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CSME and the Intra Regional Migration of Nurses: Some Proposed Opportunities[1]

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Abstract

Caricom as a small regional trading agreement is characterised by economies with differing degrees of development. This paper reviews the differing economic attributes of these various Caricom states and then discusses in detail how the intra regional movement of skilled workers such as nurses can help to solve some of the regional shortages of skills in this category of work that may exists whilst at the same time providing considerable benefits for migrant nurses without the drift of their skills beyond the region.

1. Introduction

The migration of nurses has been at the forefront of discussions in international health policy debates since the 1990s (Buchan 2000, Chanda 2002, Martineau et. al. 2002). Health care is a labour-intensive service and nurses play an important part of this whole process.[4] However, there is an acute shortage of skilled personnel, including nurses and this is one of the biggest obstacles to achieving the Millennium Development Goals (MDG).[5] Several of these MDGs are directly related to health issues; specifically the eradication of extreme poverty and hunger, improving maternal health, combating HIV/AIDS, malaria and other diseases and ensuring environmental sustainability.

The majority of the Member States of the World Health Organization report a resource imbalance in the nursing sector[6]. It is well known that there has been a massive exodus of nurses from the public health care system in the Caricom to extra-regional sphere. Nurses leave the region on account of a variety of push and pull factors and their departure has placed a tremendous strain on the management of the health care sectors of the region.[7] This paper evaluates the economic conditions in the Caricom and reviews a number of related attributes and conditions under which nurses in the various member

[4] Nursing personnel account for up to 70% of health care staffing and provide 80% of direct patient care, facts that, in part, explain why governments, employers, the public and the profession are concerned about supply and demand issues.

[5] *The eight Millennium Development Goals (MDGs) – which range from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015 – form a blueprint agreed to by all the world's countries and all the world's leading development institutions-UN Millennium Development Goals http://www.un.org/millenniumgoals/*

[6] (www.nursingworld.org/about/summary/sum99/).

[7] See Hosein and Thomas (2006) for a detailed review of the push and pull factors conditioning the migration of nurses from the Caricom sphere.

states exist. The paper then goes on to discuss the various benefits that a strategy promoting the intra regional migration of nurses can foster.

The rest of this paper proceeds as follows. The next section discusses some of the theoretical consideration that arises in terms of the labour market when an integration arrangement such as the CSME is formed. Section 3 discusses the migration of nurses in the context of other integration arrangements such as the European Union, the North American Free Trade Area (NAFTA) and the recent free trade area started between the Philippines and Japan. Section 4 provides a profile of the nursing profession within Caricom whilst Section 5 discusses some of the costs associated with migration beyond the region. Section 6 discusses the intra regional mobility of skilled workers in the context of the CSME, whilst Section 7 briefly outlines the role of the General Agreement in Trade and Services and the Movement of Workers within Caricom. Section 8 discusses the policy implications associated with the analysis and section 9 concludes the paper.

2. Caribbean Single Market and Economy CSME and a Common Labour Market – some theoretical considerations

In 1989, at the Tenth Heads of Government Meeting of the Caricom sphere (the Gran Anse Declaration) agreed to establish the Caribbean Single Market and Economy.[8] The objectives of the CSME are to:

i. Provide a Single Market: This will facilitate the movement of goods and services without tariffs and without restrictions to the economic space within which producers and consumers from the region exist.

ii. Single Economy: the Single economy will further the harmonious implementation of monetary, fiscal and economic policies across all Caricom economies.

With the formation of a Caribbean Single Market and Economy there should emerge in the region a seamless economic space, to the extent that regional market transactions should be no different to conducting business within a single economy.

There are numerous benefits that can be gained through the formation of the CSME, including:

- Free movement of goods and services as well as capital and investments by business people. The free movement of goods was already provided for under

[8] At this meeting it was decided that it was necessary for member states *"to work expeditiously together to deepen the integration process and strengthen the Caribbean Community in all of its dimensions to respond to the challenges and opportunities presented by the changes in the global economy."* (Gran Anse Declaration, page 1)

CARICOM. The CSME widens the scope creating greater economic cooperation especially in terms of greater cooperation between business entities which will work towards providing goods and services of greater quality at better prices to the region[9].

- Hassle free travel for Caricom nationals - This involves the removal of restrictions on intra regional travel for CARICOM nationals. Ultimately the aim is to establish common travel documents for all CARICOM nationals and to synchronize policies for entry and exit from territories.
- No work permits for Caricom nationals: This entails the right of Caricom nationals to seek employment in any Caricom territory without need for a work permit. This can be as a wage earner or not.

- FDI flows may expand: Increased economic co-operation amongst CARICOM territories and an improvement in the efficiency of business operations within the region can serve to attract more foreign direct investment into the region.

- Economies of scale: Economies of scale previously unattainable prior to the formation of the CSME can now be realised as regional firms can now increase the size of their operations across territories. The widening of the market will also allow for increased production of goods and services.

[9] CARICOM Secretariat "Establishment of the CARICOM Single Market and Economy." www.caricom .org

Some of the advantages of a common market are that it encourages increased economic competition, accelerates structural adjustment and, in the medium term, increases the rate of innovation in the economy. Increased competition pushes prices downwards while average national income and output grows. The traditional model used to analyse the impact of regional integration and factor markets within these integration arrangements is the Heckscher Ohlin Samuelson (HOS) model. The HOS model germinated with the work of HOS in the 1920s but blossomed in the 1950s as a model to explain inter industry trade between countries of the North and countries of the South.[10]

Two facets of the HOS model influence discussions on the integration of labour markets. In the first instance, given the factor endowment base in each economy, liberalised intra regional trade will lead to the emergence of clear-cut national comparative advantages. In the second instance, perfect integration and free trade either with or without perfect factor mobility will lead to factor price equalization. [11]

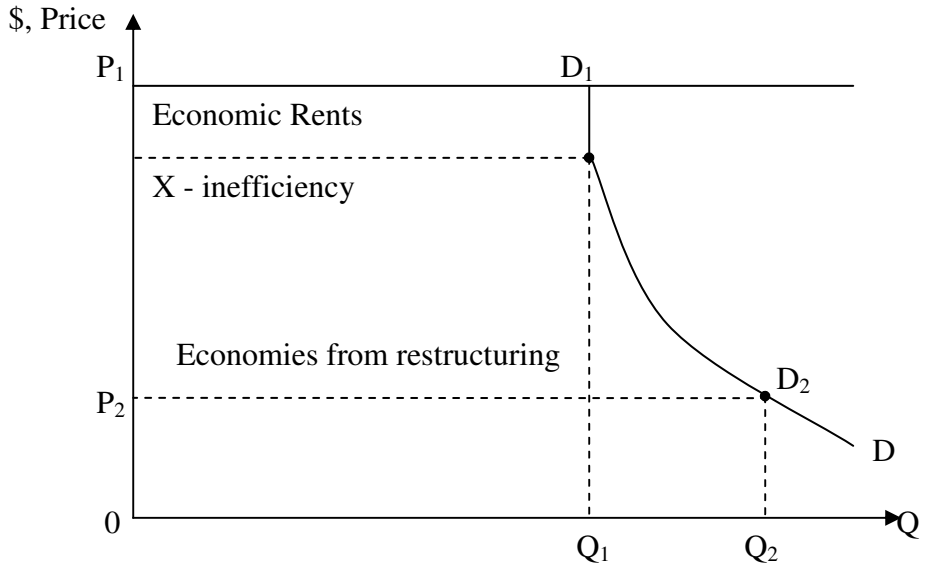
With the formation of a Common Labour market, the allocation of scarce labour resources across the intra regional labour market as compared to within national markets will assist in improving the economic welfare of the block as a whole.

