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Working Paper

International migration of health workers: Labour and social issues

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Working papers are preliminary documents circulated
to stimulate discussion and obtain comments

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Preface

International migration has become an important feature of globalized labour markets in health care. The impact of international migration is very complex both for health workers and for the countries involved. There has been concern about international migration in health services for some years now, but recently the situation has become more acute for a number of reasons, mostly reflected in severe staff and skill shortages in the health systems of many countries. While industrialized countries, in addressing the problem of staff shortages, become "recipient" countries and actively recruit health personnel abroad, the emigration of qualified health workers in a number of "donor" countries may undermine the functioning of their health systems.

The Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness (Geneva, October 2002) raised the migration of health workers as one major concern and requested the International Labour Office to take further action. The Sectoral Activities Department commissioned this study as a direct follow-up to the recommendations of the Joint Meeting. The study provides an overview of existing information on migration of health workers with an emphasis on related labour and social issues; it considers migration policies and practices, working conditions and the role of international standards and trade agreements.

As a Sectoral Working Paper, the study is meant as a preliminary document; it is circulated to stimulate discussion and to obtain comments. We hope that it will contribute to a discussion on policies and practices for socially acceptable management of health worker migration, allowing for decent working conditions for migrant health workers as well as for health workers remaining in their countries, with the aim of ensuring the equal access to quality health services for all.

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Contents

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Executive summary

This study provides an overview of existing information on the migration of health workers, with an emphasis on related social and labour issues. It considers trends in migration, the working conditions of migrants, migration policies and recruitment practices, the impact of international standards and trade agreements on conditions of migrant health workers. The study also outlines policies and practices associated with more socially acceptable forms of managed migration. It focuses on nurses and doctors, who have been in the forefront of current debate about health worker migration.

The paper demonstrates that governments and employers have a key role in the migration of health workers. In all countries a higher profile for human resource management in the health sector would not only alleviate some of the "push" factors that encourage migration, but also reduce the shortage of health professionals that underpins increased international recruitment. It is an indictment of governments and employers that they prefer to rely on the relatively straightforward panacea of international recruitment rather than focusing on underlying problems of pay and working conditions. Improvements in these areas would ensure increased recruitment and retention amongst the existing health sector workforce.

Governments and employers should do more to safeguard and improve the working conditions of migrant health workers by ensuring the ratification and enforcement of ILO Conventions. When state authorities use policies of international recruitment, the detrimental impact on source countries should be minimized by focusing on regulated, managed migration. Professional associations and trade unions also have an important role in making migrant workers aware of their legal rights, monitoring and documenting abuses, and ensuring that the welfare of migrant workers is seen as a priority by employers and government agencies.

Abbreviations

AFL-CIO	American Federation of Labor-Congress of Industrial Organizations
ANA	American Nurses Association
CGFSN	Commission on Graduates of Foreign Schools of Nursing
DENOSA	Democratic Nursing Organisation of South Africa
DHHS	Department of Health and Human Services
EEA	European Economic Area
EEOC	Equal Employment Opportunity Commission
GATS	General Agreement on Trade in Services
GMC	General Medical Council
HR	human resources
ICN	International Council of Nurses
ILO	International Labour Office
IOM	International Organization for Migration
IT	information technology
ITU	intensive therapy unit
MFN	most favoured nation
NAFTA	North American Free Trade Agreement
NHS	National Health Service
NMC	Nursing and Midwifery Council
OECD	Organisation for Economic Co-operation and Development
POEA	Philippine Overseas Employment Administration
PSI	Public Services International
RCN	Royal College of Nursing
RN	registered nurse
TUC	Trades Union Congress
UN	United Nations
WHO	World Health Organization

WONCA	World Organization of Family Doctors
WTO	World Trade Organization

1. Introduction

The migration of health workers has become a more prominent and controversial feature of health sector analysis in recent years. The industrialized countries of the North stand accused of sucking in labour from some of the poorest countries in the world, countries that can ill afford to lose health sector staff. The more aggressive recruitment of overseas workers is viewed as symptomatic of a failure to address underlying recruitment and retention difficulties, and of problems with workforce planning in industrialized health-care systems.

For key custodians of the global economy, including the World Trade Organization (WTO), the migration of workers forms an integral and beneficial component of globalization and the liberalization of the service sector (Adlung, 2002). In contrast to these essentially neo-liberal perspectives, the International Labour Office (ILO) and the International Organization for Migration (IOM), whilst recognizing the benefits of managed migration, have raised concerns about the possible detrimental effects. These include the consequences of a brain drain of highly skilled workers, the dislocation associated with migration, the gender consequences of these trends and the need to safeguard the interests of a potentially vulnerable group of workers (ILO, 1999, p. 38; IOM, 2003a). These issues were highlighted at the ILO Joint Meeting on Social Dialogue in the Health Services, which identified health worker migration as a major area of concern (ILO, 2002a, pp. 34-35).

This study provides an overview of existing information on the migration of health workers, with an emphasis on related social and labour issues. It considers trends in migration, the working conditions of migrants, migration policies and recruitment practices, the impact of international standards and trade agreements on conditions of migrant health workers. The study also outlines policies and practices associated with more socially acceptable forms of managed migration.

It focuses on occupational groups that have been in the forefront of current debate about health worker migration – nurses and doctors, who occupy a pivotal position within health systems. Nurses and doctors are distinctive in terms of their occupational characteristics, labour market position and political profile, which merits separate analysis. It has been suggested that the employment experience of skilled labour such as health professionals is more favourable than that of unskilled labour because of their qualifications and bargaining power (Wickramasekara 2002, p. 3). This basic distinction is useful but should not divert attention from the vulnerability of migrant labour in the health sector, as documented in this paper.

2. Health worker migration: Patterns and trends

2.1. Context

There is often a degree of imprecision in the definitions and statistics used in analysing migration. An international migrant worker is defined by the 1990 United Nations (UN) International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families as "a person who is to be engaged, is engaged or has been engaged in remunerated activity in a State of which he or she is not a national".

The number of international migrants has more than doubled since 1975. It has been estimated that the total number of international migrants is 175 million people (2.9 per cent of the world population) of which 48 per cent are women. Most of the world's migrants live in Europe (56 million), Asia (50 million) and North America (41 million). Of this total, 60-65 million are economically active (United Nations Population Division, 2003). International migration has existed for centuries, but this recent growth is significant in that it reflects a new dynamic in population movement in terms of size and velocity (IOM, 2002, p. 8).

International migration should not divert attention from internal migration from rural to urban areas, between states within a country, or from public to private sectors. In large countries, such as Nigeria and India, with large differences in health status and health care provision, state-to-state migration forms an important component of the migration process (Stilwell et al., forthcoming). Internal migration to urban areas and the impetus to recruit internationally are often interrelated because the authorities in many countries seek migrant labour to work in rural and remote geographic regions where shortages are most acute. In addition, internal migration may be a precursor to international migration. Martineau et al. (2002, p. 12) cite the case of nurses moving from rural parts of the Eastern Cape in South Africa to more highly skilled jobs in Kwazulu Natal to improve their prospects of gaining employment overseas.

Policy-makers are directing more attention to the increase in skilled labour migration. These occupational groups raise particular challenges in ensuring a fairer distribution of benefits between source and destination countries (OECD, 2002a, p. 1). New opportunities exist for health-care professionals in search of better pay and enhanced career opportunities to work in other countries. This process has been facilitated by the growth of free trade blocks, reinforced by service sector liberalization arising from the General Agreement on Trade in Services (GATS), (OECD, 2002b).

There is increased awareness of the important role that gender plays in international migration. This reflects the increased proportion of migrant women alongside increased recognition that the experience of migration differs for men and women (Taran and Geronimi, 2003, p. 10). Women are more vulnerable to physical, sexual and verbal abuse. This is a central issue for the health sector because workplace violence is a continuing concern amongst the predominantly female workforce (ICN, 2002a, p. 10). The migration of women reinforces what Hochschild (2000, p. 131) has termed global care chains: "a series of personal links between people across the globe based on the paid or unpaid work of caring". The implication is that policy analysis of migration has been gender-blind, ignoring the emotional labour expended by women and the stress they confront as part of transnational families in which filial obligations are altered rather than severed. Women migrants are not a homogeneous group; nevertheless, female migrants tend to be more reliable remitters, despite being deskilled in the positions they occupy (IOM, 2002, p. 10).

2.2. Dimensions of health worker migration

In the 1950s and 1960s many countries expanded their welfare states rapidly and accompanied this by recruiting health workers from abroad. Fears of a brain drain prompted WHO to undertake a detailed study on the flow and stocks of physicians and nurses in 40 countries (Mejia et al., 1979). They concluded that in 1972 about 6 per cent of the world's physicians (140,000) were located in countries other than those of which they were nationals. Significantly, about 86 per cent of all migrant physicians were working in five countries (Australia, Canada, the Federal Republic of Germany, the United Kingdom (UK) and the United States (US). The stock of nurses overseas was estimated to be lower, at about 5 per cent, but the main recipient countries were the same as for physicians with the exception of Australia (Mejia et al., 1979, pp. 399-400).

The absence of comparably detailed studies of health worker migration since the 1970s reflects the limitations of the existing data sources, a difficulty that is generic to migration studies (Hoffmann and Lawrence, 1996; OECD 2003a, p. 19). The most common difficulties include the variety of sources used by countries to record migrants (e.g. work permits, population registers) and the absence of data linked to occupation that makes it difficult to analyse health worker migration. The establishment of accurate data on stocks and flows of health workers remains a major challenge that continues to inhibit effective migration management.

Data on inflows into receiving countries are considered more reliable than data on outflows, not least because there is a widespread belief that many countries, through error or omission, underestimate the extent of outflows, as has been shown in the case of South Africa (Stilwell et al., forthcoming). Nonetheless verification data (i.e. when a check is made that an individual is on the professional register) can be used as an indicator of intention to work overseas. Similarly, registration data record the number of nurses or doctors registered to practise in a particular recipient country. This does not eliminate all difficulties because in many federal countries, such as Australia or the US, registration is at state level, which may lead to double-counting if nurses register in more than one state. The major limitation, however, is that registration data indicate the intent to work rather than actual employment status (Buchan, 2002, p. 10). Because registration data have usually been compiled on a consistent basis over time, however, they provide a valuable source of trend data, despite these caveats.

