

9 Globalization and the Cross-Border Flow of Health Workers

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INTRODUCTION

Recent decades have seen an increase in cross-border flows of health professionals. Of greatest health equity concern are flows from poorer countries which have existing and severe shortages of health human resources (HHR) and high burdens of disease to richer countries with shortages (but much less severe) and comparatively lower burdens of disease. Operating simultaneously, “push” and “pull” factors serve to create human capital flight or “brain drain” where workers with high levels of training or technical skills emigrate in search of a job and a better life for themselves and their families. While not a new phenomenon, such migration has been accelerated by the past three decades of globalization. The deteriorating economic and broader social and environmental conditions in many so-called “source” countries, for example, are at least partly attributable to liberalization or other forms of global market integration, directly and negatively affecting working conditions, availability of jobs and career development, and thus serving to “push” health workers out of their countries (Marchal & Kegels, 2003). Conditionalities associated with loans or debt relief from the international financial institutions (IFIs) that constrain governments’ abilities to pay adequate salaries or to provide incentives for health workers to remain exacerbate the situation. Globalization also makes it easier for rich countries to “pull” or attract health professionals. Border barriers in high-income countries are being actively lowered for professional, technical, and skilled immigrants, even as they are (frequently) raised for semi- or lesser-skilled individuals. High-income countries, such as the United States (US), Australia, New Zealand, Canada, and, until very recently, the United Kingdom (UK), have come to rely on the immigration of foreign-trained health workers to fill their own HHR vacancies. Although there have been attempts to frame the flows of health professionals as a continuous “brain circulation” rather than a brain drain, evidence demonstrates that HHR flow overwhelmingly and increasingly from poorer to richer countries,

with the poorest countries unable to replace or attract new workers. For these countries, the inevitable result is diminished health care access and services, both critical barriers to improving global health equity. Other factors associated with globalization foster HHR migration, notably the internationalization of professional credentials and, in some instances, notably the European Union (EU), of citizenship. Professional credentials in health as in other fields are increasingly recognized across borders, particularly where free trade areas have been formed. Eased migration and mobility (including, for instance, through cheaper, faster, and easier travel, multilingualism, postcolonial ties, and common academic curricula) have contributed to a veritable sense of “global citizenship” worldwide with professional credentials serving as passports. Finally, regional and global trade agreements, key tools of modern globalization, can facilitate international labor mobility.

In exploring these issues, this chapter begins by describing some of the known empirics of HHR density and flows. It then examines in more depth how these flows relate to globalization, and what their impacts have been, notably on lower-income source countries. (We accept as given that receiving countries benefit both health-wise and economically by these flows.) The chapter concludes by reviewing critically the feasibility and desirability of various policy options to manage health-professional migration.

THE GLOBAL PICTURE

Most analysts have found strong evidence indicative of major and enduring global shortages in nurses and doctors over the next decades (Bach, 2003; Joint Learning Initiative, 2004; Liese & Dussault, 2004). While workforce prediction is imprecise, recent surges in HHR out-migration from a number of poor countries to a small handful of rich countries instantiates a trend likely to continue, in some cases risking a virtual collapse in source nations (Pond & McPake, 2006). As in many facets of globalization discussed in this book, the effects to date of the global HHR flow have been highly asymmetrical, with the main receiving countries being high-income, largely (though not exclusively) Anglophone countries. According to a 2008 Organisation for Economic Co-operation and Development (OECD) report, New Zealand has the highest proportion of migrant doctors among OECD countries, and one of the highest for nurses (Zurn & Dumont, 2008). The World Health Organization’s (WHO) *World Health Report 2006* indicates the United States received the highest number of foreign-trained doctors and nurses, followed by the UK. As one simple metric of this asymmetry: doctors trained in sub-Saharan African countries (SSA), largely at public expense, who now work in OECD countries represent close to one-quarter of the current total physician workforce in those SSA source countries.

Table 9.1 Doctors and Nurses Trained Abroad Working in OECD Countries

OECD country	<i>Doctors from Abroad</i>		<i>Nurses from Abroad</i>	
	Number	% of Total	Number	% of Total
Australia	11,122	21	—	—
Canada	13,620	23	19,061	6
Finland	1,003	9	140	0
France	11,269	6	—	—
Germany	17,318	6	26,284	3
Ireland	—	—	8,758	14
New Zealand	2,832	34	10,616	21
Portugal	1,258	4	—	—
United Kingdom	69,813	33	65,000	10
United States	213,331	27	99,456	5

Source: World Health Organization (2006), p. 98. Note: Only a portion of foreign-trained physicians and nurses come from underserved low-income countries.

While the literature on health worker migration is typically limited to physicians and nurses, other health workers, such as ophthalmologists and radiologists, are also part of the phenomenon of brain drain. A snapshot of pharmacists, for instance, shows a situation of global shortage, with wealthy OECD countries suffering mild but increasing shortages of pharmacists and developing countries experiencing extreme shortages (International Pharmaceutical Federation [FIP], 2006). This has obvious implications for the dispensing of antiretroviral drugs, or treatments for malaria, tuberculosis (TB), other infectious diseases, and the increasing burden of chronic disease in all developing countries. Specifically, pharmacist shortages in many SSA nations are cited as one constraint on more rapid roll-out of antiretroviral (ARV) treatments (Attaran & Walker, 2008).

