

## *Policy Brief for the Global Policy Advisory Council*

### **The Gulf Cooperation Council (GCC) and Health Worker Migration**

#### **Summary Points**

- Disparity in human resources for health, based upon national wealth, exists within the Middle East.
  - GCC countries, Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and United Arab Emirates, have over ten times more nurses and doctors per 1,000 population than do Afghanistan, Djibouti, Somalia, Sudan, and Yemen.
- Vast majority of the health workforce in GCC is foreign born and foreign trained.
  - 75% of the physicians and 79% of the nurses working in GCC countries are expatriates.
- Demand for health care in GCC countries is expected to increase by 240% over the next two decades, highest of any region in the world.
  - Spending on health care is estimated to increase to \$60 billion per year, five times what it is today.
- Health workers are migrating to the Gulf from both developed and developing nations, breaking the conception of North and South as destination and source.
- A two-tier system is emerging, where health worker migrants to the GCC who are “Western trained” are valued higher, compensated better, placed in urban centers, granted more senior positions, and have greater opportunities/training available.
  - To date little policy focus has been placed on furthering equity of treatment *amongst* migrant health workers.
- Examining the role of the GCC, both within the Middle East context and globally, allows us to also consider the role of other emerging hubs for health care delivery and to better shape an informed global policy response to the concerns raised by health worker migration.

## **Introduction**

This policy brief aims to highlight current themes and future trends related to health worker migration to and within the Middle East, focusing particularly on the demand for health personnel in the Gulf States. Despite increasing demand for health services over the last few decades in the Gulf Cooperation Council (“GCC”) countries of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates, the role of GCC countries in the context of the global migration of health workers has been relatively unappreciated and understudied<sup>1</sup>. The pronounced economic emergence of the six oil-rich GCC has fueled the rapidly increasing recruitment of health workers from both the developing and developed world. The significant rise in demand for health workers in the GCC, anticipated to increase dramatically over the next few decades, will become increasingly salient globally and especially within the Middle East region where certain cultural, linguistic, and religious values are shared. Examining the role of GCC countries as emerging hubs for health care delivery breaks the traditional conception of the North and South in discussions surrounding health worker migration and can enable us to better contextualize proposed policy solutions.

This policy brief has been prepared by staff at Realizing Rights, secretariat for the Health Worker Migration Initiative’s Global Policy Advisory Council, in order to inform the Council about the increasing relevance of the Middle East, particularly the Gulf Cooperation Council countries, to our discussions.

## **Methodology**

The information presented in this brief has been obtained through literature review and interviews with two key informants: Dr. Elsheikh Badr and Mr. Nick Hays. Dr. Elsheikh Badr is the Director for General State Affairs in the Ministry of Health of Sudan and has significant expertise on the migration of health workers occurring *within* the Middle East

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<sup>1</sup> See The Cooperation Council for the Arab States of the Gulf website. Available at <http://www.gcc-sg.org/eng/index.php>. Site last visited September 8, 2008.

region. Mr. Nick Hays is the managing director of a private recruitment agency, Latitudes Group International, based in Australia. Mr. Hays' company recruits health professionals from Australia, Canada, New Zealand, the United States, and Western Europe and places them in medical centers in the Gulf region. His current work and fifteen years of experience in the recruiting industry has allowed him to observe trends in the global movement of health workers during this period.

## **Findings**

The term Middle East is an ambiguous and highly charged one. It is often used to refer to countries based in Western Asia and Northern Africa. While many countries within the region are Islamic and Arab, the region is far from homogeneous. It includes Afghanistan, Israel, Iran, Pakistan, and Turkey, none of which are Arab. It also includes Somalia, Djibouti, and Sudan, sub-Saharan African countries which though sometimes not thought of as part of the region, share important cultural and linguistic similarity, as well as geographic proximity to traditionally conceived Middle Eastern nations. The similarity and proximity of these sub-Saharan nations to Gulf Cooperation Council countries, exacerbated by their limited financial resources, has had and will continue in the near future to have negative effects on the national health resources profile of these nations.

