The Neoliberal Globalization of Services Now Includes Nursing: The Exploitation of Low-Income Countries via Brain Drain

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Accepted

January 31, 2024

Published Online

April 18, 2024

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Abstract

In response to rising nursing vacancies, many high-income countries are turning to low-income countries to recruit nurses into their healthcare systems, a process that has exacerbated global health inequities. This review challenges the dominant neoliberal worldview of achieving economic prosperity through a largely unregulated free market at the expense of population health – instead suggesting that high-income country governments should implement alternative local solutions rather than reinforce global health disparities through the exploitation of migrant nurses. In fact, increased nursing vacancies in high-income countries are the result of domestic nurse retention crises, not nurse shortages. The primary drivers of migration of nurses from low-income countries to high-income countries include remuneration, security, career prospects and job satisfaction. The Global South faces a collapse of healthcare systems due to scarcity and maldistribution of nurses, while nurses who relocate face exploitation in their receiving high-income country. The reliance of high-income countries on recruitment of nurses from low-income countries is an unsustainable mechanism for global healthcare.

Keywords: globalization, nursing shortage, retention crisis, health equity, migrant nurses, migrant healthcare workers

Background

High-income countries are recruiting nurses from low-income countries to fill their bedside vacancies. This 'brain drain' of nurses from low-income countries such as Nigeria, India, and Philippines, to higher income countries such as Canada and the United States, has characterized globalization in recent decades. Human capital flight, colloquially known as 'brain drain', refers to the departure of educated, trained health personnel from one country to another in search of better opportunities, such as higher pay, better standards of living, increased quality of life, and more stable political conditions (1). The neoliberal global economy has opened international borders for goods and labour, which now includes nursing. Over the past decade, the World Health Organization reports a 60% increase in the number of migrant healthcare professionals working in high-income countries (2). Additionally, the World Health Organization reports that 81% of the world's nurses work in three regions (the Americas, Europe, and Western Pacific), where only 51% of the of the world's population resides within (2). Unprecedented levels of exodus of healthcare workers, especially nurses, from low-income countries to high-income countries, have created a pressing global health issue with implications for population-level health outcomes. Moreover, the inequities in density and distribution of nursing personnel within low-income countries is exacerbated by this approach to filling nursing vacancies in high-income countries (3). This review explores the main drivers of the migration of nurses from low-income countries to high-income countries and the implications of this phenomenon. The brain drain of nurses is a pressing global health concern and its harms are disproportionately felt by low-income country populations, while also failing to address the root causes of the nurse retention crisis in high-income countries (4).

The Retention Crisis in High-Income Countries

High-income countries are claiming a nursing shortage; however, this issue is more accurately described as a nursing retention crisis (4). A 'nursing shortage' implies a lack of citizens with nursing credentials or too few students registered in the education streams. This is not the case. In Canada, according to the 2021 Labour Force Survey conducted by

Statistics Canada, the number of vacant registered nurse positions increased 85.8% from 2019 to 2021, despite a 2.5% net growth of nurses from 2020 to 2021 (5). There are enough nurses to fill these vacancies, but not enough Canadian nurses willing to work in the poor conditions which characterize many current nursing positions.

A few documented barriers to nurse retention in Canada include unsafe nurse-patient ratios and workplace violence. These are rampant issues in the nursing profession. Unsafe nurse to patient ratios causes reduced quality of patient care as well as documented increased likelihood of patient death, with a patient's odds of dying within 30 days of admission increasing by 7% for every additional patient added to a nurse's workload (6). In terms of workplace violence, the Canadian Federation of Nurses Unions reports that 93% of nurses experienced at least one form of violence at work in the past year, including verbal abuse, physical assault, threats of physical violence, bullying and aggression, and sexual harassment (7). Globally, 59.2% of nurses reported exposure to workplace violence in the past year, defined as any physically or non-physically violent incident where staff were abused, threatened or assaulted in circumstances related to their work (8). Taken together, barriers to nurse retention are the result of a poorly maintained health system in Canada.

