New Research in

Global Political Economy

Sarah
Becklake

‘Ethical’, but Gender-Biased?

A Gender-Sensitive Analysis of the International Migration of Nurses and its Governance through ‘Ethical’ Recruitment Codes

New Research in GPE
Working Paper
No. 1/2008

Department of Social
Sciences

“Globalisation & Politics”

UNIKASSEL
VERSITÄT

About New Research in GPE

Contributions to this working paper series chiefly embody the work of the Global Political Economy masters program of the University of Kassel. It mirrors the broad spectrum of theoretical approaches and empirical topics which are the trade mark of the fast expanding field of the Global Political Economy. This series represents exemplary work from graduate level seminars, individual research projects within the department, and consolidated versions of the top masters theses produced by the department. Papers are released on an irregular basis and paper copies can be ordered upon request.

urn:nbn:de:hebis:34-2008082723463

Author:
Sarah Becklake: becklake@hotmail.com

Editors:
Pia Eberhardt
Dr. Helen Schwenken

Published by KOBRA, University Library, University of Kassel
Other papers in this series are available online at:
https://kobra.bibliothek.uni-kassel.de/handle/urn:nbn:de:hebis:34-2008010719914
Managing Editor: Aaron Leopold: aaron.leopold@ufz.de

Global Political Economy Masters Program at Kassel University website:
http://www.uni-kassel.de/fb5/globalisation/ma_gp

‘Ethical’, but Gender-Biased?

A Gender-Sensitive Analysis of the International Migration of Nurses and its Governance through ‘Ethical’ Recruitment Codes

Sarah Becklake
Kassel University

New Research in Global Political Economy
Working Paper No. 1/2008
Department of Social Sciences
“Globalisation & Politics”
Kassel University
August, 2008

Abstract **iii**

List of Abbreviations **iv**

1 Introduction **1**

2 Literature and Data **3**

3 Migration Impetuses: Conventional and Gendered Accounts **5**

3.1 Push and Pull Factors: A Conventional View *5*

3.2 Further Complexities: A Gendered Account *6*

4 Nurse Recruitment: Coaxed from South to North? **10**

5 The International Recruitment of Nurses: The Stakeholders **11**

5.1 Individual Level *11*

5.2 Institutional Level *15*

5.3 National Level *17*

5.4 International Level *19*

6 Policy Responses: Ethical Recruitment **23**

6.1 National Codes *23*

6.2 Codes from Organizations and Associations *24*

7 Room for Improvement: Room for Gender? **26**

8 Conclusion **31**

Bibliography **32**

Appendix 1: Codes Reviewed **36**

Appendix 2: Reproduced Copy of the Commonwealth Code **37**

Abstract

The migration of healthcare professionals from developing to developed countries, often aided by recruitment agencies, is a phenomenon of great international concern, as reflected in the construction of numerous ethical recruitment codes, which aim to govern the process. In an attempt to provide an overview of the situation, dealing specifically with the migration of nurses, as well as a critical and gender sensitive analysis of the codes, this paper follows three broad steps: first, it reviews the literature dedicated to the migration of nurses from developing to developed countries, adding a gendered account to more conventional push-pull explanations; second, it delineates the positive and negative effects that nurse migration has at the stakeholders levels of the individual, institutional, national and international level, paying particular attention to the role of gender; and third, it reviews and compares numerous codes for the ethical recruitment of nurses, highlighting the gendered rationale and consequences they may have. In showing that nurse migration is a gendered phenomenon, the paper questions whether the codes, written in gender neutral language, will come to bear unintended consequences that will effectively work to uphold gender stereotypes and inequalities.

List of Abbreviations

AFSC	American Friends Service Committee
ANA	American Nurses Association
ANMC	Australian Nursing and Midwifery Council
DoH	Department of Health (United Kingdom)
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
HCCA	Health Care Corporation of America
ICN	International Council of Nurses
ILO	International Labour Organization
IMF	International Monetary Fund
IOM	International Organization for Migration
JPEPA	Japan-Philippines Economic Partnership Agreement
PSI	Public Services International
PSLINK	Public Services Independent Confederation
SAPs	Structural Adjustment Programs
WHO	World Health Organization
WTO	World Trade Organization

1. Introduction[1]

The migration of healthcare professionals[2] occurs in many guises: within and between developing countries, within and between developed countries, as well as, increasingly, between developing and developed countries. While each of these well trodden migration flows includes and affects a wide range of actors, which may be perceived as either benefiting or losing from the process, the flow receiving the most international attention is that which moves healthcare professionals from developing to developed countries. This is not surprising, as healthcare workers provide essential services to the populations in which they are embedded; thus the exodus of healthcare workers – often 'aided' and encouraged by recruitment agencies – from those countries which already suffer disproportionately from high levels of disease and weak healthcare systems, to countries with comparatively fewer problems, appears synonymous to looting the resource-poor in order to add to the resource-rich. The active scouting of healthcare professionals from developing countries has been touted as unscrupulous by many of the involved stakeholders as well as observers. Given this, several nation states and international bodies have implemented policies – such as codes for the ethical recruitment of nurses – that aim to deter the recruitment of healthcare workers from regions experiencing dire shortages, while simultaneously acknowledging the benefits this migration flow brings to many of those implicated.

The literature dedicated to this ethical quandary, focusing specifically on the migration of nurses as well as a comparison of various codes for the ethical recruitment of nurses, is the subject of this paper. Through highlighting the 'mainstream' explanations of this controversial migration flow, the winning and losing stakeholders, as well as the current policy responses and criticisms, this paper hopes to provide a synthesized account of the issue's debates and complexities. Furthermore, by including feminist observations throughout, it aims to illuminate and expand on areas that the existing literature does not include. Applying a feminist lens is not only instructive, it is necessary, especially when discussing the migration of nurses, as the vast majority of these professional migrants are

---

[1] The working paper is an outcome of the research project „Economic gender knowledge in the governance of migration" funded by the Ministry of Higher Education, Research, and the Arts in Hessia/Germany (2007-2008, funding scheme 'Gender differences', no. 2007/14, project management: Helen Schwenken and Christoph Scherrer, University of Kassel, Germany).

[2] Healthcare professionals are defined by the UK's department of health as "[…] medical staff, nurses, dentists, radiographers, physiotherapists, occupational therapists, and all other allied health professionals" (2004: 3).

female. Framing the issue from a variety of angles, including gender, it is contended, may help to ensure that policy tactics employed by nations and international organizations are as inclusive and effective as possible.

In following this agenda this paper will, first, provide a conventional and gendered account of the impetuses behind nurse migration; second, outline the positive and/or negative outcomes nurse migration has at the individual, institutional, national and international level; and, third, review and critique some of the ethical recruitment codes for nurses from a gendered perspective.

2. Literature and Data

International migration patterns often follow well established and historical ties between different countries; this appears especially true in the case of healthcare professionals. In a study regarding the migration of physicians, Bourassa Forcier, Simoens and Giuffrida state:

> Historical, administrative and legislative frameworks, training institutions, professional associations and regulations have influenced practices in former colonies and affected the migration of physicians for training and employment opportunities (2004: 6).

One might thus expect a variety of healthcare professional migration flows between linguistically and historically connected countries, for instance those using English, French or Spanish – often a result of colonialism. The assumption of diverse historically rooted healthcare migration flows, however, is not reflected in the obtained literature. The literature reviewed, compiled from organization websites as well as academic journals, exhibited a clear Anglophone bias, as most of the articles collected focused on the actions of, and experiences in migrating to the receiving countries of Australia, Canada, Ireland, the United Kingdom and the United States. The fact that all the literature reviewed was published in English undoubtedly contributed to this Anglo focus, yet the English bias may also be due to the relative ease nurses from the *many* English speaking and utilizing developing countries, such as: India, Ghana, Jamaica, the Philippines, South Africa, Zimbabwe, and others, have in migrating to the *many* developed English speaking countries (Bach, 2006; Bourassa Forcier et al., 2004). Given this, it is arguable that the most substantial developing-to-developed country flows of healthcare professionals are currently between English speaking nations (Clark et al., 2006). The lack of information found regarding the migration of healthcare professionals between non-English utilizing countries indicates an area in need of further investigation.

While the formidable movement of nurses, as well as other healthcare professionals, from developing (source) to developed (receiving) countries is causing considerable international concern, many scholars that have researched these migration flows concede that the actual numbers are debatable (Bach, 2006; Buchan et al., 2003; Diallo, 2004; Stilwel et al., 2003). For instance, receiving countries report more international healthcare workers within their jurisdictions than source countries report ‘missing’ (Diallo, 2004). Such incongruities are largely caused by a dearth of documentation within certain countries, a lack of international standardization of databases used to identify the movement of healthcare professionals,

such as: population registers, migration visas, residence or work permits, censuses and surveys (Buchan et al., 2003; Stilwel et al., 2003), as well as fundamental differences in definitions, for instance, who qualifies as a healthcare worker and what constitutes 'temporary' movement (Bach, 2006; Diallo, 2004; Stilwel et al., 2003). Thus, it is extremely difficult to determine the *actual* number of healthcare workers on the move, as the data available is piecemeal and hard to interpret. Despite these limitations, many academic and organizational studies, which have used the available data with all its constraints in mind, have come to the same conclusion: the migration of healthcare workers is increasing (Bach, 2006; Buchan et al., 2006; Clark et al., 2006; Stilwel et al., 2003; Van Eyck, 2005). While nurses are but one category of this group, they compromise a substantial proportion of migrating healthcare workers, and have been the primary focus of various studies.