Trends in stocks and flows of health professionals need to take account of considerable differences between occupational groups, geographical regions and differences between countries in terms of classifying them as predominantly a source or destination country. A distinction is usually made between the short-term temporary flows which occur when countries such as China and Cuba send health personnel abroad to earn foreign exchange, and the permanent migration which occurs more between countries of the South and the industrialized North (Chanda, 2002, p. 159). In practice, this distinction is often blurred because temporary migration is ill-defined (e.g. in GATS) and may result in permanent migration.

The migration of health workers is distinctive because it is strongly influenced by the regulatory frameworks of individual governments that control the training, recruitment and deployment of health professionals; such frameworks give rise to particular national patterns of migration. The centrality of government regulation in the health sector is a significant factor, which contrasts strongly with the information technology (IT) sector, for example, and this provides greater scope for policy interventions. Health sector work is characterized by both a highly interdependent labour process and the proliferation of specialized professional roles with long lead times in terms of training. These features can jeopardize health provision because even small-scale changes in migration flows amongst specialist groups (e.g. intensive therapy nurses) can undermine a country's health system.

2.3. Source countries

The Philippines has a central role in the political economy of migration, with an estimated 7 million Filipinos (approximately 10 per cent of the population) working or living abroad (Go, 2003, p. 350). This reflects the country's historical evolution in which high levels of unemployment led the Philippines Government to encourage labour migration with initially large outflows of doctors to the United States. This has been supplemented by nurses and the Philippines is the largest source of registered nurses working overseas. This policy has been incorporated into the 2001-2004 Medium Term Philippines Development Plan which views overseas employment as a key source of economic growth (Go, 2003, p. 350). As the Philippine Secretary of Labor and Employment commented: "It's an industry. It's not politically correct to say you are exporting people, but it's part of globalization, and I like to think that countries like ours, rich in human resources, have that to contribute to the rest of the world" (cited in Diamond, 2002, p. 2).

During the mid-1970s a total of 13,480 physicians were working in the Philippines compared to 10,410 Philippines-trained physicians who were employed in the United States (see Goldfarb et al., 1984, pp. 1-2).

The overseas employment of nursing staff started slightly later but has increased markedly, stimulated by the expanding supply. In the 1970s there were 63 schools of nursing; the number had increased to 198 by 1998. As a result, in 1970 there were almost 40,000 registered nurses in the Philippines, but by the end of 1998 this total had increased to approximately 306,000 (Corcega et al., 2002, p. 3). This has enabled a massive increase in overseas employment. The destination of Filipino nurses has diversified compared to the mid-1980s when Saudi Arabia accounted for two-thirds of the total (Ball, 1990, p. 102). Over 70 per cent of the 7,000 nurses who graduate each year leave the country, and this contributes to the annual estimated outflow of 15,000 nurses per annum bound for more than 30 countries (Adversario, 2003). It has even been suggested that doctors are retraining as nurses because of the greater opportunities available for employment abroad (Sison, 2003). This outflow is reinforced by unattractive home working conditions and funding shortages which contribute to the estimated 30,000 unfilled nursing positions in the Philippines (OECD, 2003a, p. 75).

The Philippines is not the only Asian country that is an important source of health professionals. In absolute numbers, India was the largest source country of doctors in the 1970s (Mejia et al., 197, p. 277). This has ensured that Indian-trained doctors continue to make up a substantial proportion of the stock of doctors in Canada, the United Kingdom and the United States (see Khadria, 2002, p. 32). Since Mejia's study India has become a more important source country for nurses with concern expressed about increasingly aggressive recruitment, especially by US recruitment agencies, in India and Sri Lanka (e.g. Hindu Business Line, 2002). During 2003 the US Commission on Graduates of Foreign Nursing Schools (CGFNS) opened a new examination centre in Cochin, Kerala state, India (CGFNS, 2002a), facilitating entry to the US labour market. Sri Lankan nurses are being targeted for recruitment not only by the United States but also by Malaysia, Singapore and Europe. It is estimated that from a stock of approximately 22,000 nurses, about 150-200 are recruited by these countries annually (Thompson, 2003, p. 5).

It is amongst African countries that anxieties about the effects of a "brain drain" have been expressed most strongly (see WHO/World Bank, 2002). In conjunction with other aspects of the working environment, migration has contributed to the problems faced by African health systems, as signified by high vacancy rates (table 1). An important dimension which is often overlooked is the degree to which sub-Saharan countries are significant importers of migrant labour from other African countries and beyond, for example, Cuban doctors in Ghana (Adams and Kinnon, 1998, p. 37). Many doctors work

overseas and the number of nurses is higher; for example, 18,000 Zimbabwean nurses work abroad (Mangwende, cited in Pang et al., 2002).

Table 1. Vacancy levels in 1998 in selected public health services (%)

	Ghana	Lesotho	Namibia	Malawi
Doctors	42.6	7.6	26.0	36.3
Nurses	25.5	48.6	2.9	18.4

Source: World Health Organization, Regional Office for Africa, 2001.

Much recent attention has focused on South Africa. Martineau et al. (2002, p. 6) report that almost 80 per cent of rural doctors were non-South African in 1999. At the same time Alberta in Canada has recruited South African doctors to work in rural areas that are equally unattractive to its own citizens (Bundred and Levitt, 2000, p. 246). South Africa has become an important source country for nurses, as indicated by the fact that the number of nurses seeking verification of their qualifications before applying for overseas employment increased from 511 in 1995 to 2,543 in 2000 (Xaba and Phillips, 2001, pp. 2-3). The flow of nurses from South Africa has increased eightfold since 1991 and well over half of these leave for the United Kingdom (*The Economist*, 17 May 2003, p. 33).

In many parts of the world regional flows are very significant, often facilitated by specific regional agreements. The Trans-Tasman travel arrangement authorizes free movement between New Zealand and Australia and similar arrangements include the Nordic Passport Free Area (Denmark, Finland, Iceland, Norway and Sweden) and the North American Free Trade Agreement (NAFTA). NAFTA has proved a significant catalyst for Canadian nurses to work in the United States but less so for Mexicans whose education and training are not generally comparable to US nurses (Flaherty, 1999). The Caribbean Region exhibits intra-regional flows alongside international migration. Thomas-Hope (2002, pp. 18-19) documents the decline of nurses in the Jamaican health system from 3000 to 1000 since the 1970s. Emigration patterns have altered markedly with a decline in flows to the United Kingdom being replaced by emigration to the United States and Canada. Attempts to replenish this stock of nurses have included agreements with Cuba and efforts to manage migration between Caribbean countries.

In Europe, historical links play a part in explaining, for example, flows of physicians between North Africa and France. The European Union (EU) has been keen to promote the free movement of labour within the EU as well as encouraging migration into certain regions and sectors (see European Foundation, 2003). The liberalization of labour markets and the mutual recognition of qualifications are necessary but not sufficient to stimulate mobility. The movement of nurses and physicians between countries remains at a relatively low level, partly because of linguistic and cultural barriers (Jinks et al., 2000). The context is altering, however, with the enlargement of the EU to incorporate ten countries from Central and Eastern Europe in April 2004. Health professionals may be attracted to migrate to take advantage of higher salaries and better working conditions (Irwin 2001, p. 13). The Netherlands and the United Kingdom are in discussions with Poland and Hungary about recruitment opportunities (O'Dowd, 2003, p. 10) and Norway has also been recruiting nurses from Poland (Buchan et al., 2003, p. 23).

2.4. Destination countries

With its growing population, a history of migration, and a health sector that has no parallel in terms of the scale of health expenditure, the United States could be expected to play a central role in the migration of health workers. The country faces a shortage of pharmacists and nursing staff, especially amongst registered nurses (RNs) (Department of

Health and Human Services, (DHHS) 2000). It has been estimated that a 6 per cent shortfall (110,000) out of a RN workforce of 1.89 million in 2000 could increase to a shortage of 800,000 RNs by 2020. At present approximately 100,000 US nurses were trained abroad (DHHS, 2002; First Consulting Group, 2001; Laitner, 2003). In the early 1970s graduates of foreign medical schools comprised 18 per cent of the physician workforce (52,217), increasing to 25 per cent (196,961) by 2000 (Biviano and Makarehchi, 2002, p. 10).

The United States has historically recruited from many overseas countries and since the late 1960s there has been a switch in recruitment from Canada and the United Kingdom to the Philippines and other Asian countries (e.g. Sri Lanka). Recruitment to the United States is influenced by the complex and changing system of immigration. In recent years there has been considerable relaxation of restrictions on skilled labour, including some specialist nurse categories, which could be expected to continue (OECD 2003a, p. 21). The previous consensus that the United States confronted a surplus of physicians is now being questioned, with some commentators predicting shortages (see Cooper et al., 2002).

The United Kingdom has historically been a major destination country for doctors and nurses. In 2002 over 200,000 doctors held provisional, full and limited registration. In terms of full registration over half were trained in other countries (table 2). The data indicate high levels of registration by overseas-trained doctors, especially from outside the European Economic Area (EEA). This situation could be expected to continue as the Department of Health's global recruitment campaign for doctors gathers momentum (Department of Health, 2002a).

Table 2. New full registrations of doctors in the UK by place of training

	1994	1996	1998	2000	2002
UK	3 657 (47%)	3 822 (38%)	4 010 (44%)	4 214 (50%)	4 288 (42%)
EEA [1]	1 444 (19%)	2 084 (21%)	1 590 (17%)	1 192 (14%)	1 448 (14%)
Rest of world	2 539 (33%)	4 047 (41%)	3 580 (39%)	2 993 (36%)	4 456 (44%)
Total	7640	9953	9180	8399	10,192

[1] The European Economic Area comprises members of the European Union plus Norway, Switzerland and Liechtenstein.

Source: GMC Annual Reports www.gmc-uk.org

Overseas-trained nurses have accounted for an increasing proportion of the 655,854 nurses on the register at March 2003 (table 3). In the year to March 2003, there were almost 13,000 overseas-trained nurses registered in comparison to more than 18,000 UK-trained registrations. The Philippines remains the primary source country (5,594 or 43 per cent of overseas-trained registrants), but numbers from India had risen rapidly in the previous year.