Moreover, the nurse retention crisis in high-income countries is projected to worsen. Intentions to leave the nursing profession are at an all-time high. For example, the 2022 United States National Nursing Workforce survey found that 100,000 (2.8%) nurses have left positions since the COVID-19 pandemic, and that 800,000 (22.6%) more nurses plan to leave the profession in the next 5 years, excluding those who plan to retire (9). Similar trends were reported by Canadian nurses, with a 2021 survey conducted by the Canadian Federation of Nurses Unions finding that 19% of nurses reported intending to leave the profession in the next year and another 27% intending to leave their current nursing position in the next year (7). It is likely that the dissatisfaction with unsafe nurse-patient ratios and experience of structural and workplace violence has been compounded by the demands placed on nurses due to the COVID-19 pandemic. The COVID-19 phenomenon of praising nurses as 'heroes', coupled with governments simultaneously ignoring their calls for safe staffing ratios has compounded nurse burnout levels and their concerns with capacity issues, unable to provide adequate levels of care for their patients (4). Critical care nurses based in the United Kingdom, Australia, and North America report concern for unrealistic expectations and risks to workplace safety as a result of the pandemic heroism narrative (10). The framing of the issue by high-income country governments and health leaders as a nursing shortage is problematic as it allows these institutions to evade responsibility for the conditions of their workers.

Drivers of Migration

In general, the primary drivers of migration of nurses from low-income countries to high-income countries include remuneration, security, career prospects and job satisfaction (11). Interestingly, these drivers of migration do not differ across geographical regions in low-income countries (11). International organizations have described the main push and pull factors involved in migration and international recruitment of health workers. Push factors are those which motivate healthcare workers based in low-income countries to migrate out of their countries for work. Main push factors include absolute low pay or relative low pay, poor working conditions, lack of resources, limited career growth opportunities, economic instability, and dangerous work environments (12). Pull factors are those which draw in healthcare workers based in low-income countries to high-income countries, and these are reported to be higher pay, opportunities for remittances, better working conditions, better resourced health systems, and political stability (12). Specifically in Canada, the pull factors for migrant nurses are improved quality of life for their families, improved educational opportunities for their children, opportunities to advance their nursing education with specialty certifications and a higher income (13). As of 2019, 9% of the nursing workforce in Canada were migrants, an increase from 6.9% of the Canadian nursing workforce in 2007 (14).

The Globalization of Services and Exploitation of Migrant Workers

The neoliberal global economy has opened international borders for goods and labour, which now includes nursing. High-income countries are resorting to recruiting nurses from low-income countries to fill their vacancies. Concerningly, the nurses recruited from low-income countries are being recruited to work in the identical poor conditions which pushed out the existing nurses in high-income countries. Migrant workers are a vulnerable population at increased risk for exploitation, such as lower wages compared to their domestically trained counterparts, threats of deportation if they do not comply with excessive work demands, or delayed payment, all of which is further aggravated by the systemic racism they may face (4,7,8). Migrant nurses report discrimination, lack of recognition in comparison to non-migrant nurses, and limited opportunities for promotion (15).

The documented unsafe nurse-patient ratios and experience of workplace violence of the system will be burdened onto migrant nurses.

Compounded with poor work conditions, migrant nurses in Canada can also face complicated policy barriers to begin working, such as extensive skill and language requirements and lengthy, expensive licensing and registration processes (16). Internationally educated nurses may migrate to Canada due to various pull factors, such as better opportunities and renumeration, yet they instead face obstacles at every stage of the migration and relicensing process (17). As many as 47% of migrant healthcare workers who come to Canada for work cannot find employment in their profession (16). Issues in coordination are also to blame in the case of Canada's migrant health workers, as the immigration is incentivized and selected by the federal government. However, nursing employment is organized by the provincial governments, resulting in many migrant workers poached by Canadian incentive programs arriving in Canada and subsequently discovering their qualifications do not meet Canadian requirements (16).