3. Migration Impetuses: Conventional and Gendered Accounts

A tacit assumption that nurses from developing countries migrate out of *need* rather than *want*, pervades much of the literature. Migration is often perceived to be a strategy used to escape dire situations or to obtain new opportunities not possible in home countries; it is provoked by wider societal situations (Van Eyck, 2004). The most common way of conceptualizing the decision to migrate from a developing to a developed country is thus to delineate the impetuses behind the choice to migrate, or, in other words, the push and pull factors which entice such movement. However, this assumption is not without its blind spots, as a gendered perspective illustrates other dimensions of migrations often overlooked by this mainstream perspective. Gendering the push-pull perspective should therefore give a more thorough understanding of the origins and outcomes of nurse migration.

3.1 Push and Pull Factors: A Conventional View

The *pull* factors most often cited in the literature are: prospects of better remuneration and working conditions within developed countries, as well as the hope of further professional advancement and education (Bach, 2006; Buchan et al., 2003; Buchan et al., 2006, Clark et al., 2006). These elements essentially reflect an anticipated improvement over those factors deemed *push* factors: poor pay and working conditions with few opportunities for further education and promotion. Thus Buchan et al. note that:

> To a certain extent, the push and pull factors present a mirror image – on the issues of relative pay, career prospects, working conditions and environment available in the source and destination countries. Where the relative gap (or perceived gap) is significant, the pull of the destination country will be felt (2003: 41).

The relative gap between healthcare workers' situations in developing countries and those in developed countries appears to be on the increase; this observation has led some to argue that the steady flow of nurses from developing to developed countries must be contextualized (Bach, 2006; Van Eyck, 2004). For instance, in Bach's 2006 article, *"International Mobility of Health Professionals: brain drain or brain exchange?"*, he asserts that pull factors must be seen in relation to the further deterioration of already weak health systems as a result of the structural adjustment programs (SAPs) of the International Monetary Fund (IMF) – neoliberal macroeconomic policies which reduce public spending and hamper already fragile health systems, making employment more precarious and

difficult to obtain. Such unfavorable situations provide few incentives for recent graduates to remain in their home countries, as they may feel frustrated in their local health context due to school training which exceeds the level of service provided in occupational settings (Bach, 2006). In addition to the effects of SAPs, Clark et al.'s article, *"The globalization of the labour market for health-care professionals",* highlights the intensification of push factors stemming from political instability, health crises such as HIV/AIDS combined with a lack of protective gear and thus increased risk of exposure to disease as well as increased violence within the workplace, all which have contributed to the further erosion of the working conditions of healthcare providers (2006). The literature thus suggests that the 'traditional' push factors encouraging the migration of health professionals – poor remuneration, working conditions and career prospects – have been magnified as a consequence of deteriorating health systems resulting from faulty macroeconomic reforms.

Occurring simultaneously to the increase in push factors is an intensification of many developed countries' need for nurses. Their nurse deficit, as suggested by Buchan et al. 2003, was caused by poor foresight and lack of investment in the profession, for the rising demand for nurses has not been met with an adequate rise in trained personnel. In fact numerous scholars note that in many developed countries there is slow or no growth in nurse graduates, high turnover and an ageing workforce (Buchan et al., 2003; Buchan et al., 2006; Clark et al.; 2006, Troy et al., 2007). The nurse shortage has resulted in an increase in international recruitment (expanded on below), as developed countries scramble to fill vacancy positions and public need. Thus, the increased advertisement and availability of nursing jobs in developed countries suggests that pull factors have also intensified.

3.2 Further Complexities: A Gendered Account

The above accounts are not necessarily in need of dispute; however, by applying a gendered lens the situation becomes even more complex. Nurses, of which 90% are female (Jolly & Reeves, 2005: 10), have been heavily affected by neoliberal reforms – both as women and as workers. Van Eyck notes that in the 1990s, a series of 'cost-cutting' policies were implemented in the health sectors of varying developed countries. She states that:

> Health sector reforms followed an "American model" of industrial restructuring in which the cheapening and reduction of the workforce was designed to reduce costs and increase efficiency (2005: 85).

Thereby, nurses were consciously laid off even with the knowledge that populations were ageing and demand would soon increase; those that remained found their workloads amplified and stress levels exasperated (Ibid.). The reduction in public spending and the concurrent swell in the responsibilities of individual nurses effectively contributed to the construction of a shortage in at least two ways: it made the profession less desirable for would-be nursing students (not to mention potential male entrants), and it pushed already established nurses out of their positions. These health reforms, which de-generated a job indispensable to human welfare, were supported by the tacit assumption that *all* women will continue to provide such essential services privately; hence, the word 'nurse' in many governments' minds appears to be a synonym for 'female'. Thus, declining national investment in the health sector is gender biased; cutbacks in the public sector, a generally good employer of women, means fewer career avenues (Denis, 2003). Furthermore, as healthcare and other public services are increasingly trimmed, they become 'privatized' within the home, essentially, due to the gendered division of labor, increasing the workload of women who come to supply once state provided services free of charge (Elson, 1995). The nurse deficit was thus constructed on gendered assumptions and bias.

The phenomenon of health sector cutbacks, as already mentioned, is also occurring in developing countries. Van Eyck notes:

> Public health service budgets are in relative decline in many developing countries, as governments follow neoliberal prescriptions for growth: reduce the role of the state and develop the private sector. The quality of the services has suffered, pay is well below similarly qualified professions and the work environment is often demeaning and dangerous (2005: 6).

While parallels can be drawn between the North and the South, given that the economic conditions of developing countries are more volatile to begin with, a spending-cut in female dominated professions may spark experiences and 'choices' for Southern based nurses that are far more dire than those facing their Northern counterparts. For example, the nurse shortage in developed countries has *also* been attributed to the proliferation of new career opportunities for women, which has allowed women to take up professions that offer more remuneration and status (Clark et al., 2006; Troy et al., 2007). Instead of nursing, therefore, women based in Northern countries may be able to find other, even better, forms of employment. While there may be some examples of women in developing countries that have undergone similar career transformations, it is more likely that deteriorating health systems in developing countries forces a choice between unemployment and migration.

A look at the Philippines provides an instructive example. Public Services Independent Confederation (PSLINK) notes that the new Japan-Philippines Economic Partnership Agreement (JPEPA), a treaty which will expand trade in goods, services, investments and labor, also includes the increased export of Filipina nurses to Japan (2007). Occurring simultaneously to the Philippine government's push to liberalize and thereby solidify migration routes for the export of its Filipina labor, is the government's refusal to "[…] fully implement RA 9173 or the Nursing Act of 2002 which sets the minimum base pay of nurses working in the public health institutions […]"; rather the healthcare budget continues to shrink (PSLINK, 2007: 2). Therefore, nurses that choose to stay within the Philippines receive pitiful wages unreflective of their work or they face no work at all (Ibid.). While the Philippine government differs from many developing countries in that it is actively supporting the migration of its nurses, Bach notes that in general, due to SAPs, more and more women, such as nurses, are seeking overseas occupations (2006).

HIV/AIDS has also contributed to the deterioration of public health systems in the South. This is not only due to increased demand for health services, but also because females are more physiologically[3] and socially susceptible to infection than men, which is leading to a 'feminization' of the disease (Urdang, 2006). Thus, nurses, who are vastly female, are not only carers of the sick they are also increasingly becoming the ill. In Dixon et al.'s study they found that in South Africa, approximately 20% of all student nurses were infected with the disease (2002: 232). Furthermore, Clark et al. state that "Zambia alone lost 185 nurses to HIV/AIDS in 1999 (the equivalent of 38 per cent of new nurses trained there that year)" (2006: 40). They further note that nurses are experiencing an upswing of violence in the workplace, including gendered violence and abuse (Ibid.). The increased threat of violence, perhaps sprouting from frustration due to poor care as a result of overstressed and low-paid workers, makes female nurses even more vulnerable to infection. The vulnerability they feel as a result of their gender, may act as another push factor toward emigration.

In sum, while the more conventional push-pull description of the impetuses behind nurse migration provides some insight, it largely ignores the gendered rationale that is used to support declining investment in the profession, as well as keep it poorly remunerated and its status low – two elements that have surely helped contribute to the nurse deficit and to emigration. Therefore, when discussing the global shortage of nurses and subsequent

---

[3] Women have a greater risk of catching HIV and other sexually transmitted diseases from an infected man than vice versa due to women's "[…] greater mucosal surface exposed to pathogens during sexual intercourse, particularly young girls whose genital tracts are not fully mature" (Ackermann & de Klerk, 2002: 166).

migration and how to address it, it is also necessary to discuss the underlying gendered processes that have led to the status quo.

4. Nurse Recruitment: Coaxed from South to North?

While varying national strategies have been suggested and enacted in several developed countries in an attempt to solve their nursing shortages internally, such as promoting nurse retention and new entrants, extending the age of retirement, providing incentives to return and utilizing 'skill mix' strategies, the international recruitment of nurses remains a standard strategy (Buchan et al., 2006). Recruiting methods include advertising job positions in strategic places (newspapers, journals, online forums, etc.) and direct contact with the potential employees through email, telephone or career fares, among others. Due to modern technology, the recruiting field appears to have few limits, as countless recruiting agencies scour the globe looking for talent.[4]

The recruitment of nurses from developing countries to 'fix' problems in developed countries is highly controversial, as nursing shortages are occurring all over the world. Through the active recruitment of nurses and other healthcare professionals from developing countries, it would appear that developed countries are utilizing their assets as lures in an attempt to rectify their own healthcare crisis. In so doing they effectively capitalize on the eroding health systems and relative dissatisfaction of nurses in developing countries. However, some developing countries encourage the situation and also 'benefit' from the 'international trade in nurses' (as noted with the Philippines and discussed in further detail later); others, however, have found themselves in precarious situations as they experience severe staffing shortages and are no longer able to care for the sick (Bach, 2006; Clark et al., 2006; Zurn et al., 2005).