[10] The Heckscher - Ohlin theorem as expressed in Ohlin's own words argues: *Commodities requiring for their production much of [abundant factors of production] and little of [scarce factors] are exported in exchange for goods that call for factors in the opposite proportions. Thus indirectly, factors in abundant supply are exported and factors in scanty supply are imported (Ohlin, 1933, p. 92).*

[11] The equalization of output prices between countries as a result of free trade will lead to the equalization of factor prices between countries. This implies the equalization of wages across countries as well as rents earned from capital investment.

The integration process also brings the added advantage of access to larger markets which would allow more price competitive firms to expand output and achieve unrealised economies of scale. This has the potential to produce a community wide gain in microeconomic efficiency and macroeconomic growth. This overall gain can be illustrated by reference to Fig 1 below.

Fig 1 : Impact of Removing Trade Barriers on Economic Efficiency



The reduction of barriers associated with the formation of an integration agreement forces domestic producers to follow by reducing costs or exiting the market. In the diagram above let P_1 be the initial price level in the national economy with protection. With the formation of an integration arrangement and the fall in price to P_2, the national economy benefits from a series of economic efficiency gains. These include economic rents (gains to domestic producers from market protection), X-efficiency (internal efficiencies such as

reduced overhead costs), restructuring economies (through economies of scale, Raines 2000).[12]

If initially there were income differentials amongst the participating member states then with the formation of a Common Labour Market, absolute income differentials amongst partner nations may fall and as a consequence other factors may then assume a greater role in conditioning the movement of labour.[13] It is not always the case, however, that wages will equalize with greater labour mobility and any remaining gaps is attributable to the cost of migration, e.g. cost of changing homes, etc.

Whether or not trade in goods and factors flows are complementary or substitutable is a contested matter in the international trade literature. If trade and factor flows are substitutable, this indicates that as trade increases there is a decrease in the migration of factors of production, especially labour. Specifically, if an economic integration arrangement removes barriers to the movement of goods then a shift in factor prices due to the differing factor intensity of comparative advantage sectors in each country will result. Overall the effects of trade mobility with perfect integration will be the creation of single factor markets between the two countries.

The redistribution of factors of production within an economic integration arrangement is conditioned by several factors, including the degree of similarity amongst members of the economic integration arrangement in terms of the structure of production and labour

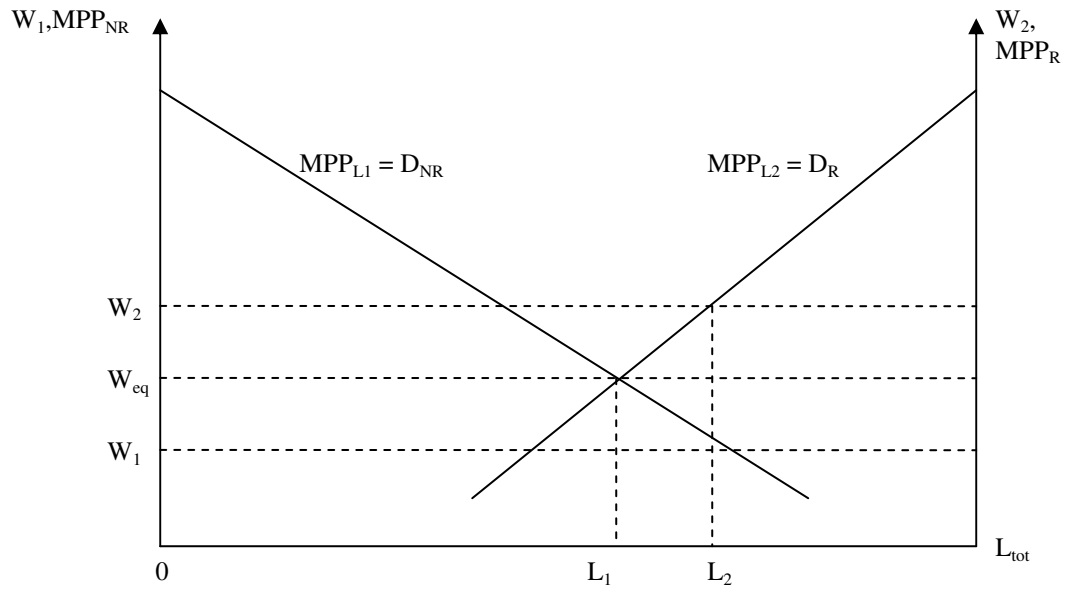
[12](Raines 2000, The Impact of European Integration on the Development of National Market). Restructuring economies will include accommodating to the Schumpetrian process of creative destruction.
[13] E.g. the crime rate in individual member states or the level of political freedom.

productivity. There is considerable room for intra-regional factor flows if there are significant structural differences amongst member states (Straabhar and Fuchs 1996).

Because a common market can cause social problems and unemployment to emerge in some areas, a greater degree of intra-regional labour mobility can help smoothen out such disequilibria and provides a counter balancing force to work towards preventing structural unemployment problems from persisting in some areas.

To illustrate some of the specific mechanics associated with the intra regional migration of nurses, consider the diagram below. On the horizontal axis we show the combined stock of nurses whilst on the vertical axis the wage rate is shown for both wealthy Caricom (R) and not so wealthy Caricom economies (NR). MPP_R represents the demand for labour in the richer Caricom economies whilst MPP_{NR} represents the marginal product of labour in the less wealthy Caricom economies. If we assume that the nursing stock as produced in the various Caricom economies are homogenous then nurses will flow from NR economies with initial wage W_1, to R with initial wage W_2, intra regionally.

Fig 2: Determining the migratory flows of nurses in a two country



Economic integration will trigger a fall in the wage rate in the R type CARICOM and an eventual rise in the wage rate of the NR type Caricom economies. Eventually equilibrium will be restored with the wage rate settling at $W_{eq.}$ At this point L_1 nurses will be employed in NR Caricom economies while L_{ltot} will be employed in the wealthier Caricom economies.