The Collapse of the Healthcare Systems in Low-Income Countries

A key implication of this phenomenon is the collapse of healthcare systems in low-income countries due to loss of staff and expertise. The low-income countries disproportionately bear the cost of this exchange, while high-income countries stand to disproportionately gain. There is a persistent global maldistribution of nurses. According to the WHO's 2019 global health workforce statistics, high-income countries have approximately 12 nurses per 1,000 patients, compared to 1 nurse per 2,000 patients in low-and middle-income countries (18). For example, in 2020, the Americas had a ratio of 83 nurses per 10,000 people, while Africa had 9 nurses per 10,000 people (2). Moreover, the WHO's 2020 State of the World's Nursing report announced that nurse shortages are primarily in the African, South-East Asia and Eastern Mediterranean regions (2), such that an estimated 89% of the global nurse shortage is concentrated in low-and middle-income countries, and growth in number of nurses is not keeping pace with the population growth (2).

Furthermore, high-income countries are primarily recruiting nurses from these regions with the lowest-documented nurse to patient ratios (2). This is of critical significance as the reliance on this brain drain mechanism stands to deepen the global healthcare inequities, especially in relation to countries with the lowest numbers of nurses (4). Reliance on low-income countries for nurse recruitment leads to a collapse of their healthcare systems as they are left without adequate staff. In addition to aggravation of the existing workforce shortages, low-income countries face increased costs for healthcare, decreased access to care, and adverse population health outcomes (11,19). According to the Chief Executive Office of the International Council of Nurses, the risks are incredibly concerning; a low-income country may only lose a few specialist professionals to emigration, however this can be enough to end a specialized service for patients in a given country or region, resulting in severely decreased availability of care (17). The overwhelming loss of specialist expertise out of low-income countries as well as the extent of attrition of health care professionals is highly concerning as it compounds global inequities in access to health care.

Alternative Solutions

To address the problematic implications of the recruitment of nurses from low-income countries, various policy approaches have been proposed. These approaches encompass international agreements, domestic policies, and strategic interventions. In terms of international agreements, one such proposed solution is the introduction of a compensation mechanism where high-income countries would financially compensate the low-income countries from which they recruit workers (20). This compensation mechanism could be structured in two forms; either direct investment in educational institutions for nursing in the source country or general financial support to the source country to repay for their investment in human capital (to cover the invested cost of public nursing education for each migrant nurse) (20). The direct investment mechanism has been ongoing in the Philippines, whereby a high-income country interested to recruit nurses will fund private nursing schools for Filipino students intending to migrate upon completion of their nursing education (20). The latter form of bilateral financial agreements, general financial repayment, is less likely to be feasible (20). The human capital investment of a given low-income country in the public education of one nurse is a challenge to estimate and there are barriers to implementation of legally binding payments by high-income countries for each recruited nurse (20, 21). Throughout the evolution of various voluntary codes of best practices for international recruitment of nurses, the concept of financial compensation to low-income countries by high-income countries was replaced by the concept of mutuality (21). Rather than direct compensation, mutuality encompasses other trade-offs to balance the needs of the source and destination

countries, such as training exchanges (20, 21). Yet, in theory, a compensation mechanism may at least reduce the harms to the low-income countries caused by overwhelming loss of human capital investment in nursing education, compounded by loss of workers and expertise from the national health system (20, 21).

With regard to international health trade service agreements, the General Agreement on Trade in Services (GATS) treaty of the World Trade Organization (WTO) is a set of legally enforceable rules on trade in goods and services. However, they are only enforceable to members of the WTO who commit to modes of the GATS. Specifically, Mode 4 of the GATS pertains to the movement of people including the international mobility of health workers, including nurses (21). GATS commits WTO members to rounds of negotiations of their service sectors, in which members settle which service sectors they will commit to a higher level of liberalisation via GATS (22). The potential benefit provided by GATS on health care services is controversial (20). GATS may positively contribute to the international harmonization of nursing qualifications (20). GATS can also have positive economic impact for both high and low-income countries, as liberalization of the trade in services for nurses enables all countries to enter global markets, such as exporting of services abroad or to operate abroad (23). For example, low-income country economies may argue for increased freedom to work abroad since the associated remittances boost their economy (23). However, when it comes to health care services, experts warn against commitments to liberalist trade policy embodied by accepting remittances as this can seriously compromise health care quality and availability (24). Market competition for health care can exacerbate health inequities since public hospitals must compete with private. In low-income countries, the introduction of foreign private hospitals can recruit the most experienced healthcare professionals out of the public sector, compromising the number of professionals and level of expertise in the local public health care system, thereby reducing or removing the opportunity to access health care for those of lower socioeconomic status (24). The GATS is a step in the right direction for the equitable movement of people in health services, as global regulation efforts are integral, but it is not sufficient as it can reinforce inequities (20). There are opportunities for deeper, more equitable bilateral commitments related to health worker mobility, such as financial compensation to low-income countries from which nurses are recruited for high-income countries (21).

