The globalization of nurse migration: Policy issues and responses

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Abstract. *Many countries are involved in the "production" and overseas recruitment of care workers in a major international response to the "care crisis" affecting advanced industrialized economies. But the distribution of gains and losses from care-labour migration is becoming increasingly unequal, and the pressure to develop alternative policies is intensifying. The author assesses the relevance of different policy approaches to nurse migration in promoting sustainability, social equity, the "care commons" and social development. She argues for sustained international cooperation and coordination to address the major global challenges that nurse migration currently poses for public health, social reproduction and social development.*

T he drivers, dynamics and impacts of migration for the purposes of providing social and health care overseas have become a significant feature of scholarly and policy debates about the social dimensions and impacts of contemporary globalization. Care-labour migration is not without historical precedent, but it has increased in magnitude and significance over the past two decades. The "globalization" of household and family survival strategies is driven by uneven development globally and capitalist dynamism generally, and also by processes of health and welfare restructuring in developed and developing countries. In this context, a major policy response among developing countries has been the adoption of export-oriented "care-labour production" strategies, often as part of their economic development plans, while developed countries have responded with strategies of active recruitment of overseas care labour to address the "care crisis" unfolding in their economies.

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This article reviews key problems and policy issues in global care-labour migration[1] and analyses the policy approaches being followed. Care-labour migration is a broad and complex phenomenon, covering diverse occupations, locations, settings and policy fields (Yeates, 2004 and 2009). The present analysis focuses on the health sector, which accounts for one in three international migrants (WHO, 2006), and on nurses in particular. Nurses are a significant group of migrant health-care providers and, more generally, of skilled female migrants; they illustrate the importance of socio-political and institutional factors in shaping the construction of the global care crisis and the pace, directions and impacts of care-labour migration. The "public good" nature of the care labour provided by nurses, together with the global interdependencies and inequalities that their migration entails, tangibly elucidate key policy issues regarding the regulation and governance of international trade in the wider public interest.

Dynamics of global nurse migration

Over the past decade the migration of nurses has become a significant issue on national and global policy agendas. In part, this can be attributed to a global nursing shortage caused by diverse socio-demographic and institutional factors. There is increasing demand for health-care workers – especially in OECD countries – as a result of rising incomes, new medical technology, increased specialization of health services and population ageing (OECD/WHO, 2010). But the size of the nursing workforce has failed to keep pace with that growing demand. Policy decisions to contain public health-care costs have had a detrimental effect, bringing insecurity to existing nursing posts, recruitment freezes and redundancies, alongside limitations on training capacity and the numbers of nurses being trained (Simoens, Villeneuve and Hurst, 2005). In the United States, for example, where the nursing shortage exceeded 200,000 in 2005, 30,000 applicants were turned away from baccalaureate nursing programmes because of educational and training capacity limitations (Aiken and Cheung, 2008). Nurse shortages in other rich countries such as Australia, Canada, Ireland, New Zealand and the United Kingdom can also be attributed to the long-term effects of financial under-investment in nurse education and training (Simoens, Villeneuve and Hurst, 2005; WHO, 2006). Of those who qualify as nurses, many may find themselves underemployed or unemployed (WHO, 2006). Fewer women are choosing to enter nursing due to poor pay, working conditions and opportunities for professional advancement; many trained and qualified nurses are leaving the profession for another career offering better prospects.

Overseas migration has become an increasingly attractive option for individuals and government policy alike. Individual nurses seeking to improve their

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[1] This article focuses on paid care work, but the division between paid and unpaid work is not totally clear-cut. See Lan (2008) in relation to domestic work and Yeates (2009, especially ch. 7) in relation to nursing.