Table 3. Overseas-trained nurses registered per annum in the UK 1998-2003 (excluding the European Union)

Country	1998-99	1999-00	2000-01	2001-02	2002-03
Philippines	52	1 052	3 396	7 235	5 594
India	30	96	289	994	1 833
South Africa	599	1 460	1 086	2 114	1 480
Australia	1 335	1 209	1 046	1 342	940
Nigeria	179	208	347	432	524
Zimbabwe	52	221	382	473	493
New Zealand	527	461	393	443	292
Ghana	40	74	140	195	255
Pakistan	3	13	44	207	172
Kenya	19	29	50	155	152
Zambia	15	40	88	183	135
US	139	168	147	122	89
Mauritius	6	15	41	62	60
West Indies	221	425	261	248	57
Malawi	1	15	45	75	57
Canada	196	130	89	79	53
Botswana	4	-	87	100	42
Malaysia	6	52	34	33	27
Singapore	13	47	48	43	25
Jordan	3	3	33	49	18
Total	3 440	5 718	8 046	14 584	12 298

Source: Nursing and Midwifery Council (NMC) www.nmc-uk.org

2.5. Discussion

Countries that in the past were fairly immune to the migration of health professionals are being drawn into an increasingly integrated global labour market in which migration is a more significant and volatile component of human resource planning. This overall increase arises from a variety of factors. Recent policy analysis has tended to focus exclusively on the pull arising from shortages in developed countries, but this approach distorts a more complex picture. Each country's pattern of migration reflects context-specific factors that relate to the level of economic development, the influence of structural adjustment programmes, civil war or other forms of civil unrest and the impact of HIV/AIDS. Focusing exclusively on the "pull" factor of shortages in developed countries risks ignoring the "push" factors, diverting attention away from the full spectrum of policy interventions.

In many countries the flows of health professionals are in both directions. For example, whilst recent attention in the United Kingdom has focused on the recruitment of overseas staff, many UK-trained nurses and doctors work abroad (see Goldacre et al., 2001). In a period of nursing shortages the numbers of nurses seeking work abroad has reached an eight-year high, whilst remaining small as a percentage of the nursing workforce. This can be illustrated by examining the number of verifications (checks) of

UK nursing qualifications by nursing regulatory authorities overseas. However, these figures (table 4) do not distinguish between UK and non-UK-trained nurses so it is not possible to establish whether some nurses are using the United Kingdom as a "staging-post" before moving to another country.

Table 4. Verification trends of UK registered nurses 1994/5-2001/2

Country/bloc	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02
Africa	120	127	93	39	30	92	50	40
Australia	1 118	1 215	1 102	1 329	1 504	1 661	1 859	1 973
Canada	206	150	143	143	189	262	474	490
EEA [1]	451	510	1232	544	719	827	600	1 057
New Zealand	332	693	720	549	478	630	655	753
US	197	197	281	320	288	319	472	1 089
Private [2]						353	297	497
Others	632	715	473	476	622	939	249	357
Total	3 056	3 607	4 044	3 400	3 830	5 083	4 656	6 256

Source: NMC.

[1] Of the 1,057 EEA verifications in 2001/2 almost 95 per cent (958) were nurses who returned to Ireland. No other country had more than 30 verifications.

[2] This relates to the growing importance of private credentialing agencies.

The co-existence of "inflows" and "outflows" within a single country is not unusual. In Canada there has been active recruitment of overseas-trained nurses and physicians, particularly to fill posts in Alberta and Saskatchewan, whilst at the same time there has been long-standing concern about the "brain-drain" of Canadian physicians to the United States (table 5).

Table 5. Physicians who moved abroad and returned to Canada 1990-2000

Year	Moved abroad	Returned from abroad	Net loss
1990	478	263	215
1991	479	256	223
1992	689	259	430
1993	635	278	357
1994	777	296	481
1995	674	256	418
1996	726	218	508
1997	658	227	431
1998	568	319	249
1999	584	340	244
2000	420	256	164
Total 1990-2000	6 688	2 968	3 720

Source: Canadian Institute for Health Information, cited in Barrett, 2001

There is often a disconnection between analysis of inflows and outflows, but they need to be considered in tandem when planning the health service workforce. For governments, however, there may be unpalatable implications of acknowledging the extent

of outflows and it may be considered easier, and requiring less sophisticated HR policies, to focus on recruitment without paying sufficient attention to retention.

Historical links and associated cultural ties play a role in explaining migration pathways between Australia, Canada, India and the United Kingdom. Similarly, Portugal has links with Mozambique and the Netherlands has looked to former colonies such as Suriname or countries such as South Africa as a source of health professionals (Tjadens, 2002, p. 35). Nevertheless, an important facet of the globalization of health labour markets is that these historic ties are loosening as destination countries become more utilitarian in encouraging migration primarily on the basis of economic requirements rather than historical or family connections. The reverse side of this process, as far as the source country is concerned, is the importance of countries such as the Philippines, which are encouraging overseas employment on a global basis. This development strategy is being emulated on a smaller scale by other Asian countries. A key question concerns whether migrants with few historical links to the destination country are more vulnerable to employment abuse and xenophobic attitudes.

The migration of health professionals to industrialized countries can be expected to increase. This reflects the well-known demographic profile of most OECD countries (ageing populations, etc.) alongside the marked reluctance or inability of most governments to train sufficient workers to meet the demands of their health sectors. Although in general commentators emphasize the shift from permanent to temporary patterns of international migration, there are strong reasons to doubt that this will be the case for the health sector. Worldwide shortages of nurses exist (ICN, 2002a) and these shortfalls extend beyond supply-side constraints and cyclical features of labour markets that can possibly be remedied. Instead, shortages signify deep-seated concerns about unattractive pay and working conditions, relative to other occupations with similar educational requirements (for example, on the United Kingdom, see Bach, 2003). Similar concerns have emerged in relation to the medical profession (Smith, 2001, pp. 1073-4).

3. Influences on health worker migration

Analysis of migration has become more eclectic and has shifted from its roots in economic orthodoxy and the assumption that migrant behaviour can be understood in terms of economic utility maximization. This equilibrium approach stems from Todaro's (1969) work on rural-urban migration in which the decision to migrate to urban areas is underpinned by push-pull factors, especially wage differentials. The emphasis on factors that encourage expulsion and attraction for the individual remains the dominant mode of analysis within the health policy literature but needs to be complemented by a wider range of analytical perspectives on the reasons for migration and how migration fits into a wider set of relationships (see de Haan, 1999).

In *Immigrant America: A portrait*, Portes and Rumbaut (1990) are critical of the push-pull model because of its inability to explain why similar migration movements do not arise out of equally poor countries. They note that major labour flows often arise from countries at intermediate levels of development rather than the poorest countries, as implied by the push-pull model. They suggest that migration is more fruitfully analysed in terms of geopolitical influences rather than on the individualistic calculations of migrants. This type of structuralist approach emphasizes how States and multinational corporations can structure labour markets.

A related development has been increased attention to social networks which are important sources of support and identity. It is recognized that networks of social ties are drawn upon by newly arriving migrants, reducing the costs and risks associated with migration (Massey et al., 1993). This implies that once migration pathways are established they will stimulate further migration. This is an important issue that is rarely acknowledged in the analysis of health worker migration. The growth of overseas nurse associations and other support networks in the destination country, for example, of Guyanan, Jamaican, Nigerian and South African nurses in the United Kingdom, comprises an important element in networks that foster further migration.

By focusing on the individual, the push-pull model is in danger of downgrading the role of institutions, including state and supra-national institutions, in generating and sustaining international migration. This is a weakness, because it excludes variations in national policy, notably the influence of States which actively insert themselves into the global economy to promote overseas employment (e.g. the Philippines) or alternatively countries including Canada, the United Kingdom and the United States that are actively seeking to recruit health workers from overseas. Similarly it is in danger of ignoring the under-researched but growing role of private sector intermediaries (i.e. recruitment agencies) in generating and sustaining demand for international migrants. The implications of this analysis are that in a highly regulated sector such as health, the influences on migration need to be considered explicitly, rather than implicitly, as part of a wider analysis of health systems and the socio-economic conditions that shape their performance. It is not sufficient to consider the circumstances of individuals or even households, as has also been advocated (e.g. Harrison, 1998), without retaining this broader perspective. With these caveats in mind the existing literature can be more fruitfully examined.

3.1. Remuneration and employment opportunities

For individuals the possibility to enhance earnings remains a pivotal factor in explaining the propensity to migrate within a context in which state policies can foster or inhibit migration. Differentials in salary levels between source and destination countries are an important stimulus to migration. Articles on Filipino nurses routinely cite earnings figures of $75-$200 per month in the Philippines compared to $3,000-$4,000 per month

available in the United States. South African nurses have also indicated their intent to migrate in search of better remuneration prospects (Xaba and Phillips 2001, p. 5). The data are illustrative, but actual differentials in terms of purchasing power parities may be less important than perceptions of higher earnings, especially when private sector agencies are actively marketing overseas employment.

The attractiveness of migration may also be influenced by differential tax regimes providing a further access point for policy interventions. In Canada, taxation regimes have been viewed as a contributory factor in accounting for the migration of physicians to the United States. For 1995-96 Barrett (2001, p. 40) notes that the average net income of US physicians was $269,000 compared to $119,000 for Canadian physicians.

Finally the availability of employment opportunities within the source country has been identified as an important influence encouraging exit. Programmes of structural adjustment have frequently targeted reductions in health sector employment. Retrenchment of public health staff over the last few years has been noted in Uganda (Corkery, 2000, p. 99), Poland (Domagala et al., 2000, p. 73) and in transition countries such as Estonia, Latvia and Bulgaria (ILO, 2002b, p. 15). Until recently, Germany had an over-supply of doctors that prompted migration to the United Kingdom (Jinks et al., 2000, pp. 57-8). A number of the former Eastern bloc countries are coping with a legacy of over-supply of physicians, many of whom were very poorly paid. Although in some countries such as the Czech Republic salaries have risen rapidly, in Romania the attraction of specialist training and employment overseas remains strong (Ianus, 1999; Scheffler and Duitch, 2000).