Voluntary codes of practice have evolved since adoption of the GATS. The 2010 WHO Code of Practice on the International Recruitment of Health Personnel serves as a core component of international, domestic and bilateral responses for the promotion of ethical principles in recruitment and retention of healthcare professionals (21, 25, 26, 27). The Code facilitates the strengthening of health systems, particularly low-income country health systems, by mitigating aspects of healthcare worker that may be detrimental (21, 25, 26, 27). Its main recommendations to member states include: ethical international recruitment by discouragement of active recruitment from low-income countries facing critical shortages of health personnel, health workforce development and health systems sustainability, fair treatment of migrant health workers, international cooperation, support to low-income countries, data gathering, and information exchange (25). Overall, the WHO Global Code of Practice emphasizes the importance of equitable access to healthcare services worldwide.

In low-income countries, non-financial incentives are effective strategic interventions against the mass emigration of nurses, which include training, study leave, and the opportunity to work in a team (20). Policy interventions may also be effective – specifically the replacement of traditional restrictive donation rules with more relaxed rules to allow donor money to be directed toward recurring health care costs such as wages (20).

The improvement of working conditions for nurses is another proposed domestic solution within high-income countries, achieved via policy and strategy interventions. This would stimulate the retention of trained local nurses as a means to address the root cause of the lack of nursing staff and the increase in vacant nursing positions. Local governments can implement evidence-based targeted solutions to ameliorate working conditions and to retain nursing staff: safe nurse to patient ratios, adequate wages, benefits, organizational support, and policy development to facilitate the reporting of workplace violence (20, 28, 29). In Canada, the government released a 2023 report stating strategies for nurse retention following the pandemic: Health Canada's Nursing Retention Toolkit draws upon evidence-based practice and lived experiences of nurses to call for immediate action (30). The Toolkit calls for safe staffing practices, flexible and balanced ways of working, and reduced administrative burden on nurses, in addition to other organizational adjustments (30). A joint report from the World Health Organization, International Council of Nurses, and Nursing Now (2020) recommends that countries who are over-reliant on migrant nurses focus on their self-sufficiency through investment in domestic retention and production of nurses (2). This is also an optimal solution to ameliorate the global nursing deficit

(4). The most sustainable approach to the lack of nurses in high-income countries is to fix longstanding systemic problems in their healthcare system by increasing the number of institutions providing safe working conditions.

Conclusion

The brain drain of nurses from low-income countries to high-income countries is a pressing global health concern which has been exacerbated in recent years. Adverse effects of the migration of nurses are disproportionately felt by low-income country populations, as this approach to low nurse retention in high-income countries is further worsening the global maldistribution of nurses (4). The communities of already resource-poor countries are burdened by increased costs for healthcare, decreased access to care, and adverse health outcomes (11, 18). The reliance of high-income countries on recruitment of nurses from low-income countries is an unsustainable mechanism for healthcare systems worldwide. To promote equity, it is necessary for all stakeholders to reinforce the implementation of the WHO Global Code of Practice. This review calls for two actions. Firstly, urgent global prioritization of preventative strategies against the unsafe nurse-patient ratios, and structural and workplace violence of nursing staff. Secondly, high-income countries ought to cease the unethical poaching of nursing staff from low-income countries. In sum, coordinated and synergistic work from both low- and high-income countries on their domestic safe working conditions for nurses will facilitate the recruitment and retention of nurses globally, thereby alleviating disparate global health inequities.