3. The migration of nurses within other integration arrangements

An inclusive model of integration has been established within the European (EU) where, for example, first-level registered nurses or mid wives are free to work in any other EU member state. Professional qualifications do not create barriers to mobility as much as linguistic and other cultural factors do in this region (Buchan et al 2003, page 9).

Through the North American Free Trade Area (NAFTA), citizens of Canada and Mexico are allowed to work temporarily in the United States. This agreement provides a framework for mutual recognition of professional competency. Nationals who meet minimum educational requirements and are licensed in their own country are allowed entry into other member countries. NAFTA has also encouraged Canada, Mexico and the US to examine their respective nursing education systems and establish mutually acceptable criteria for licensing and certification (Oulton 1998, pg 31).

In 2004, an FTA was established between Japan and the Philippines which allows among other things, Filipino health care professionals to work freely in Japan. The Philippines Overseas Employment Agency has processed the migration of over 34,000 nurses from the Philippines between 2001 and 2004 with the situation becoming so critical that doctors are training to become nurses in order to capitalize on strong overseas demand for nurses. (The FTA between the Philippines and Japan, however, is supposed to allow only 100 nurses into Japan in the first year. This is to guard against possible wage distortions as well as crime and terrorism that may result from increased worker migration to that country)[14].

[14] See Seig (2004).

4. Profile of the Nursing Profession within Caricom

Table 1: Trends in real GDP in various Caricom states, 1992-2003.										
	Antigua & Barbuda	Barbados	Belize	Dominica	Grenada	Guyana	St Kiits & Nevis	St Lucia	St Vincent & the Grenadines	T&T
1992	100	100	100	100	100	100	100	100	100	100
1993	105.1	100.8	104.3	101.9	98.8	108.2	105.4	101	99.3	98.5
1994	111.3	105.4	105.7	104	102.1	116.6	110.8	102.8	97.8	102.1
1995	106.3	107.8	106	105.6	105.2	121.7	114.2	105.1	106.1	106.1
1996	112.4	111	107.7	108.7	108.1	128.7	120.1	106.2	107.3	109.9

1997	118	115.6	111.3	110.7	112.5	135.8	127.4	106.8	110.5	112.7
1998	122.9	121.8	114.5	113.5	120.4	134.1	128.4	110.2	116.2	120.5
1999	127.8	122.3	123.2	115.1	127.7	137.1	132.3	114	119.8	124.9
2000	131.1	124.6	136.2	116.4	134.7	135.8	138.8	113.6	121.8	132.2
2001	132.6	122	140.5	112.2	130.3	138.1	140.5	117.9	121.7	136.4
2002	134.7	122.5	144.8	107.2	129.9	139.3	140.1	118.4	123.7	144.3
2003	140.2	124.5	154.1	107.2	135.6	138.6	140.5	122	127.3	157.7
% change	40.2	24.5	54.1	7.2	35.6	38.6	40.5	22	27.3	57.7
Source: Annual Report of the CDB (Various issues).										

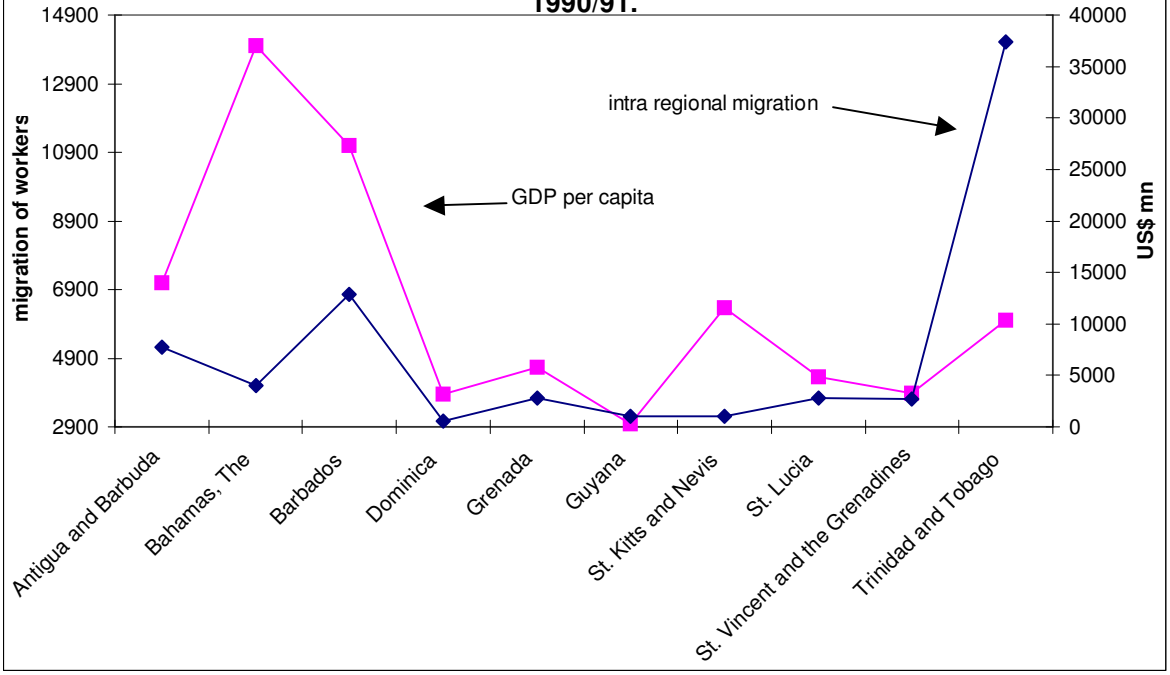
The Table 1 above provides data, which reflect on the trend in the real economic growth performance of Caricom economies. It is clear that the growth performance of the various member states have indeed been different, ranging from an overall percentage change of 7% in the period 1992 – 2003 for Dominica to 57.7% improvement in GDP in T&T. Belize was the only other Caricom state to record in excess of 50% improvement in constant price economic activity in the interval 1992-2003.

Intra Regional Migration and per capita GDP

Data on intra-regional migration is available only for the period 1990/91. Line graphs of intra-regional migration flows and per capita GDP respectively are provided in the Figure 3 below. The indication is that there is a tendency for the higher income economies to attract a greater element of intra-regional migration flows. Two exceptions to this generic tendency seem to stand out, these are that the Bahamas receives a small

proportion of the intra regional migration population, 5.4%, and T&T which does not carry the highest intra regional per capita GDP receives a very high fraction of intra-regional migrant flows.

Fig 3: Linegraph of GDP per capita (PPP) and intra regional migration, 1990/91.



