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NAFTA and the Mobility of Highly Skilled Workers: The Case of Canadian Nurses*

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This article examines the impact of trade treaties on health professionals' international mobility. It presents a case study of the impact of labour mobility clauses in trade agreements on the Canadian nursing labour market. It provides statistical evidence on the impact of NAFTA's Chapter 16 on the cross-border movement of Canadian nurses in the 1990s. We observed that an increasingly large number of Canadian nurses went to work in the United States using the NAFTA facilitation mechanism but that this growth could not be attributed to the trade agreement alone; domestic labour market conditions are key to understanding this cross-border movement. The article concludes that trade treaties and international migration of health personnel do not offer simple solutions to health personnel shortages, but can pose a danger to precarious health systems in developing countries.

Keywords: labour mobility, NAFTA, nurses

Introduction and Context

In recent years, trade agreements have increasingly expanded their scope to include the cross-border mobility of workers, including health professionals. Chapter 16 of the North American Free Trade Agreement (NAFTA) includes labour mobility provisions for more than sixty categories of professions, several of them health professions. The General Agreement on Trade in Services (GATS) of the World Trade Organization (WTO) facilitates the liberalisation of the temporary entry of foreign providers of services, including providers of health services. To better understand the potential impact of such trade treaties on health professionals, this article presents a case study of the impact of labour mobility clauses in trade agreements on the Canadian nursing labour market. After a brief discussion of the global context of nurses' international mobility and the barriers to cross-border mobility for Canadian nurses, we look at the various sources of statistical evidence on the mobility of Canadian registered nurses. The article concludes with a policy discussion of the potential of using trade agreements to deal with shortages of nurses and other health professions.

A case study of the cross-border labour mobility of Canadian nurses is best understood in the larger context of global nursing shortages and migrations. The World Health Organization identifies global shortages of nurses as a key concern, given their central role in all health systems. The problem touches both industrial and developing countries, although it "is particularly acute in developing countries, where unstable and dwindling funding of the health sector, low salaries and poor working conditions have conspired to promote emigration to countries offering better prospects" (WHO, 2001b). Cross-border migration is central to the issue of global shortages of nurses. Such migration can take a permanent or a temporary form, but the latter is the most relevant for international trade agreements. The debate on the impact on developing economies of the "brain drain", i.e., the migration of skilled workers such as health professionals, is not new. However, the direct negative impacts of such migration have to be assessed against other effects that can increase economic growth such as return migration, remittances and transfer of knowledge and technology (Lowell et al., 2001). The net effects of migration may vary from one country to another and from one sector to another.

In trade negotiations, especially in the negotiations on the General Agreement on Trade in Services (GATS), the temporary movement of workers has been an important issue for developing countries, as they see this mode of supply as an important mechanism by which they can export services abroad (Chaudhuri, Mattoo and Self,

2004). They are therefore seeking commitments from industrial countries to liberalise the temporary entry of service providers. Even in the health sector, some developing countries, for example, India, Cuba and the Philippines, perceive they have a surplus that can allow them to be exporters of health personnel (WHO, 2001a). Nevertheless, when it comes to the health sector, the cost of migration, even though it be temporary, may exceed the economic benefits of exporting health services. Policymakers are also recognizing the negative impact of active recruitment of nurses and physicians from developing countries and have adopted some measures. For instance, in 1999, the Department of Health of the United Kingdom adopted guidelines on international recruitment of nurses which state that "it is essential that all NHS employers ensure that they do not actively recruit from developing countries who are experiencing nursing shortages of their own" (United Kingdom Department of Health, 1999, 10). More recently, in 2003, the Commonwealth adopted a Code of Practice for the International Recruitment of Health Workers, which also aims to discourage the recruitment of health professionals from countries experiencing shortages.

Labour mobility provisions in trade agreements can facilitate temporary entry in various ways. For instance, temporary workers are usually allowed by immigration authorities to enter the domestic labour market in order to address a specific labour shortage. Trade agreements often aim at removing this first requirement and eliminating the labour market test required for the employment authorization for temporary foreign workers (Nielson and Cattaneo, 2003). The provisions of NAFTA facilitate the movement of nurses by removing the economic need test. Temporary work permits can be issued by immigration officials under the professional category of NAFTA without labour market assessments or economic need testing.[1] At the WTO, no member has made full commitments on the movement of professionals in the four subsectors relevant to health services (medical and dental services; services provided by midwives, nurses, physiotherapists and paramedical personnel; hospital services; other human health services such as ambulance services); Canada has made no commitments at all in these four areas. This pattern is similar to other service sectors; members made very limited mode 4 commitments and subjected them to very restrictive limitations such as economic need tests (Adlung and Carazaninga, 2001). (Mode 4 of the GATS refers to the movement from one member country to another of "natural persons" who then supply services.) Therefore, the GATS currently has little impact on nurses' mobility.