3.2. Professional development and training

For highly skilled workers, continuous professional development is an integral component of individual career planning and progression. Kingma (2001, p. 209) reports the findings of a survey undertaken by the International Council of Nurses (ICN) that examined the incentives and disincentives to nurse migration. Although the results are only indicative, as response rates were low, the strongest incentive cited by respondents was the availability of learning opportunities. This includes scope to acquire specialist training that may not be available in the home country or similarly the chance to use technologies and other equipment which is not routinely available. Similar findings have been noted amongst other professional workers, such as the movement of the Igbo people of Nigeria to work in the United States (Reynolds, 2002). Brazilian doctors have sought a period of specialist training abroad in the belief that it will enhance their career prospects when they return (Zarrilli, 1998, p. 182).

The absence of opportunities for professional development and promotion, in contrast to perceived opportunities abroad, reinforces the attractiveness of overseas employment. South African nurses have complained about the lack of opportunities for promotion within hospitals and the difficulties of being granted study leave (Xaba and Phillips, 2001, p. 5).

3.3. The working environment

In addition to the above factors that are usually presented as enticing health professionals to go overseas, a poor working environment may encourage individuals to seek employment abroad. The influences that are frequently cited in this context relate to violence, whether in the work environment or outside, and the devastating toll reaped by the HIV/AIDS pandemic.

Health professionals are vulnerable to physical, verbal and other forms of abuse at work (ICN, 2002a, p. 10; ILO, 1998, p. 63). In response to these concerns a joint programme by the International Labour Office (ILO), International Council of Nurses (ICN), World Health Organization (WHO) and Public Services International (PSI) has led to the development of guidelines to prevent violence in the workplace (ILO, 2002c). Nurses in South Africa specifically cited fears about their safety at work as a factor that encouraged them to consider emigration. Similarly war and civil unrest are common factors encouraging health professionals to seek employment abroad (Kingma, 2001, p. 207). In Fiji, Indo-Fiji Islanders are leaving because of political uncertainty and the country has started to recruit doctors from abroad (Lal, 2003, p. 3). Finally HIV/AIDS, especially in sub-Saharan Africa, is having a devastating effect on the health workforce. In parts of southern Africa 50 per cent of adults are HIV/AIDS infected (Shapiro, 2002, p. 2189). HIV/AIDS exacerbates staffing problems as health workers die, contributing to increased workloads and low morale (DENOSA, 2001).

To summarize: the migration decision is ultimately a personal choice, but a choice that is influenced by the individual migrant's social and economic context. One of the clearest illustrations of these linkages occurs in the case of Filipino nurses as highlighted by the work of Rochelle Ball (1990). She demonstrates that the initial decision to become a nurse is often influenced by the knowledge that overseas opportunities exist, reinforced by encouragement from friends and family. This decision is shaped by the financial circumstances of the household, with individuals attempting to maximize their attractiveness to overseas employers by careful selection of the hospitals and specialties in which they gain employment experience.

4. Impact on health systems

Much recent discussion has been dominated by concern that increased migration is undermining health systems. In May 2003 health ministers from the majority of Commonwealth countries agreed a code of practice and companion document that highlighted concerns about brain drain:

> In recent years, international migration, fuelled by many factors, has grown to such proportions that it is affecting the sustainability of health systems in some countries. While both developed and developing countries are experiencing the negative impact of loss of skills, such loss is more keenly felt in developing countries, which are finding it increasingly difficult to compete for skilled human resources in the existing global market (Commonwealth Secretariat, 2003, p. 1).

This perspective, however, has been challenged with concerns about brain drain giving way to discussion of brain exchange and brain circulation. This shift is underpinned by three main arguments. First, in a more networked global economy with increased foreign direct investment the idea of a straightforward brain drain is viewed as passé in countries like India (Khadria, 2002, p. 31). Second, amongst some economists there is a strong belief that migration of highly skilled workers is beneficial to all because of the emergence of transnational communities that link the diaspora to the home communities, stimulating investment and entrepreneurship (Saxenian, 2002). The third argument is that migration is often more temporary than in the past, enabling countries like India to attract migrant return, providing a new dynamic for investment.

It is doubtful how applicable these arguments are to the health sector. Notwithstanding the development of tele-medicine, health services require health professionals to be located in the same physical place as their patients. This is not the case for many other services and manufactured goods. Consequently, whereas health professionals migrate to employment opportunities, in other sectors more "source" country employment has developed (e.g. call centres). Discussions of brain circulation and brain exchange invariably draw heavily on the experience of the IT industry. Migration of IT professionals, however, has not undermined an existing industry in the source country but reflects strong growth in demand for IT professionals overseas. By contrast health care is an essential service that is needed in source and destination countries. Moreover, shortages in destination countries often reflect poor working conditions as much as an absolute numerical shortage of appropriately qualified staff. One important implication of the brain exchange debate however, is the emphasis it places on return by examining incentive structures in relation to training, taxation and pension arrangements.

4.1. Implications for the destination country

The main consequences for health systems of international migration are usually divided between its impact on the destination and source countries. The main benefit for the destination country is the degree to which international migration can be used to address staff shortages. There is little doubt that the relative ease with which the UK Government achieved its 2004 target to increase the nurse workforce by 20,000 would have been unachievable without the sustained increase in overseas nurses employed in the United Kingdom.

Overseas workers are often employed in posts that are hard to fill either in terms of particular specialties or geographical areas. International medical graduates in the United States can gain three year H-1B visas for a pre-arranged job or an exchange visitor visa (J-1) for medical education with a requirement that they return to the home country for two years. The only exception to the two-year home residency rule is when a waiver visa is

received (J-1 visa waiver), which requires sponsorship by a government agency. In return for a service commitment in a rural area permanent residency can be gained. Consequently international medical graduates make a substantial contribution to providing health care in rural areas; 30 per cent of all rural counties have physician shortages (see Biviano and Makarehchi, 2002). Similar patterns are observed in other countries such as Australia and Canada.

4.2. Implications for the source country

The consequences of health worker migration are highly variable. The first issue to consider is whether the education and training of health workers is funded by the State or privately. For example, nursing colleges in the Philippines are predominantly private establishments. Nonetheless the State still provides the resources to fund primary and secondary education and loses the tax revenue that would have accrued from these earnings streams in the Philippines. There is a requirement in many countries for doctors to work in rural areas before being allowed to work in other parts of the country. Variants of these bonding schemes require graduates to work for the government for approximately three years or buy back the bond before they can work overseas. Trinidad and Tobago has recently introduced a three year requirement for nurses (Commonwealth Secretariat 2003, p. 11). Martineau et al. (2002, p. 14) point out that poor policing in conjunction with rising inflation may undermine the deterrent effect of such bonds, but this type of arrangement could be more effective if not only the source country but also the destination country ensured that it did not recruit workers who had not fulfilled their obligations.

A second issue relates to the employment situation within the source country and the degree to which health professionals would have been gainfully employed in their home country. This is crucially dependent on the degree to which individual States have planned their workforce requirements effectively. Poor workforce planning has regularly created imbalances in the health sector workforce, with many countries confronting shortages of health sector personnel (see Zurn et al., 2002). International migration has therefore been viewed as exacerbating shortages in source countries. It cannot be assumed, however, that health professionals would have been retained within the public health sector in their own country. In addition to poor working conditions, exit of doctors to an expanding private sector has been noted in many countries including Angola, Thailand and South Africa (Wibulpolprasert, 1999).

A third issue relates to the consequences for those workers who remain as their colleagues depart for employment abroad. Nurses in South Africa have expressed their frustration and envy of those going overseas. They have also been confronted with increased stress because they have to cover for staff who have left. This is a particular source of frustration in public institutions where gaining agreement for the employment of new staff is a very cumbersome process (Xaba and Phillips, 2001, p. 6). There is also the knock-on effect of the erosion of a country's human resources capacity in terms of its ability to plan and deliver education and training for its health workforce. Paradoxically it may make sending countries more reliant on the inflow of specialist workers. Moreover, in countries in which health professionals are trained for employment overseas a mismatch can arise between the training priorities of the source country's health service (e.g. orientated to primary health care), compared to the competencies needed to work in a more technologically intensive model of care.

A fourth issue relates to whether these movements reflect a temporary or permanent shift in location. In a politically sensitive area like health services, destination countries are less vulnerable to the charge that they are depleting the human capital of source countries if international migration is a temporary phenomenon. In general, temporary migration is viewed positively as an opportunity to develop new skills and competencies and to widen

experience that can benefit the source country on return. Permanent migration, by definition, signifies a permanent loss of expertise from the source country. In his analysis of recent trends in skilled labour migration to the United Kingdom (Finlay 2002, p. 11) demonstrates that professional workers from developing countries are relatively unlikely to leave after a few years of residence; this contrasts with the more temporary and highly mobile pattern of their developed-world counterparts. Whilst individuals in the health sector may re-migrate from one country to another, the stock of overseas-trained nurses and physicians in countries including Canada, the United Kingdom and the United States suggests that health migration has not been a predominantly temporary phenomenon.

Finally the health systems of source countries benefit indirectly from remittances. It is notoriously difficult to estimate the scale of remittances because of the often informal manner in which they are returned but there is little doubt of their contribution to the national income of many countries. India ($11.5 billion), Mexico ($6.5 billion) and Egypt ($3.5 billion) received the largest share of remittances (IOM, 2003b, p. 2). There are few studies on remittances specifically related to the health sector. An exception is a study of Filipino physicians practising overseas which suggested that the volume of remittances was sufficient to compensate for the associated economic losses of emigration (Goldfarb et al., 1984). Nonetheless the study is far from conclusive because, as the authors acknowledge, their analysis is weakened by data limitations and the questionable assumptions incorporated into their model. Doubts remain about the value of remittances for economic development because of uncertainties about how they are utilized within the source community, but this should not divert attention from the scale of the sums involved.

5. Working conditions and treatment of migrant workers

A great deal more is known about working conditions in the health sector than a decade ago (ILO, 1998; 2002a). Many of the difficulties that confront health workers in terms of high workload, staff shortages, stress and violence at work, gender and racial discrimination, as well as comparatively poor pay in relation to levels of education, apply to migrant workers as well as the local workforce. It is not straightforward to disentangle the influences of ethnicity, gender and the nature of the labour market from the specific experience of being a migrant worker. Despite these caveats, a number of common features in the working lives of migrants emerge from the existing research. It has been noted that immigrants are frequently discriminated against in terms of access to employment and are disproportionately consigned to the lower echelons of the job distribution, to a greater degree than would be expected on the basis of their skill levels (de Beiji, 2000; Dejong and Madamba, 2001).