Figure 1. Foreign-born nurses in OECD countries by main source regions, circa 2000
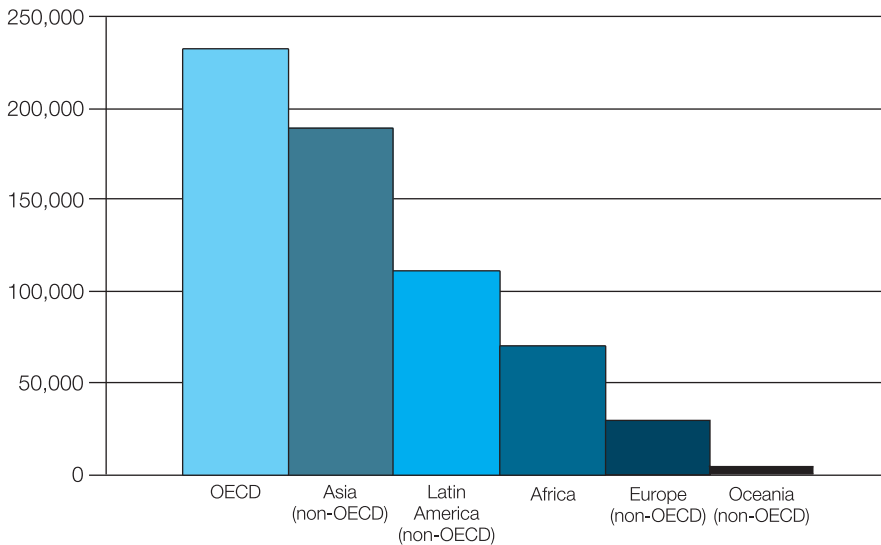
Source: OECD (2007).

prospects are drawn to working overseas by higher wages, the desire for wider professional experience, better and more specialized training, increased promotional opportunities and a higher standard of living. The scarcity of people with nursing skills on the global market means that nurses can to a certain extent choose the country to which they wish to migrate.[2] Governments in the "Global North" are increasingly recruiting abroad to fill domestic nursing labour shortages. These strategies are supported by policies that variously relax regulatory and certification processes, fast-track visa or work permit applications and/or institute campaigns of active and targeted recruitment (Simoens, Villeneuve and Hurst, 2005). In 2000, foreign-born nurses represented 10.7 per cent of the OECD nursing workforce, and nurse migration has increased in many OECD countries since then. Two-thirds of the migrant nurses in OECD countries originate from non-OECD countries (OECD, 2007; OECD/WHO, 2010; and see figure 1).

The impetus for overseas recruitment stems in part from the length of time it takes to train a nurse – up to seven years from the commissioning of training places to the certification of trained staff. Overseas recruitment of qualified nurses has become an attractive response to "quick fix" labour gaps. But such

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[2] This is not to say that nurse migration is *determined* by economic or market factors. Migration also expresses a desire for travel, adventure, a better climate, greater personal autonomy and security. It may also be prompted by family or kinship obligations to gain socio-economic security and social advancement (Percot, 2005). The proximity of countries is also a factor. This partly relates to the ease and cost of travel, the existence of a culturally available set of options, and a common language (Buchan, Parkin and Sochalski, 2003).

recruitment also generates cost savings even after taking account of recruitment agency fees and the costs of adaptation of foreign-trained nurses. In the United Kingdom, for example, the costs of recruiting a foreign nurse are between 5 and 10 per cent of the cost of an experienced "home-grown" nurse (Padarath et al., 2003). Importing labour from abroad helps keep wages from rising, as they would in a situation of scarce labour supply. The health system is thus able to integrate cheaper and possibly more submissive labour without incurring the costs involved in educating and training that labour (though some adaptation costs can arise). At the same time, many governments across the Caribbean, Africa, Asia and the Middle East are responding to the global nurse shortage by "producing nurses for export" (Buchan, Kingma and Lorenzo, 2005; Hosein and Thomas, 2007; Thomas, Hosein and Yan, 2005; Yeates, 2009). This production often forms part of a wider economic development strategy to promote labour exports. Migrants' remittances raise the sending State's foreign exchange holdings, help governments pay off debt and obtain loans, and invigorate the economy by supporting consumption, investment and business (and profits) for educational institutes, recruiters and travel agents.

These overseas nursing strategies map on to institutional formations so facilitative of – and influential on – nurse migration that it is possible to speak of a global "nursing labour migration-industrial complex" (Yeates, 2009). This matrix is formed by the confluence of state, commercial, professional and labour interests, and it tethers national labour markets to regional and global divisions of labour, mobilizing nursing labour for export and channelling it into occupational fields overseas. The resulting patterns of nurse migration map onto global structures of power and inequality, essentially reflecting global inequalities in power and wealth, with migrants tending to move from poorer to richer countries. Countries at the top of the "global nursing care chain" (Yeates, 2009) are supplied by those lower down the chain. For example, the United States draws nurses from Canada; Canada draws nurses from the United Kingdom to make up for its losses to the United States; the United Kingdom draws nurses from South Africa to fill its own vacancies; and South Africa draws on Swaziland. Global nurse migration is also expressed regionally, with movements from weak core countries to strong core countries (e.g. central and eastern Europe to western Europe), and from weak peripheries to strong peripheries, e.g. from Bangladesh, Egypt, India and the Philippines to the Arab Gulf States (Yeates, 2009; Buchan, Kingma and Lorenzo, 2005).