The Joint Learning Initiative on Human Resources for Health (JLI), a two-year global study of the impact of HHR on health performance, aptly describes health workers as the “glue of the health system,” without which technologies, drugs, infrastructure, knowledge, and information cannot be applied (Joint Learning Initiative, 2004). The situation is so severe that the JLI concluded that the fate of global health and development in the twenty-first century lies largely in the management of the HHR crisis (Joint Learning Initiative, 2004). It also documented the severe shortages currently experienced by many low-income countries. While imperfect, vacancy rates are in many instances the best available measure we have of such shortages. Ghana’s Health Service, as one of the more extreme examples, had 2,002 vacancy rates of nearly 50 percent for doctors and 57 percent for nurses. A memo issued that year by the director-general of the Ghana Health Service indicated that more Ghanaian doctors worked outside the country than within (Mensah, Mackintosh, & Henry, 2005). While vacancies are not singularly a result of out-migration, as we shall discuss later, they are

affected by it. Additionally, countries with relatively small workforces and inflows, such as Malawi, can be hugely affected by even numerically small outward flows (Gerein, Green, & Pearson, 2006a).

REGIONAL FEATURES

While globalization is enabling the creation of a global labor market in health professionals, its form (that is, the direction and ease of such flows) has distinctive regional features.

Europe

Some countries in Europe face specific HHR challenges. As Dubois et al. (2006) explain, states of the former Union of Soviet Socialist Republics (USSR) that became independent in the early 1990s (such as Armenia, Russia, and Ukraine) and the countries of Central and Eastern Europe (CEE) had “inherited a workforce that was especially ill-suited to the demands facing modern health care systems. Large numbers of physicians were trained but many received limited and often narrowly specialized training . . . [while] [t]heir inherited nursing workforces had low levels of skills and were ill-equipped to take on the roles adopted by their equivalents in Western Europe”. Once these earlier problems were overcome, these same countries began to face the challenge of increased international mobility of professionals (Nicholas, 2007). With the enlarged European Union (EU), health professionals in CEE countries, such as Lithuania and Poland, are increasingly attracted by better-paying jobs in other EU countries (Buchan, Jobanputra, Gough, & Hutt, 2006). Slovenia, as one case, is already experiencing a significant deficit of physicians due to out-migration (Nicholas, 2007).

Some wealthier countries in Europe are experiencing challenges at a different end of the spectrum. Spain and France, for instance, presently have an oversupply of physicians and nurses (judged so by the lack of available positions for all those actively seeking employment); the lack of jobs is drawing these professionals to seek work elsewhere, which could eventually precipitate a rebound shortage in both countries. In contradistinction, other wealthy European countries, such as Ireland (where over half of newly registered nurses in 2000 were foreign-trained), the Netherlands, Norway, and the UK are or have been experiencing severe HHR deficits. The immediate impact of shortages in these countries is long waiting lists for patient treatment and surgery (Tjadens, 2002). These nations draw in physicians and nurses not only from other European countries but also from India, the Philippines, Pakistan, the Caribbean, and South Africa, as well as from rich countries such as Canada and Australia (Buchan et al., 2006). The aging populations of Western

Europe, creating more complex and HHR-demanding health problems, suggest ongoing or increasing HHR flows, particularly of nurses or other health workers capable of providing live-in care (World Health Organization, 2006).

North America, Australia, and New Zealand

Australia, New Zealand, Canada, and the United States have all experienced minor to significant shortages in domestically trained physicians and nurses (Hawthorne, 2001; Bourassa, Forcier, Simoens, & Giuffrida, 2004; Mullan, 2005). At present, all depend heavily on foreign-trained health professionals to fill important gaps in their HHR supply. If all foreign-trained physicians were to leave these countries today, one-fifth to one-third of all posts would become vacant. Certain regions within these developed countries would suffer even greater impacts. For instance, in Canada more foreign-trained physicians fill posts in rural and underserved regions than do domestically trained physicians (Canadian Institute for Health Information, 2006). The Canadian province of Saskatchewan has nearly 55 percent foreign-trained physicians, this figure rising even higher in the smaller towns and urban centers of the province (Labonté, Packer, & Klassen, 2006). Certain areas of practice, such as family medicine (general practice), would also suffer acute shortages in the absence of foreign-trained physicians (Canadian Institute for Health Information, 2005). Canada's experience is broadly generalizable: stated simply, foreign-trained physicians take jobs that domestically trained physicians do not want.