An observation of the data in Appendix 1 indicates that the largest source economy for intra-regional migration flows of labour is Guyana. In particular there were 12,426 Guyanese living in the other Caricom member states in 1990/91, this accounted for 16.8% of the total intra regional migrant population. If we assume that the intra regional migrant pattern is strongly correlated with economic incentives, then one would expect that this type of flow of migrant workers into the T&T economy since 1991 would have increased, because of the strong economic performance of that economy in recent times.

In particular the real GDP in T&T doubled between 1990 and 2005 and the unemployment rate declined sharply from 20.2% in 1990 to 9% in 2005. Even more T&T is now the world's number one producer of ammonia, methanol and urea and into the medium term period growth is expected to be buoyant (see Hosein 2005).

Intra-regional costs of various categories of labour

Table 3: Labour Costs (US$ per Hour)

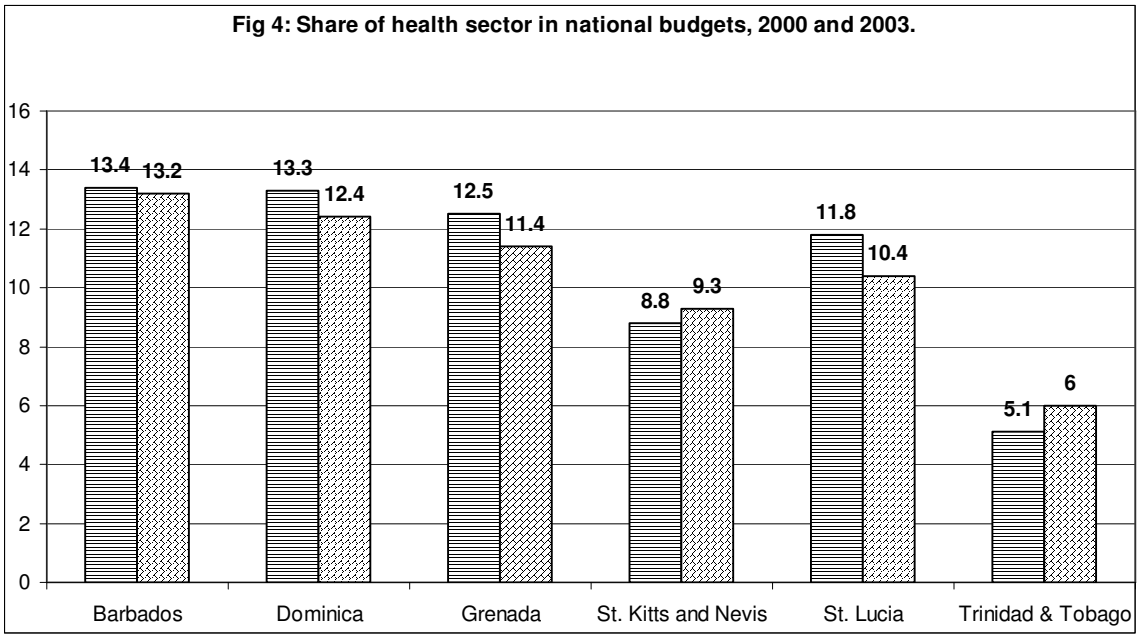
	Barbados	Grenada	Jamaica	Trinidad & Tobago
Professional Labour	30.00	63.70	23.10	32.40
Skilled Labour	12.00	10.30	8.96	13.50
Unskilled Labour	4.66	4.65	4.53	2.88

Source: World Bank (2005).

The Table 3 above shows the labour costs per hour in various Caricom member states. Professional workers secure a much higher salary per hour in Grenada than in the other listed Caricom member states. For skilled and unskilled labour, Bajans receive the highest hourly rates[15].

[15] It is possible that since the passing of hurricane Ivan in 2004 that the wage rate in Grenada may have been modified downwards.

Health Sector expenditures amongst CARICOM states

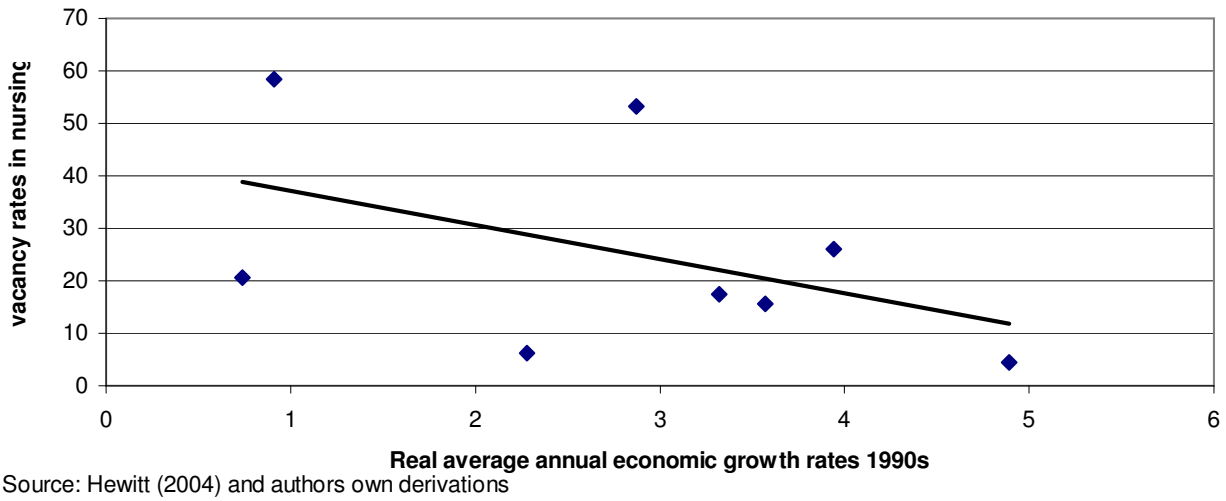


The various economies within the Caricom sphere spend differing proportions of their budgetary outlays on their health sectors. Barbados expended 13.4% of its budgetary outlay on the health sector in 2000 and 13.2% in 2003, with T&T committing the least amount to its health sector, although the sector's budgetary allocation increased from 5.1% to 6.0% between 2000 and 2003 (Commonwealth Secretariat 2005).

The Caricom region has an average nursing vacancy rate of 35%. In four countries, vacancy ratios exceeded 20 percent: Barbados (20.6%), Jamaica (58.4%), St Kitts (26%) and T&T (53.3%). Ironically, the highest numbers of unfilled posts were to be found in the two member states with the most training institutions - Trinidad and Tobago and Jamaica. The scatter plot in Figure 5 below posts vacancy rates in nursing against real

average annual growth rates for various Caricom member states. The clear indication is that those countries with lower real economic growth performance tend to also be those member states with the highest amount of nursing vacancies, providing indicative evidence that nurses move out of slowly growing economies.