Cross-border Mobility of Canadian Nurses

There is no single source of information that provides reliable and complete data on how many Canadian nurses are working abroad or how many foreign nurses are practicing in Canada. However, there are a number of sources which, when examined together, provide indications of the key trends. These can help to verify whether the adoption of labour mobility clauses included in NAFTA that came into effect in 1994 and in the Canada–United States Free Trade Agreement (CUSFTA) of 1989 had an impact on nurses' mobility.

A first source is the statistics compiled by the Canadian Nurses Association (CNA) on the requests for verification of credentials made by Canadian nurses who are considering leaving the country for the United States. Table 1 shows a large increase in the number of requests in the 1990s, with peaks in 1992 and 1996 of more than 5,000 nurses seriously considering cross-border movement; not all these requests to the Canadian Nurses Association led to the migration of Canadian nurses, but there is clear indication of a growing trend.

Table 1 Canadian RNs Requesting Verification of Credentials and New RN Registrants from Foreign Countries, 1988–2000

Year	Request for verification for USA	Request for verification for other countries	Total Canadian RNs requesting verification	New foreign-educated RNs registered in Canada
1988	930	102	1,032	961
1989	1,218	137	1,355	1,303
1990	1,466	173	1,639	1,680
1991	1,788	143	1,931	2,289
1992	4,653	180	4,833	1,589
1993	2,005	119	2,124	1,205
1994	3,912	185	4,097	928
1995	3,922	338	4,260	875
1996	5,040	383	5,433	653
1997	4,336	458	4,794	654
1998	2,876	360	3,236	764
1999	3,231	372	3,603	653
2000	3,108	440	3,548	1,072

Source: Canadian Nurses Association, 2002

Another source of data regarding the movement of Canadian nurses toward the United States is the Immigration and Naturalization Service (INS) data on visas issued to Canadian nurses.[2] Table 2 shows that the INS issued 4,380 visas to Canadian nurses in 2001, with a peak in 1998 of over 9,000 visas issued to nurses from Canada. However, there are several problems with the collection of these data. One of the key problems is that these data are not based on a people count, but on a document count. Many documents can be issued to the same person in a given year, as he or she enters and leaves the United States. An engineer or a nurse can go from Canada to the United States for a three-month contract early in the year and go back later for a two-month contract. Moreover, for some years (i.e., 1996, 1997), useful information is not available about the professions of the temporary workers entering the United States, as the data collection was not done in a systematic and reliable manner.

Table 2 TN Visas Issued to Canadian Registered Nurses by the U.S. Immigration and Naturalization Service (1991–2001)

	1991	**1992**	**1993**	**1994**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Female	1,998	2,643	3,571	2,927	17	5	7,976	5,975	957	3,759
Male	197	303	396	366	2	4	1,157	834	193	621
TOTAL	2,195	2,946	3,967	3,293	19	9	9,133	6,809	1,150	4,380

Source: Data set provided to the author by the U.S. Immigration and Naturalization Service

A more reliable source of information on the movement of Canadian nurses to the United States is the survey on foreign nurses in the United States prepared by the Commission on Graduates of Foreign Nursing Schools (2002). This survey, conducted in 2000, asked questions on conditions of employment, visa status and country of origin. It was administered by phone to a sample of 789 foreign nurses. The population for the study was composed of 18,754 foreign-educated nurses who had taken the National Council Licensure Examination for Registered Nurses between 1997 and 1999.

Canada is the main country of origin of licensed foreign nurses in the United States, followed by the Philippines and India (see table 3). The vast majority of these Canadian nurses received a NAFTA visa to enter the United States. Indeed, 100 of the 110 Canadian respondents identified NAFTA as their method of entry. Unlike Canadian nurses, other foreign nurses often enter the United States under a permanent

or immigrant visa: 344 out of the sample of 789 had immigrant visas. Canadian participants in the survey most commonly resided in Texas, Florida, North Carolina and California. The large majority of foreign nursing graduates entering the United States are female: men represented just over 7 percent of the sample (compared to 5 percent of the total American nursing population).

Table 3 U.S. Survey of Graduates of Foreign Nursing Schools: Country of Origin of Respondents

	Canada	**Philippines**	**India**	**Nigeria**	**Russia/ Ukraine**	**Other countries**	**TOTAL**
Licensed foreign nurses	105	79	37	25	18	197	461
Unlicensed foreign nurses	5	133	49	26	10	105	328
TOTAL	110	212	86	51	28	302	**789**

Source: Commission on Graduates of Foreign Nursing Schools, 2002

What conclusions can be drawn from these three sources about the impact of trade agreements on the mobility of nurses? It is evident that there was a clear increase of Canadian registered nurses working in the United States during the 1990s and that the vast majority of them resorted to the facilitation mechanism created by NAFTA. But to what extent does the adoption of NAFTA explain this increase of nurses' continental mobility? We do not see a similar trend in the mobility of American and Mexican nurses. The provincial professional associations and colleges have not observed an increase in the number of nurses coming to Canada from the United States or Mexico since the entry into force of the NAFTA or CUSFTA.