Latin America and the Caribbean

There is little literature on health worker migration from Latin America. Within the region, migration tends to be from poorer countries (e.g., Ecuador and Peru) to wealthier ones (notably Chile, where increasing numbers of public sector physicians have migrated to the private sector) (Bach, 2006). In the Caribbean, the loss of health workers has become a significant concern. At a Commonwealth Secretariat-sponsored Caribbean conference on the "managed migration" of nurses, participants estimated that the Caribbean is losing a minimum of 400 nurses annually through migration to the United States, Canada, and the UK (Public Services International, 2006). In Trinidad and Tobago it has been estimated that each year about one-third of nursing graduates resign from their duties in the public sector to take up positions abroad (Public Services International, 2006). Approximately 35 percent of posts in the region for registered nurses are vacant. As a result, some countries in the region are now actively recruiting nurses, pharmacists, and physicians from the Philippines, Cuba, Nigeria, and Guyana in order to satisfy severe staff shortages (Public Services International, 2006). Cuba singularly stands out as

a considerable overproducer and intentional exporter of physicians, both for the contractual earnings repatriated by émigré health workers and as stated acts of solidarity with other developing countries. Unlike other countries with deliberate HHR export policies discussed following (India, the Philippines), Cuba does not have a domestic HHR shortage, provides health care access to all its citizens, and posts high-income country health outcomes despite being a low-income nation (Evans, 2008).

Asia and the Persian Gulf

With a quarter of the world's population, the Southeast Asia region has only 12 percent of the global health workforce. Numerous Asian countries have characteristics that foster professional mobility to key English-speaking receiving countries. They tend to be less developed than Western countries, have large and well-trained labor pools, and have the potential to supply English-speaking professionals in many different fields. India, the Philippines, and Sri Lanka are prime examples in the health care field (Khadria, 2006).

India is a principal source of physicians in the four main OECD receiving countries. It ranks number one in both the UK (10.9 percent of the total physicians workforce) and the United States (4.9 percent), supplies the second greatest number of foreign-trained physicians to Australia (4.0 percent), and the third greatest number to Canada (2.1 percent) (Mullan, 2005). The country provides the largest absolute number of physicians to recipient countries worldwide (Mullan, 2005). Developed and prosperous countries alike have also discovered India as a new source country for recruiting well-trained English-speaking nurses to meet their own shortages. In India nurses qualifying with a bachelor of science in nursing are educated and trained to international standards of "registered nurses," making it very easy for them to move abroad and work (Khadria, 2006). Private recruitment agencies have sprung up in India specifically with the aim of sending trained nurses to key Western English-speaking and Gulf countries. Around four million Indian migrants are working in Gulf countries, of whom an estimated 40,000 to 60,000 are nurses (Percot, 2006).

The Indian government in turn has established its own exporting department as a means of facilitating international migration of nurses and to safeguard them against exploitation. Yet India has amongst the lowest nurse-to-population ratios of all source countries, far behind South Africa and the Philippines, with a high number of unfilled positions, particularly in rural areas. Some of the best hospitals in the country are reportedly experiencing mass resignation and exodus of nurses to hospitals abroad (Khadria, 2006).

In the Philippines in 2002, nearly 13,000 health workers left the country to work abroad, 93 percent of whom were nurses. In December 2004, the government-administered professional licensure examination for Filipino nurses counted at least 18,000 test takers (Anon., 2006). This means that the country experienced a loss of nurses that was the equivalent of approximately

two-thirds of the numbers taking the licensure exams. Like India, and for a longer period of time, the Philippines has been deliberately training nurses for export; yet, also like India, but unlike Cuba, it experiences very low nurse-to-population ratios, particularly in rural areas, and high levels of nurse vacancies (Khadria, 2006).

Evidence from Sri Lanka shows a similarly dramatic loss of physicians through internal and external migration, ranging from 15 percent to 85 percent, depending on the region. Unfortunately, the study does not provide information on the years covered by these estimates (Aluwihare, 2005). There are only around 800 specialists in Sri Lanka to serve a population of eighteen million people. Each year around sixty doctors head to the UK, Australia, and other nations in the developing world to complete their year's compulsory training to become a consultant. However, only half return, exacerbating a growing crisis in health provision (Burke, 2005). The economy of Sri Lanka, like many other professional-exporting nations, depends heavily on remittances sent home by their émigré workers. Remittances contributed 8.1 percent to Sri Lanka's gross domestic product (GDP) in 2004–2005—57 percent of the amount coming from workers in the Middle East (Central Bank of Sri Lanka, 2005).

It has been noted at international meetings on health worker migration that, while there is little hard data on health worker migration to the Persian Gulf, these states are considerable importers of health workers. Some estimate that 80 percent of health workers in the Gulf states are foreign-trained. The absence of representation from states such as Kuwait, the United Arab Emirates, Bahrain, and Saudi Arabia at international meetings on health worker migration has been noted as a concern. Although Sudan and Saudi Arabia have entered a bilateral agreement on the managed migration of Sudanese physicians to Saudi Arabia, Sudanese physicians are still being recruited through the back door.¹ The ability to circumvent provisions appears to be a weakness common to all such agreements.

