1976), pp. 25-50.

3. Paul J. Feldman, "The Politics of Health," in The Nation's Health, ed. Phillip R. Lee; Caroll L. Estes; and Nancy B. Ramsey (San Francisco: Boyd and Fraser, 1984), p. 336.

4. Laurie Gunter, "Federal Financing," in Current Perspectives in Nursing Education, ed. Janet Williamson (St. Louis: C. V. Mosby Co., 1976), pp. 9-17.

5. Lynda Flanagan, One Strong Voice: The Story of the American Nurses Association (Kansas City: Lowell Press, 1976), pp. 274-88; Janet A. Williamson, Current Perspectives in Nursing Education: The Changing Scene (St. Louis: C. V. Mosby Co., 1976), pp. 1-10; and Michael Millman and Miriam Ostow, Nursing Personnel and the Changing Health Care System (Cambridge, Mass.: Ballinger Publishing Co., 1978), pp. 1-6.

6. U.S., Department of Health, Education, and Welfare, National Institute of Health, Division of Nursing, Present and Future Supply of Registered Nurses, 1971, p. 66.

7. Eugene Levine, "Nursing Supply and Requirements: The Current Situation and Future Prospects," in Nursing Personnel and the Changing Health Care System, ed. Michael L. Millman (Cambridge, Mass.: Ballinger Publishing Co., 1978), pp. 23-43.

8. Joan Acker, "Women and Social Stratification," in Changing Women in a Changing Society, ed. Joan Huber (Chicago: University of Chicago Press, 1976), p. 173.

9. Cynthia Epstein, Woman's Place (Berkeley: University of California Press, 1971), pp. 21-22.

10. Barbara Ehrenreich, "The Health Care Industry: A Theory of Industrial Medicine," in The Nation's Health, ed. Philip R. Lee; Caroll L. Estes; and Nancy B. Ramsey (San Francisco: Boyd and Fraser, 1984), pp. 187-95.

11. Ibid.

12. Ester Lucile Brown, "The Future Role of the Professional Nurse," in Nursing for the Future. A report prepared for the National Nursing Council (New York: Russell Sage Foundation, 1948), pp. 73-74; U.S., Department of Health, Education, and Welfare, National Institute of Health, Division of Nursing, Present and Future Supply of Registered Nurses, 1971, p. 66; and Kathleen Cannings and William Lazonich, "The Development of Nursing Labor Force in the United States: A Basic Analysis," Internal Journal of Health Services 5 (1975): 193.

13. Brown, "The Future Role of the Professional Nurse," p. 66.

14. Hildegard Peplau, Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing (Philadelphia: Saunders Publications, 1952), pp. 1-45.

15. Joseph Gerald Griffin and Joanne King Griffin, History and Trends of Professional Nursing (St. Louis: The C.V.O. Co., 1973).

16. Eugene Levine, "Nursing Supply and Requirements: The Current Situation and Future Prospects," in Nursing Personnel and the Changing Health Care System, ed. Michael L. Millman (Cambridge, Mass.: Ballinger Publishing Co., 1978), pp. 23-43.

17. Lynda Flanagan, One Strong Voice: The Story of the American Nurses Association (Kansas City: Lowell Press, 1976), pp. 274-88.

18. Janet Williamson, Current Perspectives in Nursing Education: The Changing Scene (St. Louis: C. V. Mosby Co., 1976), pp. 1-10.

CHAPTER V

THE CASE STUDY

In this chapter we will report the findings of the study which highlights, essentially, the following:

1. The demographic characteristics of the sample, taking into account age, marital status, occupational status, place of employment, income, and residence variables
2. Reasons for migrating, with emphasis on sponsorship and year migrated
3. Adaptation to the United States, with respect to citizenship, property ownership, satisfaction with occupational status, desire to return to Jamaica, occupational mobility in the United States, income from current job by occupational status, income from current job by number of years employed, and income from present job by type of institution employed

The tables that will be presented here describe the salient characteristics of the study. As was stated in chapter I, this study did not set out to test any given hypothesis but is essentially a pilot study. The questionnaire was not designed to generate complex statistical analysis, because the sample size is small. The result is, therefore, a descriptive, rather than a statistical, study, and the presentation and discussion are carried out within the

framework of the push-pull, or social demographic, approach. The study provides a profile of the Jamaican nurse and shows the pattern of female migration and adaptation which is characteristic of the sample.

DEMOGRAPHIC CHARACTERISTICS

Age

Table 2 represents the age of the respondents at the time of their arrival in the United States.

TABLE 2

AGE DISTRIBUTION OF RESPONDENTS AT TIME OF ARRIVAL IN THE UNITED STATES

Age	Percentage	N
19 and Under	5.7	8
20-29	58.6	82
30-39	27.9	39
40-49	6.4	9
50 and Over	1.4	2
Total	100	N = 140

From table 2 we observe that 58.6 percent of the respondents were between the ages of twenty and twenty-nine years when they migrated. This would tend to support general migration theory (Bogue 1961) which states that migration for economic reasons is highly selective of young but mature persons.[1] The theory also suggests that qualified and skilled members of the sending country are more likely than the less able ones to migrate, particularly if opportunities for improving material standards and upward mobility are limited in the country of origin.

Marital Status

Table 3 represents the marital status of the respondents since they migrated to the United States.

TABLE 3

MARITAL DISTRIBUTION OF RESPONDENTS

Marital Status	Percentage	N
Married	56.4	79
Divorced or Separated	22.2	31
Never Married	21.4	30
Total	100	N = 140

We observe that the majority of the sample, 56.4 percent, got married since they migrated, while the remaining 43.6 percent are either divorced, separated, or never married. These results also lend support to general migration theory which suggests that the majority of migrants are single or divorced individuals who can independently make the decision to migrate.

Occupational Status

Table 4 represents the distribution of the sample by occupational status. It shows that the majority of the respondents (87% N = 112) are working in the capacity of licensed registered nurses. It appears that this category of nursing is one in which the demand is greatest for qualified personnel in the United States. There is also a demand for licensed practical nurses and aides to carry out the functions of the productive aspect of nursing.

TABLE 4

DISTRIBUTION OF RESPONDENTS BY OCCUPATIONAL STATUS

First Job	Percentage	N
Licensed Registered Nurses	81.0	112
Licensed Practical Nurses	5.0	8
Nurse's Aide	14.0	20
Total	100	N = 140

We expected to find that registered nurses would be in demand because of the ongoing changes in nursing, which were discussed in earlier chapters. It was pointed out in the discussion that, because of the technological advancements and increased budget through Medicare and Medicaid legislation which came into effect in 1965, the health care industry has expanded. These factors also had a profound effect upon the changing role of the nurse because of the introduction of specialized areas of nursing, such as nurse clinician and nurse practitioner, which did not exist in nursing previously. It is partly due to these reasons that it became necessary to recruit registered nurses to fill the growing demand in the United States.

Place of Employment

Table 5 shows the distribution of the respondents by the type of medical institutions in which they are employed since migrating.

TABLE 5

DISTRIBUTION OF RESPONDENTS
BY PLACE OF EMPLOYMENT

Place of Employment	Percentage	N
Government Hospitals	35.0	49
Semi-Private Hospitals	46.4	65
Nursing Homes and Clinics	18.6	26
Total	100	N = 140

We observe that 46.4 percent of the sample work in semi-private hospitals, while the remaining 53.6 percent work in municipal hospitals, clinics, and nursing homes. We were not surprised to find the majority of Jamaican nurses working in municipal hospitals, nursing homes, and clinics. In these institutions they tend to the health care needs of persons in low-income levels and of the elderly, the sector of the population which benefited most from the Medicare and Medicaid legislation which expanded the provisions of health care services, making available funding to meet their health care needs.

Municipal hospitals, nursing homes, and clinics are institutions offering the lowest occupational status. Our findings lend support to studies documented by Ehrenreich (1973: 15) and Doeringer and Piore (1971: 1-2) that minorities are overrepresented in job categories that are labeled "secondary labor market," which is the sector of the work force with the lowest occupational status.[2]

Income

The findings from this study show that economic considerations were important to the respondents. Looking at table 6, we see that the majority, 52.1 percent (N = 73), earned approximately $19,000 per year. This far exceeds the amount they would have earned in the country of origin.