To speak of a global nurse migration complex does not deny differentiation. Its underlying socio-institutional frameworks are made of historical (colonial, missionary, training) connections between particular countries and more recent migratory routes constructed by diverse trade, investment, development, labour, health and welfare policies and agreements adopted and implemented unilaterally, bilaterally and multilaterally. These shape the production of vacancies and determine those parts of the world from which they are to be filled and on what terms. State agreements, policies and practices regarding mutual recognition, licensing, accreditation and immigration influence conditions of ac-

cess to a country, its health sector and the nursing profession, while state social entitlements and legal guarantees explain why nurses prefer certain countries over others. Many OECD countries grant nurses social protection rights and legal guarantees that make it possible for them to settle, buy a house, raise a family and obtain citizenship. None of these possibilities exist in the Gulf States, where migrants are confined to a narrow labour-supply role (Massey et al., 1998). Such guarantees also explain why Australia is increasingly preferred over other OECD countries, since it offers rights of permanent residence, permission to work after studies, family reunification, permission for the partner to work, and various child benefits (Yeates, 2011).

The meaning of nurse migration therefore varies according to where in the "global nursing care chain" a country, government, employer or individual migrant is situated (Yeates, 2009). The experiences, consequences and impacts of nurse migration thus need to be contextualized. For example, the significance of nurse emigration from a rich developed country where health and welfare provision is, by global standards, generous and secure, differs markedly from emigration from a poorer country where such provision is lacking or non-existent. It is precisely these differences in meaning that inform the analysis of global nurse migration and policy.

What's the problem with nurse migration?

A major concern about nurse migration relates to its adverse impacts on the quality of health-care provision and health outcomes. Although most countries simultaneously import and export nurses, poorer countries tend only to export nurses. The problem for these countries is that there are no countries lower down the supply chain from which to recruit to make up for the loss of their own nurses; they consequently experience nursing shortages. For example, both the Philippines and India – two major global nurse exporters – experience chronic nursing shortages (Tan, Sanchez and Balanon, 2005; Hawkes et al., 2009). Such problems are not confined to countries which only export nurses. Jamaica, for example, has been able to make up some of its nursing losses by recruiting from Burma, Cuba, Ghana, Guyana, India, Nigeria and the Russian Federation, but it still experiences serious nurse shortages (Salmon et al., 2007). Sub-Saharan Africa has been especially adversely affected by such shortages, with disadvantaged and rural areas being the worst affected (Adepoju, 2007; Dovlo, 2007; Awases et al., 2004) – to the extent that nurse emigration from such countries has been described as a "fatal flow" due to its adverse impacts on health outcomes (Chen and Boufford, 2005). In Malawi, for example, where 64 per cent of nursing posts are unfilled, the high maternal mortality rate and the inability to expand antiretroviral (ARV) therapy are attributed to the lack of trained midwives and nurses (Muula, Panulo and Masela, 2006). The lack of nursing staff is thus linked to higher rates of death, disability and morbidity, with this "widening of the population health gap [resulting] in reduced productivity, loss of national economic investment, and potential damage to economic development" (Ahmad, 2005, p. 43). Countries which have

no other (i.e. poorer) countries from which to recruit tend to become reliant on medical charity, with nursing labour often provided by the same countries that have recruited their own nurses (Yeates, 2009). In Malawi, 25–30 per cent of medical staff come from overseas, whether as volunteers attached to the United Nations or the United Kingdom's Voluntary Services International, or under agreements with various European governments (Muula, Panulo and Masela, 2006).

For some countries, the loss of skilled qualified nurses thus represents a loss of public educational investment and human/intellectual capital, and of financial investment more generally. The savings in training achieved by the United Kingdom from recruiting 1,021 Ghanaian nurses to practise in the United Kingdom in 2003–04 were worth GBP35 million (Mensah, Mackintosh and Henry, 2005), while for Malawi, the emigration of each enrolled nurse-midwife represented a loss of between US$71,081 and US$7.5 million; and for each certified nurse-midwife the lost investment ranged from US$241,508 to US$25.6 million (Muula, Panulo and Masela, 2006).[3] With nearly one in eight Malawian nurses working in an OECD country, this represents not only a sizeable loss to Malawi but also a sizeable subsidy to rich countries. Such examples illustrate why international nurse migration is commonly likened to asset stripping and characterized as regressively redistributive. Indeed, it entails a *net* flow of benefits from poor to rich countries: the economic value of nurse migration from poorer to richer countries exceeds the value of international medical aid to developing countries. And although migrants' remittances provide a significant form of revenue for source countries, remittances are private transfers that neither flow directly into the public sector nor translate into funding for health-system improvements (Chanda, 2003).