Migrant workers frequently pay into systems of national health insurance and pension schemes, but only remain in the destination country for a few years and never receive the benefits they have accrued. Conversely, breaks in service from their home country are frequently very disadvantageous for individuals in terms of their access to health insurance and social security provisions. By their nature racism and discrimination are not always straightforward to identify, not least in industrialized countries in which an ideology of "democratic racism" prevails (Henry et al., 1996). This expression refers to the gap between espoused organizational values of justice, equality and fairness that co-exist with attitudes and behaviour which demean and discriminate against overseas workers. Many of these issues have been identified in relatively small-scale ethnographic studies which give voice to the life experience of migrant workers.

5.1. Registration and licensing

Before commencing employment, health professionals have to fulfil the appropriate registration and licensing requirements of the destination country. These licensing systems have a legitimate need to ensure that trained health workers meet the recipient countries' requirements so as not to jeopardize standards of patient care. At the same time they may act as a barrier to the employment of overseas-trained health workers or hinder registration. Licensing procedures are frequently viewed as lengthy, complex and costly processes that may delay or prevent integration into the destination country's workforce. In recognition of the delays that often occur between arriving in a country and gaining employment because of registration requirements, a pre-employment programme for overseas-trained doctors was established in New South Wales, Australia. Results from 66 participants demonstrated an enhanced understanding of staff and communication issues and a more realistic understanding of the role of a junior doctor (Sullivan et al., 2002). Based on experience in Victoria and New South Wales, it has also been argued that competency-based assessment of overseas nurses can lead to substantial improvements in qualifications recognition, in comparison to a process solely based on qualifications (Hawthorne, 2002).

The Filipino Nurses Support Group in Canada has identified a range of barriers to licensing. A primary concern is the cost, which can amount to 13,000 Canadian dollars. Many nurses come to Canada and are employed as licensed practical nurses (LCPs) but to gain full registration they are required to undertaken further training. They are then caught in a difficult situation because they require a student visa to access these programmes, which are costly (Standing Committee on Citizenship and Immigration, 2003). In the United Kingdom the registration process is often slow, partly because of the backlog of

applicants, which has delayed nurses gaining registration and access to better paid registered nurse posts. This has caused uncertainty and frustration not least because of the media portrayal of health service staff shortages. Difficulties can arise when individuals flee from countries because of political turmoil and do not have the required documentation to enable them to register. A further concern relates to when overseas nurses are required to undertake a period of supervised practice "adaptation" before registration, in which little consistency exists (Employability Forum, 2003, p. 6; RCN, 2003). Reflecting the feelings of many migrant workers, a nurse seeking registration in Australia commented that it was a "lonely path" in which little support was provided to overseas applicants (Omeri and Atkins, 2002, p. 500).

Many countries include a language test as part of the certification process because it is essential that health professionals be able to communicate with patients. A distinction is often drawn between technical language competencies and communication skills. Testing for technical language skills may be necessary but not sufficient to gauge whether an individual can communicate effectively with patients. In some UK hospitals effective induction has included training in local idioms and colloquialisms to ease integration into the workforce. In the United States, overseas-trained medical graduates have to pass an additional clinical skills assessment (CSA) test that can only be taken in Philadelphia. This obliges overseas-based physicians to incur travel costs and the costs of the exam, prior to gaining certification (Biviano and Makararehchi, 2002, p. 6).

Some commentators have held up the Commission on Graduates of Foreign Nursing Schools (CGFNS) in the United States as a possible model for addressing difficulties with licensing requirements. The CGFNS was established to ensure that nurses trained outside the country met US licensing requirements, but it also enables many overseas nurses to gain the CGFNS certificate at home. The CGFNS exam is a good predictor of the likelihood that they will pass the examination and licensing requirements of each State, thus facilitating entry into the US workforce (CGFNS, 2002b). The CGFNS process has not been immune from criticism in terms of the fee levels set and the use of multiple choice formats that may be unfamiliar to overseas-trained nurses, but it provides a degree of transparency whilst reassuring US nurses about competency levels and could therefore be expected to aid integration into the workforce (see Xu et al., 1999; Flynn and Aiken, 2002). On the other hand, making it easier for nurses to work abroad by setting up test centres in a source country could be expected to increase worker outflow, potentially exacerbating shortages, at least in the short run.

5.2. Pay and conditions

Many countries that rely on overseas health workers have traditionally employed migrants in low-skilled, low-paid work that is unattractive to host country nationals (de Beiji, 2000). This tradition continues, as graphically illustrated by Toynbee's account of working as a porter in a London teaching hospital in which the majority of staff were from Eastern Europe, the Caribbean and East Asia. In addition to low pay, her portrait also identifies the deskilling that occurs through migration; for example, the Russian accountant constrained by his poor English to take portering work (Toynbee, 2003, p. 59).

These issues affect both nurses and doctors. Caribbean nurses who migrated to the United Kingdom in the 1960s were often channelled into non-career grades in unpopular specialties. Various forms of deskilling and under-utilization of skills have been documented. For some overseas health workers the type of visa that they are allocated serves to limit their job options. Pratt (1999) analyses the case of Filipino domestic workers in Vancouver being admitted to Canada to work as nannies despite being university educated. They are required to work as live-in caregivers for two years before

they can apply for an open visa but this experience serves to narrow their occupational opportunities. As one of the interviewees commented:

> It takes two years before you can have an open visa here in Canada. By that time you shall have been deskilled and it becomes extremely difficult to get jobs beside housework. So your past training is almost nothing. If you are a nurse and you haven't worked as a nurse for two years, you can hardly go back to the profession any more. Two years is a long time (Pratt, 1999).

It was not until early 2002, following lobbying from the Filipino Nurses' Support Group, that immigration rules were modified.

A common experience amongst overseas nurses has been the lack of recognition of their skills and previous experience, leading to a feeling that their competence as a nurse is being questioned (RCN, 2003). An experienced community midwife working in Australia noted how she was assigned low level tasks such as bed-making (Omeri and Atkins, 2002, p. 500). Similar concerns were raised by South African nurses working in a UK trust hospital, who felt their training and skills were being wasted (Hardill and MacDonald 2000, p. 689). Overseas nurses in Canada often perceived that they were treated very differently from their Canadian colleagues, with more intensive controlling supervision (Hagey et al., 2001, p. 391). This lack of recognition can result in a sense of injustice because the tasks allocated and the pay received do not correspond to experience. As a refugee nurse in the United Kingdom commented:

> What is hard for some nurses to swallow is not being paid less while in training or supervised practice, but when their 15 years of experience is not taken into account in the grading system. So even if you have had experience in your country of origin relevant to the job in this country you may have to start at D grade [the basic grade for newly qualified nurses]. There needs to be some recognition given to overseas experience (Employability Forum, 2003, p. 4).

Discrimination in terms of pay and conditions is often only revealed when cases are taken to national employment tribunals/labour courts. In 1999, the US Equal Employment Opportunity Commission (EEOC) decreed that $2.1 million dollars should be paid to 65 Filipino nurses who were discriminated against by a nursing home in Missouri. Contrary to its pledge to pay the Filipino nurses the same wages as it paid US-registered nurses, they were paid about $6.00 an hour less and were generally assigned to nursing aides jobs. Even those nurses who were ultimately provided with registered nurse jobs were paid at lower rates than their US counterparts (EEOC, 1999). In Ontario Canada, Hagey et al. (2001, p. 390) highlight a case of racial discrimination in a particular hospital in which black migrant nurses were streamed into long-term care whilst white nurses were offered a choice of specialties.

Migrant health workers often feel constrained in making complaints about their employment conditions because of their sense of vulnerability. They fear that employers will retaliate by dismissing them. Without a job they will not be able to pursue their claim and will have forfeited their right to remain in the country (TUC, 2003). The difficulties that overseas nurses have encountered in registering a complaint against their employer has also been noted by the American Nurses Association (ANA). This situation is reinforced when nurses are seeking permanent residency which is likely to discourage the individual from filing a complaint (ANA, personal communication).

The employment of migrant labour is also associated with a high incidence of fixed-term contracts that often arise from their temporary status within the destination country (European Foundation, 2003, pp. 7-8). There is little information available on trends in the health sector, although in the United Kingdom it is reported that many nurses are employed on rolling fixed-term contracts. The vulnerability of migrant health workers to exploitation

is also reflected in the degree to which internationally recruited nurses, particularly in the private sector, reported working undesirable shifts (i.e. weekends and evenings), with financial obligations and their precarious employment status forcing them to comply (RCN, 2003).

For many health workers their experience of discrimination and exclusion is less overt, but comprises an "ethnic penalty" which results in less access to training and poorer career progression. This is evident in the composition of the UK medical workforce. The proportion of non-white consultants (the most senior grade) varies, being lowest in surgery (14 per cent) and highest in accident and emergency (27 per cent) and geriatrics (30 per cent), the least popular specialties. The sub-consultant career grades which do not ensure the financial rewards or status of consultant posts, comprise of almost two-thirds of doctors who qualified overseas (see Decker, 2001). Overseas doctors also struggle to gain the training which is provided to their home country counterparts. For some doctors this arose because of a lack of understanding of the structure and organization of training (Jinks et al., 2000, p. 60), for many others it reflects the view that overseas doctors' careers and training needs are systematically ignored (Unwin, 2001, p. 125).

5.3. Migrant worker integration: The role of trade unions and professional associations

The employment experience of migrant workers within the health sector varies greatly and a number of influences shape this experience. First, private employment agencies are becoming integral to the movement of health workers but their role and practices have been subject to little investigation. They differ substantially in the fees they charge from workers and/or employers and in the degree to which they fulfil their contractual obligations. Trade unions and professional associations are very conscious of differences between private sector agencies. In some cases nurses anticipate that they will be working in general hospitals and are actually destined for employment as poorly paid care assistants in nursing homes (RCN, 2003). A recent illustration reported by the Korean American Nurses Association in California, concerns Korean immigrants lured to Los Angeles by the prospect of guaranteed jobs and permanent residency who are then refused jobs at hospitals (Vongs, 2003).