TABLE 6

ESTIMATED INCOME DISTRIBUTION OF RESPONDENTS

Income	Percentage	N
$ 9,000	2.9	4
14,000	13.6	19
19,000	52.1	73
24,000	27.9	39
27,000	3.5	5
Total	100	N = 140

The average income among these nurses was $19,760 per year. The registered nurses earned approximately $6,000 per year more than aides, and approximately $4,000 more than practical nurses. The differences in salary scale could be interpreted to mean that licensed registered nurses are at the entry level position in the nursing occupation, while licensed practical nurses and aides are below entry level. This may indicate that even though most migrants are attracted by economic factors, as measured by income, economic benefits may only be obtained by those who have needed skills. Additionally, it could indicate that, although the sample as a whole is making more income than

if they had not migrated, proportionately persons with low-level skills are at a disadvantage in the host country.

Residence

From table 7 we observe that the majority of the respondents, 70 percent (N = 98), live in multi-ethnic neighborhoods, such as St. Albans, Laurelton, Queens Village, and Flushing.

TABLE 7

DISTRIBUTION OF RESPONDENTS BY RESIDENCE

Type of Neighborhood	Percentage	N
Multi-ethnic	70	98
Mostly West Indian	30	42
Total	100	N = 140

The results also indicate that the second largest category of migrants, 30 percent (N = 42), live in neighborhoods that are populated mostly by West Indians, such as the Flatbush and Crown Heights areas of Brooklyn. These figures bear out the increased West Indian migration to the United States over the past two decades.

Reasons for Migrating

One of the important objectives of this study was to determine the reasons why Jamaican nurses migrated to New York City. From table 8, we observe that higher income in New York may have been the single most important reason for migrating.

TABLE 8

DISTRIBUTION OF RESPONDENTS BY FIRST REASON FOR MIGRATING

First Reason for Migrating	Percentage	N
Friends and relatives in the United States	25.0	35
Better employment opportunities in the U.S.	14.3	20
Greater economic independence in the U.S.	7.1	10
Better educational and cultural benefits in the U.S.	13.6	19
Higher income in the U.S.	35.7	50
Higher standard of living in the U.S.	4.3	6
Total	100	N = 140

The three main statements that measure economic achievements--income, employment opportunities, and greater economic independence--constitute 57.1 percent of the sample, which supports the study done by Friedlander (1965)

which stated that the composition of a migrant population, with respect to occupational skill levels, would be determined in part by the differential rate of salary scale, both absolute and relative, of occupational earnings in the sending and receiving societies.[3] From our study, it appears that economic considerations played an important role in the decision to migrate.

Sponsorship

Sponsorship is the mechanism used by the host country to ensure that persons who migrate have skills that can be utilized upon arrival. This safeguards against the possibility of migrants being a liability to the host country. From the findings of this study, as seen from table 9, we observe that 75.7 percent (N = 103) of the migrants were sponsored on the basis of occupation.

TABLE 9

DISTRIBUTION OF RESPONDENTS BY SPONSORSHIP

Sponsorship	Percentage	N
Sponsorship by relatives	24.3	37
Sponsorship by occupation	75.7	103
Total	100	N = 140

Studies done by Glass (1961) on female migrants to Great Britain indicated a pattern in which women who migrated from the West Indies were sponsored by their male relatives or husbands.[4] The difference between Glass's studies and this study arises from the more selective procedures applied by United States immigration authorities to ensure that employment requirements in this country are matched with commensurate migrant skills. Immigration policies here changed the occupational structure, sex and age of migrants, and played an important role in the migration of women from the Caribbean in occupations such as nursing. These women were able to migrate independently of spouse or relatives, as long as they had the necessary skills that could be utilized in the United States.

Year Migrated to the United States

Table 10 represents the distribution of the respondents by the year they migrated to the United States. These findings indicate that 89.3 percent (N = 125) of the sample migrated between the years 1960 and 1980. We expected to find, and did find, that the majority of the nurses would migrate during this period because of the changes in immigration policies in the United States previously mentioned.

TABLE 10

DISTRIBUTION OF RESPONDENTS BY YEAR WHEN MIGRATED

Year	Percentage	N
1950-59	10.7	15
1960-69	67.9	95
1970-80	21.4	30
Total	100	N = 140

Adaptation to the United States

Most of the literature on the adaptation of migrants, Eisenstadt (1954), Heiss (1967), Chodin (1973), is mainly concerned with the acculturation and assimilation of European immigrants.[5] It is only over the past decade that the adaptation of black immigrants in the United States has been studied to any large extent (Bryce LaPorte (1976), Bonnett (1976), Gordon (1979)).[6] This issue is still under investigation and continues to be studied by Caribbean scholars in the United States.

The adaptation of immigrants to the new society, or the receiving society, is dependent upon the reception given to the new immigrants by the receiving country. This reception influences the formation of a new identity

or adaptation to the host society in a positive or negative way. Immigrants from the Caribbean are mostly black and enter the American society where the majority of the population are white and, more importantly, where the existence of discrimination confers inferior status on black persons, as documented by studies, including those of Glazer and Moynihan (1963) and Mestre (1971).[7]

Jamaican migrants experience status inconsistency when faced with the reality that, even though they satisfy the objective criteria (i.e., economic successes), racial characteristics supersede to deny them the social status they would normally enjoy in the country of origin. This is evident from the findings suggested by tables 11, 12, 13, and 14. The variables, which are indicators of the adaptation process in this study, are citizenship, desire to return to the homeland, satisfaction with professional status, occupational mobility, and income in the United States.

Citizenship

Citizenship is granted to residents in the United States after they have resided in the country for five years. This is the stated qualification for citizenship; however, if the migrant wishes to become a citizen, he or she must petition through the immigration authorities.

Looking at table 11, we find that two-thirds, or 67.1 percent (N = 94), of the sample acknowledge that they are American citizens.

TABLE 11

DISTRIBUTION OF RESPONDENTS
BY AMERICAN CITIZENSHIP

American Citizenship	Percentage	N
Yes	67.1	94
No	32.9	46
Total	100	N = 140

Considering that a length of residence of five years is necessary to give the immigrant the opportunity for citizenship and the right to participate in political activities in the United States, these figures would suggest that Jamaican nurses have decided to relinquish their "sojourner" status for a more permanent one. The decision to obtain citizenship also provides migrants with certain rights and privileges, such as protection at home and abroad. It was suggested by Gordon (1979) that citizenship

may be an indicator of identification with the host country.[8] However, these findings suggest some degree of ambivalence among the respondents, as shown by tables 11, 12, 13, and 14, as to whether they have fully accepted their status in the host country.

Property Ownership in the United States

The findings of table 12 show that 64.3 percent (N = 90) of the respondents own property, either with spouse or alone. This appears to be a further indication of some degree of settlement in the United States.

TABLE 12

DISTRIBUTION OF RESPONDENTS BY PROPERTY OWNERSHIP

Property Ownership	Percentage	N
Ownership of house alone	29.3	41
Ownership of house with spouse	35.0	49
Rented apartment alone	22.9	32
Rented apartment with spouse	7.1	10
Lived with relatives or friends	5.7	8
Total	100	N = 140

Satisfaction with Occupational Status

Occupational status is an important issue, because we wanted to know how satisfied Jamaican nurses were with their work situation since they migrated. Overall, table 13 showed that 84.2 percent (N = 118) of the sample enjoyed some level of satisfaction with their occupational status. The satisfaction expressed could be interpreted to mean that the respondents may be satisfied, not so much from the fulfillment obtained from the utilization of skills, but rather that some level of economic benefits is being achieved.

TABLE 13

DISTRIBUTION OF RESPONDENTS BY SATISFACTION WITH OCCUPATIONAL STATUS

Satisfaction with Occupational Status	Percentage	N
Very Satisfied	36.4	22
Satisfied	15.7	51
Fairly Satisfied	32.1	45
Not Satisfied	15.8	22
Total	100	N = 140

Desire to Return to Country of Origin

The findings from table 14 are interesting from the standpoint that 71.4 percent (N = 100) of the sample expressed the desire to return to the country of origin. Even when we correlated desire to return to country of origin with other variables such as length of stay in the United States and reasons for migration (tables not shown), the results show that the majority of Jamaican nurses (approximately 60 percent) would like to return home. It would appear, therefore, that there is a contradiction between attitudes and feelings for homeland and the actual behavior as observed in terms of citizenship, property ownership, and desire to return to country of origin. We may attribute this ambivalence to the fact that economic considerations, and not assimilation, are strong motivations for migration.

