

642026

homelands

Two

dom

and

Inštitut za slovensko izseljenstvo in migracije ZRC SAZU

Glavni urednici / Editors-in-Chief
Kristina Toplak, Marijanca Ajša Vižintin

Odgovorna urednica / Editor-in-Charge
Marina Lukšič Hacin

Tehnični urednik / Technical Editor
Tadej Turnšek

Mednarodni uredniški odbor / International Editorial Board
Synnove Bendixsen, Ulf Brunnbauer, Aleš Bučar Ručman, Martin Butler, Daniela I. Caglioti,
Jasna Čapo, Donna Gabaccia, Jure Gombač, Ketil Fred Hansen, Damir Josipovič,
Aleksej Kalc, Jernej Mlekuž, Claudia Morsut, Ikhlas Nouh Osman, Nils Olav Østrem,
Lydia Potts, Maya Povrzanović Frykman, Francesco Della Puppa, Jaka Repič,
Rudi Rizman, Matteo Sanfilippo, Annemarie Steidl, Urška Strle, Adam Walaszek,
Rolf Wörsdörfer, Simona Zavratnik, Janja Žitnik Serafin

Lektoriranje in korektura / Copyediting and proofreading
Jana Renée Wilcoxon (angleški jezik / English)
Tadej Turnšek (slovenski jezik / Slovenian)

Oblikovanje / Design
Anja Žabkar

Prelom / Typesetting
Inadvertising d. o. o.

Založila / Published by
ZRC SAZU, Založba ZRC

Izdal / Issued by
ZRC SAZU, Inštitut za slovensko izseljenstvo in migracije /
ZRC SAZU, Slovenian Migration Institute, Založba ZRC

Tisk / Printed by
CICERO, Begunje, d.o.o.

Naklada / Printum
100

Naslov uredništva / Editorial Office Address
INŠTITUT ZA SLOVENSKO IZSELJENSTVO IN MIGRACIJE ZRC SAZU
p. p. 306, SI-1001 Ljubljana, Slovenija
Tel.: +386 (0)1 4706 485; Fax +386 (0)1 4257 802
E-naslov / E-mail: dd-th@zrc-sazu.si
Spletna stran / Website: <https://ojs.zrc-sazu.si/twohomelands>



Revija izhaja s pomočjo Javne agencije za
znanstvenoraziskovalno in inovacijsko dejavnost
Republike Slovenije in Urada Vlade Republike Slovenije
za Slovence v zamejstvu in po svetu /
Financial support: Slovenian Research and Innovation Agency and
Government Office for Slovenians Abroad

PHYSICIAN EMIGRATION AND GLOBALIZATION: A MARKET LOGIC AND POLITICAL ECONOMY PERSPECTIVE

Taqiyeddine Benfifi,^I Naima Outaleb^{II}

COBISS: 1.02

ABSTRACT

Physician Emigration and Globalization: A Market Logic and Political Economy Perspective

This paper discusses the integration of the health-care sector into the globalized economy through the liberalization of trade in medical services. Governments and companies are increasingly hiring physicians from global labor markets, leading to the widespread mobility of physicians from many low- and middle-income countries to high-income countries. This mass movement of physicians, prompted by the global political economy, has hindered low- and middle-income countries' ability to attract and retain domestically trained medical professionals, raising concerns about the effects of this emigration on public health in countries of origin.

KEYWORDS: labor markets, health care, globalization, physician emigration, political economy

IZVLEČEK

Izseljevanje zdravnikov in globalizacija: perspektiva tržne logike in politične ekonomije

Avtorja v prispevku obravnavata integracijo zdravstvenega sektorja v globalizirano gospodarstvo z liberalizacijo trgovine z zdravstvenimi storitvami. Vlade in podjetja na svetovnih trgih dela vse bolj povprašujejo po zdravnikih, kar povzroča vse pogostejše selitve zdravnikov iz številnih držav z nizkimi in srednjimi dohodki v države z visokimi dohodki. To množično odhajanje zdravnikov kot posledica svetovne politične ekonomije državam v razvoju preprečuje, da bi privabile in zadržale svoje zdravniške kadre, kar vzbuja skrbi glede učinkov te emigracije na javno zdravje v državah izvora.

KLJUČNE BESEDE: trgi dela, zdravstveno varstvo, globalizacija, izseljevanje zdravnikov, politična ekonomija

^I PhD in sociology of health; University of Tipaza Morsli Abdellah, Department of Social Sciences, Laboratory of Studies in Culture, Personality, and Development, Tipaza; benfifi.taqieddine@univ-tipaza.dz; ORCID <https://orcid.org/0009-0005-7119-2817>

^{II} PhD in science in demography; University of Bouira Akli Mohand Oulhadj, Department of Sociology, Bouira; n.outaleb@univ-bouira.dz; ORCID <https://orcid.org/0009-0002-8977-7504>

INTRODUCTION

Conventional discourse on the migration of physicians is a recurring theme within the broader context of international migration, encompassing the movement of physicians from low- and middle-income countries (LMICs) to high-income countries (HICs). LMICs are those countries with a GNI per capita, calculated using the World Bank Atlas method, of \$1,135 or less in 2024; lower middle-income economies are those with a GNI per capita between \$1,136 and \$4,495; high-income economies are those with a GNI per capita of more than \$13,935 (World Bank, 2025).

Since physician emigration is a known contributor to poor health systems in low-income countries, it poses a significant danger to achieving the health-related Millennium Development Goals (IOM, 2005). Physician emigration has been identified as a social phenomenon, with its occurrence being linked to the historical, political, and economic context in which it transpires. In this regard, globalization poses a significant challenge to health policies in the twenty-first century. This trend is due to transnational epidemiological effects and migratory impacts on health, as well as the emergence of unhealthy lifestyles (Cabello et al., 2017; Frenk et al., 2011; Pang & Guindon, 2004). These have led to the development of numerous chronic and deadly diseases, which have become important aspects of globalization. The primary challenge in this regard concerns the globalization of the health sector itself, characterized by direct trade in health goods and services, the movement of individuals (patients and professionals), and the emergence of a distinct market within the health field (Smith et al., 2009).