Sub-Saharan Africa

African health care systems suffer severely from migration of health professionals. Physicians and nurses based in rural and poor areas move to cities for better working conditions and environments. Urban-based physicians and nurses move from the critically underequipped and underfunded public sector to the private sector (Gerein, Green, & Pearson, 2006b). There are frequently noted, though less studied, flows from the public sector to non-governmental health organizations or other structures administering the growing number of disease-specific global health initiatives (see Chapter 8, this volume). Finally, health professionals in both private and public sectors leave to work in more developed countries to obtain higher pay, better working conditions, an overall better quality of life, and improved opportunities for them and their families.

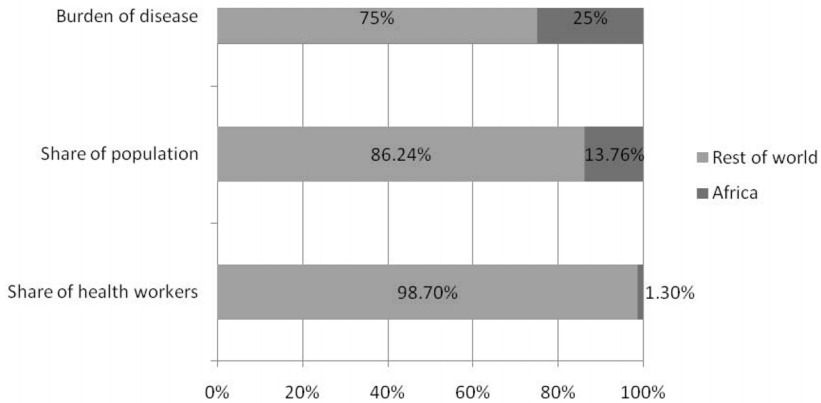


Figure 9.1 Burden of disease, share of population, and share of health workers, Africa and rest of world.

Source: Figure adapted from *Our Common Interest: Report of the Commission for Africa*, 2005, p. 184. Available at: http://www.cfr.org/publication/8292/our_common_interest.html.

The need for medical professionals is arguably greatest in sub-Saharan Africa (SSA) (Dovlo, 2005a; see Figure 9.1), and yet significant numbers of African-trained health workers migrate to developed countries to work each year. Six of the twenty countries with the highest physician emigration factors (arrived at by measuring the loss of physicians from a country as a proportion of the physicians remaining to do the work of health care) are in sub-Saharan Africa (Mullan, 2005). There are at least 11,000 SSA-trained physicians known to be licensed and practicing in the UK, the United States, and Canada alone (Hagopian et al., 2005). According to one report, SSA is approximately 700,000 physicians and 700,000 nurses short of staffing requirement necessary to meet the Millennium Development Goals (MDGs) (Bueno de Mesquita & Gordon, 2005).

GLOBALIZATION'S DRIVERS OF HHR MIGRATION

At the Macro Level

There are various ways to understand how globalization is influencing the global HHR flows. Framed broadly, HHR migration, as with all forms of migration, defines one aspect of globalization and the relationship between the two becomes somewhat tautological. To the extent that increased trade and investment liberalization, defining qualities of contemporary globalization, lead to higher per capita gross domestic product (GDP) and in theory enhancing the funds available for health systems, they can reduce a source country's

push factors. Most low-income economies from which significant numbers of health workers are migrating, however, despite in some instances recently recording high levels of growth due to dramatic rises in world prices for their export commodities, still lack sufficient capital to develop their health systems adequately (Bundred, Martineau, & Kitchiner, 2004).

In narrower and more evidence-informed terms, there are multiple ways in which different aspects of globalization are leading to increased HHR flows from poorer to richer countries. Some of the more important of these include:

1. Deteriorating economic or broader social and environmental conditions at least partly attributable in some regions (notably Latin America and Africa) to rapid and ill-timed market liberalization required as structural adjustment conditions on grants and loans by the IFIs (the International Monetary Fund [IMF], World Bank, and regional development banks) during the 1980s and 1990s.
2. Continuing conditionalities associated with grants, loans, or debt relief from the IFIs that limit governments' spending in the public sector and therefore their abilities to employ and retain HHR through adequate salaries and incentive mechanisms (see Chapter 7, this volume).
3. Eased migration restrictions on the flows of HHR from low- to high-income countries with perceived HHR deficits. In health labor markets under conditions of global shortage, a person's professional skills become a valuable commodity; the result is out-migration of those with internationally accredited qualifications (Bundred et al., 2004).
4. Specific policies to overproduce and export HHR in order to achieve a better balance of payments via remittances, in part to create domestic conditions more favorable to foreign investors or lenders, or to improve debt-servicing capacity (though again emphasizing the stark differences between countries such as India, the Philippines, and Cuba).

Finally, because increased health inequities arise from lack of workers in poorer countries with high burdens of disease, HHR migration can also be seen as a problem requiring global policy intervention. In this framing of the HHR crisis, the empirical relationship of globalization drivers to HHR migration is less a concern than is the international *obligation* or *duty* of all nations to manage flows in a way that does not compromise their legal or normative commitments to other countries under human rights treaties or the internationally agreed upon Millennium Development Goals (see Packer, Labonté, and Spitzer, 2007, for more detailed discussion).