TABLE 14

DISTRIBUTION OF RESPONDENTS BY DESIRE TO RETURN TO JAMAICA

Desire to return to Jamaica	Percentage	N
Yes	71.4	100
No	23.6	33
Undecided	5.0	7
Total	100	N = 140

Since migration is usually associated with the desire for self-improvement, we assumed that those who expressed the desire to return to Jamaica may have achieved their goals since they migrated to the United States. It is the opinion of the researcher that many respondents became American citizens because of the advantages accruing to them from this status while residing in the United States. On the other hand, the promise of steady employment and better salaries in the host country cannot be traded for the sentiment or nostalgia experienced by many immigrants for their homeland.

Occupational Mobility of Jamaican Nurses

Occupational mobility in the host country can be used as an indicator of achievement. From table 15 we observe that Jamaican nurses are working in the area of nursing that is considered the productive level, as opposed to administrative or clinical areas. We notice that

TABLE 15

ESTIMATED DISTRIBUTION OF RESPONDENTS BY JOBS HELD IN THE UNITED STATES

First Job	Second Job	Third Job	Percentage	N
Aide	Aide	Aide	12.5	17
Aide	Practical nurse	Practical nurse	3.5	5
Practical nurse	Registered nurse	Registered nurse	5.0	7
Registered nurse	Registered nurse	Registered nurse	29.0	41
Registered nurse	Head nurse	Head nurse	33.5	47
Registered nurse	Head nurse	Supervisor	16.4	23
Total			100	N=140

approximately 60 percent (N = 82) moved from one level to another. Within this particular pattern, approximately 50 percent of the registered nurses moved up to supervisory status. However, the movement is within one category of nursing (i.e., entry level), as shown by the organizational chart of the modern hospital. The important aspect of this finding is that it appears that the nurses are moving horizontally (i.e., within the same level of nursing), rather than towards vertical or upward mobility.

It was shown by the study of Blau and Duncan (1969: 425-27) that the career of migrants in the host country is usually better off than if they had remained in the homeland.[9] This appears to be the case with the respondents in this sample, because the majority (84.2 percent) expressed some degree of satisfaction, as shown by table 13. In the study by Blau and Duncan, it was suggested that the indigenous population in the host country gained a certain advantage from migration, because of the upward mobility produced by the flow of migrants into the lower occupational positions, making the chances for advancement among persons in the host country possible. In this context, migration may be considered as a social mechanism for the distribution of qualified human resources

to fill the need for occupational services, as this study suggests. It would appear from the findings presented here that Jamaican nurses were recruited to function as resource persons in nursing, while other nurses moved into administrative and clinical aspects of nursing.

Income Analysis

In this section, we will discuss the income of Jamaican nurses in relation to other variables, such as occupational status, number of years employed, and the types of institutions in which they are employed.

Table 17 represents the relationship between income and occupational status. We observe that there is quite a difference in salary scale between registered nurses and the other categories of nursing. The results of these findings show that only 2.7 percent (N = 3) of the registered nurses earned $14,000 per year, while 71 percent (N = 20) of the other categories earned $14,000 per year. Of the registered nurses, 61.3 percent (N = 68) earned $19,000 per year while only 29 percent (N = 8) of the other categories earned $19,000 per year.

TABLE 16

INCOME FROM CURRENT JOB
BY OCCUPATIONAL STATUS

Income	Registered Nurses		
$14,000	2.7% (3)	71% (20)	
19,000	61.3% (68)	29% (8)	
24,000	31.5% (36)	-	
27,000	4.5% (5)	-	
Total	100% (112)	100% (28)	N = 140

In general, the salary scale among these categories appears to be above the average salary scale for nurses; therefore, we assume that many of these nurses either worked overtime, which is frequently done by nurses because of the overwhelming demand, or they may have been on the job for a number of years with regular annual increases annually.

Income from Current Job by Number of Years Employed

Table 17 shows the relationship between income and the number of years on the job. We observe that 54 percent (N = 54) of the respondents who have been working on the same job for approximately five years earned

$19,000, while 32 percent (N = 11) earned $24,000 per year. These findings show very little difference in salary scale between those respondents who have been on the job for five years and those who have been on the job for ten years and more. One possible explanation could be that those who have been working on the present job for over ten years have arrived at the maximum salary scale for that particular category of nursing. If this is so, then in order to increase their income, it would be necessary to achieve a higher level of training in some specialized area of nursing.

TABLE 17

INCOME FROM CURRENT JOB
BY NUMBER OF YEARS EMPLOYED

Income	Length of Employment	
	1 - 5 years	10 - 15 years
$14,000	18% (19)	12% (4)
19,000	51% (54)	56% (19)
24,000	31% (33)	32% (11)
Total	100% (106)	100% (34) (N=140)

Income from Present Job by
Type of Institution Employed

Table 18 represents the relationship between income and the type of medical institution in which the respondents are employed. The findings show that the majority of the respondents worked in semi-private hospitals (N = 65). However, only 78.5 percent (N = 51) of those working in semi-private hospitals earned between $19,000 and $24,000 per year, while those who worked in municipal or government-operated hospitals, 87.8 percent (N = 43), earned between $19,000 and $24,000 per year. Of those working in nursing homes, 69.2 percent (N = 18) earned between

TABLE 18

INCOME FROM PRESENT JOB
BY TYPE OF INSTITUTION EMPLOYED

Income	Government Hospital	Private Hospital	Nursing Home
$ 9,000	2.0% (1)	1.5% (1)	7.7% (2)
14,000	8.2% (4)	13.8% (9)	23.1% (6)
19,000	59.2% (29)	47.7% (31)	50.0% (13)
24,000	28.6% (14)	30.8% (20)	19.2% (5)
27,000	2.0% (1)	6.2% (4)	0%
Total	100% (49)	100% (65)	100% (26) (N=140)

$19,000 and $24,000 per year. These observations suggest that the nurses who are employed in municipal or government-operated hospitals and nursing homes are about on the same salary scale as those in semi-private hospitals. We can speculate, therefore, that the salary scale for this level of nursing is approximately the same whether the nurse works in a semi-private or municipal hospital.

Notes to Chapter V

1. Donald J. Bogue, "Techniques and Hypotheses for the Study of Differential Migration," International Population Conference Paper 114 (1961), pp. 4-6.

2. Barbara Ehrenreich and John Ehrenreich, "Hospital Workers: A Case Study on the New Working Class," Monthly Review 24 (January 1973): 15; and Peter Doeringer and Michael Piore, Internal Labor Market and Manpower Analyses (Lexington, Mass.: Heath & Co., 1971), pp. 1-2.

3. Stanley L. Friedlander, Labor Migration and Economic Growth (Cambridge, Mass.: M.I.T. Press, 1965), p. 106.

4. Ruth Glass, Newcomers: The West Indian Migrants (Cambridge, Mass.: Harvard University Press, 1961), p. 15.

5. Samuel N. Eisenstadt, Absorption of Immigrants (London: Routledge and Kegan Paul Ltd., 1954), pp. 1-21; J. Heiss, "Factors Related to Immigrant Assimilation: The Early Post-Migration Situation," Human Organization 26 (1967): 265-72; and Harvey Chodin, "Kinship Networks in the Migration Process," International Migration Review 7 (1973): 1-10.

6. Simon Bryce LaPorte, "New York City and the New Caribbean Immigration: A Contextual Statement," International Migration 13 (1979), p. 2; Aubrey Bonnett, "Rotating Credit Association Among Black West Indians in Brooklyn" (Ph.D. dissertation, City University of New York, 1976); and Monica Gordon, "Identification and Adaptation: A Study of Two Groups of West Indians in New York City" (Ph.D. dissertation, City University of New York, 1979).

7. Nathan Glazer and Patrick D. Moynihan, Beyond the Melting Pot: The Negroes, Puerto Ricans, Jews, Italians and Irish (Cambridge, Mass.: M.I.T. Press and Harvard University, 1963), pp. 50-55, and Elroy R. Mestre, Economic Minorities in Manpower Development (New York: Heath Lexington Books, 1971), p. 57.

8. Monica Gordon, "Identification and Adaptation: A Study of Two Groups of West Indians in New York City" (Ph.D. dissertation, City University of New York, 1979).

9. Peter M. Blau and Otis Dudley Duncan, *The American Occupational Structure* (New York: John Wiley & Sons, 1967), pp. 425-27.

CHAPTER VI

SUMMARY AND CONCLUSION

The motives and intentions of migrants which are the causal factors of migration are not always evident from the literature on migration and, from this study, the ability to obtain employment in the receiving country is a necessary condition for migration. It has now apparently been recognized that migration is a process by which individuals can obtain social mobility in modern societies. With improved education and training, the level of expectation among the population rises in proportion to the promise of improved material status. If these aspirations cannot be met in the country of origin, opportunities are usually explored in other countries.