Second, there are frequently differences between the experience of employment in a nursing care/aged care environment compared to a hospital setting. Hospitals are usually large workplaces and are more likely to be unionized and to incorporate human resource specialists than the nursing care sector. It is in private nursing that some of the worst abuses have been documented. Human Rights Watch monitors freedom of association in the United States and has documented a number of cases in which migrant labourers in the nursing care sector have been intimidated and dismissed because of their efforts to organize the Haitian workforce. In one case Haitian workers were dismissed for conversing in Creole, which was viewed as a subterfuge to defeat an organizing drive (Human Rights Watch, 2001). In the United Kingdom, problems have been reported with terms and conditions of employment being altered and threats of penalties being levied if nurses do not complete their contracts (Johnson and Oldham 2001, p. 30). The health workers' union, UNISON, has "rescued" nurses from private nursing homes who were being paid less than the agreed wages and required to undertake ancillary tasks, such as cleaning.

Third, the role of trade unions is crucial in safeguarding the interests of overseas workers. The trade union movement in the majority of countries has shifted its focus away from a protectionist and exclusionary stance in which the dominant concern has been that migrants would erode wages and conditions towards a more open and inclusive perspective towards labour migration. This altered stance reflects a belief that immigration is an inevitable component of a more globalized economy and that instead of forcing migrants

underground into precarious working conditions, trade unions should encourage the regulation and normalization of migrant working conditions, thereby drawing migrants into union membership (Watts, 2002, p. 2). This shift in approach was reflected in the United States by the AFL-CIO decision in 2000 to reverse its protectionist stance and pass a resolution to protect the rights of all workers irrespective of immigration status (Duncan, 2001, p. 18).

Trade unions have focused on ensuring that overseas health workers obtain the same terms and conditions of employment as other health workers and they have publicized abuses. Their stance towards overseas recruitment is more complicated, and there are often differences of emphasis between professional associations and trade unions. In source countries professional associations are sympathetic to their members seeking employment overseas and oppose government measures such as bonding newly qualified nurses for three years (e.g. the Zimbabwe Nurses Association). In destination countries a range of considerations needs to be accommodated. Trade unions respect the right of individuals to migrate, value the role of overseas health workers in augmenting the workforce, and seek to increase their membership by recruiting overseas health workers, often using low subscription rates to entice overseas nurses into membership. Nevertheless trade unions remain critical of the inadequate working conditions that have led to poor retention of all health workers and are wary of supporting overseas recruitment. They view targeted, large-scale recruitment from countries with shortages of health workers as unethical and have established guidelines on international recruitment (UNISON, 1999; RCN, 2002).

Trade unions can play an important part in incorporating migrant workers into existing systems of social dialogue. Within the health sector a variety of different forms of social dialogue has been documented (see Lethbridge, 2002). Social dialogue can help to ensure that migrant workers are aware of their employment rights and that they receive the same terms and conditions of employment as their fellow workers. The existing workforce can also be reassured that the employment of migrant labour will not undermine their own terms and conditions of employment or reduce employment opportunities for newly qualified staff (ILO, 2002b, p. 19).

There are many examples of the ways in which trade unions and employers have acted to integrate overseas workers into the workplace. A variety of good practice guidelines and examples of best practice exist. These include structured induction and orientation programmes; effective mentoring systems and other support mechanisms; identifying clear pathways to integration e.g. via personal development plans; enforcing zero tolerance of racism; and taking active steps to ensure workers' rights are respected (Greenhill, 2000; Employability Forum, 2003; RCN, 2002).

6. Recruitment practice and ethical codes of practice

Increased awareness of health worker migration and a belief that migrant health worker flows will continue have shifted attention towards managed migration. This term implies a more strategic approach by governments and other agencies towards migration. It attempts to link international migration to the health policy goals of individual nation States, and tries to regulate the flows of health workers in a way that is beneficial to source and destination countries. It implies a broad range of policy interventions that extends beyond international recruitment to incorporate the management of retention, training, deployment and return of health workers. Most attention has focused on bilateral agreements between countries and the incorporation of ethical codes of practice into national practice but a range of other policy options are available. These include measures to cap the number of internationally recruited health workers entering countries; funding increased supply in sending and receiving countries; and policies of return. These issues are addressed below by drawing on the experience of the Philippines and the United Kingdom.

6.1. Managed migration: The case of the Philippines

The Philippines is not only a very significant country in terms of the number of health workers employed overseas but has also been identified as a leading example of state-managed migration (Abella, 1997, p. 32). This signifies the Government's attempt to actively manage migration flows and outcomes. It involves the establishment of a specialized agency, in this case the Philippine Overseas Employment Administration (POEA), to formulate and oversee migration policy. The POEA has a number of key functions which mirror many of the processes involved in international recruitment. They include marketing Filipino workers to potential employers; countering illegal migration; negotiating agreements; regulating private sector recruitment agencies and protecting Filipino workers by a variety of mechanisms including assessment of employers, inspection of employment contracts prior to departure, pre-departure orientation seminars and the gathering of information about working conditions overseas.

The POEA has been held up as an example of the beneficial effects of a managed approach to migration and the manner in which the POEA tries to protect migrant workers has been well documented (Brillantes, 1998). It seems indisputable that once a government has decided to train health workers for employment abroad, a managed approach builds in more safeguards. The difficulty, as Ball's (1990) work illustrates, is that a state agency whose primary function is to maximize remittances may not be able to accommodate other social priorities. The OECD (2003a, p. 75) notes that the Philippines confronts a shortage of nurses so the policy of encouraging employment overseas may conflict with domestic priorities.

6.2. The impact of codes of practice: The UK experience

The Labour Government of the United Kingdom views overseas recruitment as an integral component of government policy to increase the NHS workforce and combat staff shortages (Department of Health, 2002b, p. 15). There have been two main components of the Department of Health's approach to international recruitment: coordinating the activities of NHS trusts which includes encouraging them to recruit within an ethical framework; and establishing bilateral agreements to enable the United Kingdom to recruit directly from the country concerned. The focus has shifted from a preoccupation with

recruiting nurses towards a much greater emphasis on recruiting doctors; there are also shifts in the countries that are being targeted for recruitment.

International recruitment has generated controversy, notably in 1997 when Nelson Mandela criticized the United Kingdom for recruiting nurses from South Africa. In reaction to these criticisms the Department of Health issued guidelines to all NHS employers in November 1999 that stated: "It is essential that all NHS employers do not actively recruit from developing countries which are experiencing nursing shortages of their own" (Department of Health, 1999, p. 11). South Africa and the Caribbean were specifically indicated as areas where active recruitment should be avoided. The key word is *active* because NHS trusts were not prevented from accepting unsolicited applicants from overseas nor were countries excluded if there was a formal agreement between the Department of Health and another government.

It is difficult to make definitive judgements about the impact of the guidelines, but table 3 (section 2.4) shows a substantial fall in the number of nurses registered from the West Indies and South Africa in the year to April 2003, indicating that given lags in the system (e.g. delays in registration) the guidelines are having some impact on employer behaviour. A major limitation of the guidelines, however, was that they did not apply to the private sector or to recruitment agencies.

In September 2001 a more detailed code of practice (box 1) was issued which included guidance on working with recruitment agencies and reiterated that NHS trusts should not target recruitment at developing countries unless the Department of Health had a formal agreement with a particular country (Department of Health, 2001). The Department of Health was reluctant to identify which countries it considered to be developing countries, but in early 2003 it finally published the Department for International Development's list of less developed countries. Registrations from several developing countries on this list increased in the year to April 2003 (Ghana, Nigeria, Zimbabwe) or remained stable (Kenya, Mauritius), but it will be several years before the impact of these guidelines can be fully assessed.

Box 1
International recruitment: Guiding principles

- International recruitment is a sound and legitimate contribution to the development of the NHS workforce.
- Extensive opportunities exist within the NHS in terms of training and education and the enhancement of clinical skills.
- Developing countries should not be targeted for recruitment.
- Candidates will only be appointed who demonstrate a level of knowledge and effectiveness comparable to that expected of an individual in the UK.
- Candidates will only be appointed who demonstrate a level of English proficiency consistent with safe and skilled communication with patients, clients, carers and colleagues.
- Staff legally recruited from abroad to work in the United Kingdom are protected by UK employment law in exactly the same way as all other employees.
- Staff recruited from abroad will have the same support and access to further education, training and continuing professional development as all other employees.

Source: Department of Health, 2001.

The development of codes of practice serves a useful function in publicizing good practice for employers on issues such as induction and training. It also ensures a level of transparency about the requirements placed on employers. Voluntary codes of practice, however, are relatively weak regulatory mechanisms because they have no legal basis. The difficulty with codes of practice, which have similarities to the labour codes that some

multinational companies have signed, is that of enforcement and monitoring (Rubery and Grimshaw, 2003, p. 258). The charge that has been levelled at the NHS is that the 2001 Code of Practice provides the NHS with a kitemark to indicate that it is an ethical employer, but at the same time the reliance on overseas recruitment continues. Employers have indicated that international recruitment is a relatively straightforward method to address their staffing requirements compared to other recruitment and retention methods (Buchan, 2003, p. 22). Given the prominence of ethical codes of practice, under what circumstances are they likely to be a more effective policy tool in managing migration ethically? This is a key question.

The structure and financing of the health system will have an important influence on the effectiveness of codes of practice. The UK health system is unique amongst large OECD countries in terms of the degree of government supervision of the financing, provision and regulation of health care (Bach, 2003). This ensures that the Department of Health exercises tight central control over the international recruitment practices of NHS trusts via recruitment targets and the monitoring role of international recruitment coordinators. There has also been a concerted effort by the Department to improve implementation, which is likely to result in further strengthening of the guidelines in future. The Labour Government views international recruitment as integral to its HR policies for the NHS and therefore has a strong incentive to ensure that it is carried out in an ethical manner to deflect criticism. In many other countries, however, in which the State has less control over the actions of health-care providers and health services are less politically sensitive, the impact of ethical codes of practice are likely to prove much less effective.

A second issue concerns the extent to which codes of practice incorporate the private sector. A weakness of the 1999 UK code of practice was that it excluded the private sector. This enabled the private sector, often using private sector recruitment agencies active in developing countries, to act as a staging post for employment in the health service. In the 2001 code, private sector recruitment agencies were invited to sign up to the code of practice. There has been concern that only 68 out of approximately 115 private sector agencies have done so to date (Hartley, 2003, p. 8). One difficulty, however, for some private sector recruitment agencies is that they are only eligible to be on the Department of Health's list of approved agencies if they obtain two references from NHS trusts verifying that they adhere to the code of practice. This can create difficulties for some recruitment agencies because they cannot gain access to the approved list unless they have references from the NHS, and NHS managers will not use an agency that is not on the approved list. Overall it is essential that private sector agencies are brought under the umbrella of any code of practice, but governments are often reluctant to enforce these types of regulations on private sector employers.