The strategies of international nurse recruitment developed by richer countries to solve their own (nursing) care crises thus export those very crises to poorer countries, exacerbating extant nurse shortages and health and social crises caused by restrictions on social investment resulting from the "Washington Consensus" policies. Not only is this global crisis of social reproduction causing a global public-health crisis, but since the majority of nurses are women, nurse emigration also contributes to the distortion and erosion of social solidarities and the "emotional commons" that these women would have otherwise sustained in their home countries (Isaksen, Devi and Hochschild, 2008). The "public good" nature of the care work that women perform in their paid work as nurses and in their unpaid work and informal capacities as members of families and communities means that nurse migration is inextricably bound up with the erosion of the "care commons".

Current gains and losses from nurse migration are unevenly distributed between the destination country, the nurse and the source country. Destination

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[3] These losses take into account the expense to the Government of training a nurse or a midwife, including the costs of primary and secondary education, at interest rates ranging from 7 to 25 per cent over a period of 30 years.

countries bear minimal costs and enjoy most of the economic benefits from overseas nurse recruitment (e.g. increased tax revenue, reduced education, training and staffing costs, support for the recruitment industry). Source countries' gains – e.g. from migrants' remittances, fees to the nurse export industry, and possible skills transfer and investment if the nurses return – are outweighed by the economic and social costs of depleted health-care services, poor health outcomes, eroded care commons and the postponement of economic and social development. Gains to the individual migrant (and her family) can be substantial but are mediated by racialized labour hierarchies which limit possible wage gains, and by other losses not amenable to monetary expression.

It is this unequal spread of costs and benefits at the individual, governmental and societal levels that has led to calls for reforming the system of global nurse migration governance. As global nurse migration is a multi-actored, multi-locational process, it follows that what is needed is a multi-faceted, international response that engages diverse stakeholders. Yet the diverse interests at stake in global nurse migration not only coalesce, but they also come into conflict. Questions arise as to how the competing interests – state, commercial, professional, labour and household – can be balanced and whether they can be reconciled. Is it possible, for example, to balance – let alone reconcile – the strategies of individual nurses in low-income countries with the need for nursing staff to fill vacancies in middle- and high-income countries and with its wider social development impacts? In other words, the need for nurses to take care of older people in developed countries has to be weighed against the need for nurses in developing countries to help care for people with HIV/AIDS. This goes to the heart of the problem: how to regulate nurse migration in the interests of public health, welfare, care and social development worldwide?

Policy approaches for sustainable and equitable nurse migration

While the various gains from nurse migration cannot be denied, its current dynamics are, on balance, inequitable and unsustainable. But what strategies are consistent with socially sustainable and equitable nurse migration? Sustainability in this context means a level of migration that ensures all nations have adequate nursing labour, while equity means that gains and losses from nurse migration are shared more fairly between the nurse, the destination country and the source country. There is a synergy between sustainability and equity in so far as both are directed at ensuring that one country's public health and social development are not prioritized over those of another. Three main policy approaches that could contribute to the realization of these goals are outlined below.

Workforce planning, investment, retention and valorization

The first approach addresses the underlying reasons for nursing shortages and why nurses migrate. Many studies have demonstrated that nurses would stay in

nursing in their home country if their working conditions and prospects improved. Measures that improve wages, working conditions, training, promotional and career prospects, personal security, and the status of nursing in home countries would indeed make a very significant contribution to curbing the need to emigrate. Such measures are key elements of the workforce planning and investment frameworks that would be needed to ensure an adequate stock of nurses to meet service requirements. Such frameworks may involve increasing the production of domestic nurses where necessary but, crucially, they would also address retention, management and recruitment issues (Little and Buchan, 2007). This policy approach can be applied by all countries. It would reduce the need to recruit internationally, by greatly limiting or even eliminating reliance on foreign nurses.