Employers no longer confine themselves to a local labor force in seeking workers, whether they require skilled or unskilled labor. Consequently, labor circulates at the international level--in our case the exchange is between Jamaica and the United States. It appears that this migration was primarily in response to better opportunities as the migrants perceived these opportunities. As pointed out

by Schultz (1978), natural resources are location-specific, and the location of reproducible physical capital and of people is determined by human decisions in response to alternative opportunities.[1] The effects of economic and population growth on where people live and what they do persistently call for major adjustments over time.

Migration is one of the major consequences of the interaction between changes in the economy and the size and composition of the population, and it has always been an important feature of the economics of the Caribbean. Although these islands may only provide a small percentage of the migrants in the international migration stream, those who migrate comprise a high proportion of the skilled population of these islands.

From the literature on Caribbean migration, it would appear that most migrants from this region view the United States as a place which can provide the opportunities they hope will compensate for their dissatisfaction with the socioeconomic conditions in the country of origin. Patterson (1978) states that, in Caribbean societies, migration has become institutionalized and this influences, both directly and indirectly, the socioeconomic base and the cultures of these societies.[2] The consequences of this institutionalization of migration have, in economic terms,

reinforced the external orientation and chronic dependence of these societies on foreign economies and have prevented the emergence of alternative strategies of development.

DISCUSSION OF STUDY

The migration of Jamaican nurses to New York City is, to a large extent, a response to developments and expansion in the health care delivery system in the United States, brought about in part by the passage of Medicaid and Medicare legislation, which created a demand for nurses, especially at entry level positions. There is also the expectation on the part of migrants that they will achieve higher salaries and standard of living in the host country. In addition to these factors, this study is unique because of the following reasons:

1. The migrants are women
2. They are diploma nurses who were sponsored on the basis of profession
3. This study confirms general migration theory (Bogue 1961) that migration stimulated by economic growth and technological improvements attracts the better educated, while areas tending toward stagnation lose their better educated and skilled people

We observe from these findings that these nurses migrated because of higher salaries, the single most important reason stated for migrating. It was shown that the

average salary for the respondents was $19,760.00, which far exceeds the salary they would earn in the country of origin. Another important aspect of this migration process was that the majority of the respondents (75.7 percent) were sponsored on the basis of occupation, indicating a certain independence among these female migrants, which was not evident prior to 1965. This independence was mainly due to the changes in United States immigration policies of 1965, granting preference to persons with skills that were needed in the country. It was also shown that the majority of the respondents (82.4 percent) showed some degree of satisfaction with their occupational status in the United States. Nevertheless, many of them (71.4 percent) expressed the desire to return to the country of origin at some future time.

There is some degree of ambivalence among the respondents with regard to adaptation to United States society. American citizens comprise 67.1 percent of the sample, and 54.3 percent own property in New York City. However, despite these indications of settlement in the host country, most of the respondents were unsure as to whether or not they wanted to spend the rest of their lives in the United States. This adaptation pattern is interesting in that it shows a stronger ethnic identity with the country of origin than was expected.

It was shown in the literature on adaptation of migrants that the individual's adjustment to the host country depended on the following factors:

1. The personal and social background of the migrants
2. The expectations in the host country, the motives for migration, the racial characteristics, customs, and values of the migrant population
3. The treatment that migrants receive in the host country

From an economic standpoint, the adjustment of migrants to the host country depends on the employment policies and the general opportunities for career advancement. Adjustment also hinges on resources such as the availability and location of housing and prevailing attitudes with regard to racial discrimination. It was pointed out by Gordon (1964) that some degree of prejudice and discrimination is inevitable whenever outsiders do not enter freely into the primary groups of the receiving country, as is the case with Jamaican migrants.[3] The process of assimilation in the host country is not always possible nor is it always the desired goal of every immigrant group. As observed by Wirth (1955), this process varies widely among minorities within the United States, producing what he calls a pluralistic pattern of adaptation, which occurs among blacks and other minorities because of racial factors.[4]

Ethnicity is also a persistent factor in American life, and ethnic cleavages were documented by Glazer and Moynihan (1963) in relation to economic, social, political, and residential factors of the various ethnic groups in New York City. Glazer and Moynihan suggested that the ethnic and political behavior of minorities in the United States is a reaction to the rejection by the dominant groups.[5] This is inevitable because race intruded in all aspects of life for non-white persons, making assimilation almost impossible.

It was shown by Mestre (1971: 51) that changes in the structure of the economy or the level of economic activities tended to affect minorities disproportionately because of the marginal status they occupy in the labor force.[6] Jamaicans in the United States are likely to be affected by these factors because of their minority status, preventing them from fully participating in American society--thus they still think of Jamaica as home. Therefore, in addition to the distinct characteristics of the respondents, who are black, it would appear that there is a stronger ethnic identification with the country of origin, in contrast to European immigrants who migrated to settle in the United States at the turn of the century.

Chaney (1979: 209) noted that many Third World migrants, for the most part, intended to return to their homeland at some time in the future.[7] These migrants are viewed as "economic exiles" who leave the country of origin for a time to work and accumulate capital and return. Circumstances may cause repatriation to be postponed several times, until the migrants educate their children, accumulate certain consumer goods, or invest in property or business in the homeland. The desire to return remains in the immigrants' thoughts and calculations, an issue that may have implications for their adjustment and accommodation in the host country. As observed by Armstrong (1979: 393), collectives of immigrants are formed and exist in the United States, with strong links to their homeland.[8] He suggested that a deeper historical perspective and political awareness on the part of the immigrants are responsible for this situation, and he concluded that multiethnic societies have become the norm, rather than the exception.

The peculiar characteristic of this study, and of others such as those done by Armstrong (1979) and Fitzpatrick (1971: 196) is the presence of so many migrants from Third World countries who strongly identify with their homeland.[9] It may be that in the case of Caribbean migrants, the

proximity of the Caribbean to the United States allows for frequent visits to the homeland to renew ties and acquaintances. Perhaps persons who migrate from the Caribbean to the United States do not intend to remain in the United States for the rest of their lives, but are economic exiles, as is the case of the Puerto Rican experience.

THE NEW IMMIGRATION - SOCIAL POLICY AND IMPLICATION

The migration of Jamaican nurses to New York City is part of the newest wave of immigrants to the United States from the Third World. These new immigrants come mainly from Asia, Mexico, Latin America, and the Caribbean. They represent a configuration of ethnic groups with various occupations, legal statuses, sex and age ranges. This development corresponds to certain trends in the United States economy (mainly in the service sector) and the dominant and aggressive political and economic policies pursued by the United States in the Third World over the past two decades.

The new Immigration Act of 1965 was the most comprehensive immigration bill since the McCarran-Walter Act of 1952 (Keely 1975).[10] This new bill was a radical departure from previous policies, which were exclusionary, selective,

and unfavorable to Third World countries. The Act was apparently an outgrowth of the policies instituted by the Kennedy administration, which attempted to redress inequality, both nationally and internationally. The period of the 1960s was also a time of the emergence of many independent nations and revolutionary struggles throughout the Third World.

The migration of persons from the Third World to the United States is in part due to the result of inequalities in trade and the socioeconomic and political policies that exist between rich and poor nations. This is demonstrated by the flow of illegal aliens from Mexico, presenting new areas of international problems to be resolved. The new wave of migrants to the United States from Mexico and other Third World countries and the implications of this new immigration for United States domestic policy and ethnic politics, as well as its impact on international relations with the Third World, are issues of utmost importance to the United States government, as documented by Keely (1975) and Bryce LaPorte (1979).[11] These issues are currently being debated by the Congress and the Senate under the auspices of the Simpson-Mazzoli bill.

To help alleviate the immigration crisis, the Simpson-Mazzoli bill provides three important stipulations, which are as follows:

1. The illegal immigrants in the United States since and before 1982 who meet certain requirements (i.e., proof of entry and residence in the United States) will receive legal resident status
2. Employees will be penalized by law if they knowingly employ illegal aliens
3. Guest worker programs will permit foreign workers to enter the United States to harvest perishable crops

The bill, however, only seeks to remedy immediate domestic imbalances while leaving untouched the root of the problems.

The immigration flow to the United States will not be checked until serious measures are taken to address the internal sociopolitical and economic problems of Third World regions. The problems existing in Latin America and the Caribbean are of long standing and are mainly economic in nature. With regard to Caribbean societies, one of the major problems is that of minimum resource utilization capacity in relation to the provision of goods and services to the majority of the population. This is a direct result of the lack of capital for industrial expansion, and the absence of technological know-how to make these countries competitive with the highly industrialized nations. Unless the United States government institutes a foreign policy to address these problems, people will always leave these developing regions to find employment in the United States.