The second main strand of managed migration concerns the development of bilateral agreements with particular countries. The Department of Health has concluded a variety of accords with other countries, which extend beyond international recruitment to include cooperation on health systems development. In Egypt there is a programme to improve the care of the elderly, pathology and mental health services as well as a fellowship programme for Egyptian doctors to work in England in order to gain additional experience (Amos, 2001, p. 20). Most attention has focused on the recruitment agreements signed with India, the Philippines and Spain.

The agreement signed with the Philippines in 2002 nominates the Philippine Overseas Employment Administration (POEA) to undertake pre-recruitment, with NHS employers interviewing candidates in the Philippines. The agreement sets out in detail the requirements placed on the POEA and the NHS, to ensure transparency and eliminate potential for abuse. For example, it is stated that the NHS employer will pay the cost of initial application to the NMC (£70), entry visa application cost (£70) and the cost of initial

airfare to the United Kingdom provided workers remain in the post for 12 months. Employers are also required to pay the POEA a processing fee of £140 for every successful application, £17 as a contribution to the Workers' Welfare Fund and £35 as a contribution to the Employees' Guarantee Trust Fund administered by the POEA. These charges must not be passed on to the selected applicant. The agreement also includes requirements related to induction and other forms of good practice.

It is relatively early to assess the effectiveness of these bilateral agreements, but they have a number of potential advantages compared to the code of practice route. First, they reduce the need to utilize commercial recruitment agencies. There are many well managed and responsible agencies but their image is tarnished by the poor practice of others. As noted earlier much of the abuse associated with migration stems from the activities of these agencies. They facilitate unmanaged migration, often charging high fees and misleading applicants about their final employment destination and job. The bilateral agreement approach ensures a more predictable and transparent process for both parties. It also has the important effect of shifting the cost of migration from the individual migrant to the final client. Second, these agreements are flexible tools that can incorporate a variety of provisions. For a start they can include best practice guidance related to induction, training, etc. They also, however, have scope to be much more ambitious. There is no reason why an agreement could not incorporate a genuine partnership between the two countries which could tip the terms of trade more in favour of the source country. An illustration could be a five-year agreement in which overseas health workers were committed to working in the United Kingdom for three years and in the source country for two years, with all five years of employment paid for by the United Kingdom.

7. The role of international standards and the impact of trade agreements

Interventions to manage migration can also occur at international level. There are a number of overlapping constituencies that have become more active in their consideration of health worker migration. Amongst the United Nations (UN) institutions, the ILO has a commitment to implementing basic labour standards and is promoting opportunities for decent and productive work. ILO activities reflect the importance of labour migration in the world economy and recognize that labour migration can be beneficial, but that unregulated migration has a number of detrimental consequences (ILO, 1999, p. 38). The World Health Organization (WHO) has been concerned about the impact of labour migration in undermining the performance of health systems. All parts of the world are affected, but the situation in Africa is particularly acute: "shortage and migration of nurses and midwives continues to threaten the performance of health systems" (WHO, 2003, p. 2). WHO is systematically examining flows and stocks of migrant health workers, costing the impact of migration on health systems, and supporting policies of managed migration in the Caribbean and elsewhere. The International Organization for Migration (IOM) promotes the orderly management of migration for the benefit of migrants and societies. It assists governments by advancing understanding of migration issues (IOM 2003b, p. 6).

7.1. Policy options

What policy approaches have been utilized by UN organizations and other international professional and trade union organizations to promote managed migration and how effective have they been? The ILO, drawing on its tripartite structure, operates on the basis of establishing international labour standards. A first strand comprises passing Conventions which are then subject to ratification by member States. A second strand draws on the 1998 Declaration on Fundamental Principles and Rights at Work which was approved by all 176 member States. The ILO promotes these standards through programmes of technical assistance and cooperation.

Several ILO Conventions specifically cover the treatment of migrant workers. The Migration for Employment Convention, 1949 (No. 97), provides the foundations for equal treatment between national and regular migrants in areas relating to recruitment, working conditions, social security, etc., and has been ratified by 42 countries. The Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143), addresses irregular migration and has been ratified by only 18 countries. These Conventions formed the basis for the 1990 UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (see Taran and Geronimi, 2003, pp. 12-13).

The Nursing Personnel Convention, 1977 (No. 149), considers the employment, training, career development, remuneration and working time and involvement of nurses and has been ratified by 37 countries. In terms of the key source and destination countries discussed in this paper, the Philippines has ratified this Convention, whilst Canada, India, the United Kingdom and the United States have not done so. The Nursing Personnel Recommendation, 1977 (No. 157), provides more detailed guidance on these areas. In particular, many of its provisions in relation to international recruitment of nursing staff have similarities with the policy guidelines on ethical nurse recruitment established a quarter of a century later by organizations such as the International Council of Nurses (ICN). Together, these standards provide important benchmarks in terms of the values and legal standards to be incorporated into national policy. They outline a framework for action that can be built upon to elaborate areas for policy development (box 2).

Box 2
Five core elements for national policy on labour migration and related support measures

1. An informed and transparent labour migration admissions system designed to respond to measured, legitimate labour needs, taking into account domestic concerns as well.
2. A standards-based approach to "migration management" protecting basic rights of all migrants and combating exploitation and trafficking.
3. Enforcement of minimum national employment conditions standards in all sectors of activity.
4. A plan of action against discrimination and xenophobia to sustain social cohesion.
5. Institutional mechanisms for consultation and coordination with social partners in policy elaboration and practical implementation.

And

(a) Policies for labour mobility – freedom to move – in regional integration areas.

(b) Changing terms of aid, trade and international relations to facilitate development in more equal terms.

(c) Creating specialized institutions for policy coordination, enforcement and monitoring.

(d) Encouraging voluntary return and reintegration into countries of origin.

(e) Combating trafficking and exploitation of migrants by organized crime.

(f) Gender-sensitive policies focusing on equal treatment and equal outcomes.

Source: Based on Taran and Geronimi, 2003, pp. 17-18.

A second important approach would be for international organizations to draw up codes of practice and policy guidelines that their members can persuade employers and governments to adopt. ICN adopted a statement in 2002 (box 3) and similar principles were endorsed by the World Family Doctors Association in Melbourne (WONCA, 2002). The Commonwealth, at its meeting of Health Ministers in May 2003, endorsed a code of practice and associated companion guide on international recruitment. It is intended that the Commonwealth Code of Practice should be extended to other non-Commonwealth countries.

Box 3
International Council of Nurses: Position statement on ethical nurse recruitment

ICN and its member associations firmly believe that quality health care is directly dependent on an adequate supply of qualified and committed nursing personnel, and supports the evidence that links good working conditions with quality service provision.

ICN recognizes the right of individuals to migrate and confirms the potential beneficial outcomes of multicultural practice and learning opportunities supported by migration. The Council acknowledges the adverse effect that international migration may have on health care quality in countries seriously depleted of their nurse workforce.

ICN condemns the practice of recruiting nurses to countries where authorities have failed to implement sound human resource planning and to seriously address problems which cause nurses to leave the profession and discourage them from returning to nursing.

ICN denounces unethical recruitment practices that exploit or mislead nurses into accepting job responsibilities and working conditions that are incompatible with their qualifications, skills and experience.

ICN and its member national nurses' associations call for a regulated recruitment process based on ethical principles that guide informed decision-making and reinforce sound employment policies on the part of governments, employers and nurses, thus supporting fair and cost-effective recruitment and retention policies.

Source: ICN, 2002b.

A key feature of the Commonwealth Code of Practice, replicated in the WONCA guidelines, is a strong emphasis on mutuality of benefits for both countries, including compensation. According to the Commonwealth Companion Document (2003, p. 7):

> The capacities of countries to recruit staff vary significantly. Many developing Commonwealth countries have expressed the view that recruiting developed countries should in some way compensate source countries for the loss of personnel trained at great expense. Compensation may be in a variety of ways such as building capacity in training institutions.

This proved to be a step too far for Australia, Canada and the United Kingdom, which declined to sign the Code because of the phrases on compensation.

The strengths and weaknesses of international codes of practice are similar to the issues that arise in relation to national guidelines. When attempts have been made to strengthen codes, as in the case of the Commonwealth, the priority of destination countries – to continue to recruit internationally on a cost-effective basis – conflicts with the aspirations of source countries to ensure more equitable terms of trade.

A third policy focuses on the return of health workers from abroad. Policies of return are difficult to manage effectively and the costs of assisted return programmes need to be considered in conjunction with investment in retention, which may be more cost effective. Incentive mechanisms are often used to encourage return, but difficulties often arise subsequently which lead to high levels of attrition. A key human resources (HR) challenge is ensuring that returning health workers are placed in jobs that use the skills they have acquired effectively. This is not straightforward because their skills do not match the conditions under which they are working. The IOM has highlighted other difficulties of facilitating return in relation to African professionals abroad. The challenges include prolonged job search arising from cumbersome recruitment processes, lack of trust in African governments amongst the diaspora, and weak recipient government ownership (IOM, cited in WHO/World Bank, 2002, p. 13).

A fourth policy option involves setting annual caps or targets for the number of internationally recruited health workers. In Norway the Public Employment Service, which is the main state-sponsored source for overseas recruitment of nurses, is set an annual limit (260 in 2002) (Buchan et al., 2003, p. 22). In general, however, there is limited support for such an approach. It is not easy to reconcile a policy of capping international recruitment with the belief amongst governments, employers and trade unions that individuals should have the right to move if they so wish. A simple quantitative target runs the risk of being discriminatory with the cap used as justification to exclude certain overseas applicants. It may also be very difficult to enforce and encourage covert recruitment, as the growth of illegal immigration testifies. In practice governments already operate a form of capping by the visa and work permit regulations they apply, so there does not seem much to be gained by going down this route.

7.2. Future prospects: The role of GATS

Most of this paper has considered health worker migration from an employment relations and health policy perspective. An increasingly important dimension, however, views migration as an integral component of the growth of trade in health services. The development of free trade blocks has incorporated measures designed to encourage the free movement of labour within these areas. The EU has established an inclusive model of mutual recognition of qualifications in which, for example, first-level registered nurses or midwives are free to work in any other member State. The barriers to mobility have less to do with recognition of qualifications and more to do with linguistic and other cultural barriers (Buchan et al., 2003, p. 9).