Globalization has facilitated the dissemination of physicians from the developing to the developed world, and even between developed countries, in pursuit of what is often termed “greener pastures” and a satisfactory standard of living (Opoku & Apenteng, 2014; Packer et al., 2007b). The repercussions of the health services trade on the liberalization of general trade, international law, and international institutions raise several questions about the outcomes of the continued physician employment, which reflects a state of competition for this human resource (Benfifi, 2025; Byrne et al., 2021). This challenge represents one of the most significant dangers posed by the globalization of the health market.

In the same context, many health systems have become vulnerable due to the emigration of their health staff, who are a critical human resource for the health sector (Clark et al., 2006). Despite the rising number of medical graduates, many HICs are struggling to meet their health staff requirements. In an effort to address this imbalance, HICs have been compelled to recruit medical professionals from LMICs (Eaton et al., 2023). The services that physicians provide have become products bought and sold in global markets by countries and governments, as well as by private and multinational companies. This has led to the emergence of international organizations such as the World Health Organization (WHO), which seeks to ensure the fundamental right of access to essential health care (WHO, 2010).

This study contends that comprehending physician emigration is intrinsically linked to the functioning of health-care markets and the political economy. Moreover, it underscores that globalization, through its causes and impacts on countries and international collaboration, has emerged as the quintessential feature of international relations, especially between HICs and LMICs.

The present study addresses the following questions: What effects have the global health market and political economy had on the migratory patterns of physicians from LMICs to HICs, and what are the implications for the countries of origin? How has globalization made patterns of physician mobility more complex?

METHOD

The study draws on statistics from the OECD, the WHO, and the World Bank, which provide up-to-date data about the health labor market. These data sources were chosen due to their reliability and consistency. We reviewed the published literature in the Scopus, Web of Science, PubMed, and JSTOR databases using the following keywords: "Health labor market," "physician emigration," "globalization," and "political economy of health".

The inclusion criteria are studies that focus on physician emigration and have a direct link with LMICs and HICs, and studies that highlight the nexus between globalization, political economy of health, and demand and supply, and physician emigration. The exclusion criteria were studies and technical reports about medical training and technical studies unrelated to health policies.

CONCEPTUAL AND THEORETICAL FRAMEWORK

The concept of globalization

The concept of globalization emerged in sociological literature in the late 1980s (Dollar, 2005). It refers to "the compression of the world and the intensification of consciousness of the world as a whole" (Robertson, 1992, p. 8). According to Giddens (1990), globalization is "the intensification of social relations across the globe that connect distant regions so that local events are shaped by events occurring many miles away and vice versa" (p. 64), thereby changing all aspects of our daily lives. Tomlinson (1999) defines globalization as a "complex communication" process because it "refers to the rapidly evolving and intense web of interconnectedness and interdependence that characterizes modern social life" (p. 2).

Therefore, globalization refers to three fundamental elements: First, internationalization, which characterizes the increase in cross-border economic transactions, affecting trade flows, capital mobility, and human movement. Second: technological

power, Globalization would not have gained such momentum without the ease of movement between countries, thanks to rapid technological advancements and new communication technologies. Third: liberalism, which is based on free markets and the integration of weaker countries into the global economic system.

These three elements work together to greatly facilitate the movement of physicians from LMICs to HICs. Bilateral and multilateral agreements between countries on interdependence, which have grown significantly in recent decades, have facilitated this mobility. The availability of transportation, information, shorter distances, and the internet have also been crucial factors in the ease with which physicians emigrate from developing to developed countries. Furthermore, the liberalization of the international economy has facilitated the development of new patterns of economic activity that extend beyond the movement of goods to include the movement of services provided by migrating physicians.

Physician migration: market-based perspective

The notion of the international labor market signifies a substantial shift in the dimensions and confines of labor markets, transcending geographical boundaries and the traditional nation-state framework. Mooney & Evans (2007) have argued, “The global labor market is predicated on the assumption and promotion of the mobility of workers on a global scale” (p. 109). The labor market is a multifaceted system of social and economic interactions that is ever evolving. Therefore, it is essential to analyze and regulate this system to account for the specificities of the context in which it operates and to ascertain the future of work (Ključnikov et al., 2023). The term “market” is generally understood to denote a scenario in which buyers (i.e., consumers) and sellers (i.e., producers) engage in direct or indirect interactions to facilitate the exchange of goods and services. In such a scenario, the forces of supply and demand interact to determine the prices of the goods and services being exchanged (Mwachofi & Al-Assaf, 2011).

The labor market is defined as “the aggregate supply and demand for labor” (Kotlia, 1998, p. 53). The concept under discussion encompasses two fundamental dimensions: supply and demand. The supply and demand model elucidates the determination of the price of a good or service (over a given period) in a perfectly competitive market. The market comprises a group of buyers and sellers interested in trading identical units of a particular good (Sepulveda, 2020) at a price that determines its value, which can increase or decrease. In this paper, the commodity is physicians and the services they provide in the destination country, namely health care, and the price is the fee, bonus, and allowance the physicians receive for their services.

The labor market in the health sector is a dynamic system comprising two distinct yet closely interconnected economic forces: the supply of health-care workers and the demand for them, whose employment is shaped by state institutions and

regulatory frameworks (McPake et al., 2013). Governments and the private sector determine the demand for health-care workers in a given country, while international actors—such as donors and multinational corporations—decide how much they are willing to pay for their employment. The “willingness to pay” depends on the level of health-care funding, just as the “desire to employ” health-care workers depends on the financial resources available to do so. Willingness to pay distinguishes demand from “need.” There is often a mismatch between the financial resources available—and thus the willingness to pay—to employ health-care workers and the number of workers needed to meet the population’s health-care needs (McPake et al., 2013).

Wage levels, as well as other economic, social, technological, legal, demographic, and political factors, influence the supply of health-care workers. Two critical considerations regarding wages arise in health labor markets: market failures and wage-setting processes in the public sector imply that wages cannot be assumed to reflect productivity measures or to be value-based on demand or need for health-care professionals. Furthermore, wage rigidity tends to be greater in the public sector than in the private sector (McPake et al., 2013). It is suggested that these two considerations may be responsible for a series of phenomena within the health labor market, including the international migration of physicians and the shortage of health workers.