Quantitative data on health worker migration to and within the Middle East is incomplete<sup>2</sup>. What is clear, however, is the shortage of health workers in many of these countries and the disparity of the shortage in physicians and nurses based upon national wealth. The resource rich Gulf Cooperation Council countries for example have between 1.6 to 2.8 physicians per 1,000 population<sup>3</sup>. Afghanistan, Djibouti, Somalia, Sudan, and Yemen on the other hand have well over a ten fold deficit in physicians, ranging between

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<sup>2</sup> See El-Jardali, F. et al., *Human Resources for Health Planning and Management in the Eastern Mediterranean Region: Facts, Gaps, and Forward Thinking for Research and Policy*, Human Resources for Health, March 2007, Vol 5:9. Also available at [http://www.emro.who.int/hrh-obs/Media/PDF/research\\_countries\\_leb\\_biomed.pdf](http://www.emro.who.int/hrh-obs/Media/PDF/research_countries_leb_biomed.pdf). Site last visited September 8, 2008.

<sup>3</sup> See WHO Eastern Mediterranean Region Observatory on Human Resources for Health. Available at <http://www.emro.who.int/hrh-obs/>. Site last visited September 8, 2008.

only 0.04 to 0.3 physicians per 1,000 population<sup>4</sup>. The disparity in nurses between High and Middle Income countries and Low Income Middle Eastern countries remains just as stark, with the GCC countries ranging between 3.3 and 7.4 nurses per 1,000 population, while the afore mentioned Low Income countries have only 0.1 to 0.6 nurses per 1,000 population<sup>5</sup>.

While there is little known on the precise volume of migration to and within the Middle East or its demographic and socioeconomic characteristics, we do know that in many GCC countries the vast majority of the health workforce is foreign-born and foreign-trained. As a whole, 75 percent of the physicians and 79 percent of the nurses working in GCC countries are expatriates<sup>6</sup>. The Kingdom of Saudi Arabia provides striking illustration of the reliance on foreign health workers within the GCC. In 2001, despite two decades of “Saudization” policies, only 21.7 percent of the physicians working in Saudi Arabia were Saudi nationals<sup>7</sup>. Similarly, only 19.3 percent of nurses and 45.9 percent of allied health workers were Saudi<sup>8</sup>. Furthering this finding presented by the Institute of Developing Economies and relating its impact to Low Income countries, Dr. Badr stated that though migration of health workers from Sudan to Saudi Arabia began in earnest only after 1975, the trend has intensified in the 1980’s, 1990’s, and in the new millennium. Dr. Badr estimates that as many Sudanese doctors may be currently working in Saudi Arabia, as do in Sudan. Dr. Badr additionally stated that of the approximately 800 or so Sudanese doctors that emigrate each year, approximately 70 percent go to Saudi Arabia while 25 percent are absorbed by other Gulf States<sup>9</sup>. Cultural, linguistic, and religious similarity forms a significant part of the reason why health workers are

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<sup>4</sup> Id.

<sup>5</sup> Id.

<sup>6</sup> See Mourshed, M., Hediger, V., Lambert, T., *Gulf Cooperation Council Health Care: Challenges and Opportunities*, McKinsey & Co. Report. Available at [http://www.weforum.org/pdf/Global\\_Competitiveness\\_Reports/Reports/chapters/2\\_1.pdf](http://www.weforum.org/pdf/Global_Competitiveness_Reports/Reports/chapters/2_1.pdf). Site last visited September 8, 2008.

<sup>7</sup> “Saudization” refers to a set of national policies in Saudi Arabia to encourage greater employment of Saudi nationals.

<sup>8</sup> See Yamagata, T. *Securing Medical Personnel: Case Studies of Two Source Countries and Two Destination Countries*, Institute of Developing Economies, Discussion Paper No. 105, May 2007. Available at [http://ir.ide.go.jp/dspace/bitstream/2344/570/1/ARRIDE\\_Discussion\\_No.105\\_yamagata.pdf](http://ir.ide.go.jp/dspace/bitstream/2344/570/1/ARRIDE_Discussion_No.105_yamagata.pdf). Site last visited August 8, 2008.