A combination of the facilitation of movement created by the trade provision and domestic factors can better explain the increase of migration of Canadian nurses to the United States. The cuts in public health care budgets in the early 1990s led to the elimination of nursing positions in many Canadian provinces as well as to the conversion of many full-time positions into part-time or casual positions, and a large number of nurses either left the profession or the country (CNA, 2002, 10). Some evidence collected by nurses' associations confirms this scenario. In 2000–2001, the Registered Nurses Association of Ontario (RNAO) surveyed nurses registered with the College of Nurses of Ontario who were residing outside Canada. The objective of

the survey was to understand why nurses had left the province and what factors would make them consider coming back. Indeed, the funding cuts and lay-offs of the 1990s led to nurses' shortages in Ontario, as many left the profession or the province. The need to find nurses to face the current shortage motivated the RNAO to commission the study.

At the time of the survey there were 5,407 nurses still registered in Ontario but working outside the province. Contact information was available for 3,272 (RNAO, 2001). Of these, 80 percent resided in the United States, 4.9 percent in Hong Kong, 3.2 percent in Saudi Arabia and 3.1 percent in England. Within the United States, the majority of nurses in the sampling frame were concentrated in a few states: Texas (19 percent), Florida (16 percent), North Carolina (10 percent), and California (8 percent). The survey reached over 1,000 Ontario registered nurses working abroad. When asked why they left the province, almost 63 percent named downsizing or the lack of job opportunities as the main reasons, (based on open-ended questions, unprompted; see table 4). This was still true for nurses leaving as recently as January 2000. As one respondent commented, "There were no full-time positions available in Ontario. Only part-time or casual work. Hospitals and long-term care facilities all offered poor staffing, increased workload and nurse-patient ratios" (RNAO, 2001). The lack of employment opportunities was especially important for nurses who left Ontario in the 1990s, compared to the ones who left earlier. The majority of the respondents (52.2 percent) left Ontario in the late 1990s, coinciding with the lack of full-time employment opportunities in the province (see table 5). Domestic labour market conditions, combined with the facilitation mechanism created by NAFTA, are the key variables related to cross-border mobility of Canadian nurses.

Table 4 Nurses' Reasons for Leaving Ontario

Downsizing/lack of job opportunities	62.7%
Family/personal issues	28%
Pay and benefits	13.2%
Travel/weather	8.8%
Workload/work conditions	7.6%
Cost of living	3.8%
Work not valued by system	3%

Source: RNAO, 2001b

Table 5 Number of Ontario RNs by Date of Departure

	1956-1960	1961-1965	1966-1970	1971-1975	1976-1980	1981-1985	1986-1990	1991-1995	1996-2000	TOTAL
	2	5	9	13	44	24	78	315	535	1,025*
% of sample	0.2	0.5	0.9	1.3	4.3	2.3	7.6	30.6	52.2	100

* No date of departure was provided for 26 respondents.

Source: RNAO, 2001b

Conclusion: Cross-border Mobility and Shortages of Health Professionals

In the course of our case study on the mobility of Canadian nurses, we also conducted interviews with representatives from six nurses' organizations, as well as with representatives from five federal departments, during the fall of 2002. We also held a focus group discussion with 15 participants from academia, government and nurses' organizations. The interviewees agreed that the cuts to health care spending in Canada, which led to the lay-off of nurses in many provinces, are crucial to an understanding of the increase in the number of Canadian nurses who went to the United States. Nevertheless, trade agreements are perceived as an important element that can influence the migration of nurses. Recognizing the potential impact of international trade agreements and the mobility of health professionals on accessibility and quality of health services, the Canadian Nurses Association recommended that the government monitor these agreements and labour migration and immigration trends and assess their impact on domestic health and social policy (CNA, 2000). Nurses' representatives generally expressed the view that the impact of trade agreements on mobility of nurses was still limited at this time, but highlighted the potential consequences of current or future agreements.