Fig 5: Scatterplot between real average annual growth of some Caricom economies in the 1990s and nursing vacancy rates 2004.



Source: Hewitt (2004) and authors own derivations

Observe that the density of nurses in the region varies widely from 0.86 per 000 inhabitants in Guyana to 5.12 nurses per 000 inhabitants in Barbados. If we use density as an indicator of demand it may be argued that Barbados has the greatest demand for nurses, (See Table 4).

Table 4: Nurses per 1000 inhabitants, 2000

Country	Nurses 1000 inhabitants
Anguilla	3.13
Antigua and Barbuda	3.32

Bahamas	2.34
Barbados	5.12
Dominica	4.16
Grenada	1.95
Guyana	0.86
Jamaica	1.65
T&T	2.87

4.3 Intra regional Nurses salaries

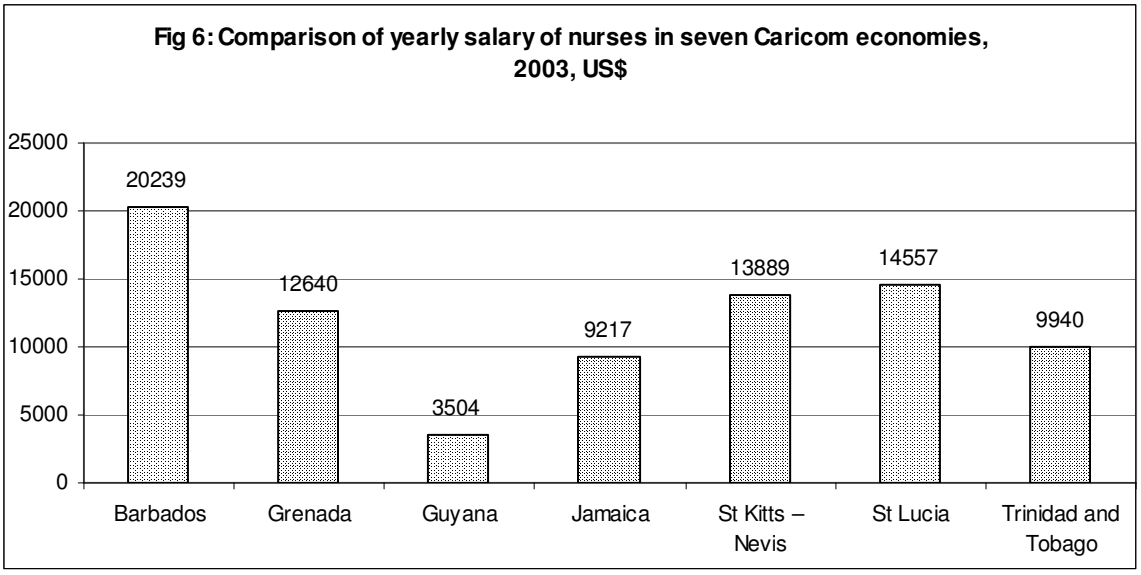
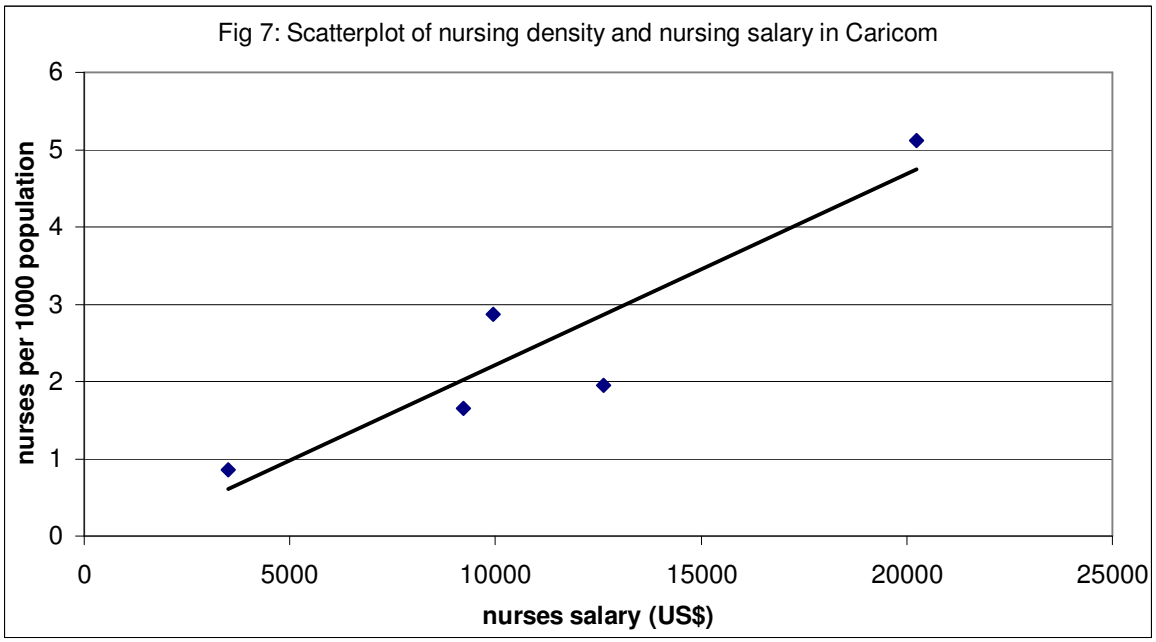


Figure 6 above shows the salaries of staff nurses in various Caricom economies. There is a clear disparity in nursing staff salaries with the salary of a staff nurse in Barbados being 578% that in Guyana, 480% that in Jamaica and 204% times that in T&T, for 2003. Note that the HOS model of integration predicts that there should be a tendency to the equalization of wages across countries whether integration takes place by the full mobility of goods or factors or a combination of both. Therefore the CSME should lead to a narrowing of wage differentials across labour markets with wages increasing in low wage countries and falling in high wage countries.

As indicated in Figure 7, the countries with the highest nursing density tend to carry the highest nursing salary providing some evidence that the pressure of effective demand for nursing skills bids up nursing sector wages.



5. Migration to extra regional perimeters and the associated costs

Migration to the Caribbean took place from as early as the 15th and 16th centuries when Europeans migrated to the West Indies on a temporary basis. With the emergence of the sugar trade a large number of slaves were brought in to work on Caribbean sugar plantations in the 18th and 19th centuries. Indians arrived as indentured labourers in the 19th century after the abolition of slavery. However, there would be a reversal of migratory trends as there was an exodus of West Indians to the UK, Canada and the USA in the early 19th century, after many of the islands gained independence. Today the region has one of the highest net migration rates in the world growing mainly out of a heavy demand for both skilled and unskilled labour in the developed world, (Thomas-Hope, 2002).