As with any other labor market, the health labor market consists of buyers and sellers of health workers. The behavioral characteristics of these buyers and sellers shape their responses to changes in economic incentives and the institutional environment, thus determining the demand and supply of labor (Araujo & Dussault, 2017). The key variables of interest are demand and supply rates and wages (prices), which regulate both supply and demand. Demand is defined as the number of hours that health workers (government, private sector, and international actors, including donors and multinational corporations) are willing to hire and that physicians are willing to work. The demand for health workers is derived from the demand for health services; ultimately, the funding available for health care determines the demand for health workers. Supply is defined not only as the total number of hours that health workers are willing to provide (Araujo & Dussault, 2017) but also the competence and experience of physicians in medical care.

In a well-functioning market, the interaction between the forces of demand and supply—for example, between buyers and sellers of labor—determines labor market outcomes, such as employment rates and the geographical and sectoral distribution of labor. The fundamental premise of this theory is that the wage rate aligns with the interests of both buyers and sellers, thereby facilitating the attainment of equilibrium in the labor market. Due to significantly lower physician salaries in many countries than in the United States, even compensation considered moderate by US standards in rural or underserved regions may appear appealing to International Medical Graduates (IMGs) (Braga et al., 2024).

In essence, this theoretical framework posits that the market reaches a state of “market clearing,” signifying that the quantity of labor supplied corresponds with the quantity of labor demanded at a specific wage rate. An increase in demand for health services raises the willingness to pay for health workers. It also increases labor market demand, which in turn affects future labor allocation, as more people become health professionals. If the market fails to clear, there is a shortage or surplus (unemployment) of labor (McPake et al., 2015).

Health labor markets are characterized by persistent imbalances. As a result, virtually every health-care system worldwide is struggling to produce and retain the medical human resources it needs with the appropriate numbers and skills. The main reason is that wage rates fail to reflect consumers’ valuation of health-care professionals. Consequently, health worker hiring decisions are rarely linked to changes in the need for health care. For example, in low-income countries, the majority of households live in poverty and insurance coverage is limited, resulting in a significant gap between the need for qualified health workers and the labor market’s ability to generate sufficient demand for these workers (Araujo & Maeda, 2013).

While the above perspective provides a relative explanation of physician emigration, it still has limitations. Health systems are not regulated by a purely competitive market or the laws of supply and demand. Instead, they are progressively co-created by various players and influenced by local, national, and global causes (Bloom & Standing, 2008), such as health-care professionals, finance, unions, the nature of health systems, public policies, the wage system, employment, insurance companies, service chains, and others. Furthermore, the recruitment of physicians, as stipulated by the code of practice, is subject to ethical standards (WHO, 2010). Besides, there is a nexus between the state, the market, and the international actors. Consequently, the health sector transcends mere economic reasoning. It also entails the establishment of legal regulations and the governance of national and local policies (Koivusalo, 2014). Consequently, physicians cannot be seen only as commodities for exchange, nor can their services be simplified to the tenets of supply and demand. When recipient nations recruit physicians and encourage their relocation, they deprive the originating country of a fundamental component of its health-care system—a cornerstone of its society.

Physician migration: A political economy perspective

The concept of “the political economy of health” is associated with Marxism. It includes a wide range of concepts that have shaped the Marxist legacy, such as class, class struggle, exploitation, profit, relations of production, working conditions, global imperialism, and underdevelopment. Political economy is about the relationships among the state, economy, and civil society (Raphael & Bryant, 2006). In this context, Salvador Allende analyzed how high-income countries built and enforced exploitative international economic relationships with impoverished countries,

initially through colonialism and, subsequently, through various forms of corporate, political, and economic neocolonialism (Waitzkin, 2007). Raphael (2015) examined political economics through the lens of political and economic frameworks that distribute resources based on the varying levels of power held by individuals and groups within society. This assumption of inequality in the distribution of power, income, and health applies even between countries; as Krieger (2001) argued: "At issue are priorities of capital accumulation and their enforcement by the state, so that the few can stay rich (or become richer) while the many are poor, whether referring to countries or to classes within a specified country".

This foundation provides a perspective for understanding the inequalities in the distribution of health workers across countries. Internationally, uneven productivity growth has led to significant income disparities, a key factor contributing to more serious health concerns regarding the international distribution of health workers, particularly physicians (Dacuycuy, 2008). Researchers have highlighted how international organizations impose neoliberal policies on developing countries through normative and coercive means (Chorev, 2013). Countries in the global South were promised much-needed assistance in paying off their debts if they signed agreements with the World Bank and the International Monetary Fund. However, these lending arrangements were contingent on changes to market-liberalizing policies. Moreover, under the neoliberal system, structural adjustment policies imposed on LMICs have widened the wage gap between LMICs and HICs. Governments have advocated privatization, commodification, deregulation, and austerity measures, with serious repercussions for access to, equity in, and the quality of care. The reliance of LMICs on neoliberalism has led to the emergence of inequality and an unequal distribution of wealth between countries and to a shift from traditional colonialism to neocolonialism, in which countries of the North exploit countries of the South through political, economic, and legal means. While LMICs have little negotiating power, HICs set the guidelines for hiring practices, immigration requirements, and credential recognition.

These policies in LMICs have weakened their ability to retain physicians. Due to low income, limited employment opportunities, and poor working conditions, coupled with the recruitment programs pursued by HICs, physicians emigrate in search of better employment opportunities and working conditions. These are called pull factors in the migration literature. These elements provide a somewhat symmetrical image of the comparable salaries, career opportunities, working conditions, and environments found in the source and destination countries. Destination countries will be appealing where a substantial gap (or perceived gap) exists. However, factors such as concerns about one's own safety in conflict areas and unstable economies can also be significant factors in certain countries at certain times. Supplementary pull incentives, such as the prospect of travel or participation in relief initiatives, could be highly effective (Buchan & Perfilieva, 2006).

Historically, physicians have frequently emigrated to countries with which they share historical connections. For instance, Algerian physicians favor emigrating to France (Benfifi & Outaleb, 2024), whereas Indian, Pakistani, and Nigerian physicians favor emigrating to the UK (Daniel et al., 2023; Saleem et al., 2021; Trewby, 2017). This trend signifies the perpetuation of colonial connections. Physicians emigrate to these countries mostly because of linguistic proximity, as they are proficient in the colonizers' language owing to their medical education conducted in that language; this factor significantly influences their choice of destination countries.