Another aspect of the migration process to be looked at, besides the push factors, is the nature of those

elements in United States society which make it attractive to aliens. It was pointed out by Bryce LaPorte (1979: 216) that the appeal of the United States lies in the migrants' need to fulfill their dreams, curiosities, sense of achievement, and the desire to become part of a more affluent society.[12] Also demanding our consideration is the fact that the United States economy is structured in such a way that there is always a demand for persons to do the less desirable jobs in the society. The immigrant population provides low-wage labor for the expanding service sector, thereby maintaining the life style of persons in the host country while contributing to the rehabilitation of the economy of the country.

The United States benefits from immigrant labor because the majority of those who service the hotel and restaurant industry, hospitals, nursing homes, and medical centers, the garment industry are immigrants and minorities. Therefore, we observe that because of the complex nature underlying the migration process, it will take careful planning and drastic economic changes between developed and developing nations to arrive at an equitable solution to the problem.

Notes to Chapter VI

1. Theodore Schultz, "Migration: An Economist's View," in Human Patterns and Policies, ed. William H. McNeil and Ruth Adams (London: Indiana University Press, 1978), pp. 381-86.

2. Orlando Patterson, "Migration in Caribbean Societies," in Human Migration: Patterns and Policies, ed. William H. McNeil and Ruth Adams (London: Indiana University Press, 1978), pp. 106-145.

3. Milton Gordon, Assimilation in American Life: The Role of Race, Religion, and National Origin (New York: Oxford University Press, 1964), pp. 71-73.

4. Louis Wirth, "The Problem of Minority Groups," in The Science of Man in the World Crisis, ed. Ralph Linton (New York: Columbia University Press, 1955), pp. 10-25.

5. Nathan Glazer and Patrick D. Moynihan, Beyond the Melting Pot: The Negroes, Puerto Ricans, Jews, Italians and Irish (Cambridge, Mass.: M.I.T. Press and Harvard University, 1963), pp. 50-55.

6. Elroy R. Mestre, Economic Minorities in Manpower Development (New York: Heath Lexington Books, 1971), p. 51.

7. Elsa M. Chaney, "The World Economy and Contemporary Migration," International Migration Review 13 (1979): 204-213.

8. William Armstrong, "Mobilized and Proletarian Diasporas," The American Political Science Review 70 (June 1979): 393.

9. Ibid., and Joseph Fitzpatrick, "The Importance of Community in the Process of Assimilation," International Migration Review 1 (1966): 196.

10. Charles B. Keely, "Effects of United States Immigration Law on Manpower Characteristics of Immigrants," Demography 8 (1975): 157-69.

11. Ibid.

12. Simon Bryce LaPorte, "New York City and the New Caribbean Immigration: A Contextual Statement," International Migration 13 (1979): 216.

APPENDIX A

QUESTIONNAIRE

DO NOT WRITE YOUR NAME. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

Demographic

1. WHAT IS YOUR MARITAL STATUS?

(a) I am married ( )
(b) I am not presently married ( )
(c) I was never married ( )

2. HOW DID YOU ENTER THE U.S. (Check only one response)

(a) I was sponsored by a relative ( )
(b) I was sponsored on the basis of occupation ( )
(c) Other (Specify) ( )

3. WHEN DID YOU MIGRATE TO THE U.S. (Check only one response)

(a) 1950 - 1959 ( )
(b) 1960 - 1969 ( )
(c) 1970 - 1980 ( )

4. HOW OLD WERE YOU WHEN YOU MIGRATED TO THE U.S. (Check only one response)

(a) 19 and under ( )
(b) 20 - 29 ( )
(c) 30 - 39 ( )
(d) 40 - 49 ( )
(e) 50 and over ( )

5. HOW LONG HAVE YOU BEEN IN THE U.S. (Check only one response)

(a) 1 - 9 years ( )
(b) 10 - 19 years ( )
(c) 20 years and over ( )

6. WHICH PHRASE BEST DESCRIBES YOUR NEIGHBORHOOD? (Check only one response)

(a) Integrated neighborhood ( )
(b) Mostly Black Americans ( )
(c) Mostly White Americans ( )
(d) Mostly West Indians ( )
(e) Other (Specify) ( )

7. WHICH OF THE FOLLOWING APPLIES TO YOU? (Check only one response)

(a) I own my house ( )
(b) My husband and I own our house ( )
(c) I live in a rented apartment alone ( )
(d) I live in a rented apartment with my husband ( )
(e) Other (Specify) ( )

8. WHAT WAS YOUR FATHER'S OCCUPATION? (Check only one response)

(a) Accountant ( )
(b) Teacher ( )
(c) Farmer ( )
(d) Clerk ( )
(e) Other (Specify) ( )

9. WHAT WAS YOUR MOTHER'S OCCUPATION? (Check only one response)

(a) Secretary ( )
(b) Nurse ( )
(c) Housewife ( )
(d) Teacher ( )
(e) Other (Specify) ( )

Reasons for Migrating

10. PEOPLE HAVE DIFFERENT REASONS FOR MIGRATING FROM ONE COUNTRY TO ANOTHER. CHECK IN THE SPACES BELOW YOUR FIRST AND SECOND CHOICES.

		First Choice	Second Choice
(a)	I migrated because I had friends and relatives living and working in the U.S.	( )	( )
(b)	I migrated because the employment situation in Jamaica offered fewer professional opportunities than the U.S.	( )	( )
(c)	I migrated because I wanted greater social and economic independence than I could have in Jamaica	( )	( )
(d)	I migrated because there are better opportunities here educationally and culturally for me and my family	( )	( )
(e)	I migrated because of greater possibilities for earning higher income and career advancement than Jamaica	( )	( )
(f)	I migrated because the political situation in Jamaica was unstable	( )	( )
(g)	I migrated because I could enjoy a higher standard of living than I would in Jamaica	( )	( )

(h) Other (Specify) ______________________________

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Labor Force Status

11. WHICH OF THE JOB TITLES LISTED BELOW HAVE YOU EVER HAD, AND IN WHAT APPROXIMATE ORDER. (Check in space provided)

		First Job	Second Job	Third Job
(a)	Nursing Supervisor	( )	( )	( )
(b)	Head Nurse	( )	( )	( )
(c)	Licensed Registered Nurse	( )	( )	( )
(d)	Licensed Practical Nurse	( )	( )	( )
(e)	Nurse's Aide	( )	( )	( )
(f)	Other (Specify) ______________________			

12. WHERE DO YOU PRESENTLY WORK? (Check only one response))

(a) Public Hospital ( )
(b) Private Nonprofit Hospital ( )
(c) Other (Specify) ______________________

13. HOW LONG HAVE YOU BEEN WORKING AT YOUR PRESENT JOB? (Check only one response)

(a) 1 - 4 years ( )
(b) 5 - 9 years ( )
(c) 10 - 14 years ( )
(d) 15 - 19 years ( )
(e) 20 years and over ( )

14. CHECK THE STATEMENT THAT APPLIES TO YOU.

(a) I am employed on a part-time basis
(b) I am employed on a full-time basis

15. WHICH OF THE FOLLOWING IS CLOSEST TO YOUR INCOME DURING YOUR LAST YEAR OF EMPLOYMENT? (Check only one response)

(a) $1,000 - $9,000 ( )
(b) $10,000 - $14,000 ( )
(c) $15,000 - $19,000 ( )
(d) $20,000 - $24,999 ( )
(e) $25,000 and over ( )

16. IN WHAT COUNTRY DID YOU RECEIVE YOUR NURSING TRAINING? (Check only one response)

(a) The West Indies ( )
(b) The United States ( )
(c) England ( )
(d) Other (Specify) ________________

17. AT PRESENT, WOULD YOU PREFER PART-TIME EMPLOYMENT OR FULL-TIME EMPLOYMENT? (Put a check next to your preference)

(a) Part-time Employment
(b) Full-time Employment

Identification with Profession

18. WHICH OF THE FOLLOWING BEST DESCRIBES THE REASON WHY YOU CHOSE TO WORK IN NURSING? (Check only one response)

(a) Because it gives me a chance to help people ( )

(b) Because it is a good profession for a woman ( )

(c) Because it is a good way to make a living ( )

(d) Because it is an interesting job ( )

(e) Because nursing is a good career ( )

19. WHAT WOULD YOU LIKE YOUR JOB TO BE IN THE FUTURE? (Check only one response)

(a) I would like to move up in my job to a higher position ( )