Organizations representing Canadian nurses do not perceive temporary entry of nurses in the context of mobility clauses in trade agreements (or for that matter the permanent migration of health professionals) as a serious solution to the nurses' shortages. Resorting to foreign workers, whether in the framework of a trade agreement or unilateral temporary worker program, is not seen as a feasible plan. First, as global competition for nurses is already very fierce, it is unlikely that Canada would succeed in recruiting a large number of qualified nurses. There were over 15,000 registered nurses in Canada in 2001 who had received their initial nursing degree abroad. This represents more than 6 percent of all registered nurses working in Canada. Every year, an additional 600 to 2,000 foreign-educated nurses pass the

Canadian RN examination and become registered to practice. The main countries of origin are the Philippines, the United Kingdom, the United States and Hong Kong. However, "since 1992, it is almost certain that there has been a net loss when comparing the numbers of new registrants gained through immigration and the losses incurred through emigration of RNs [see table 1]. Because of the worldwide competition for nurses, it will be more difficult than in the past to recruit large numbers of nurses from other countries who can pass the RN examinations. For this reason, in the coming years, Canada will not be able to greatly relieve its nursing shortage by recruiting overseas" (CNA, 2002, 75).

Second, such a program would probably involve recruitment from developing countries whose health systems are in dire need of nurses and physicians; such recruitment would go against Canada's international development assistance objectives and commitments in international health. In fact, increasingly, discussions now focus on guidelines against the active recruitment of health professionals from developing countries where there is a shortage of nurses and physicians. For instance, the position statement on ethical recruitment adopted at the International Council of Nurses (ICN), to which the Canadian Nurses Association belongs, acknowledges the need to balance the opportunities and the risks linked to international mobility of nurses. The statement "recognizes the right of the individual nurses to migrate" while acknowledging "the possible adverse effect that international migration may have on health care quality in countries seriously depleted of their nursing workforce" (ICN, 2001). Indeed, aggressive recruitment of nurses from developing countries with already fragile health systems can be very damaging to these countries. "Governments and employers faced with the challenges of shortages need to address the contributing factors relevant to their situation." The council condemns the recruitment of nurses to countries "where authorities have failed to implement sound human resource planning and to seriously address problems which cause nurses to leave the profession or discourage them from returning to nursing" (ICN, 2001).

Finally, a large influx of temporary foreign nurses could further destabilize the health system. In order to face this challenge, many recommend that the Canadian government and the provinces develop and adopt comprehensive human resources policies for nurses and other health professionals (see the report of the Canadian Nursing Advisory Committee, 2002). Such a domestic strategy would focus on training, retention, remuneration, skills and patterns of practice:

> Employers must create more full-time positions, improve working conditions, especially adequate staffing, and address ongoing education needs of nursing staff. Governments must invest adequate, earmarked

> funds to support employers having adequate staffing, and at least 70% of their nursing staff in permanent, full-time positions. ….
>
> A large influx of temporary workers is a quick fix that will exacerbate the current crisis and contribute to further destabilization of the health care system and the nursing profession (RNAO, 2001a, 1; see also CFNU and CNA, 2001).

What lessons can be drawn from the Canadian case for current trade negotiations in health services? The main lesson is one of caution. On their own, labour mobility clauses in trade agreements do not cause the movement of health professionals. However, when the labour market conditions are conducive to cross-border movement, such clauses can greatly facilitate movement. In most developing countries, there is not an oversupply of health professionals, but rather a shortage. Therefore, in the current negotiations at the WTO on trade in services through mode 4, the relevance of gaining liberalisation commitments from industrial countries in health services is limited to the few countries that have a surplus of health care workers (on GATS and health services, see Blouin, Drager and Smith, forthcoming). In these cases, temporary movement of health personnel could bring benefits for both the importing and exporting countries, as well as the individual service providers who could improve their skills and knowledge. On the other hand, for the majority of developing countries, such exports can exacerbate existing human resources problems. Where skilled personnel are in short supply, even short-term loss can result in considerable loss of health services to nationals. At the 2004 World Health Assembly, members requested that the WHO conduct research on the impact of trade agreements on the international migration of health personnel. The potential adverse impacts of labour mobility clauses in trade agreements could work against the current efforts in many quarters to develop fair practices in international recruitment of health personnel.

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Endnotes

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1. Entrants must seek temporary entry, be U.S. or Mexican citizens and meet all other relevant immigration criteria (such as health and security regulations). They must seek to enter for the purposes of working as a nurse (which is certified by a letter from a potential employer), meet their domestic minimum education requirements (state license, provincial license, Licenciatura Degree) and they must obtain a provincial license *before* entry into Canada under this category. Nurses *must* have a signed contract of employment indicating the proposed employer, the position/duties of the job, the purpose of entry, educational qualifications, and the arrangements for remuneration. Fulfillment of these obligations will result in a temporary work permit from CIC. There is an applicable cost-recovery fee of C$150.00. Work permits have a maximum duration of one year, and are annually renewable "for as long as the temporariness of the situation remains bona fide" (Registered Nurses: Employment in Canada under NAFTA, HRDC site 2002, retrieved November 2002).
2. This data set is not published and was provided directly to The North-South Institute by the INS. It is available upon request from the author.