There has been a long tradition of migrating nurses from the Caricom sphere, principally to the UK, Canada and the USA. PAHO (2004), estimated that the migration of nurses to extra regional perimeters cost the region US$16mn and posted a number of implications for the Caricom sphere, including the following.

- There is a decreased capacity to deliver health care services. Health care systems lose the ability to deliver health care equitably as well as meet national, regional and international development goals, for example the United Nations Millennium Development Goals.

- There is an increase cost to retain existing nurses. For instance, the large wage differentials between developed and developing countries is one of the major factors for the migration of nurses from developing countries. Governments have therefore had to resort to significant wage increases and remuneration packages to retain nurses in developing countries. Some CARICOM countries such as Jamaica have also resorted to incentives such as health insurance, paid vacations and transportation[16]. In St Vincent proposals, have been made to offer nurses low interest loans for securing a home and a car.

For migrating nurses, a common experience, was a lack of recognition of their skills, and this sometimes left nurses with a feeling of incompetence, (RCN, 2003). Omeri and Atkins (2002, pg 500) comments that an experienced migrant mid wife working in

[16] "Nurse retention and recruitment: developing a motivated workforce" The Global Nursing Review Issue Paper 4. Pascal Zurn, Carmen Dolea, Barbara Stilwell Copyright © 2005 by ICN - International Council of Nurses,

Australia noted that they (immigrant nurses) were assigned responsibilities such as bed-making etc. i.e. migrant nurses sometimes had their skills downgraded.

Hagey et. al. (2001, pg 390) identifies that there were cases in Ontario, Canada where racial discrimination was exercised against black migrant nurses who were zoned into long term care responsibilities whilst their white nurses were offered specialties more aligned to their preferences. Dicicco-Bloom (2004) reports the comment of a developing economy immigrant nurse working in a hospital in the USA:[17]

"I know I am not treated the same as the other (white) nurses … Nobody learned my name for 4 months when I first came, and when they did … they shortened it and pronounced it wrong. I finally stopped correcting them … I think I am the hardest working nurse on the floor, and three times my supervisor has requested a promotion for me, and yet, each time someone else has been promoted instead who I knew, and everyone knew, did not deserve it. They were all White. Even my supervisor thought this was wrong…" (page 36).

Migrant nurses also experience grave difficulties in making complaints against their employers. This situation is compounded if the nurse is seeking to remain permanently in the country. In this latter type scenario the nurse is often times pushed to the fringe of

[17] B, Dicicco-Bloom "The Racial and Gendered Experiences of Immigrant Nurses from Kerala, India" This study was carried out through a series of semi structured interviews with women who migrated from Kerala, India and are now actively employed as nurses in the United States. It was carried out to describe the inequities, which still exist in the U.S. Health care system.

tolerance, given the night shifts and the generic ward duties that other nurses find more arduous.

Despite the economic benefits of remittances from emigrants,[18] experience has shown that the children left behind in these cases suffer from a lack of guidance from absentee parents. The migration of nurses to developed countries has also contributed to the phenomenon of *absentee mothers, unaccommodating fathers, kin helpers and children haunted by the feeling of being left behind*[19]. This has been one of the major factors contributing to youth delinquency in the Caribbean.[20]

The international recruitment of nurses has been openly chastised by many commentators, including Nelson Mandela, who spoke out against Britain's 'poaching' of nurses from South Africa in 1997. In response to these type of criticisms, the UK Department of Health noted:

"It is essential that all NHS employers do not actively recruit from developing countries which are experiencing nursing shortages of their own." (Department of Health, 1999,

[18] Remittances are certainly an important pull factor conditioning the flow of labor from the developing to the developed world. However, in a recent paper, Mishra (2006) identified that the losses to the region as a whole were larger than the inflow of remittances. At the Caricom member state level, the only exceptions to this type of generalization were in Grenada and St Lucia.
[19] Rachel Parrenas, "Servants of Migration"
[20] Jones, Sharpe and Sogren (2004) in a study investigating the impact of migration on children from Trinidad and Tobago found that children who were separated from their migrant parents were more than twice as likely to have emotional problems as compared to other children, even though they were generally materially better off. (The Caribbean Journal of Social work, Vol., 3, pg 89-109).

page 11).[21] The Caribbean (and South Africa) have been identified as areas from which recruitment should be restricted.

In 2001, the Department of Health provided a more detailed code of practice and in 2003 published a list of developing countries from which recruitment should not be targeted. The effect of this stance was a decline in the number of nurses recruited from the West Indies from 221 in 1998/99 to 57 in 2002/03.

The International Council of Nurses in 2002 expressed its opinion in this regard and identified that:

"The Council acknowledges the adverse effect that international migration may have on health care quality in countries seriously depleted of their nurse workforce."

Migration has been restricted through several mediums in the developed world. One example is through laborious licensing procedures. However, there is concern that such procedures may result in a downward levelling of standards to the detriment of quality healthcare.[22] Additionally, due to security concerns post September 11th 2001, the

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

[22] (page 14, Public Service International: WTO and the GATS: what is at stake for public health? PSI: France, 1999, www.world-psi.org).

temporary migration of nurses is governed more by immigration policies than by trade policies.[23]

The migration of nurses is also governed by labour market regulations such as economic needs tests, and certification requirements. However, internationally these regulations are characterised by a number of problems, including non-transparent rules and discriminatory abuses.

Mishra (2006) defined the emigration loss to an economy as the reduction in welfare measured in terms of GDP which occurs when the workers which migrate received a wage rate lower than the value of their marginal product. Borjas (1995), has identified that with the migration of skilled workers there is an adverse productivity impact on some segments of the labour force remaining behind. In particular, highly skilled workers may confer a better degree of monitoring and motivation of workers and so the costs of migration on account of this positive externality will certainly extend above the simple emigration loss (Mishra 2006). In addition, when TLE graduates migrate the source economy loses the associated public education investment expenditure subsidy. Following Mishra (2006), the total losses on account of the migration of skilled workers can be treated as the sum of the simple emigration loss, the externality effect and government expenditure. Another cost of migration to the source economy as cited by

[23] It has been raised by a number of researchers that a GATS visa be specifically designed for temporary movement of service providers (Stephenson, S.M. (1999)), "Approaches to Service Liberalization by Developing Countries". This view, however, has been challenged by others, e.g. Young, A. Labor Mobility and the GATS, on the basis that it would present a significant amount of challenges to the immigration and labor market development authorities, including (but not restricted to) the need to retain customs and other border officials, (cited in Ifill 2001 pg 19).

Desai et. al. (2002) is fiscal losses on account of tax revenues the government would have accrued from these workers if they had remained behind.