At the Micro Level

Individuals are motivated to migrate for different reasons (Crush, 2002; Bundred et al., 2004) that can be country-specific; at the same time, there

Table 9.2 Summary of Push and Pull Factors of HHR Migration

<i>Push Factors</i>	<i>Pull Factors</i>
<i>Job Security</i>	
<ul style="list-style-type: none"> • No jobs available • Lack of promotions • Risk of losing jobs due to lack of funds 	<ul style="list-style-type: none"> • Jobs available • Colleagues, friends, and recruiters telling them about opportunities • Fairness in granting promotions
<i>Working Conditions</i>	
<ul style="list-style-type: none"> • Deteriorating work environment/facilities • Inadequate medicine and equipment • Inability to treat patients appropriately • For nurses, unhappiness with prevalent social attitudes towards the profession • Significant stress, overtime, and generally poor conditions of service resulting in fatigue and burnout • Impossible patient-health care provider ratios making quality care difficult 	<ul style="list-style-type: none"> • Satisfaction of practicing medicine and nursing as trained and capable of doing • Reasonable workload and conditions of work
<i>Economic Considerations</i>	
<ul style="list-style-type: none"> • Disarray in severely economically depressed countries • Low salaries • Inability to accrue savings • Nonpayment of salaries, housing allowance, pension 	<ul style="list-style-type: none"> • Higher pay (and opportunities for remittances) • Reasonable remuneration—able to save money • Recruiters actively sourcing workers internationally with promise of high income and good benefits
<i>Political Considerations</i>	
<ul style="list-style-type: none"> • Political, racial, ethnic upheaval • Gender discrimination • Government training health workers for international export 	<ul style="list-style-type: none"> • OECD countries wealthy, stable, and democratic • Absence of corruption
<i>Physical Security</i>	
<ul style="list-style-type: none"> • Criminality • Gender-based violence • Exposure to HIV—risk of infection through treatment of patients 	<ul style="list-style-type: none"> • Safe country • Safe working environment • Appropriate medical equipment to prevent HIV infection
<i>Quality of Life</i>	
<ul style="list-style-type: none"> • Poor accommodation • Lack of transport to go to work • Inability to live a decent life 	<ul style="list-style-type: none"> • Multiethnic and tolerant of diversity • Good quality of life
<i>Education</i>	
<ul style="list-style-type: none"> • Diminishing quality of education for children 	<ul style="list-style-type: none"> • Greater opportunities for children—good education and ability for them to earn a decent living

Compiled from: McDonald & Crush, 2002; Bundred et al., 2004; Thomas, Hosein, & Yan, 2005; World Health Organization, 2006.

are well-established, evidence-based “push” and “pull” factors summarized in Table 9.2. There is also a well-developed culture of medical migration. Hagopian et al. explain how this culture has become firmly rooted in many source and receiving countries: it not only fails to discourage medical migration but actively encourages it. Medical school faculty in source countries are often role models of, or advocates for, the benefits of migration, and are proud of their students who successfully emigrate to higher-income countries affording greater professional opportunities (Hagopian et al., 2005).

There is little evidence that significant numbers of doctors and nurses return to their source country to practice their profession, ostensibly because the conditions which led to their departure remain unchanged. HHR shortages in the key receiving countries are merely fuelling a fire that was already started. In this light, one word, admittedly oversimplifying the situation, describes the most important and yet most complicated step towards resolving the HHR migration crisis: *retention*. For retention efforts to take root and be truly successful, the fundamental labor, economic, and social conditions that drive health workers to leave in the first place must be improved. This will require enormous adjustments in public health systems (e.g., improvements in procurement and safety procedures, in telemedicine, in the balance of skills of health workers, etc.) and increases in funds. It might be argued that remittances from émigré HHR could partly provide such funding, but remittances are private transfers not structured to finance public health services, although there is some evidence that poorer families receiving remittances often use them to purchase health care when quality publicly funded services are not available.

THE IMPACTS OF MIGRATION ON SOURCE-COUNTRY HEALTH SYSTEMS

While health care is not the only determinant of population health, it is certainly an important one. Human resources are a prerequisite for effective, quality health care, with most medical interventions requiring the services of physicians, nurses, or other types of trained health workers. A poorly resourced health workforce inevitably affects negatively the health of populations (Dussault & Dubois, 2003; Marchal & Kegels, 2003). In their correlational study of HHR and health outcomes, Anand and Bärnighausen (2007) found that human resources for health in aggregate terms (specifically physicians, nurses, and midwives) matter significantly in health outcome measures of maternal, infant, and under-five mortality rates, even after controlling for other variables that are typically used to explain health outcomes.