Management of nurse migration

The second approach advocates optimizing the mutuality of benefits involved in nurse migration. It attempts to reconcile the right to freedom of movement and the right to health services (World Bank, 2009). Possible measures include international cooperation and coordination on selection and recruitment, wages and working conditions – including duration of stay and the possibility of returning to the source country to jobs commensurate with experience – as well as labour rights and social protection entitlements for the individual migrant and social benefits for accompanying family members. Such measures may also embrace more robust regulation of recruitment agencies and employers to safeguard against exploitation and provide access to redress. The harmonization of educational, training and nursing standards would contribute to reducing risks currently borne by nurses. Unilateral action can be supported by international cooperation based on bilateral and/or multilateral agreements and partnerships.

Nurse migration dividends

The third approach addresses the distribution of benefits of, and returns from, nurse migration. It integrates measures from the previous two policy approaches to improve the conditions under which nurse migration occurs, reduce risks and improve benefits. Measures that ease the process, and reduce the cost, of remitting would facilitate financial transfers and release savings for the benefit of health, welfare and education in the home country. Improving returns to individual nurses, however, needs to be balanced with obligations to the source country that financed the formation of their human capital. Consideration could be given to harnessing remittances in the wider public interest – i.e. the relationship between remittances and government health, education and training budgets – and to compensation for the source country's investment in producing each nurse that it loses through emigration. Compensation arrangements from the recruiting country to the source country may take the form of financial compen-

sation to change the cost advantage to recruiters or to improve, say, educational and health support in donor aid. Compensation can also involve measures to improve return flows of trained and qualified staff, skills and technology transfers, and to provide technical assistance (Buchan and Sochalski, 2004).

The above approaches are not mutually exclusive; indeed, their efficacy would be enhanced through combination. The issue is not only a question of identifying what needs to be done, but also of the requisite political will to make available the necessary economic resources and to construct institutions that enable meaningful reform of global nurse migration governance and policy.

Current policy responses

I now proceed to outline actual policy responses and initiatives that give expression to the goal of socially sustainable and equitable nurse migration. Since it is beyond the scope of this article to map and evaluate these initiatives comprehensively, I mention only a few of them by way of illustration and raise some issues for further consideration.

The principles of improving the attractiveness of nursing as a profession and of instituting adequate workforce planning and management systems have been widely accepted as key components of any strategy to tackle nurse shortages and to manage health-care labour more generally (European Commission, 2005; ILO, 2005; World Bank, 2009; WHO, 2006; Simoens, Villeneuve and Hurst, 2005). The activation of these principles into policy initiatives is more variable, however. In the OECD countries, where foreign-born nurses account for 10 per cent of the total number of practising nurses (OECD, 2007), an OECD review of nurse migration concluded that "policies designed to reduce flows of nurses out of the workforce appear to be relatively underdeveloped in many OECD countries" (Simoens, Villeneuve and Hurst, 2005, p. 49).

The OECD review urged member countries to implement measures aimed at maximizing the participation of qualified nurses in the nursing workforce. The measures it recommended on the basis of their previous success included strategies to increase retention rates, reduce the rate at which nurses take early retirement, delay nurse retirement, attract retired nurses back into the workforce, and increase wages. Its authors cite studies on Norway, the United Kingdom and the United States indicating that higher wages reduce the level of nurse turnover (ibid., p. 47) and that significant increases in pay are an effective means of maintaining the nursing workforce more generally (ibid., p. 50; see also Kingma, 2006). Aside from the effectiveness of increased wages, the OECD study also notes the importance of family-friendly policies, though wage equity is also a decisive issue (Kingma, 2006). Among successful non-wage measures is legislation setting minimum nurse–patient ratios: in the Australian state of Victoria, this prompted thousands of former nurses who had left the profession to rejoin the nursing workforce, while demand for nursing-school places increased by one-quarter; in the United States as well, the implementation of minimum staffing

ratios has been successful in reducing nurse turnover (Simoens, Villeneuve and Hurst, 2005; Kingma, 2006).

Outside the OECD countries, measures to improve pay, working conditions and general welfare provision have proved similarly effective. Namibia pioneered incentives to become a nurse and remain in the profession, including subsidized car- and home-ownership, together with access to continuing and specialized vocational training (Padarath et al., 2003). In the Caribbean, measures to increase benefits for Caribbean nurses working in the region include low-interest loans for housing, training benefits, tax incentives and opportunities for staff mobility (Salmon et al., 2007). The importance of pay as a valorization measure is highlighted by the experience of Fiji, where the Government's plan to evaluate public-sector jobs, reclassify nurses and improve their pay and working conditions significantly reduced the number of Fijian nurses emigrating (Kingma, 2006).