References

1. Dodani, S., & LaPorte, R. E. (2005). Brain drain from developing countries: how can brain drain be converted into wisdom gain? Journal of the Royal Society of Medicine, 98(11),487–491. https://doi.org/10.1177/014107680509801107

2. World Health Organization. (2020). State of the World's Nursing 2020. Executive Summary. Investing in Education, Jobs and Leadership. Available from: https://iris.who.int/bitstream/handle/10665/331677/9789240003279-eng.pdf?sequence=1

3. Boniol, M., McCarthy, C., Lawani, D. et al. Inequal distribution of nursing personnel: a subnational analysis of the distribution of nurses across 58 countries. Human Resources for Health 20, 22 (2022). https://doi.org/10.1186/s12960-022-00720-5

4. Bortolussi-Courval É., Stake-Doucet N., Umaigba B. (2023). Incentivizing an exodus: The implications of recruiting nurses from low-middle income countries to high-income countries. PLOS Glob Public Health 3(9): e0002355. https://doi.org/10.1371/journal.pgph.0002355

5. Statistics Canada. (2021) Job vacancies, second quarter 2021. The Daily. Ottawa, Ontario: Statistics Canada, 2021. Available from: https://www150.statcan.gc.ca/n1/daily-quotidien/210921/dq210921a-eng.htm

6. McHugh, M. D., Aiken, L. H., Sloane, D. M., Windsor, C., Douglas, C., & Yates, P. (2021). Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals. Lancet (London, England), 397(10288), 1905–1913. https://doi.org/10.1016/S0140-6736(21)00768-6

7. Canadian Federation of Nurses Unions. (2022). Canadian Federation of Nurses Unions Member Survey Summary Report. Viewpoints Research Ltd. Available from: https://nursesunions.ca/wp-content/uploads/2022/02/Viewpoints_Survey_Results_2022_January_EN_FINAL-1.pdf

8. Liu, J., Gan, Y., Jiang, H., Li, L., Dwyer, R., Lu, K., Yan, S., Sampson, O., Xu, H., Wang, C., Zhu, Y., Chang, Y., Yang, Y., Yang, T., Chen, Y., Song, F., & Lu, Z. (2019). Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis. Occupational and environmental medicine, 76(12), 927–937. https://doi.org/10.1136/oemed-2019-105849

9. Smiley RA, Allgeyer RL, Shobo Y, Lyons KC, Letourneau R, Zhong E, et al. (2023, April). The 2022 National Nursing Workforce Survey. Journal of Nursing Regulation. 2023;14(1):S1–S90.

10. Stokes-Parish, J., Barrett, D., Elliott, R., Massey, D., Rolls, K., & Credland, N. (2023). Fallen angels and forgotten heroes: A descriptive qualitative study exploring the impact of the angel and hero narrative on critical care nurses. Australian critical care : official journal of the Confederation of Australian Critical Care Nurses, 36(1), 3–9. https://doi.org/10.1016/j.aucc.2022.11.008

11. Toyin-Thomas, P., Ikhurionan, P., Omoyibo, E. E., Iwegim, C., Ukueku, A. O., Okpere, J., Nnawuihe, U. C., Atat, J., Otakhoigbogie, U., Orikpete, E. V., Erhiawarie, F., Gbejewoh, E. O., Odogu, U., Akhirevbulu, I. C. G., Kwarshak, Y. K., & Wariri, O. (2023). Drivers of health workers' migration, intention to migrate and non-migration from low/middle-income countries, 1970-2022: a systematic review. BMJ global health, 8(5), e012338. https://doi.org/10.1136/bmjgh-2023-012338

12. World Health Organization. (2006). Health Worker Migration in the European Region: Country Case Studies and Policy Implications. Available from: https://iris.who.int/bitstream/handle/10665/347915/WHO-EURO-2006-3956-43715-61498-eng.pdf?sequence=1&isAllowed=y

13. Covell, C. L., Neiterman, E., & Bourgeault, I. L. (2014). A scoping review of the literature on internationally educated nurses in Canada: Mapping a research agenda. Canadian Journal of Nursing Research Archive, 26-45. https://doi.org/10.1177/084456211404600303