6. Caricom, CSME and the intra regional mobility of skilled workers

For Caricom economies, intra-regional wage differentials between member states coupled with the economic constraints on job opportunities that small economic markets present provide a strong impetus for the migration of nurses and other category of workers. In this regard, the World Bank (2005) notes:

"Promoting intra-regional labour market integration through increased labour mobility within the Caribbean would improve skills matching and wage arbitrage." (page 136)

With the CSME, there is a progressive movement towards a harmonised system of regional labour laws. With the harmonization process, there is not only emphasis on preserving legislation, but also on improving labour laws. To date, a total of 4 Model laws have been completed, these are:

1. The Termination of Employment,
2. Trade Union recognition,
3. Occupational, Safety and Health and the working environment,
4. Equality of opportunity and treatment.

The drift towards a greater degree of intraregional movement of skilled labour however, continues, although at a much slower pace (World Bank 2005).

7. GATS and the Movement of Workers Within Caricom

There has been heightened debate on the migration of nurses due to negotiations on the General Agreement on Trade in Services (GATS). The GATS is essentially a multilateral agreement governing international trade in services. The GATS governs everything from educational services to financial health services.

In the case of nursing services, the GATS provide four principal modes of supply by which this can be influenced:

- Mode 1- Cross Border Trade,
- Mode 2- Movement of consumers,
- Mode 3- Commercial presence,
- Mode 4- Movement of natural persons.

These modes are illustrated along with examples from the health sector in Table 5 below.

Table 5: Modes of Supply of Health services

Mode of Supply according to GATS	GATS Definition	Examples in Health Sector
Mode 1 Cross-border supply	The supply of a service "from the territory of one Member into the territory of any other Member." The service travels, but both the provider and the	Telediagnosis from T&T to Guyana. Shipment of laboratory supplies from Guyana to T&T for testing.

	consumer stay at home. Comparable to the export of a good.	
Mode 2 Consumption Abroad	The supply of a service "in the territory of one Member to the service consumer of any other Member." Comparable to tourism or business travel by the consumer.	A Guyanese resident obtaining treatment in T&T
Mode 3 Commercial Presence	The supply of a service "by a service supplier of one member, through commercial presence in the territory of any other Member." i.e.- Foreign Direct Investment	Hospitals from T&T sets up a subsidiary in St Kitts
Mode 4 Movement of natural persons	The supply of a service "by a service supplier of one Member, through presence of natural persons of a member in the territory of any other member." Comparable to temporary emigration or business travel by the service provider	Trinidad and Tobago laryncologists providing their services in Guyana twice for the month or movement of nurses temporarily from Guyana to Barbados
Source: Sauve (2002) and own examples.		

The critical element of the GATS in terms of this study concerns the labour intensive nature of the service sectors and the implications for health care workers, particularly nurses. The existing shortage of nurses across all type of economies means that any movement of nurses across territories, especially from developing to developed countries puts added strain on the health sectors of developing countries.

The design of non-discriminatory rules to manage trade in services is a difficult task especially as concerns the movement of natural persons. This is due to the following

- The underlying assumption is that trade in goods closely resembles trade in services as both seek to exploit comparative advantage.
- The difficulty of distinguishing between temporary and permanent migration of nurses.

Policy implications of the Analysis

The number of nurses operating in the health sectors within the Caricom region has already dropped critically low and a further drop, no matter how miniscule, even in the form of temporarily migrating nurses can have devastating effects. Increased morbidity and mortality rates can result which may then filter into other aspects of these economies for example, slowed economic growth due to falling productivity.

Because of the poor economic stance of most Caricom member states, efforts to soften the impact of push factors in some states will take a longer period of time. It is in this regard and given the ethical stance by the main host economy markets, that an intra regional migration of nurses' strategy is considered a viable option.

This paper closes by elaborating on some of the benefits of a greater degree of intra regional migration of nurses:

1. For the more skilled nurses they may be able to offer their skills in differing Caricom economies over differing periods of time. This will help to improve the quality of health services in the region as more skilled nurses will be distributed throughout the region to provide quality health care as well as to provide an example and training to junior nurses.

2. Following on point (1), a greater degree of intra CARICOM migration of nurses can help to provide employment opportunities for nurses from some of the lower income Caricom economies in other higher income Caricom economies. These nurses will be exposed to a higher standard of living. It is acknowledged that the salaries of nurses in the extraregional traditional host economy markets for migrating nurses is much larger, but realistically the region will not be able to match these salaries. The region as a whole will benefit from this type of brain circulation associated with the migration of nurses from the region. The nurses themselves will experience, more than less likely, a lower degree of racial, religious or other forms of discrimination associated with the pursuit of their careers extraregionally.

3. In countries with a higher unemployment rate than others, an intraregional nursing migration strategy may provide the opportunity to use the Caricom sphere as a vent for surplus. In this regard, Guyana, St Vincent and Grenada can be used as base economies for producing nurses for the region as these economies already have a culture of migration. Economic activity in Guyana, for example, has not been as robust as in some other Caricom economies and even more the unemployment rate in that country continues to be in double digit terms. Because of the similarity in culture within the region[24] and the closer geographic proximity of the various economies the intraregional

[24] *Historically Caricom economies have had similar experiences. The whites were interested in the colonies because they saw them as a source of wealth. All the colonies were exploited to the greatest extent.*

movement of workers and their children may be higher and this in turn can act as a counteracting force to reduce the extent of social decay associated with extraregional migration.

4. With an intra-regional migration of nurses' strategy, health care standards in the region as a whole may be improved as compared to the existing situation entailing the migration of these nurses extra-regionally, and this in turn will redound to the benefit of the region. Very likely a greater element of intra regional migration amongst nurses will allow the Caribbean to retain this vital human resource while the nurses themselves will benefit from exposure to health care systems in different territories.

5. Ethical Recruitment drives have seriously reduced the demand for Caricom nurses in relevant extra-regional economies. The promotion of an intra regional nurses migration strategy can still help to provide some degree of ease for frustrated nurses as they move from one territory within the intra regional arrangement to another territory within the region, in search of greener pastures.

6. The expanded clientele base that an intra regional nursing migration strategy provides, may trigger dynamic investment creation as some nursing schools may use the opportunity to produce a greater amount of specialist nurses for employment in the wider intraregional community.

7. Linked to the point above, another key benefit of an intra regional migration of nurses strategy is the possibility of attracting a larger number of trainees into the field, because of the greater sense of job security the expanded labour market will now provide. This

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Additionally, slaves and indentured labourers were brought to the colonies specifically for the purpose of providing a free or cheap, docile form of labour. Both slaves and indenturered laborers were treated in the same manner from colony to colony. Even though indentured labourers were supposed to be free, they were still seen as inferior by the whites. The culture which evolved in the colonies is similar in terms of music, dance and traditions. (British Slave Emancipation. Green.)

would also facilitate intergenerational training and the 'passing on' of skills and expertise from one generation of nurses to another generation, within the region.