Shortages in HHR in poor countries can be devastating to health care and thus equity in health outcomes (Table 9.3). Significant shortages exist

Table 9.3 Selected Impacts of Inadequate HHR

Too few hospital beds causing refused or delayed treatment
Too few treatment facilities reducing level of care
Reduced emergency care
Increased wait time, reduced patient care time, and poorer infection control
Overwork in public sector pushes HHR into private sector, creating more overwork conditions in public sector caring for the poor
Increased health worker absenteeism due to overwork, stress, and emotional exhaustion, creating more overwork conditions
Care provided, of necessity, by insufficiently trained staff, particularly in rural areas

Compiled from: Aluwihare, 2005; Bach, 2006; Gerein et al., 2006a.

in certain specialties, such as anesthesiology, radiology, and pathology. Physicians with such training are in high demand in richer receiving countries and are already few in numbers in developing source countries. As physicians with specialized training take longer and cost more to train, their out-migration deals a particularly severe blow to the source country. As an example, a regional spinal injuries unit in South Africa serving a population of three million was closed in 2004 when two key doctors were recruited to open a similar unit in a Canadian city with a population of 700,000 (Bundred et al., 2004). Undergraduate and postgraduate medical education also suffers as a result of migration, affecting the next generation of HHR in some source countries (Paton, 2006). Specialized health professionals who emigrate are often among the few active or published researchers in low-income source countries. Emigration of such individuals stifles innovation and invention in dealing with persistent local public health problems, for example, HIV/AIDS, tuberculosis, and malaria (Kirigia, Gbary, Muthuri, Nyoni, & Seddoh, 2006). Finally, loss of educated health-professional pools through migration has broader impacts for societies. Physicians and their families constitute an educated sector of the population of a country and the migration of physicians depletes this pool. Physicians' spouses are also often health care professionals and children are often steered into the health profession. As such, the recruitment of one doctor overseas potentially depletes a much larger educated pool of actual and potential health professionals.

THE IMPACTS OF TRADE AGREEMENTS

A defining characteristic of contemporary globalization is the growth in the number of bilateral, regional, and multilateral trade liberalization agreements (see Chapter 5 and Chapter 8, this volume). The sheer number of bilateral agreements makes any assessment of their provisions on

the movement of HHR beyond the scope of this chapter's analysis. As one recent example, however, Japan and the Philippines concluded a bilateral agreement in September 2006 that allows for up to 500 Filipino nurses or caregivers to enter Japan each year for work, professional education, or language training. This number is expected to rise as the population of elderly Japanese increases (Anon., 2006).

A number of regional trade treaties and mobility policies have incorporated specific measures designed to encourage the free movement of labor within their defined geopolitical areas.

EU

The EU has established an inclusive model of mutual recognition of qualifications in which, for example, registered nurses or midwives are free to work in any other member state. As a result, the barriers to mobility have less to do with recognition of qualification and more to do with linguistic and other barriers (Buchan, Parkin, & Sochalski, 2003).

NAFTA

The North American Free Trade Agreement (NAFTA) enables some, but not all, Canadian, Mexican, and American citizens to work temporarily in each other's countries, and provides a framework for mutual recognition of professional competency. In practice, NAFTA has encouraged movement primarily between Canada and the United States. Medical students in both countries receive a similar education. Canadian medical graduates therefore can apply for a US residency-training program and subsequent to that become licensed to practice in the United States; and vice versa (Biviano & Makarehchi, 2003). NAFTA-approved migrants do not require visas. Health workers from NAFTA countries need only a letter of employment to present at the port of entry (Ouaked, 2002).

ASEAN

The Association of Southeast Asian Nations (ASEAN) is a participant in the global trade liberalization process through the establishment of the ASEAN Free Trade Area (AFTA), which, in turn, has started to develop the ASEAN Economic Community (AEC). The AEC by 2020 will turn ASEAN into a single market with over five hundred million consumers and free flows of goods, capital, services, and skilled labor. The health services sector has been set as one of eleven priority sectors to be accelerated and fully liberalized by 2010. At present, negotiations are in the advanced stages for specific health commitments. These would include the mutual recognition arrangements for freer movements of health professionals such as physicians, nurses, and other allied health practitioners (Kovindha, 2006).

MERCOSUR

The Southern Common Market Agreement (known by its Spanish acronym, MERCOSUR) is a regional free-trade agreement between ten South American countries. It adopted provisions for trade in health services identical to those found in the General Agreement on Trade in Services (GATS) of the World Trade Organization (WTO) next discussed.

WTO

Aside from regional free-trade agreements, WTO rules have attracted the most attention in terms of implications for health worker migration. Of specific concern are the negotiations around the General Agreement on Trade in Services (GATS), a set of multilateral, legally enforceable rules designed to encourage the liberalization of trade in services (OECD, 2002). The most forceful GATS provisions are bottom-up, applying only to those sectors and measures that governments specifically agree to cover. In making commitments to these rules, governments can specify how they apply to particular services and government measures. Commitments can be unbound (applying only to current government measures) or bound (covering current and any future government measures). They can include limitations on the range of services and measures covered, or they can be without limitations. Commitments can be limited to certain ways of providing services, or they can cover all possible ways of providing the service. However, this formal flexibility is diminished by intense negotiating pressure to extend the reach of GATS rules with full, bound commitments and minimal limitations (see Chapter 5, this volume).