GLOBAL TRENDS AND IMPACTS OF PHYSICIAN MIGRATION

Recently, the movement of physicians between countries has been greatly facilitated by the ever-increasing demand for HICs and the global environment, driven by the liberalization of trade in health services and the globalization of the health market. Besides, HICs' reliance on foreign labor was a result of the high costs of physician training under neoliberal policies. This trend has led many to hypothesize that Mode (4) of the General Agreement on Trade in Services (GATS) (which deals with the movement of natural persons) could lead to massive imbalances in human resources for health (Nielson & Taglioni, 2003). It has been argued that the architects of the GATS made highly dangerous assumptions, although these findings may not be reflected in the agreement itself. These assumptions pertain to the gradual distancing of governments from the provision, management, or intervention of services, even for fundamental needs such as water, health, and education (Kinuthia, 2002).

The international migration of health workers has long been a matter of concern for state health policy. However, with the privatization and commodification of health services, health worker migration is increasingly regulated through universal service mechanisms (Collyer & White, 2011), which can be viewed as commodities shaped and exported by state and private capitalist interests. Clark et al. (2006) point out two ways in which physician emigration occurs:

The first: through permanent recruitment by employers or agencies. HICs increasingly use this approach to recruit staff into their health-care systems. The second is more passive. One example is the National Health Service's use of relatively new communication technologies to provide potential migrants with the information they need to decide both to migrate and to actually embark on it. These technologies include websites and email, which have increased awareness among health-care workers of opportunities available in developed countries. Such strategies are considered negative because they recruit health-care professionals into national health service systems without direct personal contact. This scenario is exactly where globalization's role in enabling physician mobility becomes evident.

During the COVID-19 pandemic, hiring rates increased significantly due to the urgent need to address physician and other health-care professional shortages. Undoubtedly, the pandemic exacerbated existing inequalities and generated new injustices (Pardo, 2020), profoundly affecting the evolving health-care landscape (Dew, 2012). Since the onset of the pandemic, countries within the Organization for Economic Co-operation and Development (OECD) have expanded the recruitment of foreign health-care workers from low- and middle-income countries. In 2020, the OECD warned that:

“While international recruitment of foreign health-care workers is a quick fix to address workforce shortages in some countries during the COVID-19 crisis, it cannot be regarded as an effective or equitable solution. First, it does not address the structural imbalances between supply and demand for health-care professionals. Moreover, due to the global nature of the pandemic, it deprives sending countries—often characterized by weak health systems—of health-care workers at a time when they face a major health crisis” (OECD, 2020, p. 8)

HICs employ large numbers of physicians despite significant imbalances in the availability of this human resource and disease burden. Data on the number of physicians per capita indicate that among HICs, Norway has the highest physician density, with 44 physicians per 10,000 population in 2015. Japan employed 24 physicians per 10,000, while the United States employed 26 physicians per 10,000 in the same year (OECD, 2017). Across all OECD countries, the average was 34 physicians per 10,000 population (OECD, 2017). According to Table 1, the primary health sector attracts migrants in the United Kingdom, Australia, Norway, and the United States, as indicated by statistics for 2022 and 2023 published by the Organization for Economic Co-operation and Development (OECD, 2024b). International migration indicators have reached record highs in OECD countries since the COVID-19 pandemic, exceeding 6.5 million new migrants in 2023 and reaching well over 150 million people born outside OECD countries and settled there (OECD, 2024b).

OECD	Foreign-born population	Labor migration rates (%)	Health sector (%)	Net migration rates (%)	Natural growth rates (%)	Population growth rates (%)
United Kingdom	15.4%	39%	16.50%	7.2%	0.2%	7.4%
	10.4 million					
Australia	31%	24%	14.80%	20.8%	3.9%	24.7%
	8.2 million					
Norway	17.5%	13%	13.70%	9.6%	1.5%	11.1%
	1 million					
United States	14.5%	14%	12.30%	3.4%	1.5%	4.9%
	49.1 million					

Table 1: The distribution of OECD countries receiving migrants by health sector (greater than 10%) between 2022 and 2023 (source: OECD, 2024b).

Emigration plays an active role in fueling the health market, especially in HICs such as the United Kingdom, Australia, Norway, and the United States. It also contributes to the labor market as a whole, with migrant workers accounting for between 10% and more than 30% of the workforce. In addition, migration has become a pillar of population growth, if not its source, especially in countries that still record natural growth rates of no more than 1.5%, except for Australia, which records a natural growth rate of over 3.5% and a net migration rate of over 20%. There are currently 78,823 physicians registered in the UK Medical Register who were trained in 57 of the world’s poorest countries. Table 2 illustrates this (Eaton et al., 2023):

2017	May 2021	December 2021
50,000 (25%)	97,662	112,024

Table 2: Number of physicians employed in the UK who were trained in low- and middle-income countries (source: Eaton et al., 2023).

In a complex global health system, the asymmetry of power relations between source and destination countries is readily apparent. Ineffective health-care environments that lack the fundamental requirements for keeping physicians and guaranteeing their professional recognition are the result of structural institutional issues, such as poor governance, inadequate funding, and dwindling regulatory capacity. Additionally, underinvestment in medical resources due to state weakness under neoliberal austerity and restructuring programs has made high-income countries the preferred destination for physicians from vulnerable and low-income countries.

In 2022, more than 2.4 million work permits were issued, and in 2023, approximately 2.1 million study permits were issued for students (OECD, 2024b). These statistics demonstrate the vitality and activity of labor markets in OECD countries, most of which are classified as developed. Some countries suffer from low, even negative, natural growth rates, aging populations, population retirements, and a general shortage of skilled labor, particularly in the health-care sector.

The demand for skilled and specialized labor, particularly in the health-care sector, has become a fundamental requirement for these countries. Although they impose restrictions on immigration, their need for health-care professionals forces them to consider the market logic of supply and demand, balancing their constraints and needs. This is due to their low natural growth rates, which directly affect their future labor supply and the care they provide to their elderly, both now and in the future. This keeps them competitive in attracting skilled labor and migrant students (OECD, 2024b). The health sector continues to attract migrants in OECD countries, although in many cases it ranks behind other sectors, such as trade, industry, energy, education, administration, and accommodation and food services (OECD, 2024b).