Thus, the ethical conundrum is exposed. While nurse migration as an individual strategy to improve one's life needs to be upheld, encouraging and facilitating such migration through international recruitment at the destitute of developing countries is unethical and arguably unjust. Given this pretext, much of the literature seeks to illuminate exactly who benefits and who loses in the nurse migration process. As it will be shown, the answers are far from clear cut and uncontested.

[4] For example see: International Healthcare Recruiters Inc (www.internationalhr.net), Nursing Staffing Agency (www.nursingstaffingagency.com), International Nurses Recruiting (www.inrllc.com), Health Care Corporation of America (HCCA) International (www.hccaintl.com), Nurse Finders UK (www.nursefindersuk.com), O'Grady Peyton International (www.ogradypeyton.com), Comprehensive Medical Staffing Inc. (www.nurseonnet.com).

5. The International Recruitment of Nurses: The Stakeholders

In Xu & Zhang's 2005 article*, "One size doesn't fit all: ethics of international nurse recruitment from the conceptual framework of stakeholder interests"*, they argue that the migration of nurses involves four different levels of stakeholders: the individual, the institutional, the national and the international. Moreover, they suggest that whether international nurse migration is experienced as positive or negative depends on the geographical location of the stakeholder in question. While not explicitly, much of the literature follows a similar structure – outlining the different stakeholders and how they experience nurse migration. Due to this, Xu & Zhang's categorization will be followed in order to present the relevant literature.

5.1 Individual Level

As the push and pull factors suggest, at the stakeholder level of the individual migrating nurse, it is assumed that migration from a resource-poor to a resource-rich country will bring net benefits, such as greater remuneration, better working conditions and improved career prospects. However, costs are also incurred at this stakeholder level. In fact many studies indicate that migrating nurses may experience exploitation and discrimination, as well as difficult career progression (Buchan et al., 2006; Goodman, 2005; Likupe et al., 2005; Stasiulis & Bakan, 2003; Troy et al., 2007; Van Eyck, 2004).

The exploitation of migrants may be emitted from many fronts including recruitment agencies and potential employers. For instance, Goodman reports that some recruitment agencies have "[…] brought nurses into the UK on student visas, which restricted them to work only 20 hours per week", yet upon arrival the nurses were pressed to work 60 hours per week to repay recruitment fees (2005: 36). In another UK example, the overseas nurses were found to be making only 4.75 pounds per hour, which is merely .25 pence more than the minimum wage (Ibid.). Furthermore, Goodman reports that in several instances nurse migrants were required to do tasks unrelated to their title, such as cleaning, cooking and laundry, suggesting a waste of skills (Ibid.).

Migrant nurses working in clinical settings have reported varying forms of discrimination, stemming from fellow colleagues and patients to wider society. In one study of colored nurses in Canada, it was found that they received harder and more frequent discipline,

experienced greater job insecurity and were allocated a greater proportion of those jobs deemed unsavory (Stasiulis & Bakan, 2003). Likupe et al.'s 2005 study, entitled *"From policy to practice: recruitment of African nurses in the UK*", discovered that the expectations held by pre-migrant nurses were in some cases unfulfilled. Before coming they had expected better wages and working conditions, improved quality of life, professional development and opportunities for their children. In some cases they found racism, even between foreign nurses. Some reported exploitation by employers and others paid burdensome recruitment fees for their current positions. Most said they would go back to their home country if the wages were better; however, despite the hardships, in order to afford their children a better life they planned to stay (Ibid.).

The concern over HIV/AIDS may also result in discrimination towards nurses from areas known to have high levels of infection. For example, in Likupe et al.'s study it was discovered that one of the participating migrant nurses had been forced to undergo HIV/AIDS testing, which she felt was unfair, noting that the AIDS patients in the UK hospital had not all been infected in Africa (2005: 6).While it is unknown whether this nurse was singled out due to her origins or whether HIV/AIDS testing is mandatory for everyone and she was just not made aware of this, the manner in which the testing was carried out resulted in her feeling targeted. Furthermore, while forced HIV/AIDS testing may be standard in some jurisdictions for would-be nurses, migration itself can also affect the spread of HIV/AIDS. Jolly& Reeves argue that:

> Mobile populations, including refugees and labour migrants, may be more likely to have unsafe sex due to: isolation resulting from stigma, discrimination and differences in languages and cultures; separation from regular sexual partners; desire for intimacy, comfort and pleasure in a stressful environment; sense of anonymity; power dynamics in buying or selling sex; and lack of access to health and social services, information and condoms (2005: 27).

In addition to these factors, it could be that women's relative lack of 'negotiating power' and stereotypical ideas about female 'passivity' continue to put female migrants at risk, even in their new work settings (Ibid.). They also experience the added costs and struggles associated with cultural, and in some cases language adaptation (Troy et al., 2007). Moreover, as Van Eyck suggests in her report for Public Services International (PSI), the emigration of nurses may be accompanied by divorce due to long distances, as well as result in increased workloads for children left behind (2005) – probably female children, as they take up where their mother left off. Thus, the costs of international migration to the individual migrating nurse and their family are not to be belittled.

However, despite the reported deleterious aspects of international nurse migration at the individual stakeholder level, it would appear that the economic benefits obtained by the migrant remain a strong incentive, perhaps counterbalancing the individual costs. The likely improvement in nurses' economic situations allows them to provide, not only for themselves, but also for their families back home via remittances. Remittances are often a key component of an individual's decision to go overseas to find work. In fact, one study claimed that the career decision to become a nurse was linked strongly to a future goal of overseas work and thus the gained ability to remit (Troy et al., 2007). In this account, prospective migrants utilize their agency by taking advantage of the want of nurses in developed countries; an education in nursing becomes a 'ticket' to more lucrative settings (Ibid.).

While the ability to remit is often seen as a huge incentive to migrate, if one explores the gendered power relations behind the migration process it becomes less clear whose impulse is at work. For instance, Van Eyck notes that most migration studies are "[b]ased on neoclassical economic theories of wage differentials or rational choice, [and that] such studies locate the decision to migrate at the level of the individual, rather than within wider social or political units" (2004: 9). This not only disregards "[….] how migrants' choices are shaped by the way in which nation states are integrated into the global economy" (Ibid.: 10), but it also ignores the power relationships within homes. For instance, while Troy et al. propose that individual women decide to get an education in nursing precisely because it affords them a 'ticket' to travel to developed countries (2007), other perspectives suggest, on the contrary, that the decision to become a nurse may have been made by the family as a whole (Fernandez, 1997). For example, "[s]everal studies of internal Filipino migrants show families are more likely to send daughters to migrate because they perceive them to be more reliable in sending remittances" (Jolly & Reeves, 2005: 10). Hence, as it is generally believed that women are more reliable remitters (Bach, 2006), and that they send a greater proportion of their income back to their home countries (Fernandez, 1997), the decision to get an education in nursing and to emigrate, due to the patriarchal structure of many households, may have been 'given'.

The familial expectation that women will remit more than men could also mean that female migrants carry a heavier load of responsibility than their male counterparts. This burden is made hard to bear, as female migrants' work is still undervalued within the destination country. Bach notes:

> […] that when account is taken of purchasing power parities and the high cost of living in the London area the differential may be smaller than anticipated leading to reports about the plight of South African nurses in the UK […] or difficulties in meeting the expectations of relatives in terms of levels of remittances […] (2006: 11).

This reality is instructive, given that the UK is a popular destination country for migrant nurses, and that the vast majority of nurses migrating to Britain end up in the greater London region where living costs are astronomical (Buchan et al., 2003). Moreover, in most destination countries' urban centers, where migrants often reside, nurses may encounter similar financial situations. Therefore, while being paid more in receiving countries than in sending countries, migrant nurses may find that the cost of living in the receiving country means that their relatively higher wage does not afford them much more spending or saving power. In this case, migrant nurses' expectations of their new life abroad, and in some cases their family's expectations of what they can do for them, may be divergent and cause great stress (Bach, 2006).While much more research must be done on this topic, these preliminary observations suggest that the link between getting an education in nursing, migration and remittances is imbued with gendered assumptions and power relations. It may thus be deceptive to discuss the 'individual stakeholder' in isolation from the layers of power relations in which they are embedded.

Finally, the individual stakeholder level would not be complete without also discussing the stationary (non-migratory) nurses in the source country and those already residing in the destination country. It is possible, as Buchan et al. suggest, that individual nurses in the receiving country may perceive their job security as threatened due to the influx of foreign workers, perhaps receiving a lower wage (2003). Furthermore, they may be unaccustomed and uncomfortable adjusting to a multicultural workplace, such as learning to work with nurses which may have been trained in different procedural methods (Xu & Zhang, 2005), possibly fuelling discrimination and negative attitudes amongst colleagues as the foreign-trained nurses may be seen in opposition to nationally-trained nurses. However, it is also plausible that the foreign nurses are seen as a welcomed addition to the established staff, as they may be overstretched and happy to receive additional helping hands.