It is GATS Mode 4 (presence of natural persons) which most directly relates to the provision of health services by individuals in another country on a temporary basis (Bach, 2003). If a country allows the entry of foreign doctors and nurses as service providers, GATS requires that it must make its licensing requirements transparent and freely available, and must administer tests in a reasonable and impartial manner. At the same time, countries committed to allowing the entry of foreign health workers have the right to verify foreigners' credentials to ensure they are consistent with national credential rules. There are no specific limits on the cost, duration, or standards of this testing (Martin, 2003). In theory, Mode 4 has made international labor mobility for health workers easier. In practice, however, none of the high-recipient countries for foreign-trained HHR (Canada, the United States, the UK/EU, and Australia) has made commitments that would directly facilitate the movement of physicians, nurses, or other health professionals, although some are acting to ease accreditation and to establish global standards for competencies (Blouin, 2005; Broten, 2008). The possibility nonetheless remains that future commitments made under GATS Mode 4 could increase the flow of HHR from developing to developed countries.

POLICY OPTIONS TO MANAGE HEALTH-PROFESSIONAL MIGRATION

We discuss next a number of policy options that have been advanced as means to manage the migration of health workers such that global health equity does not suffer. While migration is a global phenomenon, many of these options have more to do with improving domestic supply and retention.

Reduced Reliance by Source Countries

Countries should commit to becoming self-sufficient in the development of their own domestic supply of HHR by a given target date. This would apply particularly to those OECD countries that remain heavily reliant on foreign-trained health professionals, and would eventually reduce pull factors (available positions). Recently, for example, the UK National Health Service began to explicitly prioritize hiring of locally trained over foreign-trained health workers in filling vacancies. As explained by Debbie Mellor, director of workforce development for the UK Ministry of Health, at a March 2007 International Organization for Migration (IOM)/WHO meeting on HHR migration, the UK's overall goal is to reduce reliance on non-European internationally educated nurses to between 25 percent and 30 percent of the total roster—which nonetheless remains a sizable number. Targeting a maximum reliance on HHR from developing countries, however, at least establishes an accountable baseline.

Several source countries are either actively or planning to begin training auxiliary (mid-level or substitute) health workers whose skills are presently less marketable globally. Examples are Tanzania, Zambia, South Africa, and Malawi, where, for example, health care workers (not nurses) are being trained to administer vaccinations and other limited treatments. There is no evidence that, with an adequate training curriculum, higher skilled backup and good supervision, the expanded deployment of such workers leads to a “second-class health system,” as is sometimes claimed by medical and nursing organizations in both source and receiving countries.

Rural Incentive Schemes

Rural areas in both source and destination countries are critically short of health workers and are the first to lose in the global flow of HHR. One solution to this problem attempted by many countries is the offer of extra pay or other incentives to health workers who take posts in rural or other underserved areas. One study observed, however, that wage differentials for those accepting posts in these regions have to be significant to be effective in attracting physicians and nurses (Vujicic, Zurn, Diallo, Adams, & Dal Poz, 2004). Incentives are not only financial but have included subsidized housing, deferred or reduced student loan schemes, better access to

promotions, and specialized training for those willing to go to rural areas (Physicians for Human Rights, 2004). A community service requirement that encourages health professionals to practice for a fixed period in rural and other underserved areas has also been tried in such countries as South Africa and Nigeria (Physicians for Human Rights, 2004). Another strategy that has been advanced is a requirement of internship rotation where nursing and medical school students in their final year work in both rural and urban areas (Serneels, Lindelow, Garcia-Montalvo, & Barr, 2005).

Reduced Wastage of In-Country Health Workers

Wastage of trained HHR occurs in both receiving and source (Dovlo, 2005b) countries. This occurs when a country develops or gains health professionals through in-migration but fails to employ them. As an example of a receiving country, in one province of Canada alone there are reportedly 3,000 to 4,000 skilled foreign-trained physicians who have not obtained Canadian certification and are therefore underutilized (College of Physicians and Surgeons of Ontario, 2004). While their training may not be comparable to or reach the standards Canadian licensing bodies require, it would arguably cost Canada less to bring these already knowledgeable individuals' skills up to par than to train new professionals from scratch.

At the same time, there is a considerable number of source countries with significant numbers of health professionals unemployed even when there are significant numbers of vacancies. For instance, between 1996 and 2001 there were 32,000 vacancies in nursing in the South African public sector and yet 25,000 registered nurses who were inactive or unemployed within the country, pointing to problems other than migration affecting the health sector (Gent & Skeldon, 2006). A similar situation is reportedly the case in Kenya as well (McVeigh, 2006). Globalization, for example, in the form of IMF-recommended or -required ceilings on the public sector wage bill, might play a role in this ironic situation; but it also attests to other underlying problems in HHR planning, management, and funding that account for crisis in undersupply.