<sup>9</sup> See Badr, E. *Brain Drain of Health Professionals in Sudan: Magnitude, Challenges and Prospects for Solution*, August 2005, Unpublished. Contact author for further detail.

specifically being recruited from Sudan and other Low Income Middle Eastern states to work in GCC countries. Moreover, according to Dr. Badr, the doctors migrating from Sudan and other Arabic speaking nations are largely placed in primary health centers and distributed over the large geographic expanse of Saudi Arabia, given little opportunity to work and expand their skill sets in the state of the art health hubs being created in urban cities.

The future health of health systems within resource poor source nations, particularly for those sharing cultural similarity and geographic proximity with GCC countries as is the case for much of Sudan, is itself in jeopardy due to current trends in health worker migration. Currently, as Dr. Badr identified, 36 percent of outreach health facilities in Sudan are not functioning and there is only 55 percent coverage of basic health services in the country, due in great part to a lack of staff<sup>10</sup>. Moreover, Dr. Badr points to the fact that Sudan loses approximately US \$24 million annually in money spent to train physicians who then emigrate<sup>11</sup>. The situation looks like it will only become grimmer. According to a recent McKinsey & Co. report, demand for health care in the Gulf Cooperation Council countries is expected to surge by 240 percent over the next 20 years, with Saudi Arabia, Qatar, and the United Arab Emirates expected to record the greatest demand<sup>12</sup>. This anticipated increase in demand for health services in the GCC over the next two decades is the most of any region in the world. The oil-rich Gulf States are rapidly expanding and developing their health systems, using new technologies to provide top-of-the-line care, renovating hospitals, and building oases for health delivery. Oman, for example, in 1970 had only a hundred health workers, with thirteen of them doctors<sup>13</sup>. In 2003 it estimated that 18,579 health workers were working in Oman, with 2,635 doctors and 7,340 nurses<sup>14</sup>. McKinsey & Co. estimates that spending on health care in GCC countries will reach \$60 billion over the next two decades, five times what

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<sup>10</sup> Communication with Dr. Badr

<sup>11</sup> Id.

<sup>12</sup> See supra note 6.

<sup>13</sup> See Little, L., Buchan, J. *Nursing Self Sufficiency/Sustainability in the Global Context*, Developed for the International Centre on Nurse Migration and the International Centre for Human Resources in Nursing, 2007. Available at <http://www.ichrn.com/publications/policyresearch/SelfSufficiency.pdf>. Site last visited September 8, 2008.

<sup>14</sup> Id.

these states currently spend<sup>15</sup>. The projected increase in demand for health services, particularly cardiovascular and diabetes-related services, translates into a growing need for more health professionals in the GCC countries. Despite considerable investments in medical education over the past twenty five years, GCC native human resources for health are not keeping pace with the demand for health professionals. Indeed, a 2004 report of the Saudi Board for Medical Specialization found that by 2020, Saudi Arabia will still be in need of 32,660 doctors and 52,420 nurses from other countries<sup>16</sup>.

Health care jobs in the Gulf region are attracting medical professionals from both the developing and the developed world. In addition to health workers from the Middle East, the Gulf is attracting workers from India, Phillipines, sub-Saharan Africa, as well as from Australia, Canada, the United States, and Western Europe. Health professionals from the Middle East and North Africa, who speak Arabic and share some cultural affinities with the destination countries, are especially desirable. They themselves are likely to desire to be recruited to work in GCC countries. The Gulf states for example are the first choice labor market for Egyptian workers<sup>17</sup>. One Egyptian private recruitment agency that specializes in health workers reported that 90 percent of its work volume is in Saudi Arabia, the rest in Bahrain, Kuwait, Qatar, and in Egypt itself<sup>18</sup>. Similarly, the vast majority of the sixty percent of Sudanese doctors and twenty five percent of Sudanese pharmacists working abroad do so in Saudi Arabia and other Gulf states<sup>19</sup>. The GCC countries are also increasingly recruiting health workers from Australia, Canada, New Zealand, United States, and Western Europe. Mr. Hays reports that his company's advertisements in these developed countries yield thirty to fifty registrants a day seeking medical jobs in the Gulf.

To date there has been little policy coherence on managing the migration of health workers within and to the region. On one hand are national policies of "Arabization", an

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<sup>15</sup> See supra note 6.