There is both internal competition among sectors and national interests within each country, as well as external competition between countries to attract health-care professionals to their sectors. In Denmark, the health-care sector accounts for over 20% of immigrants, ranking second only to the trade sector. Denmark exhibited a negative natural growth rate of -0.2% , indicative of a substantial decline in fertility rates and births, and an increase in mortality due to aging.

Finland reported a similar situation with a natural growth rate of -3.2% in 2023. However, the country's population increase was supported by a net migration rate of more than 10%. Concurrently, labor migration constitutes 32% in Finland, with the health-care sector ranking third in attracting migrants—after the industrial and administrative sectors—at 11%. Sweden shows a low positive natural growth rate of 0.5% and a net migration rate not exceeding 2.5%. Labor migration accounts for 20%, with migration to the health-care sector exceeding 12.5%. Additionally, 20% of Sweden's population is foreign-born. Ireland is the most attractive labor migration market among these countries, with over 50% recorded in 2023. The health-care sector ranked fourth, attracting 10% of migrants.

The main reason for these rates may be that these countries prioritize other sectors, such as industry and administration, or limit funding for recruiting medical

professionals, making them less competitive than other countries. Alternatively, they might be self-sufficient, with imports of professionals adequately meeting health-care sector needs. The latter assumption is unlikely given the very low or negative natural growth rates in these countries, which suggest a future workforce shortage and significant demographic changes. This situation will open competitive labor markets despite immigration restrictions and prompt these countries to re-order their priorities regarding the demand for migrating medical professionals.

Table 3 demonstrates that the health sector is not a strong competitor with other sectors in the labor market in these countries, as it does not hold a leading position, and its worker recruitment rates fluctuate between 7% and 9%.

OECD	Foreign-born population	Labor migration rates	Health sector (%)	Net migration rates (%)	Natural growth rates (%)	Population growth rates (%)
Netherlands	15.8%	16%	9.10%	7.6%	-0.3%	7.3%
	2.8 million					
France	13.8%	20%	8.30%	2.7%	0.7%	3.4%
	8.9 million					
Belgium	19%	6%	8%	7.6%	00%	7.6%
	2.2 million					
Slovakia	3.9%	78%	7.70%	0.3%	-1%	-0.8%
	0.2 million					
Germany	18.2%	14%	7%	8%	-4%	4%
	15.2 million					
Switzerland	31.2%	2%	7%	15.4%	0.9%	16.3%
	2.7 million					

Table 3: Distribution of OECD countries receiving migrants by health sector (from 6% to less than 10%) between 2022 and 2023 (source: compiled by the authors based on OECD, 2024b).

France alone recruited 30,961 physicians who obtained their medical degrees abroad, according to the National Medical Council's 2024 statistics, with most coming from non-European Union countries. The three Maghreb countries—Algeria (36.7%), Tunisia (13%), and Morocco (7%)—supplied France with medical professionals, accounting for 56.7% of the total number of emigrant physicians (Zehnati, 2024).

An overview of the evolution of the percentage of physicians who obtained their degrees outside the receiving countries (see Table 4) reveals that demand for physicians has doubled in all OECD countries except Finland, where demand has halved over the past twenty years.

As for the remaining European countries mentioned in the table, demand for medical expertise has tripled, with physicians who obtained their degrees outside the receiving countries accounting for more than a third of the total number of physicians in 2020, according to OECD statistics.

OECD receiving countries	2000	2010	2015	2020
Germany	4%	7%	10%	14%
Australia	/	/	36%	35%
Belgium	4%	8%	11%	13%
Canada	21%	23%	25%	26%
Denmark	4%	9%	9%	10%
United States	/	25%	25%	/
Finland	34%	23%	19%	16%
France	4%	8%	11%	12%
Ireland	/	/	39%	40%
Norway	/	36%	39%	43%
New Zealand	38%	44%	42%	42%
United Kingdom	/	33%	34%	36%
Sweden	14%	24%	34%	33%
Switzerland	/	24%	32%	37%

Table 4: The evolution of the proportion of physicians who obtained their degrees outside the receiving countries (2000–2020) in receiving OECD Countries (source: compiled by the authors based on OECD, 2024a).

The United Kingdom, the United States, Canada, New Zealand, Norway, and Australia have maintained similar proportions of medical professionals with qualifications from other countries. This may be due to their reliance on carefully selected immigration, which controls the health labor market, and their strategies for regulating their health sector (demanding medical professionals according to their needs).

Overall, Asian countries (India, China, and Pakistan) are the largest suppliers of migrant physicians and nurses worldwide, but there is also increasing movement between OECD countries, mainly due to growing flows within the European Economic Area, particularly from Eastern Europe (OECD, 2024b). However, small island countries continue to show the highest migration rates (OECD, 2015).

However, if we compare the aforementioned HICs with LMICs in terms of burden of diseases and the availability of health workers, it is estimated that Africa accounts for 13.76% of the global population, yet bears 25% of the global disease burden, while its health-care workforce represents only 1.3% (Packer et al., 2007a), and its share of global health expenditures is less than 1%, leaving more than half of its population without access to essential health services (Chattu et al., 2021). This paradox threatens the health security of these countries. Despite a considerable period of continuing medical education programs, the physician-to-population ratio has been declining since the 1980s. While there was once one physician per 10,000 inhabitants in sub-Saharan Africa, by 2004 this ratio had fallen to 0.2 physicians per 10,000, compared to 24 physicians per 10,000 in the United States and 28 per 10,000 in the UK (Saluja et al., 2020).

This is closely related to the political economy of health theory, which holds that how countries produce and distribute resources significantly impacts population health. An unequal distribution of power among countries and a decline in public health are demonstrated by the training of physicians and the distribution of material and financial resources, which are then exploited by countries that did not invest in their training. As a result, social and economic inequalities and privileges are maintained.

The swift escalation of LMICs' sovereign indebtedness has diverted resources from public health investment. For example, in the first year of the COVID-19 pandemic, out-of-pocket spending in LMICs dropped by about 2%, and it is unlikely to tick up further given the ongoing cost-of-living crisis (Stubbs et al., 2023). This will disproportionately impact the impoverished and most susceptible people, likely exacerbating health disparities within countries. The dismantling of inequities in global health must involve bridging the significant capacity gap between professionals in HICs and LMICs, which resulted from their emigration (Olufadewa et al., 2021).