(b) I would like to advance in my career ( )

(c) I would like to retire early ( )

(d) Other (Specify) ________________

(Circle a "yes" or "no" for each of the following statements)

20.	I AM A MEMBER OF A MINORITY NURSING ASSOCIATION	YES	NO
21.	I ATTEND MEETINGS OF SOME UNION OR NURSING ORGANIZATION AS MUCH AS, OR MORE THAN, MOST MEMBERS	YES	NO
22.	I BELIEVE THAT NURSES SHOULD BELONG TO A PROFESSIONAL ASSOCIATION	YES	NO
23.	I BELIEVE THAT NURSES SHOULD BELONG TO A UNION	YES	NO
24.	I SUBSCRIBE TO AT LEAST ONE NURSING JOURNAL	YES	NO

Adjustment to Society

25. HOW SATISFIED ARE YOU WITH YOUR WORK OR OCCUPATIONAL STATUS IN THE U.S.? (Check only one response)

(a) I am very satisfied ( )
(b) I am satisfied ( )
(c) I am fairly satisfied ( )
(d) I am not satisfied ( )

(Circle a "yes" or "no" for each of the following statements)

26.	I AM AN AMERICAN CITIZEN	YES	NO
27.	I VOTE IN U.S. NATIONAL ELECTIONS	YES	NO
28.	I WOULD LIKE TO RETURN TO JAMAICA, IF I COULD LIVE THERE AS COMFORTABLY AS I LIVE IN THE U.S.	YES	NO
29.	MORE OF MY FRIENDS ARE NATIVE AMERICAN CITIZENS THAN NATURALIZED CITIZENS	YES	NO

30. MORE OF MY FRIENDS ARE ORIGINALLY FROM THE WEST INDIES THAN FROM ANYWHERE ELSE. YES NO

31. I SPEND MORE OF MY LEISURE TIME WATCHING T.V. THAN GOING OUT. YES NO

32. I SPEND MORE OF MY LEISURE TIME WITH FRIENDS AND RELATIVES THAN GOING OUT. YES NO

33. I SPEND MOST OF MY LEISURE TIME DOING CHURCH OR RELIGIOUS ACTIVITIES. YES NO

34. I SPEND MORE TIME GOING OUT FOR RELAXATION THAN STAYING HOME. YES NO

APPENDIX B

Caribbean Migration to the United States, 1962–76

Year	Jamaica	Trinidad and Tobago	Barbados	Guyana	Total
1962	1,573	388	406	268	2,635
1963	1,880	448	376	273	2,977
1964	1,762	413	393	296	2,864
1965	1,837	485	406	233	2,961
1966	2,743	756	520	377	4,396
1967	10,483	2,160	1,037	857	14,537
1968	17,470	5,266	2,024	1,148	25,908
1969	16,947	6,835	1,957	1,615	27,354
1970	15,033	7,350	1,774	1,763	25,920
1971	14,571	7,130	1,731	2,115	25,647
1972	13,427	6,615	1,620	2,826	24,488
1973	9,963	7,035	1,448	2,969	21,415
1974	12,408	6,516	1,461	3,241	23,526
1975	11,076	5,982	1,618	3,169	21,845
1976	9,026	4,839	1,743	3,326	18,934
Total	140,199	62,218	18,514	24,476	245,407

Note: All figures are by country of birth and are for fiscal years ending June 30.
Source: U.S. Immigration and Naturalization Service, *Annual Reports*.

Migration of Professional and Technical Workers in Medical and Related Fields to the United States, 1962–76

Occupational Group	Jamaica	Trinidad and Tobago	Barbados	Guyana	Total
Nurses	3,310	1,238	446	967	5,961
Physicians, surgeons, and dentists	344	130	35	93	602
Dietitians and nutritionists	108	43	26	33	210
Optometrists	3	4	1	0	8
Medical and dental technicians	370	206	72	80	728
Therapists and healers	24	14	4	9	51
Pharmacists	63	24	8	14	109
Veterinarians	14	7	2	7	30
Total	4,236	1,666	594	1,203	7,699

Source: U.S. Department of Justice, Immigration and Naturalization Service.

SOURCE: Palmer, Ransford. <u>Caribbean Dependence on the United States Economy.</u> New York, Praeger Press, 1979 pp 90-99

Annual Incremental Growth of Selected Occupational Groups in Jamaica, 1974–76

Occupational Groups	1974	1975	1976
	Incremental Growth		
Professional, technical, administrative, executive, managerial, and related occupations	5,500*	12,8[illegible]0*	1,900*
Craftsmen, production process, and operating occupations	1,750*	−5,150*	−1,350*
	Migration		
Professional, technical, administrative, executive, managerial, and related occupations	743	694	715
Craftsmen, production process, and operating occupations	1,044	929	1,342

*Figures for each year represent the average of the figures for April and October.
Sources: Jamaica Department of Statistics, *The Labour Force*, 1976. U.S. Department of Justice, Immigration and Naturalization Service *Annual Reports*.

Interest Payments on the External Debt as a Percentage of Exports and International Reserves, Jamaica, 1970–76

Year	Interest on External Debt (J $ million)	Interest as a Percent of Exports of Goods and Services	Interest as a Percent of Net International Reserves
1970	11.8	2.7	12.3
1971	12.3	2.6	9.3
1972	14.3	2.6	15.3
1973	16.3	2.8	21.4
1974	23.6	2.6	18.1
1975	30.9	3.0	27.0
1976	32.5	3.8	110.3

Sources: *Economic and Social Survey Jamaica 1973; 1975; 1976* (Kingston: The Government Printer. 1974; 1976; 1977); International Monetary Fund, *International Financial Statistics*, October 1977.

Occupational Distribution of Caribbean Migration to the United States, Totals for 1967–76

Occupational Group	Jamaica	Trinidad	Guyana*	Barbados	Total
Professional, technical, and kindred workers	9,906	4,011	2,325	1,407	17,649
Farmers and farm managers	232	10	20	4	266
Managers, officials, and Proprietors	1,771	871	441	221	3,304
Clerical and kindred	8,449	4,329	2,143	1,191	16,112
Sales workers	1,089	480	192	176	1,937
Craftsmen, foremen, and kindred	11,054	5,442	1,587	1,518	19,601
Operatives and kindred	8,727	3,451	1,141	1,090	14,409
Private household workers	23,088	7,026	1,578	2,827	34,519
Service workers except private household	5,422	2,621	834	992	9,869
Farm laborers and foremen	976	50	51	69	1,146
Laborers, except farm and mine	1,268	513	125	243	2,149
Housewives, children, and others with no occupations or occupations not reported	58,422	30,924	11,735	6,675	107,756
Total	130,404	59,728	22,172	16,413	228,717

*Figures are for 1968–76.
Source: U.S. Immigration and Naturalization Service, *Annual Reports.*

Average Annual Increase of Skilled Manpower and Migration in Selected Occupations in Jamaica, 1973–74

Occupation	Gross Increase	Emigration	Net Increase	Emigration as a percent of Gross Increase
Medical doctors	47	19	28	40.4
Nurses	463	110	353	23.8
Teachers and other instructors	1,155	56	1,099	4.8
Engineers	90	24	66	26.7
Accountants	191	52	139	27.2

Note: Skilled manpower includes those who were trained abroad.
Source: U.S Department of Justice, Immigration and Naturalization Service; *Economic and Social Survey Jamaica 1974* (Kingston: The Government Printer, 1975).

Selected Data on U.S. Direct Investment in Jamaica and in Developed and Developing Countries, 1975 and 1976
($ million)

Item	1975	1976
	Jamaica	
1 Net capital flows	39	−83
2 Reinvested earnings	7	4
3 Receipts of income	79	67
4 Adjusted earnings	86	70
5 Direct investment	654	577
6 Percent of rate of return	13.1	12.1
7 Reinvested earnings as a percent of adjusted earnings	8.8	5.7
	Developed Countries	
1 Net capital flows	2,898	3,354
2 Reinvested earnings	4,900	6,176
3 Receipts of income	4,609	5,217
4 Adjusted earnings	9,509	11,393
5 Direct investment	90,923	101,159
6 Percent of rate of return	10.9	11.9
7 Reinvested earnings as a percent of adjusted earnings	51.5	54.2
	Developing Countries	
1 Net capital flows	3,702	1,665
2 Reinvested earnings	3,083	1,204
3 Receipts of income	3,619	5,763
4 Adjusted earnings	6,703	6,967
5 Direct investment	26,222	29,050
6 Percent of rate of return	29.1	25.2
7 Reinvested earnings as a percent of adjusted earnings	45.9	17.2

Source: U.S. Department of Commerce, Bureau of Economic Analysis, *Selectected Data on U.S. Direct Investment Abroad, 1966–76*, (Washington, D.C.: Government Printing Office, 1977).