Some countries have responded by providing disincentives to emigrate. One method, the so-called bonding used by South Africa and Zimbabwe, requires nurses to spend a certain number of years working in their national health services in return for the investment of public resources in their education and training. Another, introduced by Ghana and Lesotho, requires graduates to repay their training costs, either in cash or through public service, should they decide to emigrate (Padarath et al., 2003).

Although many examples of successful measures can be found, "policy responses that focus on one specific aspect of flows in or out of the workforce or retention [...] are unlikely to suffice" (Simoens, Villeneuve and Hurst, 2005, para. 5). Instead, these authors advocate "the introduction of mixed policies that initiate innovative approaches to nurse education and training, offer strong incentives to recruit domestic and foreign nurses, raise productivity and make pay and conditions of service attractive enough to retain nurses of all ages" (ibid.). The importance of combining wage and non-wage measures is also emphasized by recent reviews of measures taken by developing countries (Khaliq, Broyles and Mwachofi, 2009; Padarath et al., 2003). Malawi's comprehensive Emergency Human Resources Programme is a tangible example of this approach. It combines gross-salary increases, stop-gap recruitment of physicians and nurses to fill critical posts while more Malawians are being trained, expanded domestic training capacity, enhanced workforce planning systems, a period of compulsory public-health service for nurses trained at public expense, and a commitment to address over the longer-term non-financial factors affecting retention. The programme is reported to be effective in retaining existing nurses and enticing those that have left nursing to return to the profession (Little and Buchan, 2007, p. 7).

While some progress is being made to improve nurse workforce management in general, there is growing support for an explicit policy of self-sufficiency. A range of professional organizations such as the International Council of Nurses, the World Medical Association, the British Medical Association and (Canadian) HEAL all advocate this policy, as do the WHO (2006) and its World

Health Assembly[4] (Little and Buchan, 2007). The most recent global policy expression of this agenda is the WHO's Global Code of Practice on the International Recruitment of Health Personnel, Article 3.6 of which states that "Member States should strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel" (WHO, 2010).

This articulation of self-sufficiency builds upon previous codes of conduct on nurse recruitment developed by governments and nursing bodies over the past decade to regulate the recruitment of nurses from abroad. Often, these codes identified countries from which recruitment is not permitted. The United Kingdom's code, for example, prohibits active recruitment and unsolicited applications from designated countries unless they are part of a Government-approved programme. Among the problems with these codes are their restricted scope, their advisory status, and the lack of robust monitoring and implementation systems (Willetts and Martineau, 2004). The WHO's Code at least is global in coverage and more comprehensive in scope.[5] It also covers all health personnel, but it is weakened by its advisory – rather than mandatory – status.

In many ways, the WHO Code's statement on self-sustainability reflects policies already adopted in countries as diverse as Iran, Saudi Arabia, Oman, Australia and the Caribbean countries. Iran has been pursuing this policy since the 1980s with considerable success in increasing the domestic supply of health workers. The health authorities in Oman and Saudi Arabia also have introduced measures to develop a national nursing workforce, albeit more recently, in an attempt to reduce their very high levels of dependence on migrant nurses (Sarfati, 2003; El-Gilany and Al-Wehady, 2001). Australia adopted a policy of national self-sufficiency in 2004 but soon revised it to emphasize its intention to continue to rely on overseas nurses; nevertheless, it still aspires to the goal of sustainability (Little and Buchan, 2007, pp. 4–5). These examples reflect two main variants of self-sufficiency, namely, nationalization of the nursing workforce and regulation of nurse migration as part of managed migration.

Reducing reliance on overseas nurses may start with unilateral articulations of an intention to become self-sufficient, but it invariably needs to be developed and implemented through cooperation between destination and source countries:

> Managing migrations requires reaching out to destination countries, the goal being to establish and agree on annual flows, cost-sharing arrangements for necessary investment in nurse training capacity and technical support. Such agreements would be in the best interests of both source and destination countries, as they make flows more transparent and predictable and facilitate workforce monitoring and planning on both ends. It would help destination countries that struggle to

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[4] See 59th World Health Assembly Resolution WHA59.23 – Agenda item 11.12: *Rapid scaling up of health workforce production*, Geneva, WHO, 2006.

[5] Besides recruitment practices, it also covers treatment of health personnel, mutuality of benefits, national health workforce sustainability, data gathering and research, information exchange, and implementation and monitoring issues.

achieve self-sufficiency in reconciling immigration policies with foreign policies (World Bank, 2009, p. 5).