Nurse emigration, as experienced by the stationary nurse in a developing source country, may be contradictory. On the one hand their workloads increase as the ratio of patients to nurses skyrockets, compromising their ability to provide effective care (Van Eyck, 2005). One study suggests that nurses left behind feel 'frustration' and 'jealousy' towards the

migrating nurses, as they experience heightened stress and burnout (Bach, 2006). On the other hand, the nurses that migrated before often act as a source of help and assistance in the emigration of former colleagues (Ibid.). Hence, the emigration of colleagues may at first be experienced as an added burden, but evolve into assistance in obtaining a foreign position. However, not all nurses intend to or have the ability to migrate to a developed country, and it is these nurses that most likely see little benefit in the persistent dispersal of their colleagues to the North.

5.2 Institutional Level

When it comes to looking at the costs and benefits of the international migration of health care professionals at the institutional level, the literature primarily focuses on the respective national institutions responsible for delivering health services, which have a large stake in the migration of their staff. Much of the literature concurs that the healthcare institutions of the sending country are predominantly on the losing side when it comes to the emigration of their human resources for health (Buchan et al., 2006; Clark et al., 2006; Van Eyck, 2004; Xu & Zhang, 2005). For instance, it has been reported that in Zimbabwe clinics and hospital wards were shut due to the inability to fill employment vacancies (Zurn et al., 2005). Malawi has once reported a 60 per cent nurse vacancy rate (Clark et al., 2006: 47). Thus, healthcare institutions within the source country are stripped of their most skilled workers, via disease and migration, shrinking the already sparse labor market for healthcare staff and making it hard to run hospitals and clinics.

Given this, one could argue that the emigration of nurses presents a classic example of ‘brain drain’. The concept of ‘brain drain’ refers to the movement of those with education and the potential to assist a nation in its success and progress, to other countries. While the emigration of nurses and other healthcare professionals does have devastating effects, plenty of the literature challenges the notion of a one way negative ‘brain drain’. Some studies suggest that temporary migration, or migration with the potential that the migrants will return, can also have positive effects at the institutional as well as the national level, as the skills obtained abroad are brought back into the healthcare systems of sending countries in a process of ‘brain gain’ (Bach, 2006; Buchan et al., 2006; Xu & Zhang, 2005). Others doubt the feasibility of gaining from skills picked up overseas as the contexts in sending countries are often very different from that of the receiving countries, making skills learned abroad inappropriate and irrelevant in settings with far less technology (Clark et al., 2006).

Yet another perspective suggests that the emigration of nurses is a symptom of institutional decline rather than its cause, implying that even if nurses were to stay within their home countries they would potentially face unemployment (Bach, 2006; Stilwel et al., 2003). Migration may, therefore, ease source countries' problems of unemployment (Buchan et al., 2006), essentially taking labor pressure off healthcare institutions.

In any case, the 'brain gain' argument faces additional rebuttal if we expand the institutional focus to include immigration programs outside of the national healthcare sector, that attract healthcare professionals, such as programs for live-in carers. Take the Canadian 'Live-in-Caregiver Program' as an example: Canada's Official Citizenship and Immigration website states that "Live-in caregivers are individuals who are qualified to provide care for children, elderly persons or persons with disabilities in private homes without supervision" (www.cic.gc.ca/ENGLISH/work/caregiver/index.asp, accessed Oct. 20, 2007). To be 'qualified' you must have at least a 'high school education', previous long term work experience, and English language competency, as well as pay a non-refundable $150 Canadian dollar application processing fee (Ibid.). Those accepted must live within their employers' homes for the contracted period of time and can only apply for other lines of work and permanent residency after 2 years of domestic work (Ibid.). What the program highlights is first, the amount of deskilling healthcare migrants might experience within destination countries: Their skills as professional carers act as the proper qualifications for immigration programs, which usher them into feminized, low-paid jobs as domestics and nannies – another service in high demand in Northern countries (Hochschild, 2000). This challenges the argument that the devastating impact of 'brain drain' upon the health institutions of sending countries could ultimately be ameliorated upon the repatriation of healthcare professionals with further skills gained abroad ('brain gain'). Second, while the emigration of both male and female healthcare professionals may contribute to brain drain, female healthcare professionals *may* be even more likely to experience deskilling as they may more frequently move into other service jobs, such as becoming a live-in care giver, as a result of gender stereotypes equating care with women. So, in the case of some migrating female healthcare professionals, the term 'brain waste' may be more adequate than 'brain gain'. While at the time of writing this paper no data could be located that specifies how many male and female healthcare professionals have come to Canada through the live-in caregiver program, what is known, however, is that most have been women (Grandea & Kerr, 1998), some of which 'registered nurses' (Pratt, 1999). What is also known is the heavy criticism this program has received, for there have been widespread reports of

migrants experiencing exploitation and at times physical, mental and emotional abuse at the hands of their private employers (Grandea & Kerr, 1998).

Just as sending countries' institutions are thought to lose from brain drain, receiving countries' institutions are thought to gain. Not only can they fill their nursing deficit with labor they did not have to invest in (Van Eyck, 2004), the above noted low wages given to some migrant nurses may further act as a 'gain'. However, while the receiving institutions may benefit from this situation, migrant labor does not always come free of cost. For instance, Bach notes that recruitment fees are often paid for by the employer and that each successful recruit to a US health care institution can cost anywhere between $5,000 to $10,000 US dollars (2006: 14). This is a big bill considering retention of these nurses is not guaranteed. Furthermore, the in-taking systems may be subject to the 'intangible' costs of staff that does not work well together (Xu & Zhang, 2005). In fact, it is argued by Buchan et al. that improving internal strategies to deal with the nursing shortage may in the long run be more 'cost effective' than relying on international recruits (2003).

5.3 National Level

When it comes to healthcare, as already alluded to, in some ways it is arbitrary to separate the institutional from the national level, as compromised healthcare institutions will certainly affect the nation in less than palatable manners. However, inferring that that which harms the institutional level will equally harm the national level may be too simplistic.

For a clearer picture of how the migration of healthcare professionals can devastate at the institutional level, yet have ambiguous results at the national level, it is enlightening to look, once again, at the Philippines. The Philippines is well-known for exporting skilled nurses, however, within their own healthcare system they have an estimated 30,000 vacant nursing positions as well as high levels of under and unemployment (Bach, 2006: 5). In fact, according to Public Services Independent Confederation (PSLINK), the migration of nurses has led some Filipino hospitals to close due to lack of appropriate staff (2007). Despite this, the national government continues to encourage the international migration of its nurses, mainly in the hope that they will submit remittances from abroad, but also as a way to export unemployment. While remittances provide some economic compensation for the nation losing its healthcare professionals, and benefit those whom receive them, they are not reinvested directly in the healthcare sector. Thus, it would appear that the Philippines is 'producing' and 'exporting' nurses in hopes of 'developmental' remittances,

while simultaneously decreasing its national health budget. In other words, the Philippines standing is 'benefiting' from the degradation of its own health system. As emotively explained by PSLINK:

> [b]y this stance, the Philippine government acts like a salesman peddling its wares, which happen to be its skilled health workers, at the peril of the Filipino citizens' right to have a quality and adequately funded health workforce (2007: 3).

As this example illuminates, the institutional level and the national level may experience nurse migration differently; on the one hand, we find eroding healthcare institutions and 'brain drain', on the other hand, remittances, which are hailed as providing fuel for development (for example see: Acosta et al., 2007; Adams & Page, 2005; López Córdova, 2005). The lure of remittances is not to be underestimated as Jolly & Reeves state: "[r]emittances from overseas workers add up to more than US$100 billion a year. About US$60 billion goes to developing countries, exceeding funds from all overseas development assistance" (2005: 26). Foreign direct investment remains the only source of external funding larger (Stilwel et al., 2003). In conjunction with remittances, various scholars have pointed to the fact that when migrants return home or have financial success abroad, their improved investment capability will benefit their home country (Bach, 2006; Buchan et al., 2006; Jolly & Reeves, 2005; Xu & Zhang, 2005). By way of example, as argued by Jolly & Reeves, "70 per cent of the foreign investment which fuelled China's economic growth comes from the Chinese diaspora" (2005: 26). Given the potential national benefits of emigration, many countries are now actively supporting the migration of their healthcare professionals as part of national development schemes, as exemplified by India, Cuba and, more recently, China (Bourassa Forcier et al., 2004; Xu & Zhang, 2005). Thus, it would seem that some countries have decided that the potential benefits of emigration exceed the potential detriments.

In contrast to the optimistic accounts of remittances, the Council of Global Unions states:

> Much of the policy debate on migration and development focuses on the positive contributions of migrants to development through remittance transfers and reinvestment of human and financial capital back into the country of origin. While these processes are valuable and in need of sustained policy support, the evidence suggests that the real intent of proponents of this approach is to promote narrowly oriented, temporary labour migration schemes geared to filling labour market shortages in receiving developed countries. Such narrowly conceived approaches avoid issues of permanent settlement of migrants, family unity, the protection of migrants' rights, and their entitlement to decent jobs and

> quality of life. In short, they fail to incorporate a social dimension in migration policies (2007: 2).