<sup>16</sup> Saudi Board for Medical Specialization (2004). "Projections of human resources for health in Saudi Arabia." *Almoltaga Alsihi* magazine, 51, 18-19. Cited by Badr, E supra note 9.

<sup>17</sup> See Awad, I. *Merchants of Labour in the Middle East and North Africa: Egypt as a Case Study*, in *Merchants of Labour* edited by Kuptsch, C. International Labour Organization, 2006.

<sup>18</sup> Id.

<sup>19</sup> See supra note 9.

explicit commitment to employing their own nationals in all domestic sectors, and on the other hand there is a steady growth in the demand for and reliance on foreign health workers. “Saudization” policies have been in place since 1970 with limited success in the health workers<sup>20</sup>. Oman has had similar “Omanization” policies in place since 1998. Some have credited “Omanization” policies as contributing to a greater portion of the health workforce being staffed by Omani’s. Other’s however point to the fact that higher education has not nearly reached the level to meet the current and future demand for health professionals in Oman<sup>21</sup>.

The focus by GCC states on the impact of their use of expatriate health workers on source country health systems has been particularly meager. According to Dr. Badr, active recruitment of Sudanese health workers by Saudi Arabian agencies has gone unmanaged for decades. This in turn has negatively impacted Sudan’s ability to develop and manage its own human resources for health plan. In 2004, Sudan and Saudi Arabia began bilateral negotiations with the goal of launching an agreement for the management of health worker migration. There were talks between the countries’ health ministers, but in the end the draft agreement was never signed. Dr. Badr believes that the primary difficulty with implementing an effective bilateral agreement was lack of Saudi Arabian enthusiasm, as the country had been benefiting from a free rider situation for decades and had little incentive to enter into such an agreement. Active recruitment of Sudanese health workers by Saudi Arabia has intensified over the last few years. Dr. Badr reported that in July 2008, one Saudi Arabian agency recruited more than 300 Sudanese doctors. Encouragingly, Saudi Arabia has renewed contact with Sudan, hoping to work on a bilateral agreement that will not only guarantee a steady supply of doctors to Saudi Arabia but that will also help Sudan to secure the rights of its migrants and better plan its health services.

According to Mr. Hays, the recipient Middle Eastern countries want international expertise but they do not want the experts to stay; they want to “borrow” the training and

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<sup>20</sup> See supra note 8.

<sup>21</sup> See supra note 13.

thus make it difficult for expatriate health workers to get residency and own property. His company is one of four appointed agencies currently recruiting 700 health workers to staff the soon to be completed Sharjah Hospital in Sharjah; the hospital hopes to become “first world quality” and then to replace the foreign health workers with its own nationals. The new Sharjah Hospital is attached to the Sharjah University Medical School, with the direct intention to provide a tertiary training facility on campus. Many of the candidate appointments have both clinical and professorial roles. The McKinsey Report also point to the temporary nature of work in the Gulf States, with health workers from India and the Phillipines viewing “the GCC as a potential stepping stone for more lucrative careers in the west” and staff from the West viewing “a tour of service in the Gulf as an opportunity to save funds before returning home”<sup>22</sup>. Dr. Badr, however, perceives a more permanent situation for most Sudanese health workers, who can now apply for Saudi citizenship after spending ten years working in the country. Cultural and linguistic affinity might be a factor associated with length of planned duration in GCC countries.

While recruitment agencies play a large role in facilitating the migration of health professionals, personal contacts and connections to the diaspora remains an important means of securing employment abroad. The vast majority of Egyptians who find jobs in the Gulf States do so through personal relations<sup>23</sup>. In Sudan, health workers contact Sudanese doctors already working abroad to facilitate their own migration. As can be expected, this type of migration, as opposed to active recruitment, remains difficult to regulate or monitor.

Finally and troublingly, both of our informants discussed the creation of an informal two-tiered system emerging in the GCC. Sudanese and other doctors who lack Western training and board certifications are assigned more junior positions in hospitals and health centers. Doctors with Western credentials are more valued, better paid, work in senior staff positions, and have greater opportunities to increase their skill set. Another recruiter

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<sup>22</sup> See supra note 6.