U.S. Direct Investment, Net Flows of Capital and Income, Jamaica, 1966–76
($ million)

Year	Net Capital Flows (1)	Reinvested Earnings (2)	Receipts of Income (3)	Adjusted Earnings (4)	Direct Invest-ment (5)	Rate of Return (4) ÷ (5) (6)	(2) as Percent of (4)
1966	39	2	73	75	163	46.0	2.6
1967	40	2	77	79	204	38.7	2.5
1968	90	2	70	72	295	24.4	2.7
1969	92	4	87	91	392	23.2	4.4
1970	114	2	84[a]	86[b]	507	16.9	2.3
1971	107	4	77	81	618	13.1	4.9
1972	6	0	71	71	624	11.3	0.0
1973	− 9	4	79	83	618	13.4	4.8
1974	− 12	6	92	98	609	16.0	6.1
1975	39	7	79	86	654	13.1	8.1
1976	− 83	4	67	71	577	12.3	5.6
Total	423	37	856	893			

[a]This figure was not provided in the original data. It is imputed from the difference between Adjusted Earnings and Reinvested Savings.
[b]This figure was not provided in the original data. It was estimated as the arithmetic mean of the total Adjusted Earnings for 1969 and 1971.
Source: U.S. Department of Commerce, Bureau of Economic Analysis.

Labor Force and Unemployment by Age Groups in Jamaica for Selected Years

Year*	14-19	20-24	25-34	35-44	45-54	55-64	65 and Over	Total
1968								
Share of labor force	27.5		20.5	19.0	16.8	10.5	5.7	100.0
Unemployment rate	34.9		21.0	17.2	7.0	5.9	2.0	18.5
1974								
Share of labor force	13.3	14.2	21.5	17.9	15.4	10.9	6.8	100.0
Unemployment rate	44.2	30.6	19.0	16.9	11.7	10.3	6.6	20.7
1975								
Share of labor force	13.3	14.4	21.9	17.1	15.4	10.6	7.2	100.0
Unemployment rate	45.9	30.4	19.4	15.0	13.5	10.4	6.7	21.0
1976								
Share of labor force	12.8	15.2	22.3	16.7	14.9	11.1	6.9	100.0
Unemployment rate	54.3	37.5	22.7	17.1	13.2	7.7	11.2	24.2

*Figures are for October of each year.
Source: Jamaica Department of Statistics, *The Labour Force 1976*.

Bibliography

Acker, Joan. "Women and Social Stratification." In Changing Women in a Changing Society, p. 173. Edited by Joan Huber. Chicago: University of Chicago Press, 1976.

Armstrong, William. "Mobilized and Proletarian Diasporas." The American Political Science Review 70 (June 1979): 393-408.

Ashley, Joann. Hospitals, Paternalism and the Role of the Nurse. New York: Teachers College Press, Columbia University, 1976.

Beckford, George L. "The Economics of Agriculture Resource and Development in Plantation Economics." Social and Economic Studies 18 (December 1969): 322-24.

Beijer, G. "Modern Patterns of International Migratory Movements." In Migration, pp. 18-25. Edited by J. A. Jackson. New York: Cambridge University Press, 1969.

Blau, Peter M. and Duncan, Otis Dudley. The American Occupational Structure. New York: John Wiley & Sons, 1967.

Bogue, Donald J. "Techniques and Hypotheses for the Study of Differential Migration." International Population Conference Paper 114, 1961.

Bonnett, Aubrey. "Rotating Credit Association Among Black West Indians in Brooklyn." Ph.D. dissertation, City University of New York, 1976.

Brown, Ester Lucile. "The Future Role of the Professional Nurse." In Nursing for the Future. A report prepared for the National Nursing Council, pp. 73-74. New York: Russell Sage Foundation, 1948.

Bryce Laporte, Simon. "New York City and the New Caribbean Immigration: A Contextual Statement." International Migration 13 (1979): 216.

Cannings, Kathleen and Lazonich, William. "The Development of Nursing Labor Force in the United States: A Basic Analysis." International Journal of Health Services 5 (1975): 193.

Castels, Stephen and Kosack, Godula. "Immigrant Workers and Class Struggle in Advanced Capitalism: The Western European Experience." Politics and Society 5 (1973): 33-36.

Chaney, Elsa M. "The World Economy and Contemporary Migration." International Migration Review 13 (1979): 204-213.

Chodin, Harvey. "Kinship Networks in the Migration Process." International Migration Review 7 (1973): 1-10.

Davis, Fred. The Nursing Profession: Five Sociological Essays. New York: John Wiley & Sons, 1966.

Davis, Kingsley. "The Migration of Human Population." In The Human Population: A Scientific American Book. San Francisco: W. H. Freeman, 1974.

Devereux, George and Werner, Florence R. "The Occupational Status of Nurses." American Sociological Review 15 (October 1950): 629-34.

Doeringer, Peter and Piore, Michael. Internal Labor Market and Manpower Analyses. Lexington, Mass.: Heath & Co., 1971.

Dominguez, Virginia. From Neighbor to Stranger: The Dilemma of Caribbean Peoples in the United States. New Haven: Antilles Research Program, Yale University, Richmond, 1975.

Economic and Social Survey. Kingston, Jamaica: National Planning Agency, 1974, pp. 7-8.

Ehrenreich, Barbara. "The Health Care Industry: A Theory of Industrial Medicine." In The Nation's Health, pp. 187-95. Edited by Phillip R. Lee, Caroll L. Estes, and Nancy B. Ramsey. San Francisco: Boyd and Fraser, 1984.

Ehrenreich, Barbara and Ehrenreich, John. The American Health Empire, Profit and Politics. New York: Random House, 1970.

________. "Hospital Workers: A Case Study on the New Working Class." Monthly Review 24 (January, 1973): 15.

Eisenstadt, Samuel N. Absorption of Immigrants. London: Routledge and Kegan Paul Ltd., 1954.

Epstein, Cynthia. Woman's Place. Berkeley: University of California Press, 1971.

Etzioni, Amitai. The Semi-Professions and their Organization. New York: The Free Press, 1969.

Feldman, Paul J. "The Politics of Health." In The Nation's Health, p. 336. Edited by Phillip R. Lee, Caroll B. Estes, and Nancy B. Ramsey. San Francisco: Boyd and Fraser, 1984.

Fitzpatrick, Joseph. "The Importance of Community in the Process of Assimilation." International Migration Review 1 (1966): 196.

Flanagan, Lynda. One Strong Voice: The Story of the American Nurses Association. Kansas City: Lowell Press, 1976.

Foner, Nancy. Jamaica Farewell: Jamaican Migrants in London. Berkeley: University of California Press, 1978.

Frank, Andre G. "Economic Dependence, Class Structure, and Underdevelopment Policy." In Dependence and Underdevelopment: Latin America Political Economy, pp. 20-25. Edited by James D. Crockcroft, Andre G. Frank, and Dale Johnson. New York: Doubleday & Co., 1972.

Friedlander, Stanley L. Labor Migration and Economic Growth. Cambridge, Mass.: M.I.T. Press, 1965.

Friedson, Eliot. The Hospital in Modern Society. New York: The Free Press, 1963.

George, P. "Types of Migration of Population According to the Professional and Social Composition of Migrants." In _Readings in the Sociology of Migration_, pp. 40-41. Edited by C. J. Jansen. New York: Oxford University Press, 1963.

Glaser, William. "American and Foreign Hospitals." In _The Hospital in Modern Society_. Edited by Eliot Friedson. New York: The Free Press, 1963.

Glass, Ruth. _Newcomers: The West Indian Migrants_. Cambridge, Mass.: Harvard University Press, 1961.

Glazer, Nathan and Moynihan, Patrick D. _Beyond the Melting Pot: The Negroes, Puerto Ricans, Jews, Italians and Irish_. Cambridge, Mass.: M.I.T. Press and Harvard University, 1963.

Gordon, Milton. _Assimilation in American Life: The Role of Race, Religion, and National Origin_. New York: Oxford University Press, 1964.

Gordon, Monica. "Identification and Adaptation: A Study of Two Groups of West Indians in New York City." Ph.D. dissertation, City University of New York, 1979.