8. Conclusion

The CSME provides the Caricom sphere with a number of opportunities. Amongst these benefits reside those that a larger intra regional market for nurses offers. However, whilst a greater degree of intra regional movement of nurses redounds to the benefit of the region, it must not be expected to emerge like manna from heaven. The exodus of nurses from the region would continue to find market driven vents in foreign market without ethical recruitment policies. The truth is that if the structural deficiencies in the health sectors and wider macroeconomic structure of the region are not targeted for stronger remedial and even stronger surgical improvements, the region will struggle to retain its most skilled workers.

Appendix 1.

Foreign population Classified by Country and Birth and Country of Enumeration: 1990-1001													
	Ant	Bah	Bar	Dom	Gre	Guy	Jam	Mon	Stk	Stl	Stv	T&T	Total
Antigua & Barbuda		5	216	2580	122	1753	408	892	495	414	505	376	7766
The Bahamas	14		245	37	30	438	2920	2	14	26	21	290	4023
Barbados	…	54		446	559	2529	615	…	…	3279	3635	1730	12847
Dominica	190	5	63		40	71	49	61	24	105	47	115	580
Grenada	23	18	106	44		341	69	6	9	97	342	1736	2768
Guyana	6	4	173	14	60		92	7	3	317	114	209	993
Jamaica	…	…	…	…	…	…	…	…	…	…	…	…	0
Montserrat	171	0	20	409	23	357	24		175	31	45	66	1150
St Kitts & Nevis	179	3	42	89	25	343	64	190		48	76	114	994
St Lucia	80	7	406	142	130	1175	116	21	43		242	500	2782
St Vincent & the Grenadines	32	0	262	29	70	279	386	80	20	24	119	1420	2689
T&T	…	…	2411	…	16589	5140	…	…	…	1606	11625		37371
Total	695	96	3944	3790	17648	12426	4743	1259	783	5947	16771	6556	73963

Progress of the SME		
Elements	Status	Action Required
1.1 Free Movement of persons Facilitation of Travel 1.1.1. Elimination of Need for Passport	To date, 8 Member States accept forms of identification other than passport from Caricom nationals, ranging from Travel Permits, Photo ID cards, Birth Certificates and Divers Licenses as follows: Barbados accepts Travel Permits from all member states except the Bahamas, Belize and Suriname. Dominica accepts Travel Permits. Grenada accepts Travel Permits or Travel Document. Guyana accepts National ID or Drivers Licenses accompanied by official Photo ID. Jamaica accepts Birth Certificates accompanied by Photo IC, except for Suriname. Monsterrat accepts any proof of ID. Visa. St Vincent and the Grenadines accept travel permits	Compliance by Antigua and Barbuda, Belize, Saint Lucia, Suriname and Trinidad and Tobago. Publicising of Updated Information

	from all member states.	
1.1.2 Facilitation at immigration points	Common lines for citizen/residents and Caricom nationals used in all Member states, except Trinidad and Tobago and the Bahamas. Trinidad and Tobago has separate lines, which is not seen as a problem. The Bahamas does not stream passengers, and this is not seen as a problem. Meeting of Officials has identified the reluctance of Member states to implement the 1999 Decision of Heads of Government to introduce a common E/D card and use the Model Caricom card, as based on the fact that the current national form are used to Member States to collect statistical information also.	The Secretariat to organize Meetings of Officials in February 2001 to consider recommendations from the Second Special Consultation on the CSME.
Facilitation of Movement 1.1.3. Elimination of need for work permits	In 1995 Member States agreed to the free movement of Caricom nationals who are University Graduates with effect from January 1996. Nine Member States have completed the legislative process to give effect to	Monsterrat and Suriname to enact legislation. Trinidad and Tobago to complete the process by issuing the proclamation.

	this decision. Monsterrat and Suriname have not yet enacted legislative, while Trinidad and Tobago must still proclaim their Act. In 1996 Member States further agreed to extent this provision to artiste, sports persons, musicians and media workers. Jamaica, Guyana and Belize made the necessary provision in their legislation while that of St Vincent and the Grenadines authorizes the Competent Ministry to make regulations prescribing additional occupations. Barbados is facilitating these groups through an administrative arrangement. The COTED noted that the provisions in the various laws do not all give full effect to the decision of the Conference. Protocol II is in effect providing for the movement of	Urgent completion of work at regional and national levels to establish criteria for identifying such persons. The ten member states, which have not yet done so, to enact the necessary legislation for these categories of persons. The Secretariat is mandated by COTED to review the relevant laws in Member states with a view to identifying shortcomings and inconsistencies and advising Member States. The Community Council to provide resources necessary to undertake the technical work to facilitate free movement including harmonization of legislation among Member States. Member States to enact the necessary legal provisions and implement the appropriate

	persons as service providers or to establish business including management, supervisory and technical staff and their spouses and immediate dependent family members. No provision is currently made in the Treaty reflecting the general principle and objective of free movement of persons.	administrative arrangements. Policy directive to inform drafting in the integration of the Treaty to reflect 1996 Conference decision that Member states adopt a broad policy which would permit the general extension of the right of freedom of movement to Caricom nationals, as their circumstances permit, and as agreed by the Heads of Government.
1.1.4. Mechanisms for equivalent and accreditation (or mutual recognition)	Jamaica and Trinidad and Tobago have appropriate mechanism in place Guyana, Barbados, Belize and The Bahamas have taken the establishment of their national accreditation bodies to Cabinet. CXC/Lom funds identified for recruitment and fielding of experts to work on general principles.	Strengthening of capacity at national level noting that OECS will have one body for the sub-region. Mobilization of resources

	ACTI in process of agreeing on equivalency. Professional Association have initiated work at the regional level Regional qualification framework incorporated academic and technical/vocational/technological qualifications has been developed to deal with the issues of accreditation articulation equivalency and quality assurance in the Region. A seven-week consultancy is due to start in March 2001 to assist Member States to put their national bodies in place and to prepare draft model legislation for their guidance.	
1.1.5. Development of Skills register	Resource being sought from IDB	Mobilization of resources
1.1.6. Harmonization and transferability of Social Security benefits	Social Security Agreement entered into force 1 April 1997. So far it has been singed by 13 member states.	The Bahamas and Suriname to sign and ratify

	The Bahamas and Suriname still to sign. 12 member states have ratified the agreement. With the exception of Dominica, Saint Lucia, Suriname and The Bahamas, all member states have completed the process to give legal effect to the Caricom agreement on Social Security. Barbados is already paying benefit under the Agreement. Forms to be used to be approved at the next meeting {of the COHSOD}. Anguilla, the British Virgin Island and Turks and Caicos were invited to accede to the Agreement in May 1998. The Bahamas has confirmed its interest given the number of Caricom nationals employed	Dominica and Saint Lucia to enact legislation.

	there.	

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