NAFTA enables Canadian and Mexican citizens to work temporarily in the United States and provides a framework for mutual recognition of professional competency. Each country facilitates the entry of other country nationals who meet minimum educational requirements and who are licensed in their own country. In practice NAFTA has encouraged movement between Canada and the United States because medical staff are accredited by the same organization, which ensures that medical students in both countries receive a similar education. Canadian medical graduates can therefore apply for a US residency-training programme and subsequent to that become licensed to practice in the United States (Biviano and Makarehchi, 2002, p. 5). Nurses registered in Canada can access work in the United States and NAFTA has also provided the impetus for Canada, Mexico and the United States to examine the similarities and differences in their nursing education systems and move towards mutually acceptable criteria for licensing and certification (Oulton, 1998, p. 131).

Aside from free trade areas, it is the World Trade Organization (WTO) as the international body responsible for establishing the rules governing trade between countries, and specifically the negotiations surrounding GATS, that has attracted most interest in terms of its implications for health worker migration. GATS comprises a set of multilateral, legally enforceable rules covering trade in services designed to encourage liberalization of service markets (see OECD, 2002b). It is a complex treaty that incorporates a number of the fundamental principles of the WTO to ensure effective access to markets, crucially the most favoured nation (MFN) principle and the national treatment principle. The MFN obligation requires a country to treat the service suppliers of another member no less favourably than the service suppliers of any other member, unless a country tables an exemption A central element of GATS is the schedule of commitments that each country makes, detailing its liberalization commitments.

The form that liberalization takes is specified on a continuum from "no commitment" ("unbound") to commitments with no limitations, termed "full commitment" in WTO jargon. "Limited" or "partial" commitment means that some market regulation applies but these markets will not become more regulated in the future. Unbound signifies that a country reserves its position in terms of regulating overseas suppliers but signals a general commitment towards liberalization. The final key element is that GATS distinguishes between four modes through which services can be traded in health care:

- Mode 1, cross border supply. This occurs when the supplier of a medical service in one country supplies that service to another country, but both the provider and the consumer stay put (e.g. forms of telemedicine).
- Mode 2, consumption abroad. In this mode the patient physically travels to another country to obtain treatment.
- Mode 3, commercial presence. This occurs when a foreign-owned health care provider establishes a presence in another country and serves that local market, for example, by owning or managing hospitals abroad.
- Mode 4, presence of natural persons. This relates to the provision of health services by individuals in another country on a temporary basis.

GATS has generated controversy related to three key issues. First is the degree to which health services are excluded because they are provided "in the exercise of governmental authority" and are supplied neither on a commercial basis nor in competition. Second is the extent to which liberalization is synonymous with an agenda of deregulation and/or privatization. Third is the extent to which countries will be placed under pressure to open up public services to foreign competition (for differing perspectives see Adlung, 2002; OECD, 2002b, Pollock and Price, 2000; Public Services International, 1999). These issues are beyond the scope of the present paper, which focuses on the implications of GATS for health worker migration.

By examining the number and form of commitments made by countries across the different modes, a sense of the degree to which governments envisage health systems becoming more liberalized in the future can be gained. At present, 39 members have made some commitment on hospital services for modes 1-3, but commitments were much more modest on mode 4. The WTO (1998), however, warns that these commitments do not necessarily provide a full picture of market access opportunities and a great deal could change as negotiations only began in earnest in 2000. There is pressure on the European Union, for example, to adopt a more liberal regime on mode 4 because expectations "are running high" according to the OECD, "for progress in this area" (OECD, 2003b, p. 5).

Increased movement of health workers on a temporary basis is an integral component of service liberalization and is especially significant for the health sector because of its labour-intensive character. GATS, however, does not provide any definition of the term temporary, simply defining it negatively as excluding permanent migration. GATS emphasizes that individuals are service providers rather than entrants to the labour market. In practice this distinction is hard to sustain because "temporary" may signal residency for up to three years, implying that the service provider has entered the labour market providing a service which a local person could probably provide (Young, cited in OECD, 2003b, p. 3). In part this accounts for the reluctance of many industrialized countries to open up mode 4 because of concern that their ability to regulate the entry of health workers into their country would be circumscribed. On the other hand, it has been argued that by facilitating the temporary movement of health professionals this could diminish the incentive for permanent migration and relocation (Marconini, 1998, p. 58).

GATS will reinforce the movement towards the alignment of competency and recognition requirements between countries, thus facilitating increased labour migration. For advocates of liberalization there is the suspicion that professional associations use complex licensing provisions to prevent overseas entrants practising in their countries. This amounts to a restriction of trade to ensure that prices are kept artificially high (see UNCTAD secretariat, 1998, p. 10). The opposing view is that the harmonization of qualifications invariably has a tendency to spiral downwards, and this could potentially jeopardize health service standards in a number of countries (Public Services International, 1999, p. 14). The continuing enlargement of regional trade blocks such as the EU, ongoing measures to harmonize nursing and medical qualifications in most parts of the world, and the stimulus provided by the GATS negotiations will continue to facilitate the movement of health professionals across the globe.

The OECD and the WTO have argued forcefully that liberalization has led to benefits for consumers as a result of lower prices. The telecommunications industry has been used as the most prominent illustration of these trends (OECD, 2002a, pp. 28-29). In the health sector similar efficiency gains would derive in large part from changes in labour costs. The WTO (1998, p. 3) has noted that the US health system has "unusually high input prices" and that: "Among OECD countries, the United States displays the largest gap between domestic prices in general which, at current exchange rates, are comparatively low in the US."

The opposite is noted for Japan and to a lesser degree Turkey and the United Kingdom. Consequently, the WTO foresees benefits from trade mainly in relation to "staffing with more skilled, more efficient and/or less costly personnel than might be available on the domestic labour market" (WTO, 1998, p. 18). Although the highly regulated character of the health sector presents particular difficulties for the idea of a market-determined wage, making labour market outcomes hazardous to predict, it could be anticipated that an increased influx of health care workers from lower wage countries to countries such as the United States could dampen down wage pressures, not least by increasing labour supply.

8. Discussion

There have been very significant changes in the scale and consequences of health worker migration in recent years. The issue of health worker migration has rapidly climbed the health policy agenda. Although knowledge about stocks and flows of health workers remains patchy, there is broad consensus that the movement of health workers will intensify.

Long-standing explanations for health worker movement, focused on individual motivation need to be recast to recognize that supra-national institutions and the establishment of the regional or global benchmarks that they promote, in areas such as training and trade, are fostering the development of a more global labour market for health professionals. National health authorities and health service providers are not passive in the face of globalization. It has been suggested that a relatively small number of nation States have a disproportionate impact on the global movement of health professionals because of their resources and the manner in which they have actively promoted the international recruitment of health workers.

Policy development remains hampered by shortcomings in the available statistics and limited research undertaken on migration in the health sector. Governments have an important role in contributing to improved data collection, for example, ensuring that the under-estimation of outflows is addressed. Most of the analysis of the impact of health worker migration focuses on the *quantitative* dimension, but much less attention has been paid to the *qualitative* effects, positive or negative, of overseas employment for the workers themselves, users and other staff. With the exception of some small-scale ethnographic studies, the voice of women migrant workers in particular is rarely heard and we know little, for example, about whether the experience of employment fulfils their expectations, the degree to which they consider migration a temporary or a more permanent decision, and under what circumstances they would consider return. Similarly, little is known about the reactions of users or other workers to the employment of overseas staff.

A second area of research and policy intervention relates to international recruitment agencies. Relatively little is known about their activities, but they are clearly becoming more active participants in the health sector as illustrated by the increased number of verifications granted in the United Kingdom to private credentialing organizations. Much of the exploitation of migrant workers relates to abuses by international recruitment agencies such as levying high fees and spreading disinformation about the rights of migrants in destination countries. There is reason to believe that similar processes occur in the recruitment of health workers. It is not always clear at which point in the supply chain such problems arise, for example, if these abuses relate to subcontractors used by agencies in destination countries or if they occur at all points in the recruitment process. Moreover, recruitment intermediaries are also increasingly significant because of the way in which they facilitate and promote increased mobility. As discussed earlier, ethical codes of practice and other regulatory instruments can contribute to shaping the behaviour of recruitment intermediaries.

This paper has shown that governments and employers have a key role in the migration of health workers. In all countries a higher profile for human resource management in the health sector would not only alleviate some of the “push” factors that encourage migration, but also reduce the shortage of health professionals that underpins increased international recruitment. It is an indictment of governments and employers that they prefer to rely on the relatively straightforward panacea of international recruitment rather than focusing on the underlying problems of pay and working conditions that would ensure improved recruitment and retention amongst the existing health sector workforce.

Governments and employers should do more to safeguard and improve the working conditions of migrant health workers by signing the UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families and ensuring the ratification and enforcement of ILO Conventions. In addition, state authorities and employers should be required to comply with existing national and international codes of practice on ethical recruitment and these codes should be accompanied by measures to monitor compliance. In addition, when state authorities use policies of international recruitment, the detrimental impact of these policies on source countries should be minimized. This paper has suggested that such an outcome is most likely to be achieved by focusing on managed migration in which health worker flows form part of a bilateral agreement between governments with an explicit consideration of the benefits that will accrue to all parties.

Professional associations and trade unions have an important role in making migrant workers aware of their legal rights, monitoring and documenting abuses, and ensuring that their welfare is seen as a priority by employers and government agencies. Trade union policy in relation to staff shortages and working conditions could be integrated more fully into the analysis of health worker migration and links with migrant networks could be strengthened. In addition, trade unions have an important role in challenging institutional racism and xenophobic attitudes within the health sector and ensuring that a policy of zero tolerance in relation to the stereotyping of migrant health workers is enforced.

Health worker migration is an inescapable feature of the health sector. Policy responses appear to be shifting from a reactive agenda that focuses on stemming migration, towards a more ambitious and active agenda of managed migration that brings some benefits to source countries as well as destination countries. A central component of any such agenda is an enhanced recognition of the importance of improved working conditions and more effective HR practice to encourage retention of health workers in both source and destination countries.

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