This quote provides an instructive and valuable contribution to the topic, as it would appear that a focus on remittances can detract from the harmful, non-quantifiable effects that migration can have on the individuals involved and the societies in which they are embedded/ disembedded. Yet, despite other less optimistic studies on the impact of remittances on development (for example see: Amuedo-Dorantes & Pozo, 2004; de Haas, 2005; Orozco, 2006), comments such as: "[…] remittances have major financial muscle now […] the next half of the century can be our chance to conquer world poverty if migration is open and managed adequately" (Senior Policy Advisor Nigel Hans as quoted in Van Eyck, 2005: 85), proclaimed during a European Policy Centre discussion, are indicative of a remittance zeal, in which they are being hailed as the next big development 'tool'. Such a discourse, it could be postulated, may be indicative of a privatization/individualization of development aid, a process that might further silence migrating persons' experiences and struggles. Hence, the preoccupation with remittances and their supposed developmental capabilities might result in global structural inequalities – which have historically developed through exploitative practices – being framed as problems to be solved by migrants from the global South. Such a discourse would thereby effectively place development responsibility on migrating persons whom come from disadvantaged countries and alleviate the North from its 'helping' obligations. In short, the social dimensions of migration appear to be destined to remain subordinate to the economic; the personal experiences and struggles silenced under the remittance clamor.

5.4 International Level

At the international level, many civil society groups as well as international and professional organizations concur that the migration of healthcare professionals from developing to developed countries is a detrimental process that must be addressed. They include: the World Health Organization (WHO), the International Labour Organization (ILO), the International Organization for Migration (IOM), Public Services International (PSI), the Commonwealth, and the International Council of Nurses (ICN). Recently, the WHO, in collaboration with the IOM and ILO, as well as professional groups, specialists, scholars and leading national persons launched 'The Health Worker Migration Policy Initiative' (WHO, 2007). The initiative's primary goal is to find "[…] a practical solution to the worsening problem of health worker migration from developing to developed countries"

(Ibid.). The proposed prescription and aimed outcome of the initiative is to devise an outline for a 'global code of practice' (Ibid.). Mary Robinson, the past President of Ireland (1990-1997), former United Nations High Commissioner for Human Rights (1997-2002) and current president of Realizing Rights, an organization dedicated to promoting human rights in global governance and policy-making, is the initiative's head. She states:

> We cannot stand alone as individual countries continue to address their own increased needs for health workers without looking beyond their shores to the situation these migrating workers have left behind in their homelands. We cannot continue to shake our heads and bemoan the devastating brain drain from some of the neediest countries on the planet without forcing ourselves to search for – and actively promote – practical solutions that protect both the right of individuals to seek employment through migration and the right to health for all people (WHO, 2007).

Occurring simultaneously, however, to this drive for more controls on the movement of healthcare workers, is the push to liberalize services from the World Trade Organization (WTO). The WTO's General Agreement on Trade in Services (GATS), includes the "[p]resence of natural persons" (WTO, 2006), which means that "[…] country A may employ nationals from country B (mode 4) to export services cross-border into countries B,C etc." (WTO, 2006: 3). An example of mode 4 given by the WTO is as follows:

> A foreign national provides a service within A as an independent supplier (e.g., consultant, health worker) or employee of a service supplier (e.g. consultancy firm, hospital, construction company) (2006: 4).

Given this, it would appear that while some international bodies are trying to stem the recruitment of healthcare professionals, the WTO is seeking to construct an international labour market, which includes health professionals that are easily transportable. The incongruence between the WTO's agenda and the agenda of those involved in trying to formulate an ethical regulatory framework for the movement of health professionals is well exemplified in PSI's statement regarding GATS Mode 4. They argue that:

> Under the GATS Mode 4, which is the "temporary movement across borders of natural persons as service providers", countries could engage in trade deals that will move cheap and exploitable migrant contract labour to provide services, such as healthcare, education, construction, domestic services and information technology, on a highly temporary basis without guarantee of protection of their basic human and labour rights (PSI, undated).

While this statement is justified in its concerns regarding the conceivable negative effects of a fully implemented Mode 4, negotiations regarding the Mode have been in existence

since the 1986 Uruguay Round, but have not yet produced a substantial impact. To quote the faith-based social justice organization American Friends Service Committee (AFSC):

> The number of workers, occupations and sectors committed under Mode 4 is up to the individual countries. Developing country governments complain that current commitments are limited to highly skilled occupations such as doctors, lawyers, and company executives. Mode 4 currently offers little more than existing wealthy country visas, since these sectors are already favored by these systems (2005:1).

Therefore, as of now mode 4 appears to remain largely another tool to move already 'moveable' professionals; PSI's concerns regarding the movement of labor as cheap production inputs seems to have, as of yet, not materialized. Likewise, the number of healthcare workers that have moved under mode 4 as compared to more conventional means, remains unclear, as well as whether nurses will be, or even are, included under current commitments. More research appears necessary to draw any substantive conclusions in this area. Research on the mode's differential gender assumptions and impacts has also only just begun (for example: Çağlar & Schwenken, 2007).

In recap, at the individual, institutional, and national levels varying opinions exist regarding the positive and/or negative outcomes of international nurse migration. On the one hand, individuals, institutions and nations can be seen to benefit from the migration process, as nurses improve their economic situations, health sectors engage in mutual 'brain gain', and nations receive development dollars via remittances. On the other hand, not all nurses can migrate or wish to, while those that do sometimes experience discrimination and disappointment; health sectors may become unworkable due to lack of staff; and a focus on remittances may work to alleviate developed countries of some of their historically constituted responsibilities to aid developing countries. A gendered perspective further highlights that nurse migration might be fuelled not only by individual rational choice, but rather females may be pushed through family decisions into obtaining a nursing degree and to emigrate. In the migration process they may face increased threats, such as HIV/AIDS infection, high pressures to remit even while receiving dismal pay, and in some cases they may migrate under immigration programs that do not utilize their professional skills.

By bringing all these points together one has to question whether the conceptual separation of stakeholders often taken in studies about nurse migration, is an appropriate approach. Larger structures such as patriarchy and institutionalized gender bias appear to play a considerable role in nurses' migration experiences and decisions; health sector institutions

are integral parts of states as states are of health sectors, both of which are embedded in global governance processes characterized by different actors vying for divergent objectives. Therefore, while this paper followed the compartmentalized stakeholder format, in hindsight this approach appears rather simplistic; a more dynamic integrated approach to studying nurse migration from developed to developing countries should be encouraged.

6. Policy Responses: Ethical Recruitment

Despite debate regarding the positive/negative effects of healthcare professional migration from developing to developed countries, the act of the resource-rich *actively* luring essential staff from the resource-poor is being disclaimed as unjust from an increasing range of actors. Ethical recruitment codes have been constructed in response. The following section seeks to highlight a collection of these codes at both the international and national level.[5]

6.1 National Codes

The pioneering United Kingdom ethical recruitment code was established in 1999. The Department of Health's (DoH) code's proclaimed aim is to stem recruitment actions that may endanger the health systems of developing countries. The guiding principles of the code are:

- International recruitment is a sound and legitimate contribution to the development of the healthcare workforce.
- Extensive opportunities exist for individuals in terms of training and education and the enhancement of clinical practices.
- Developing countries will not be targeted for recruitment, unless there is an explicit government-to-government agreement with the UK to support recruitment activities.
- International healthcare professionals will have a level of knowledge and proficiency comparable to that expected of an individual trained in the UK.
- International healthcare professionals will demonstrate a level of English language proficiency consistent with safe and skilled communication with patients, clients, carers and colleagues.
- International healthcare professionals legally recruited from overseas to work in the UK are protected by relevant UK employment law in the same way as all other employees.
- International healthcare professionals will have equitable support and access to further education and training and continuing professional development as all other employees (DoH, 2004: 7-9).

An important point to note is that while the UK code seeks to limit the active recruitment of health professionals from certain locales, it does not seek to abolish the practice of looking overseas for human resources for healthcare. In sharp contrast, the code explicitly states that recruitment is a "sound policy" which should be upheld. Rather, the goal is to delineate

[5] For a list of codes reviewed see Appendix 1.

where this active recruitment can take place; as suggested, only where there are government-to-government agreements. In Buchan et al.'s 2006 article, they note such government-to-government agreements between the UK and Spain and the UK and the Philippines, as well as a protocol with China, a "memorandum" with Indonesia which was never implemented, and a "memorandum of understanding" with South Africa (34). Despite the aim to limit recruitment from certain locales, the code does not seek to deny health professionals from countries deemed inappropriate for active recruitment who apply independently from obtaining positions (DoH, 2004). The adjacent Scottish (2006) and Irish codes (2001) are almost identical to the UK code. The prime notable difference between the Scottish and the UK code is that the Scottish guide includes a provision for monitoring observance of the code (National Health System of Scotland, 2006).

Recently publicly chastised for its recruitment of healthcare professionals from South Africa, Canada has also drafted a provisional code (McIntosh et al., 2007). It recognizes the ethical implications involved in the international recruitment of healthcare professionals and acknowledges that currently the largest external sources of general practitioners in Canada are coming from Asia and Africa. The proposed framework for ethical recruitment includes the following principles: global justice, personal autonomy, transparency and accountability, fairness, mutuality of benefits, provider competency, equitable workplace practices, and workplace cultural integration. While national self-sufficiency is highlighted as the number one target, the proposal asserts that when recruitment takes place it must be done 'in an ethical manner', which follows the previous principles (Ibid.: 7).

6.2 Codes from Organizations and Associations

The Commonwealth Secretariat, the global union Public Services International (PSI) and the International Council of Nurses (ICN) have all released their own guides to the ethical recruitment of health professionals. The 2003 Commonwealth code[6] largely mirrors those principles outlined in the UK code, however, it further suggests that there should be "mutuality of benefits" in the migration process and that compensation of varying types should be considered when recruiting professionals from developing nations. It is this provision, which Bach suggests, has 'alienated' Australia, Canada and the UK from the Commonwealth code and kept them from endorsing it (2006).