14. Harun, R., & Walton-Roberts, M. (2022). Assessing the contribution of immigrants to Canada's nursing and health care support occupations: a multi-scalar analysis. Human resources for health, 20(1), 53. https://doi.org/10.1186/s12960-022-00748-7

15. Bayuo, J., Abboah-Offei, M., Duodu, P. A., & Salifu, Y. (2023). A meta-synthesis of the transitioning experiences and career progression of migrant African nurses. BMC nursing, 22(1), 104. https://doi.org/10.1186/s12912-023-01273-1

16. Blythe, J., Baumann, A., Rhéaume, A., & McIntosh, K. (2009). Nurse migration to Canada: pathways and pitfalls of workforce integration. Journal of transcultural nursing: official journal of the Transcultural Nursing Society, 20(2), 202–210. https://doi.org/10.1177/1043659608330349

17. McQuillan, L. (2022, November 20). Canada's push to 'poach' nurses from abroad fuels fears of shortages in developing countries. CBC News. Available from: https://www.cbc.ca/news/health/canada-international-nurses-poorer-countries-worried-1.6655231

18. Ladak, L., Khanyola, J. (2023, May 12). "Our Nurses, Our Future"–a

perspective from Low- and Middle-Income Countries. PLOS Global Public Health (Speaking of Medicine and Health).

19. Peters M. (2023). Time to solve persistent, pernicious and widespread nursing workforce shortages. International nursing review, 70(2), 247–253. https://doi.org/10.1111/inr.12837

20. Stilwell, B., Diallo, K., Zurn, P., Vujicic, M., Adams, O., & Dal Poz, M. (2004). Migration of health-care workers from developing countries: strategic approaches to its management. Bulletin of the World Health Organization, 82(8), 595–600.

21. Walton-Roberts, M. (2023). Global Health Worker Migration: Problems and Solutions. Cambridge: Cambridge University Press.

22. World Trade Organization. (n.d.). Health and Social Services, Services: Sector by Sector. Available from: https://www.wto.org/english/tratop_e/serv_e/health_social_e/health_social_e.htm

23. Carzaniga, A., Dhillon, I., Magdeleine, J., Xu, L. (2019, December 5). World Trade Organization. Economic Research and Statistics Division. International Health Worker Mobility and Trade in Services. WHO-WTO Joint Staff Working Paper. Staff Working Paper ERSD-2019-13. Available from: https://www.wto.org/english/res_e/reser_e/ersd201913_e.pdf

24. Equine Africa. (May 2003). The GATS Treat to Public Health: A Joint Submission to the World Health Assembly. Available from: https://equinetafrica.org/sites/default/files/uploads/documents/RES2003trade.pdf

25. World Health Organization. (2010). User's Guide to the WHO Global Code of Practice on the International Recruitment of Health Personnel. Available from: https://iris.who.int/bitstream/handle/10665/70525/WHO_HSS_HRH_HMR_2010.2_eng.pdf?sequence=1

26. Connell, J., & Buchan, J. (2011). The Impossible Dream? Codes of Practice and the International Migration of Skilled Health Workers. World Medical & Health Policy, 3(3), 1–17. https://doi.org/10.2202/1948-4682.1175

27. Yeates, N. & Pillinger, J. (2019). International health worker migration and recruitment: Global governance, politics and policy. London: Routledge.

28. Duru, D. C., & Hammoud, M. S. (2022). Identifying effective retention strategies for front-line nurses. Nursing management (Harrow, London, England : 1994), 29(1), 17–24. https://doi.org/10.7748/nm.2021.e1971

29. Pressley, C., & Garside, J. (2023). Safeguarding the retention of nurses: A systematic review on determinants of nurse's intentions to stay. Nursing open, 10(5), 2842–2858. https://doi.org/10.1002/nop2.1588

30. Health Canada. (March 2024). Nursing Retention Toolkit: Improving the Working Lives of Nurses in Canada. Available from: https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/health-human-resources/nursing-retention-toolkit-improving-working-lives-nurses/nursing-retention-toolkit-improving-working-lives-nurses.pdf