Arrangements to regulate nurse migration often take the form of bilateral agreements. For example, China and Cuba have implemented managed migration programmes in partnership with various African countries (Kingma, 2006). Norway, which also regulates nurse recruitment through inter-governmental agreements with source countries, has assigned responsibility to a single government agency for recruiting a given number of foreign nurses, thereby enabling the Government to balance its own need to recruit overseas nurses with concerns about the impact on source countries (Simoens, Villeneuve and Hurst, 2005). Bilateral agreements on nursing, like bilateral agreements more generally, are becoming increasingly common because they are relatively easy to negotiate, they offer flexibility, control and regulatory discretion, and they can be tailored to the particularities of each of the two partners' needs and resources. With flexibility, however, comes variability of content and standards. The terms of bilateral agreements also tend to be biased towards the interests of the richer and more powerful partner. They also cut across and potentially undermine attempts to develop multilateral solutions to the global nursing shortage (Yeates, Macovei and van Langenhove, 2009).

In the face of such problems, the emergence of regionalist self-sufficiency strategies is to be welcomed. Regional responses overcome the limitations of small-scale (bilateral) initiatives which do not sustain the interest of destination countries (World Bank, 2009, citing Dawson, 2006), but they remain on a scale that still provides ease of negotiation and flexibility while harnessing significant economies of scale (Yeates and Deacon, 2009). CARICOM's Managed Migration Programme is a notable case in point. It comprises a variety of policy approaches: training for export; the establishment of an "offshore" global nursing school in partnership with foreign investors; temporary nurse migration with frequent rotation between Jamaica and the United States; intra-regional sharing of nurse-training resources (between Grenada and Antigua); measures to encourage emigrant Caribbean nurses to return to nurse on a voluntary basis and share their nursing expertise; recruitment of nurses from destination countries to work in the Caribbean for a limited period; incentives for emigrant nurses to return to the Caribbean alongside disincentives to stay in the destination country (Salmon et al., 2007).

It needs to be emphasized that CARICOM has, unlike many other regional bodies, been the recipient of extensive and sustained international funding and technical assistance from the European Union, the United Nations and World Bank and from individual donor governments to build its capacity to function as a regional formation and respond to regional health issues (Yeates and Deacon, 2009). Equivalent investment would be needed for other regional groups of countries to respond likewise. In this regard, it should be noted that the CARICOM programme involves the participation of some 13 national, regional, bilateral and international public and private partners in addition to governments in the region (Salmon et al., 2007). The programme's overall success has yet to be

evaluated, but its focus – initially on nurse recruitment, retention, deployment and succession planning throughout the Caribbean – is "turning to opportunities for the macro-management of migration through trade and multilateral agreements" (such as the WTO's General Agreement on Trade in Services) and "the integration of the programme into regional policy decisions and regional health programming" (ibid.). In some respects, this strategy of enhanced regionalization is sensible:

> A regional effort to strengthen and scale-up nurse training is critical to success. The scarcity of tutors, the intra-regional distribution of health care capacity and the limited number of institutions offering higher degrees warrant regional coordination. Ideally, country initiatives would be collated into a single, regional strategy. Moreover, the implementation of the CSME [Caribbean Community Single Market and Economy] and associated increases in intra-regional migration requires a coordinated approach to govern the nurse education and labor markets (World Bank, 2009, p. 5).

The worry, however, is that managed migration will become increasingly dominated by the export-oriented training model, with this model shifting from being one diversification option (Thomas, Hosein and Yan, 2005) to being the prevailing one. Indeed, many more governments in the region are reported to be moving in this direction (Salmon et al., 2007). The allure of this model for governments and nursing professionals is understandable given the benefits it promises to deliver in terms of improved training infrastructures, greater numbers and quality of training staff, upgraded clinical facilities and resources for nursing education. But the risks are considerable too. Of particular concern in this respect is the active involvement of commercial nurse-migration interests – both within and outside the region – in shifting what started out as a self-sufficiency programme to a regionalized industrial nurse-export production model: "in some countries, private organizations or recruitment agencies have offered resources for governments to build larger and better health care facilities to support the clinical training of more nurses" (Salmon et al., 2007, p. 1370).