---

[6] See Appendix 2 for the Commonwealth Code.

The guides put forth by the ICN (2002) and PSI (2006) are similar in wording and are both notably more extensive than the national codes reviewed. In addition to the concern of developing countries' health systems, they also give considerable attention to the plight of the individual migrants and their rights in the migration process. The 13 principles adopted by the ICN, which are designed to protect nurses from abuse and exploitation, are:

- effective human resources planning and development
- credible nursing regulation
- access to full employment
- freedom of movement
- freedom from discrimination
- good faith contracting
- equal pay for work of equal value
- access to grievance procedures
- safe work environment
- effective orientation/mentoring/supervision
- employment trial periods
- freedom of association
- regulation of recruitment (ICN, 2002: 69).

PSI recommends similar standards, arguing that developing countries or countries experiencing shortages should not be targeted unless a government-to-government agreement is in place; that compensation to those countries which lose their human resources must be considered; that migrants should be fully informed of the migration process; and that registration and qualification of skills should be standardized (PSI, 2006).

While the Australian government has shunned the Commonwealth Code of Practice for the recruitment of healthcare professionals, the Australian Nursing and Midwifery Council (ANMC) has released a statement in 2006 which calls on their members to respect the ICN and the Commonwealth Code (ANMC, 2006). While no record could be found of a national ethical recruitment code in the United States, the American Nurses Association (ANA) has also released a position statement on ethical international recruitment, which argues that nurses should not be recruited from areas experiencing their own shortage and that overseas recruitment is not the answer to the nursing shortage in the United States (as found in Buchan et al., 2003: 29).

7. Room for Improvement: Room for Gender?

The codes for ethical recruitment have been met with criticism from a variety of sources (Bourassa Forcier, 2004; Goodman, 2005; Martineau & Willetts, 2005; Stilwel et al., 2003). As the 1999 UK code was the pioneering national code, much of the literature has focused on whether it has been successful or not, and why. The original 1999 code did not cover the private sector nor temporary staff, a point which has been criticized and pointed to as a reason why it seems to have had limited success (Buchan et al., 2003; Stilwel et al, 2003). In "Developing evidence based ethical policies on the migration of health workers: conceptual and practical challenges", Stilwel et al. suggest that the code might have initially worked to deter the recruitment of health workers from South Africa and the West Indies (2003). However, this 'success' may have resulted due to the displacement of recruitment to other countries, as they note increases in recruits from Ghana, India, Nigeria, and Zimbabwe since the code's implementation (Ibid.). Goodman concurs, claiming that:

> […] despite the code of practice stating that 'the UK is concerned with protecting the healthcare systems of developing countries', one in three work permits issued to nurses in 2003 went to applicants from proscribed developing countries, mainly in sub-Saharan Africa (2005: 36).

Furthermore, Martineau & Willetts state:

> […] since the introduction of the first ethical guidelines by the DoH (England) in 1999 the outflow from sub-Saharan Africa to the UK has increased significantly and in the case of South Africa this figure has more than quadrupled (2005: 365).

In light of such little success, the DoH's 2004 revision of the code has extended its coverage to include temporary and locum staff as well as the private recruitment sector by constructing a list of recruitment agencies adhering to the code; now all recruitment for the UK's DoH must be done through those agencies on the 'safe' list (DoH, 2004). However, it remains to be seen whether the improved code will be effective. For instance, Buchan states in reference to nurses that "[i]n the early 1990s, about one in 10 "new" entrants were from international sources. In recent years, this has risen to 40-50 percent of new entrants per annum" (2007: 1327). However, these numbers can not be taken at face-value as a sign that the code is not working, as the data does not differentiate who is moving on their own and who comes via recruitment. This makes it difficult, as Buchan asserts, to evaluate the code's impact (Ibid.).

Therefore, there appears to be a huge problem approximating the effectiveness of the code. The lack of appropriate data makes it hard to distinguish whether the increase in nurse migrants is due to sustained active recruitment in forbidden countries or, rather, the use of migrant networks. Thus, active recruitment is not always necessary, as friends and past co-workers, who have previously migrated, operate as informal networks, assisting others in the migration process and keeping them informed about upcoming opportunities (Bach, 2006; Likupe et al., 2005). Likewise, the spread and use of the internet and emails helps fuel self-initiated migration (Clark et al., 2006). Some scholars have further argued that migrants may enter a receiving country via recruitment to private health centers, perhaps switching later into the public health care system, thereby bypassing the code's stipulations and making it ineffective (Bach 2006; Likupe et al., 2005). This scenario suggests that an increase in the privatization of healthcare in receiving counties, could, so long as the codes are only applicable to the public health system, also be associated with an increase in unscrupulous recruitment. Thus, Xu & Zhang suggest that since all the codes implemented so far do not affect the private health sector, the latter's expansion may lead to an increase in recruitment (2006).

Further criticisms of the UK code come from the lack of clarity in what constitutes active recruitment (Stilwel et al., 2003). As the code states: "It is not possible to give a definition of 'active recruitment' that addresses all eventualities" (DoH, 2004: 15). Despite this limitation, the UK code suggests that active recruitment is direct advertisement, but where the line is drawn between active and passive remains obscure. The Canadian draft code suggests that the UK distinction of active and passive recruitment 'involves a value judgment'. McIntosh et al. state:

> In the end, attempting to clearly distinguish between active and passive recruitment and to pinpoint the moment where passive recruitment policies cross the line to become unethical recruitment may be unhelpful when drawing boundaries between when recruitment of IEHPs [internationally educated health professionals] is acceptable or unacceptable (2007: 13).

Therefore, they advocate for a clearer definition of what is ethical and unethical in all types of recruitment. Furthermore, they are critical of the UK list of developing countries, which takes its cue from standard gross domestic product (GDP) indicators. Due to this, McIntosh et al. argue that the code comes to overlook countries like Cuba, which have enough healthcare professionals. Any list of off-limit countries, they argue, should be a 'living-list' with clear criteria for belonging to the list and constant updates of the countries' status (Ibid.).

The vast array of criticism towards the UK code suggests that there is room for improvement and that other attempts to implement similar codes should take a close look at the UK experience. However, in Martineau & Willetts article, "The health workforce: managing the crisis ethical international recruitment of health professionals: will codes of practice protect developing country health systems?", they question the appropriateness of like codes in general (2005). The so far adopted codes, they assert, do not vary significantly, and they all have weak sanctions and monitoring. Thus neither the national nor the international codes are legally binding; while they represent standards, without strong repercussions for transgression, they are not likely to be fully effective. Furthermore, Martineau & Willetts claim that voluntary codes in environmental and labor laws have been unsuccessful, which is why they expect no better results from voluntary codes in the field of health. They state that:

> What needs to be appreciated are the powerful interests at stake: the employers desperate to relieve their staffing shortages; the recruitment agencies with strong business incentives; and the health professional with the opportunity of increasing their earnings substantially […] (2005: 365).

Their conclusion concurs with that of Xu & Zhang, who suggest that not enough attention has been given to the complexity and diversity of the stakeholders involved in the process, and the benefits they may obtain from the status quo (2006). Therefore, while Troy et al. argue for a solution that must involve all relevant stakeholders (2007), Xu & Zhang argue that *no* code will address *all* stakeholders equally, asserting that the notion of one code which can be used universally is problematic as it oversimplifies the situation (2006). In sum, not only is there disagreement about the costs and benefits incurred at the relevant stakeholder levels, there is, likewise, a difference of opinion on how to proceed. On the one side, the codes appear to be milestones in ethical forms of international governance, on the other side, critical analysis suggests we should be skeptical of their effectiveness, construction, feasibility and even their desirability. Despite this, the likelihood that the codes will be dissolved is slim; the more probable future projection, as seen in the draft code in Canada and the WHO initiative, is a refinement of those already in place and an international protocol. Due to this, it would appear that the best line of intervention, as Troy et al. (2007) contend, is to look closely at the stakeholders and try to make the codes as effective and inclusive as possible. In this case, further research regarding the migration of nurses from developing to developed countries becomes crucial.

This includes further research on the gendered dimensions of the recruitment of nurses. By including a gender perspective at the root causes of the migration of nurses, as well as the gendered implications of remittances, 'brain drain' and HIV/AIDS, the first part of this paper already indicated that ethical recruitment codes pertaining to the movement of healthcare professionals must also take into account divergent gendered experiences if they want to reach the goal of providing a framework that is both ethical and effective. However, while a thorough reading of the above mentioned codes shows that *some* do make explicit reference to gender, specifically the PSI code, the national codes and the Commonwealth code, appear to frame their policy in gender neutral terms. By ignoring gender differences in the migration process, it is likely that these codes come to silence divergent gendered realities and how they affect the migrant. Furthermore, it is possible that these codes will essentially support the status quo of nursing as a female dominated, low status profession. For example, the codes, which institutionalize the 'ethical trade' of nurses between *willing* countries, create a situation that allows receiving countries to obtain foreign, sometimes cheaper, female labor to fill their nursing needs, thereby allowing developed countries to refrain from adequately challenging the nurse deficit by raising the profession's status, its remuneration and working to encourage males to join the ranks.