<sup>23</sup> See supra note 17.



informed us of how employers are requesting workers based upon race, gender, and age criteria.

## **Discussion**

The Middle East generally and the Gulf Cooperation Council countries in particular have become increasingly salient to any discussion on the “brain drain” of health workers. The emergence of the Gulf States as an important hub for health care delivery, the anticipated increases in health care services and spending over the next two decades, and the continued reliance on expatriate health workers justifies greater attention on the region as policy solutions to mitigate the negative impacts and improve beneficial aspects of health worker migration are considered.

A focus on GCC countries is especially useful as it allows us to break traditional conceptions of the role of the South and North serving as source and destination respectively for the migration of health workers, with developed countries utilizing health workers produced in developing countries. The GCC countries serve both as “stepping-stone” for entry to the West and also increasingly are attracting health worker migrants from Australia, Canada, United States, and Europe<sup>24</sup>. The shift of perspective associated with studying the context of health worker migration to the Gulf will also enable for policy solutions to better react and respond to the emergence of other potential hubs for health care delivery, such as in South East Asia, China, and other emerging destinations.

The two-tier system that seems to be emerging in the Gulf States, where compensation, seniority, value, and treatment of migrant health workers is linked to whether they are “Western-trained” or not, requires greater attention. In addition to national legislation in many countries, a number of current health worker migration related codes of practice specifically focus on supporting the equal treatment of foreign health workers with that of nationals. The Pacific Code of Practice for Recruitment of Health Workers for example has specific language stating that “recruits will be protected by the same employment

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<sup>24</sup> See supra note 6.

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”. The Commonwealth Code of Practice for the International Recruitment of Health Workers contains similar language and principles. The WHO Draft Code of Practice on the International Recruitment of Health Personnel also is to be lauded for focusing significant attention on promoting “equality of treatment of migrant health workers with domestically trained health workforce”. None of the above policy instruments however specifically address equating treatment of migrant health workers amongst themselves, regardless of national origin or continent where training was received. Further discussion is needed to determine whether such a provision is appropriate, necessary, and politically feasible.

The role of race, age, and gender in the hiring and treatment of migrant health workers to the Gulf States also requires closer study and greater attention. Attitude towards female migrant health workers, their treatment, and potential policy responses deserves special attention. In 1997, women’s participation in the labor force in the Middle East was the lowest of any region in the world, with only 27% of women participating<sup>25</sup>. As Moghadam stated in her book on gender and social change in the Middle East, “it is said that because of continuing importance of family honor and modesty, women’s participation in nonagricultural or paid labor carries with it *social stigma*”. In this context, it is important that attitudes towards and treatment of foreign trained health professionals be examined further, especially as global normative policy innovations are developed to more ethically manage the recruitment of health workers.

Finally, the rapid growth of health services in GCC, without proportionate growth in national human resources for health, is in particular impacting the health systems of resource poor nations sharing cultural, linguistic, religious affinity and geographic proximity. In addition to Egypt, Yemen, and other traditionally conceived Middle Eastern nations, the impact is also being felt by the sub-Saharan African nations of

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<sup>25</sup> Moghadam, V. *Modernizing Women: Gender and Social Change in the Middle East*, Lynne Rienner Publishers, 1993.

Sudan, Somalia, and Djibouti. Bilateral and international efforts are to be encouraged such that the migration of health workers from resource poor to resource rich nations is better managed. Managed migration will enable resource poor nations, such as Sudan, to better predict and coordinate their own human resources for health planning. Source countries such as Sudan, in turn can endeavor to put in place retention strategies and also to make easier the registration and appointment procedures for returning physicians<sup>26</sup>.

## **Conclusion**

The growth in demand for health services and personnel in the Gulf Cooperation Council countries is clear. Also clear is the potentially significant impact on the health systems of resource poor nations sharing cultural, linguistic, and religious similarity, as well as geographic proximity. The trends in health worker recruitment and migration as can be seen in the region deserve attention through both bilateral and multilateral policy responses. Focusing on the role of the GCC countries in the migration of health workers is also useful as it allows us to broaden our frame in thinking of source and destination countries and in developing solutions that are “future proofed”.

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<sup>26</sup> Communication with Dr. Badr.