Restrictions on International Mobility

Restrictions can be applied on both the exit of individuals from source countries and on their entry into destination countries. The first has generally taken the form of temporary bonding, which requires that individuals trained at public expense work for a period within country essentially to repay that cost. While intuitively appealing, there have been numerous documented problems with bonding (Chikanda, 2005; Mensah et al., 2005; Serneels et al., 2005); for example, it fails to deal with the root causes of out-migration, can increase health workers' dissatisfaction, creating an additional incentive to leave or reluctance to return home after spending

years abroad, is prone to corruption and favoritism, and, when accompanied by fines, has proven easy to “buy out.”

Bonding has also sometimes been criticized for potentially violating peoples’ right to seek migration. If bonding is in the form of a contract for repayment of publicly subsidized education, there is no apparent violation of this right. But human rights issues do cut across many of these policy options.

Receiving countries can also place restrictions on international mobility. The South African government, for instance, does not condone the recruitment of health professionals from any Southern African Development Community (SADC) country for ethical reasons, since these neighboring countries also suffer acute HHR shortages. The South African–SADC HHR agreement includes nonretention of foreign (SADC) students who have completed their studies in South Africa.

Return of Migrants to their Source Countries

Current evidence indicates that schemes to promote the return of migrants have so far proved costly and largely unsuccessful, particularly where root factors which caused the out-migration in the first place have not been addressed. Any reduction of global health inequities through investments based on this strategy must be weighed against the opportunity costs of investing in stronger evidence-informed options. It is important, however, to distinguish health professionals who migrate primarily for purposes of advancing training that may be unavailable in their own countries. A recent Canadian study of foreign-trained physicians who eventually left Canada found that roughly half returned to their home, or neighboring, country within three years of completing their Canadian postgraduate residencies, indicative that migration for this group serves primarily as a training strategy (Watanabe, Comeau, & Buske, 2008). At the same time, the proportion of all foreign-trained physicians in Canada who left was low (around 9 percent) and those from poorer countries were least likely to return home and most likely to move from Canada to the United States—hardly convincing evidence of return migration by HHR from countries most in need.

Restitution for Loss of Human Capital

The premise of restitution is that receiving countries or émigré health professionals compensate source countries for, at minimum, the loss of training cost investment and, at maximum, estimated economic welfare losses to the country over the foregone life span of active professional service. Most source and destination countries appear to be in considerable opposition on this option. Source countries frequently argue that the scale of the “perverse subsidy” represented by such HHR flows from poor to rich, particularly in light

of international commitments such as the MDGs, demands restitution. Destination countries generally counter that individuals migrate by free volition, as is their right. Yet the grounds for restitution lie precisely in other human rights treaty obligations (notably Article 12 of the International Covenant on Economic, Social and Cultural Rights, known colloquially as “the right to health”), which requires nations to avoid acting in ways that do interfere with other nations’ abilities to fulfill their obligations under this right (Bueno de Mesquita & Gordon, 2005). A compromise strategy embodied in the World Health Assembly’s Resolution 59.23 (May 2006), and less dramatic than calling for “restitution,” emphasizes the importance of dramatically increasing training for health workers in source countries, with increased financial and nonfinancial support from “receiving developed countries.” Such support could be based on some calculi of net costs and benefits to source/receiving countries (improbable), much more generous health aid transfers from receiving (donor) to source (recipient) countries (more likely, but see Chapter 7, this volume, on the need first for substantive aid reform), or transfers based on systems of global taxation on all flows of goods, capital, and people (possible, but not for some time in the future).

CONCLUSION

Migration is an inescapable feature of humankind. People always have migrated and will continue to pursue what they feel are better opportunities. But the extent to which health workers, in particular physicians and nurses, are leaving poor countries to work in rich ones is beyond simple migration. It is a symptom, not a cause, of failing health systems.

The key element in both source and receiving countries which will stem the HHR migration crisis is retention. The central component of any retention scheme is the improvement of pay and living and working conditions to encourage health workers to remain. In very straightforward terms, money will resolve this crisis, bolstered by other strategies to improve working environment and conditions and, in many source countries, the overall economic and social health of the country. This will require specific actions, as suggested in the policy options described in this chapter, from both source and destination countries as well as the international institutions (Kapur & McHale, 2005).

The impact of trade and cross-border mobility agreements on HHR flows continues to be a concern. While such agreements generally are not the cause of, nor as yet a major factor in, the outward flow of HHR, their potential to become so exists and may be on the rise. Experience with health sector liberalization has shown that inequities tend to follow in access, largely a result of internal drains from the rural public to the urban private health systems (Packer, Labonté, & Spitzer, 2007).

Various policy options to manage the migration of health workers, both proposed and in practice, have been outlined in this chapter. The best scenario would be for *both* source and receiving countries to adopt such strategies and, where relevant, enter into bilateral agreements to manage flows in a manner suitable to both countries. But as all of the chapters in this book have argued, and the evidence in terms of “push” and “pull” in the global HHR labor market substantiates, only policies that are based on redistribution, rights, and regulation are likely to lead to a sustained resolution of the ongoing crisis of “brain drain.”

NOTES

1. Reported verbally by participants at the conference “A Call to Action: Ensuring Global Human Resources for Health,” March 22–23, 2007, Geneva. Agenda available at: <http://www.hret.org/hret/publications/ihwm.html>.

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