While it is possible that the lure of working in the more lucrative North could entice more men in source countries to choose nursing as a profession, the strong association of nursing with females may in fact prove to be a formidable roadblock. The difficulty of becoming and staying a nurse for men in certain social contexts, for example, is well exemplified in Yang et al's study of the few male nurses registered in Taiwan (2004). At the same time, the lure of a job in the more lucrative North, as solidified by the agreements, may encourage even more females from source countries to get an education in nursing, as individuals and families look for ways to ensure familial survival. Thus, whether the codes help to challenge or fortify the equation 'nurse equals female' in source countries remains to be seen.

In addition, government-to-government arrangements may also deter increased healthcare spending in source countries. For instance, governments may postulate that encouraging the migration of nurses overseas will net greater benefits than promoting their retention, as they will likely remit large sums of dollars. In the absence of an effective healthcare system, the care of the ill will subsequently be done free of charge by women within the home. Such a scenario could also contribute to a situation amenable to the privatization of healthcare, as

families receiving remittances come to be seen as capable of obtaining healthcare through private means. Privatized healthcare may make it more difficult for the poor (those not receiving remittances) to obtain adequate health services (Grown, 2006). Thus, while guess work as of now, it is probable that such 'ethical' codes could have unintended and sinister impacts.

In finale, as has been shown, many of the current codes do not challenge, or even address, gender stereotypes or gender inequalities. Instead of helping to change the undervaluation of the nursing profession and its persistent association with females, the current codes allow governments in both sending and receiving countries to continue to capitalize on women's undervalued labor through recruitment practices deemed 'ethical'. However, this kind of ethical recruitment will not protect women. For instance, Van Eyck argues that the notion of the 'infinite elasticity' of female labor not only applies to the tacit assumptions behind government policies to cut public spending, it is furthermore "[…] found in policies advocating labour migration as development strategies" (2005: 83). This is well exemplified in the case of the Philippines' endorsement of government-to-government agreements on the emigration of its nurses, thereby encouraging them to go overseas to become remitters while simultaneously making cuts to health spending. In light of this, one must question the current notion of what constitutes ethical recruitment as embodied within many of the current codes, for it appears they do not address, and even may encourage, unscrupulous gendered practices. How the codes could be modified to incorporate this oversight is a challenge that must be undertaken.

8. Conclusion

This paper's attempt has been threefold: to provide an overview of the literature and debates dedicated to the impetuses behind the migration of nurses from developing to developed countries and highlight the possible positive and negative effects felt at varying stakeholder levels; to delineate the current policy steps, and their critiques, being taken to ameliorate the conceived ill outcomes of active recruitment; and, lastly, to illuminate, through a gender perspective, some important and instructive insights missed by more conventional accounts. In doing so it has been shown that the literature is conflicted, that the codes are controversial, and that gender is an important factor when discussing the migration of healthcare professionals.

In following this line of inquiry, this paper has evolved from a literature review aimed at providing a concise overview of the current state of nurse migration and the corresponding ethical recruitment codes, into a paper calling for greater research into how these codes ignore, contribute to, or even embody, gendered rationales. As it has been argued, the codes, which seem to draw primarily on conventional accounts of health worker migration, could bear unintended consequences that are far from gender neutral. While in general such codes should be commended for their efforts to address global power relations and their detrimental effects on developing countries' health systems, their blindness to gender power relations is problematic; thus one must question whether, in their current form, these codes can be considered 'truly' ethical.

Bibliography

Ackermann, L. & de Klerk, Gerhardt W. (2002). "Social Factors that make South African Women Vulnerable to HIV Infection". Health Care for Women International, 23: 163-172.

Acosta, P. et al. (2007). "What is the impact of international remittances on poverty and inequality in Latin America?". World Development, 36(1): 89-114.

Adams, R.H. & Page, J. (2005). "Do international migration and remittances reduce poverty in developing countries?". World Development, 33(10): 1646-1669.

American Friends Service Committee (AFSC). (2005). "GATS Mode 4 and the Implications of Expansion". AFSC: Philadelphia. Accessed January 4, 2008. www.afsc.org/trade-matters

Amuedo-Dorantes, C. & Pozo, S. (2004). "Workers' Remittances and the Real Exchange Rate: A paradox of gifts". World Development, 32(8): 1407-1417.

Australian Nursing and Midwifery Council (ANMC). (2006). "Ethical recruitment of overseas nurses". ANMC: Dickson. Accessed October 10, 2007. www.anmc.org.au/docs/Ethical_Recruitment_of_Overseas_Nurses_or_Midwives.pdf

Bach, S. (2006). International Mobility of Health Professionals: brain drain or brain exchange?. World Institute for Development Economics Research: Helsinki.

Bourassa Forcier, M., Simoens, S. & Giuffrida, A. (2004). "Impact, regulation and health policy implications of physician migration in OECD countries". Human Resources for Health, 2(12): 1-11.

Buchan, J., Parkin, T. & Sochalski, J. (2003). International nurse mobility: trends and policy implications. World Health Organization: Geneva.

Buchan, J., Seccombe, I. & Hutt, R. (2006). "Internationally recruited nurses in London: a survey of career paths and plans". Human Resources for Health, 4: 14-24.

Buchan, J. (2007). "International recruitment of nurses: policy and practice in the United Kingdom". Health Research and Educational Trust, 42(3): 1322-1335.

Çağlar, G. & Schwenken, H. (2007). "Knowledge as an Analytical Category. Explaining the Contestation about the Commodification of Labour within WTO". Paper presented at the 48th Annual Convention of the International Studies Association 2007, March 1, 2007: Chicago.

Clark, P.F., Stewart, J.B. & Clark, D.A. (2006). "The globalization of the labour market for health-care professionals". International Labour Review, 45(1-2): 37-64.

Commonwealth (2003). Commonwealth code of practice for the international recruitment of health workers. Accessed May 21, 2008. www.thecommonwealth.org

Council of Global Unions. (2007). "Social Dialogue and a rights-based framework – at the heart of migration policy". Statement to the Global Forum on Migration and Development and the Civil Society Day of the Forum: Brussels. Accessed October 10, 2007. www.bwint.org/pdfs/GUsmigrationstatement.pdf

Dixon, S., McDonald, S. & Roberts, J. (2002). "The impact of HIV and AIDS on Africa's economic development". British Medical Journal (BMJ), 324(7331): 232-234.

de Haas, H. (2005). “International Migration, Remittances and Development: myths and facts”. Third World Quarterly, 26(8): 1269-1284.

Department of Health (United Kingdom). (2004). Code of practice for the international recruitment of healthcare professionals. London: Crown Copyright.

Department of Health and Children (Ireland). (2001). “Guidance for Best Practice on the Recruitment of Overseas Nurses and Midwives”. Accessed October 28, 2007. www.dohc.ie/publications/recruitment_of_overseas_nurses_and_midwives.html

Denis, A. (2003). “Women and Globalization in the Economic North and South” in Y. Atasoy & C. Carrol (Eds.), Global Shaping and its Alternative (pp.139-160). Aurora, Ontario: Garamond Press.

Diallo, K. (2004). Data on the migration of health-care workers: sources, uses, and challenges. World Health Organization: Geneva.

Elson, D. (1995). “Male Bias in Macro-Economics” in Male Bias in the Development Process (pp. 165-190). Manchester: Manchester University Press.

Fernandez, M.R. (1997). “Commodified Women”. Peace Review, 9(3): 411-417.

Goodman, B. (2005). “Overseas recruitment and migration”. Nursing Management, 12(8): 32-37.

Grandea, N. & Kerr, J. (1998). “Frustrated and displaced’: Filipina domestic workers in Canada”. Gender and Development, 6(1): 7-14.

Grown, C. (2006). “Trade Liberalization and Reproductive Health: A Framework for Understanding the Linkages” in C. Crown, E. Braunstein & A. Malhotta (Eds.), Trading Women’s Health and Rights: Trade Liberalization and Reproductive Health in Developing Economies (pp.15-46). London: Zed Books.

Hochschild, A.R. (2000). “Global Care Chains and Emotional Surplus Value” in W. Hutton & A. Giddens (Eds.), Global Capitalism (pp.130-146). New York: New York Press.

International Council of Nurses (ICN). (2002). “International Perspectives”. International Nursing Review, 49: 69-74.

Immigration Canada (2007). Official website concerning the ‘Live-in-Caregiver Program’. Accessed October 20, 2007. www.cic.gc.ca/english/work/caregiver/index.asp

Jolly, S. & Reeves, H. (2005). “Gender and migration: Overview report”. Institute of Development Studies-BRIDGE, University of Sussex. Brighton: UK.

López Córdova, E. (2005). “Globalization, Migration, and Development: the role of Mexican Migrant Remittances”. Economia (Fall): 217-256.

Likupe, G., Kelly, L.L. & Laboso-Abonyo, J. (2005). From policy to practice: recruitment of African nurses in the UK. Conference ‘Probing the Boundaries: Making Sense of Health, Illness and Disease’: Oxford.

Martineau, T. & Willetts, A. (2005). “The health workforce: managing the crisis ethical international recruitment of health professionals: will codes of practice protect developing country health systems?”. Health Policy, 75: 358-367.

McIntosh, T., Torgerson, R. & Klassen N. (2007). The ethical recruitment of internationally educated health professionals: lessons from abroad and options for Canada. Canadian Policy Research Networks Inc: Ottawa.

National Health Service (Scotland). (2006). Code of practice for the international recruitment of healthcare professionals in Scotland. Edinburgh: Crown Copyright.

Orozco, M. (2006). "Gender remittances: preliminary notes about senders and recipients in Latin America and the Caribbean". Paper presented at the United Nations high-level panel on The Gender Dimensions of International Migration as part of the Commission on the Status of Women, 27th February to the 10th of March 2006: New York.