Gorz, Andre. "Immigrant Labor." _New Left Review_ 61 (1970): 28-31.

Griffin, Joseph Gerald and Griffin, Joanne King. _History and Trends of Professional Nursing_. St. Louis: The C.V.O. Co., 1973.

Gunter, Laurie. "Federal Financing." In _Current Perspectives in Nursing Education_, pp. 9-17. Edited by Janet Williamson. St. Louis: C.V. Mosby Co., 1976.

Haberstein, Robert and Christ, Edwin A. _Professionalizer, Traditionalizer, and Utilizer_. New York: University of Missouri Press, 1955.

Jackson, J. _Migration_. London: Cambridge University Press, 1969.

"Jamaica Still Isn't Making It." _New York Times_, June 1982, p. 18.

Jansen, C. Readings in the Sociology of Migration. New York: Oxford University Press, 1970.

Jansen, Clifford. "Some Sociological Aspects of Migration." In Migration, p. 60. Edited by J. A. Jackson. New York: Cambridge University Press, 1969.

Katz, Fred E. "Nurses." In The Semi Professions and their Organization, pp. 54-56. Edited by Amitai Etzioni. New York: The Free Press, 1969.

Keely, Charles. "Effects of United States Immigration Law on Manpower Characteristics of Immigrants." Demography 8 (1975): 157-69.

________. "Effects of the Immigration Act of 1965 on Selected Population Characteristics of Immigration to the United States." Demography 8 (1971): 115.

Kennedy, R. The Irish Immigration, Marriage, and Fertility. New York: University of California Press, 1973.

Kuper, Adam. Changing Jamaica. London: Routledge and Kegan Paul Ltd., 1976.

Kuper, Hilda. Urbanization and Migration in West Africa. New York: University of California Press, 1965.

Lee, Everett S. "A Theory of Migration." Demography 3 (1966): 48-56.

Levine, Eugene. "Manpower Yesterday, Today and Tomorrow." American Journal of Nursing 69 (February 1969): 290-96.

________. "Nursing Supply and Requirements: The Current Situation and Future Prospects." In Nursing Personnel and the Changing Health Care System, pp. 23-43. Edited by Michael L. Millman. Cambridge, Mass.: Ballinger Publishing Co., 1978.

Lewis, Arthur. "The Industrialization of the British West Indies." Caribbean Economic Review (May 1950), p. 18.

Little, Kenneth. West African Urbanization: A Study of Voluntary Associations in Social Change. London: Cambridge University Press, 1965.

________. African Women in Towns. London: Cambridge University Press, 1973.

Manley, Michael. Government Policies at Home and Abroad. Kingston, Jamaica: Agency for Information, 1975.

________. The Politics of Change: A Jamaican Testament. London: Tonbridge Printers Ltd., 1974.

Maukch, Hans O. "The Organizational Context of Nursing Practice." In The Nursing Profession: Five Sociological Essays, p. 109. Edited by Fred Davis. New York: John Wiley & Sons, 1966.

Meadows, Paul. "Immigration Theory: A Review of Thematic Strategies." In Sourcebook on the New Migration: Implication for the United States and the International Community, pp. 109-397. Edited by Simon Bryce LaPorte, assisted by Delores Mortimer and Stephen R. Couch. New Brunswick, New Jersey: Transaction Books, 1980.

Mestre, Elroy B. Economic Minorities in Manpower Development. New York: Heath Lexington Books, 1971.

Millman, Michael and Ostow, Miriam. Nursing Personnel and the Changing Health Care System. Cambridge, Mass.: Ballinger Publishing Co., 1978.

Montagna, Paul D. Occupations and Society: Toward a Sociology of the Labor Market. New York: John Wiley & Sons, 1977.

Myrdal, Gunnar. The International Economy. New York: Harper & Row, 1957.

Palmer, Ransford. "A Decade of West Indian Migration to the United States: An Economic Analysis." Social and Economic Studies 23 (1974): 90-106.

________. Caribbean Dependence on the United States Economy. New York: Praeger Press, 1979.

Patterson, Orlando. "Migration in Caribbean Societies." In Human Migration: Patterns and Policies, pp. 106-145. Edited by William H. McNeil and Ruth Adams. London: Indiana University Press, 1978.

Petras, Elizabeth. "Toward a Theory of International Migration: The Division of Labor." In Sourcebook on the New Immigration: Implication for the United States and the International Community, pp. 439-48. Edited by Simon Bryce LaPorte assisted by Delores Mortimer and Stephen R. Couch. New Brunswick, New Jersey: Transaction Books, 1980).

Piore, Michael. Birds of Passage: Migrant Labor and Industrial Societies. New York: Cambridge University Press, 1979.

________. "The Role of Immigration in Industrial Growth: A Case Study of the Origins and Character of the Puerto Rican Migration to Boston," 1973. (Mimeographed.)

Ravenstein, E. G. "The Laws of Migration." Journal of the Statistical Society 48 (1880): 167-277.

Richmond, Anthony. "Sociology of Migration in Industrial and Post-Industrial Societies." In Migration (1969): 238-45.

Richmond, Anthony H. and Ravi, Verma P. "The Economic Adaptation of Immigrants: A New Theoretical Perspective." International Migration Review 12 (1978): 308.

Richmond, Anthony H.; Lyon, Michael; Hale, Sylvia; and King, Roy. Migration and Race Relations in an English City. New York: Oxford University Press, 1973.

Roberts, Mary. American Nursing: History and Interpretation. New York: Macmillan Co., 1955.

Sandis, Eva E. "Alternative Intellectual Frameworks for Studying the New Immigrant." In Sourcebook on the New Immigration: Implications for the United States and the International Community, p. 30. Edited by Simon Bryce LaPorte, assisted by Delores Mortimer and Stephen R. Couch. New Brunswick, New Jersey: Transaction Books, 1980.

________. "Ethnic Group Trends in New York." In New Ethnics: The Case of the East Indians. New York: Praeger Press, 1979.

Sassen-Koob, Saskia. "Exporting Capital and Importing Labor: The Role of Caribbean Migration to New York City." Occasional Paper, no. 28 (1981), pp. 30-31.

Schultz, Theodore. "Migration: An Economist's View." In Human Patterns and Policies, pp. 381-86. London: Indiana University Press, 1978.

Singham, Archibald. The Hero and the Crowd in a Colonial Polity. New Haven: Yale University Press, 1968.

Siu, Paul. "The Sojourner." American Journal of Sociology (July 1952): 34-44.

Strauss, Anselm. "The Structure of Ideology of American Nursing: An Interpretation." In The Nursing Profession: Five Sociological Essays, pp. 60-108. Edited by Fred Davis. New York: John Wiley & Sons, 1966.

Todman, Terrence A. "Address on Inter-American Affairs." Presented at the 2nd Caribbean Conference on Trade, Investment, and Development, Miami, January 18, 1978. (Mimeographed.)

U.S. Department of Justice. Annual Reports on Immigration and Naturalization, 1960-1976.

U.S. Department of Health, Education, and Welfare, National Institute of Health, Division of Nursing. Present and Future Supply of Registered Nurses, 1971.

U.S. Department of Labor. Manpower Report of the President, 1972.

U.S. Department of Health, Education, and Welfare. Immigration of Graduates of Foreign Nursing Schools. Report of the Conference, Bethesda, Maryland, Public Health Service, Health Resources Administration, Bureau of Health Manpower, Division of Nursing, Maryland, 1975.

U.S. Department of Health, Education, and Welfare. Survey of Foreign Nurse Graduates. Public Health Service, Health Resources Administration, Bureau of Health Manpower, Division of Nursing, Bethesda, Maryland, 1976.

U.S. Agency for International Development, Office of Women in Development. Women in International Migration, 1980.

U.S. Department of Health, Education, and Welfare. Health Manpower Source Book 1950-1980, 1980.

Watson, Hilbourne. "Migration and the Political Economy of Underdevelopment: Notes on the Commonwealth Situation." Presented to the Panel of International Migration as a Policy Issue, at the International Studies Association Conference held in Toronto, Canada, February 25-28, 1976.

________. "The Political Economy of the United States-Caribbean Relations." Black Scholar 11 (January-February 1980): 33-35.

"West Indians in the United States: Why So Many?" Amsterdam News, 2 October 1976.

Williamson, Janet A. Current Perspectives in Nursing Education: The Changing Scene. St. Louis: C. V. Mosby Co., 1976.

Wirth, Louis. "The Problem of Minority Groups." In The Science of Man in the World Crisis, pp. 1-25. Edited by Ralph Linton. New York: Columbia Press, 1955.