Previous studies assessing the cost of physician emigration to LMICs relative to the cost of physician education found that educating a physician costs between \$29,898 and \$65,997 (Kirigia et al., 2006; Mills et al., 2011). While Mills et al. (2011) estimated the total "lost investment" in sub-Saharan Africa at approximately \$2.17

billion. Table 5 illustrates the annual cost of physician emigration by WHO region and World Bank income group.

WHO regions	Total annual cost (million US\$)	% of gross national income	Cost per physician per year (thousand US\$)
Africa	6,425 (1,572 to 15,414)	0.370% (0.091% to 0.888%)	293 (71 to 740)
Americas	1,079 (216 to 2,631)	0.020% (0.004% to 0.050%)	30 (6 to 78)
Eastern Mediterranean	3,468 (610 to 8,490)	0.205% (0.036% to 0.503%)	76 (13 to 194)
Europe	434 (75 to 1,070)	0.013% (0.002% to 0.031%)	10 (2 to 26)
Southeast Asia	3,804 (780 to 9,042)	0.102% (0.021% to 0.243%)	49 (10 to 121)
Western Pacific	645 (132 to 1,598)	0.005% (0.001% to 0.014%)	34 (7 to 86)
WB income groups			
Low income	936 (233 to 2,213)	0.258% (0.064% to 0.609%)	208 (51 to 530)
Lower middle income	10,582 (2,352 to 25,350)	0.181% (0.040% to 0.434%)	82 (18 to 205)
Upper middle income	4,337 (798 to 10,682)	0.020% (0.004% to 0.050%)	41 (7 to 105)
Total	15,855 (3,384 to 38,245)	0.057% (0.012% to 0.138%)	66 (14 to 166)

Table 5: Characteristics of low and middle-income countries, by WHO region and World Bank income group (source: Saluja et al., 2020).

These statistics reflect the cost of medical brain drain to LMICs for each year that the existing emigrant workforce remains abroad. This includes the fact that brain drain is not a one-time capital loss but continues to impact LMICs each year, as their physicians are out of the country. The emigration of physicians transfers tax revenue from the source country to the destination country; it results in the loss of the contribution of employed physicians' earnings to future income and economic growth; and it creates a cooperative disadvantage—in other words, the loss of the positive effects

that a large number of professionals can have on raising the average productivity of their colleagues who choose not to emigrate (Robinson, 2007).

Saluja et al.'s study indicates that LMICs incur an annual loss of around US\$16 billion due to excess mortality costs associated with physician emigration to HICs (Saluja et al., 2020). The predominant portion of this expense, according to the model employed in the study, is attributed to under-five mortality associated with reduced physician density. The financial impact of excess deaths attributed to brain drain, expressed as a percentage of total national GDP, is most pronounced in low-income countries in the African region. Nonetheless, when evaluating the overall cost, it is highest in LMICs, particularly in the Southeast Asian and Eastern Mediterranean regions.

The shortage of physicians in sub-Saharan Africa is a widespread problem, linked to maternal mortality rates 30 to 50 times higher than in wealthy countries. Life expectancy at birth in sub-Saharan Africa is 54 years, roughly 26 years lower than in HICs today (WHO, 2011), and only three years higher than in the United States a century ago (Arias, 2010). Physician emigration constitutes a tremendous shift of wealth from impoverished LMICs to prosperous HICs. Indeed, the financial gains for HICs and the financial losses for LMICs resulting from this brain drain are enormous (Mackintosh et al., 2006; Physicians for Human Rights, 2004).

The shortage of physicians in LMICs has led to the closure of some health facilities, preventing many patients from receiving necessary care (Padarath et al., 2004). This dire situation has also made it difficult to find replacements for physicians who have emigrated. For example, in Mali, the government built 533 health centers; however, by January 2001, only 43% of these remained open. The same is true in Zambia, where access to health care has become extremely limited. For instance, of the more than 600 physicians trained in the country since independence, only 50 remain. Furthermore, in Malawi, inexperienced workers have been sent to work as midwives (USAID, 2003). The Volta Regional Hospital, a new hospital in Ghana, was forced to rely mostly on retired physicians and surgeons, who might not have the most recent medical knowledge (Physicians for Human Rights, 2004). The shortage of physicians may lead to incorrect diagnoses and inappropriate treatment as patients may have to wait a long time before beginning treatment (Awases et al., 2004).

The relationships between the "axis" countries (HICs) and the "periphery" (LMICs), along with the uneven interaction between them, contribute to the differential and inequitable development of the world. A recent study found that while some attempts were made to integrate LMICs into global trade and economy, international organizations could not translate their policy rhetoric into reality (Regmi, 2025). The unified strategy used by multilateral organizations has adversely affected least developed countries due to disparities in production, trade, and economic conditions across countries. Global neoliberal policies have resulted in considerable inequality in the allocation of health-care professionals and have enabled the replacement of democratically elected governments with a governance model in

which market forces, including multinational corporations, financial institutions, and private foundations, significantly diminish state authority in essential policy decisions (Piketty, 2020). For instance, a recent study found that hospitals transitioning from public to private ownership generally achieve higher profits than their public counterparts that remain public, mostly through selective patient admission and workforce reductions. It is also found that overall increases in privatization often correlate with deteriorating patient health outcomes (Goodair & Reeves, 2024). Another piece of evidence is that the proportion of physicians engaged in private health-care delivery, the percentage of health-care expenditures funded publicly, and the per capita private health-care financing were all inversely correlated with the degree of physician expatriation (Loh et al., 2013).

Kurowski et al. (2004) assessed the availability of health workers relative to the needs of the health system in Tanzania and Chad, both LMICs. The study results showed that, first, there is a conspicuous absence of health workers in these countries, with the number of personnel available falling significantly short of the numbers required to deliver essential health services. The researchers estimate that sub-Saharan Africa as a whole faces a shortage of 720,000 physicians and 670,000 nurses. Second, the competencies necessary to provide essential services are either insufficient or set at unreachable levels of excellence. This situation has posed considerable implementation challenges. Third, the production rates of health workers are found to be inadequate compared with the losses sustained by the health system due to mortality, attrition, and increased migration.