Public Services Independent Confederation (PSLINK). (2007). "Our Health Care Workers are Not for Sale". Accessed October 10, 2007. www.bilaterals.org

Public Services International (PSI). (2006). "Policy Statement on International Migration with Particular Reference to Health Services". Public Services International: Geneva. Accessed October 20, 2007. www.world-psi.org

Pratt, G. (1999). "From Registered Nurse to Registered Nanny: Discursive Geographies of Filipina Domestic Workers in Vancouver, B.C.". Economic Geography, 75(3): 215-236.

Stasiulis, D.K. & Bakan, A.B. (2003). Negotiating Citizenship: migrant women in Canada and the global system. New York: Palgrave Macmillan.

Stilwel, B. et al. (2003). "Developing evidence based ethical policies on the migration of health workers: conceptual and practical challenges". Human Resources for Health, 1(8): 1-13.

Troy, P.H.,Wyness, L .A. & McAuliffe, E. (2007). "Nurses' experiences of recruitment and migration from developing countries: a phenomenological approach". Human Resources for Health, 5(15): 1-7.

Urdang, S. (2006). "The Care Economy: Gender and the Silent AIDS Crisis in Southern Africa". Journal of Southern African Studies, 32(1): 165-177.

Van Eyck, K. (2004). "Women and International Migration in the Health Sector: Final report of Public Services International's Participatory Action Research 2003". Public Services International: Geneva. Accessed October 20, 2007.www.world-psi.org

Van Eyck, K. (Ed.) (2005)."Who Cares? Women Health Workers in the Global Labour Market". Public Services International: Geneva. Accessed October 20, 2007. www.world-psi.org

World Trade Organization (WTO). (2006). "The general agreement on trade in services: an introduction". World Trade Organization: Geneva. Accessed October 20, 2007. www.wto.org/english/docs_e/legal_e/26-gats_01_e.htm

World Health Organization (WHO). (2006). "The world health report 2006: working together for health". World Health Organization: Geneva.

World Health Organization (WHO). (2007). "New initiative seeks practical solutions to tackle health worker migration". World Health Organization: Geneva. Accessed October 20, 2007. www.who.int/mediacentre/news/notes/2007

Xhafa, Edlira. (2007): "Building National, Self-Sufficient Health Systems – Facing the Challenge of the Global Health Workers' Shortage." Accessed June 24, 2008. www.gurn.info/topic/health/governance_xhafa2007.pdf

Xu, Y. & Zhang, J. (2005). “One size doesn't fit all: ethics of international nurse recruitment from the conceptual framework of stakeholder interests”. Nurse Ethics, 12(6): 571-581.

Yang, C. et al. (2004). “Professional career development for male nurses”. Journal of Advanced Nursing, 48(6): 642-650.

Appendix 1: Codes Reviewed

National Codes	Title	Website
United Kingdom	Code of practice for the international recruitment of healthcare professionals (1999)	www.dh.gov.uk
Scotland	Code of practice for the international recruitment of healthcare professionals in Scotland (2006)	www.bda.org
Ireland	Guidance for best practice on the recruitment of overseas nurses and midwives (2001)	www.dohc.ie
Canada	The ethical recruitment of internationally educated health professionals: lessons from abroad and options for Canada (draft, 2007)	www.cprn.org

Codes by Organizations/ Associations	Title	Website
Commonwealth Secretariat	Commonwealth code of practice for the international recruitment of health workers	www.thecommonwealth.org
International Council of Nurses	Ethical nurse recruitment: position statement	www.icn.ch/psrecruit01.htm
Public Services International	Policy statement on international migration with particular reference to health services	www.world-psi.org
Australian Nursing and Midwifery Council	ethical recruitment of overseas nurses	www.anmc.org
American Nurses Association	US licensure requirements	www.nursingworld.org

Appendix 2: Reproduced Copy of the Commonwealth Code

COMMONWEALTH CODE OF PRACTICE FOR THE INTERNATIONAL RECRUITMENT OF HEALTH WORKERS[7]

INTRODUCTION

1. Many Commonwealth countries, both developed and developing, are experiencing shortages of skilled health workers. These shortages, which tend to be more severe in small island states, remote and rural areas, and some African countries, reduce countries' capacity to provide good quality health services to their populations.

2. Some countries are responding to the problem by systematically recruiting nurses, midwives, doctors, pharmacists, and other health care workers from other countries, in particular from developing countries. Whilst this is helping some recipient countries to overcome their staff and skills shortages, it deprives source countries of knowledge, skills, and expertise for which large amounts of resources have been expended. Although this type of international recruitment provides many health workers with opportunities to develop their careers, gain valuable experience, and improve living conditions for themselves and their families, it has also resulted in negative experiences for others.

3. Commonwealth Ministers of Health have agreed that, in keeping with Commonwealth values of cooperation, sharing and supporting each other, a consensus approach to dealing with the problem of international recruitment of health workers should be adopted.

4. This Code of Practice for the International Recruitment of Health Workers is intended to provide governments with a framework within which international recruitment should take place. The Code is sensitive to the needs of recipient countries and the migratory rights of individual health professionals. The Code does not propose that governments should limit or hinder the freedom of individuals to choose where they wish to live and work. Commonwealth governments may wish to supplement the Code with additional guidance particular to their own national needs and situations.

5. Commonwealth member states are encouraged to take into account existing arrangements, treaties between countries and within regions in the application of this Code, and any international guidelines relating to the movement of persons across borders.

6. The Commonwealth will seek to encourage the adoption of the Code by countries outside the Commonwealth. International organisations such as the International Labour Organisation (ILO), World Health Organisation (WHO), the International Council of Nurses (ICN), and the International Council of Midwives should be encouraged to promote the Code to their non-Commonwealth members.

PURPOSE

7. The Code provides guidelines for the international recruitment of health workers in a manner that takes into account the potential impact of such recruitment on services in the source country.

8. The Code is intended to discourage the targeted recruitment of health workers from countries which are themselves experiencing shortages.

[7] Accessed January 4, 2008 at: www.thecommonwealth.org/shared_asp_files/GFSR.asp?NodeID=35877

9. The Code seeks to safeguard the rights of recruits, and the conditions relating to their profession in the recruiting countries.

STATUS

10. The Code is not a legal document. Within the context of Commonwealth principles of co-operation and consensus, it is hoped that governments will subscribe to it.

GUIDING PRINCIPLES

11. This Code applies the principles of transparency, fairness and mutuality of benefits as these relate to relations among Commonwealth countries, and between recruits and recruiters.

Transparency

12. Transparency should characterise any activities to recruit health care workers from one country to another. This would normally involve an agreement between recruiting countries and the source countries.

13. The Code requires recruiters to be transparent about the type of skills, expertise, the number of recruits, and grades being sought.

Fairness

14. Recruiters should not seek to recruit health care workers who have an outstanding obligation to their own country, for example, contract of service agreed to as a condition of training. However, it is the responsibility of recruits to disclose such information, right from the outset of indicating their interest in working outside their country of origin.

15. Fairness requires that recruiters provide full and accurate information to potential recruits on:

- the nature and requirements of the job that recruits are expected to perform
- countries to which they are being recruited
- administrative and contractual requirements
- their rights

16. Fairness also requires that recruiters provide recruits with accurate information about selection procedures.

17. Recruiters should also ensure that, while working abroad, the recruits will be protected by the same employment regulations and have the same rights as equivalent grades of staff in the receiving country, for example rates of pay, professional development and continuing education, and, where possible, access to training.

18. The Code of Practice does not wish to undermine the right of health workers to migrate to countries that wish to admit and employ them. The Code seeks to encourage the establishment of a framework of responsibilities between governments – and the agencies accountable to them – and the recruits. This framework would balance the responsibilities of health workers to the countries in which they were trained – whether of a legal kind, such as fulfilling contractual obligations, or of a moral kind, such as providing service to the country which had provided their training opportunities – and the right of health professionals to seek employment in other countries.

Mutuality of benefits

19. The capacities of countries that need to recruit staff and those which lose their skilled personnel vary significantly. Recruiters may be in a position to consider ways in which they could provide assistance to source countries.

20. The expression of the principle of mutuality of benefits should/could take the form of technical assistance from recruiting countries to those from which countries are recruiting (‘*source*’ countries).

COMPENSATION / REPARATION / RESTITUTION

21. Governments recruiting from other Commonwealth countries should/[may wish to] consider how to reciprocate for the advantages gained by doing so. This could include:

- programmes to reciprocate for the recruitment of a country's health workers through the transfer of technology, skills and technical and financial assistance to the country concerned;
- training programmes to enable those who return to do so with enriched value
- arrangements to facilitate the return of recruitees (subject to application of the non-discrimination principle and to the rights of the workers concerned in accordance with immigration and other laws).

SELECTION PROCEDURES

22. The recruit, prior to signing a contract, should ensure he/she fully understands details therein and is prepared to commit him/herself to honour the contract.

REGISTRATION

23. Registration/licensure to practise is the responsibility of the relevant regulatory body in each country and the specific requirements should be made known to recruits. It is the responsibility of the recruit to understand and comply with the jurisdictional requirements around registration/licensing and education.

WORKFORCE PLANNING

24. In addition to managing migration, Commonwealth member countries should explore and pursue additional strategies for retaining trained personnel.

Adopted at the Pre-WHA Meeting of Commonwealth Health Ministers 2003, Geneva on Sunday 18 May 2003.