It would be unfair to dismiss the CARICOM initiative on the basis of its support for this one (albeit increasingly resourced) model, for it represents a multilateral strategy to gain more benefits from global nurse migration for the region. Notable in this regard is the World Bank's (2009) support for the principle that the costs of nurse training should "more fairly" fall on those that benefit from nurse migration, and this may open up policy space for models of nurse migration governance that increase benefits for source countries. One such approach involves facilitating temporary and return migration. Under the CARICOM scheme, Jamaican nurses can seek registration to practise in the United States for two weeks per month, returning to work in Jamaica for the remainder of the month. Facilitating temporary migration is expected to produce improved gains for nurses in the form of additional skills and higher wages while they remain part of the national nursing labour force (Salmon et al., 2007). Other schemes in the region promote exchanges of skills and knowledge gained from migration, notably by encouraging short-term paid work in the region by

external nurses and voluntary work in the region by CARICOM-trained nurses (ibid.).

Another approach is compensation. This has long been advocated as a means of removing the cost advantage of poaching nurses from developing countries by forcing recruiters to pay the full cost of educating and training nurses to the source country (WONCA, 2002; Mensah, Mackintosh and Henry, 2005). The Philippines, for example, advocates bilateral agreements with importing countries involving compensation for each health-care professional recruited, together with partnership agreements whereby the importing hospitals provide funds to the exporting hospitals to improve training and working conditions there (Tan, Sanchez and Balanon, 2005). The Caribbean export model also features bilateral agreements such as that providing for US$17,000 in compensation to be paid by United States health-care providers to the Government of St Vincent and the Grenadines for each Vincentian nurse they employ, with the funds received to be reinvested in nurse training (Salmon et al., 2007). Even if this does not represent the full cost of producing a nurse, it provides an example of how compensation arrangements are being built into international nursing agreements.

An alternative form of compensation consists in using international social financing provided by recruiting countries to fund educational and training programmes for nurses in the source country. One example of this is the use of development aid to fund the development of local nursing capacity. In Malawi, "public healthcare workers received a 52 percent wage top-up in 2005 and a campaign funded by Britain's international development agency (DFID) was mounted to entice nurses back from the private sector. Money from the Global Fund to Fight AIDS, Tuberculosis and Malaria is also being used to expand the capacity of Malawi's training institutions and provide extra incentives for health workers in remote, rural areas" (IRIN, 2006). Ireland's overseas development aid is similarly directed towards capacity building and training for health workers in Ethiopia, Lesotho, Uganda and Zambia (Yeates, 209).

Kingma (2006) advocates designated global funds for health worker training, though Koivusalo and Ollila (2008) point to the critical difficulties of "vertical" measures, such as the Global Fund mechanism, which selectively target certain diseases and issues and contribute to inefficiencies and imbalances in national health systems. While the proposal of a global health workers fund would be directed at general nurse-labour capacity building, it essentially poses the same problem as development aid in that it is a form of medical charity, the nature and provision of which depends on the beneficence of philanthropic donors and their particular priorities and commitments. The proliferation of global funds selectively targeting "special issues" and the world's poorest is no substitute for developing robust national and international financing and policy regimes supportive of comprehensive, democratic and equitable health and social care.

Conclusions

The global dynamics of nurse migration are central to the objective of promoting "professional, decently paid and compassionate forms of care".[6] Nurse migration embodies a coalescence of several kinds of "care crisis" – of public health, of the "care commons", of social reproduction and of social development. It also reflects the translocational nature of these crises, with nurse migration tangibly embodying the circulation of globalizing forces and their concrete realization across social formations worldwide. These dynamics elucidate a direct relationship between the recruitment of overseas nurses by richer countries and the systematic depletion of health and other care resources in poorer countries. Far from simply responding to abstract global market laws of supply and demand, nurse migration is socio-politically and -institutionally constructed by a global nursing-industry complex that is driving the production and recruitment of export nurse-labour on an unprecedented scale. While many countries have, encouragingly, instituted combinations of "downstream" and "upstream" measures in an effort to lessen the need to migrate and to mitigate the adverse consequences of the migration that does occur, these have yet to pose a serious challenge to the prevailing dynamic.

Policy-making processes need to engage with these dynamics. They need to produce robust and coherent policies that take account of both the "public good" nature of paid care work – its significance in the formation of social (and care) solidarities – and the multiple negative externalities entailed by the loss of skilled, qualified labour in this field. They also need to take account of the multi-locational, multi-actored and differentiated nature of the global nursing-industry complex, and the different positions of the countries and populations involved in global nurse migration. Concerted and coordinated international responses are needed to make tangible progress towards a sustainable and equitable global health care economy, so that public health-care and wider social development needs come to shape global nursing migration.

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[6] See Shara Razavi and Silke Staab: "Underpaid and overburdened: A cross-national perspective on care workers" in this issue of the *International Labour Review*, pp. 407–422.

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