While the significance of human resources in health policy has always been recognized, the prevailing driving forces and focal points of discussion have shifted significantly in the past decade. More recently, the issues of brain drain and the impact of globalization on health systems have assumed prominence on the agenda (Frenk & Gómez-Dantés, 2002). The process of globalization has had a significant impact on the capacity of national health-care systems to deliver essential services to their populations. The most significant impact is being felt in the least developed countries, where there has been a considerable increase in migration driven by the globalization of the labor market, alongside push and pull factors and other structural factors. The underfunding and dysfunction of health-care systems in these countries have been identified as a key factor contributing to their inability to compete effectively in the global labor market. The emigration of medical professionals from LMICs has a detrimental effect on the already fragile state of health-care systems, thereby making it even more difficult to retain specialists in this field (Clark et al., 2006). We can compare this phenomenon to a snowball effect, where each successive migration leads to an increasing influx.

Globalization has had a direct impact on national health policy through increased interaction and interdependence between states. For example, the shortage of health workers in low-income countries can be attributed to the active and passive employment of health workers by rich countries (Hagopian et al., 2005).

This, in turn, has led to inequality between LMICs and HICs. Inequality manifests through the social determinants of health, as the conditions in which people live and work are increasingly shaped by global business interests that affect the chances of living an adequate, healthy life (Labonte, 2007). HICs primarily respond to the shortage of health-care professionals by recruiting from LMICs. Health-care workers are increasingly being employed in temporary or permanent jobs abroad. Although some of this movement occurs between HICs, most occurs from LMICs to HICs (Clark et al., 2006).

In response to the consequences of physician emigration, many countries have sought to mitigate and regulate its negative effects through various international, regional, and national mechanisms. Among these tools are the Codes of Practice, which are non-binding. The extent of such statements is analogous to that of a Statement of Intent. In summary, the aforementioned codes do not impose penalties on employers who violate their provisions, nor do they provide any incentive for compliance. These accords do not preclude the recruitment of health personnel from countries identified as experiencing a deficit of such professionals; rather, they pertain exclusively to the organization of recruitment initiatives (OECD, 2004).

Despite the significance of these codes in regulating physician mobility, the lack of penalties or ongoing enforcement mechanisms has allowed emigration to persist. This is particularly evident in the context of provisions offered by host countries (such as Mode 4), which have remained limited to ethical discussions rather than binding obligations, resulting in inadequate implementation by receiving countries.

Conversely, agreements such as the Bilateral Agreements (Memoranda of Understanding), the Agreement of Understanding between the UK and South Africa, and the Agreement of Understanding between Namibia and Kenya regarding Technical Cooperation in Health are treaties established between two countries to govern recruitment protocols. Nonetheless, it is significant that these agreements have not fundamentally changed migratory patterns, since movement continues to be influenced by a combination of macro-structural forces and micro-level factors. Thus, they have failed to tackle the fundamental reasons of migration, instead of alleviating its consequences. Moreover, like the WHO's codes of conduct, these agreements are non-binding and confine themselves to outlining overarching cooperation and ethical concepts. Consequently, they have not participated in reforming, regulating, or devising measures to safeguard nations of origin.

Although discussions continue regarding regulating migration through these agreements, and debates are growing about taxes on brain drain and ethical recruitment, the absence of compensatory mechanisms undermines the possibility of reaching an effective solution that guarantees the rights of countries that have trained their physicians. Furthermore, weak data, a lack of coordination between countries of origin and destination, and the inability to track migration pathways have hindered the implementation of proposed policies. For example, the lack of evaluation in the Agreement of Understanding between Namibia and Kenya on

Technical Cooperation in Health limited its scope and resulted in short-term assessments. While the Southern African Development Community (SADC) was relatively successful, it did not address the structural causes of migration and therefore had little impact.

Regional Agreements have also been developed to remove barriers to the free movement of persons within the SADC (Southern African Development Community, 2005). In contrast to the previously stated instruments, this general migration policy does not explicitly govern the mobility of health-care professionals; it aims, among other things, to examine the legislation and regulations governing their migration. However, it was not ratified by a sufficient number of countries (Vhumbunu et al., 2024).

Furthermore, it appears that HICs possess powerful negotiating tools and mechanisms that put developing countries at a disadvantage. This perpetuates inequality and ignores structural disparities when the same mechanisms and rules are applied to countries with deep development gaps.

CONCLUSION

In response to our questions, migration from LMICs has surged to unprecedented levels, driven primarily by labor-market demand and the need for physicians in HICs. The emigration of physicians has escalated due to international policies focused on free markets and voluntary exchange, which have exacerbated disparities between nations of origin and destination. Furthermore, nations of origin have suffered significant harm due to neoliberal policies, rendering them unable to sufficiently attend to their citizens or fulfill the requirements of their own medical professionals. The emergence of globalization has prompted the integration of the health sector into the global market economy, resulting in the exchange of labor and a significant influx of physicians into high-income countries, thereby driving massive physician emigration. Nevertheless, we must acknowledge that emigrants have agency in shaping their migration decisions, since emigration is not merely a reflection of superstructures or market forces. Therefore, the reasons for emigration differ at the micro level, including personal aspirations, family circumstances, and professional opportunities that vary from one individual to another.

This article seeks to integrate the viewpoints of “the health labor market” and “political economy” to provide a more expansive and thorough understanding of physician emigration within the framework of globalization. Physicians relocate due to a global paradigm that creates incentives for migration from their current location and generates demand in alternative regions, rather than merely seeking increased remuneration. Emigration of physicians is influenced by power dynamics between nations, disparities in health system financing, austerity and restructuring policies, state fragility in LMICs, and the increasing dependence of HICs on foreign talent.

One of the central issues related to the globalization of the health sector is the emigration of physicians and its impacts on source countries, particularly LMICs. LMICs suffer from severe health-care shortages due to ongoing physician recruitment by HICs. The globalization of the health sector, like other economic sectors governed by market forces, poses a threat to the health security of source countries and creates the prospect of increased physician emigration to developed countries. This trend is driven by declining and often negative natural population growth rates, which affect and will continue to affect the health-care labor supply and demographic imbalances characterized by an aging population with growing demands for specialized health care. Additionally, a balance has emerged between domestic competition, between the health sector and other sectors, and international competition to attract medical talent.

RESEARCH DATA ACCESSIBILITY STATEMENT

All data presented can be traced through the bibliography.

REFERENCES

- Araujo, E. C., & Dussault, G. (2017). Dynamics of the health-care labor markets. In S. R. Quah (Ed.), *International Encyclopedia of Public Health (Second Edition)* (pp. 382–386). Academic Press. <https://doi.org/10.1016/B978-0-12-803678-5.00100-4>
- Araujo, E. C., & Maeda, A. (2013). *How to recruit and retain health workers in rural and remote areas in developing countries: A guidance note*. <https://doi.org/10.13140/RG.2.2.34680.55041>
- Arias, E. (2010). United States life tables 2006. *National Vital Statistics Reports*, 58(21):1–40.
- Awases, M., Gbary, A., Nyoni, J., & Chatora, R. (2004). *Migration of health professionals in six countries: A synthesis report*. World Health Organization. Regional Office for Africa. <https://apps.who.int/iris/handle/10665/358240>
- Benfifi, T. (2025). Between “here” and “there”: Toward understanding emigration representations and perceptions among Algerian physicians. *Italian Sociological Review*, 15(1), Article 1. <https://doi.org/10.13136/isr.v15i1.834>
- Benfifi, T., & Outaleb, N. (2024). Exploring the global and Algerian crisis of physicians emigration. *Algerian Review of Security and Development*, 13(2), 01–18.
- Bloom, G., & Standing, H. (2008). Future health systems: Why future? Why now? *Social Science & Medicine*, 66(10), 2067–2075. <https://doi.org/10.1016/j.socscimed.2008.01.032>
- Braga, B., Khanna, G., & Turner, S. (2024). Migration policy and the supply of foreign physicians: Evidence from the Conrad 30 waiver program. *Journal of Economic Behavior & Organization*, 226, 106682. <https://doi.org/10.1016/j.jebo.2024.106682>
- Buchan, J., & Perfilieva, G. (2006). *Health worker migration in the European Region: Country case studies and policy implications* (WHO/EURO:2006-3956-43715-61498). World Health Organization. Regional Office for Europe. <https://apps.who.int/iris/handle/10665/347915>
- Byrne, J.-P., Conway, E., McDermott, A. M., Matthews, A., Prihodova, L., Costello, R. W., & Humphries, N. (2021). How the organisation of medical work shapes the everyday work experiences underpinning doctor migration trends: The case of Irish-trained emigrant doctors in Australia. *Health Policy*, 125(4), 467–473. <https://doi.org/10.1016/j.healthpol.2021.01.002>
- Cabello, M., Miret, M., Caballero, F. F., Chatterji, S., Naidoo, N., Kowal, P., D’Este, C., & Ayuso-Mateos, J. L. (2017). The role of unhealthy lifestyles in the incidence and persistence of depression: A longitudinal general population study in four emerging countries. *Globalization and Health*, 13(1), 18. <https://doi.org/10.1186/s12992-017-0237-5>
- Chattu, V. K., Knight, W. A., Adisesh, A., Yaya, S., Reddy, K. S., Di Ruggiero, E., Aginam, O., Aslanyan, G., Clarke, M., Massoud, M. R., & Jha, A. (2021). Politics of disease control in Africa and the critical role of global health diplomacy: A systematic review. *Health Promotion Perspectives*, 11(1), 20–31. <https://doi.org/10.34172/hpp.2021.04>

- Chorev, N. (2013). Restructuring neoliberalism at the World Health Organization. *Review of International Political Economy*, 20(4), 627–666. <https://doi.org/10.1080/09692290.2012.690774>
- Clark, P. F., Stewart, J. B., & Clark, D. A. (2006). The globalization of the labour market for health-care professionals. *International Labour Review*, 145(1–2), 37–64. <https://doi.org/10.1111/j.1564-913X.2006.tb00009.x>
- Collyer, F., & White, K. (2011). The privatisation of Medicare and the National Health Service, and the global marketisation of healthcare systems. *Health Sociology Review*, 20(3), 238–244. <https://doi.org/10.1080/14461242.2011.11003086>
- Dacuycuy, L. B. (2008). *The migration of health professionals*. (Working Paper No. 7). International Labour Organization. Article 994112253402676. <https://ideas.repec.org/p/ilo/ilowps/994112253402676.html>
- Daniel, F. M., Essien, E. A., Gbuchi, M. A., Ukoaka, B. M., & Emeruwa, V. E. (2023). Mitigating physician emigration in Nigeria by improving the internship experience. *International Journal of Medical Students*, 11(4), 343–346. <https://doi.org/10.5195/ijms.2023.2255>
- Dew, K. (2012). *The cult and science of public health: A sociological investigation*. Berghahn Books.
- Dollar, D. (2005). Globalization, poverty, and inequality since 1980. *The World Bank Research Observer*, 20(2), 145–175.
- Eaton, J., Baingana, F., Abdulaziz, M., Obindo, T., Skuse, D., & Jenkins, R. (2023). The negative impact of global health worker migration, and how it can be addressed. *Public Health*, 225, 254–257. <https://doi.org/10.1016/j.puhe.2023.09.014>
- Frenk, J., & Gómez-Dantés, O. (2002). Globalisation and the challenges to health systems. *BMJ: British Medical Journal*, 325(7355), 95–97.
- Frenk, J., Gómez-Dantés, O., & Knaul, F. M. (2011). Globalization and infectious diseases. *Infectious Disease Clinics of North America*, 25(3), 593–599. <https://doi.org/10.1016/j.idc.2011.05.003>
- Giddens, A. (1990). *The consequences of modernity*. Polity Press.
- Goodair, B., & Reeves, A. (2024). The effect of health-care privatisation on the quality of care. *The Lancet Public Health*, 9(3), e199–e206. [https://doi.org/10.1016/S2468-2667\(24\)00003-3](https://doi.org/10.1016/S2468-2667(24)00003-3)
- Hagopian, A., Ofosu, A., Fatusi, A., Biritwum, R., Essel, A., Gary Hart, L., & Watts, C. (2005). The flight of physicians from West Africa: Views of African physicians and implications for policy. *Social Science & Medicine*, 61(8), 1750–1760. <https://doi.org/10.1016/j.socscimed.2005.03.027>
- IOM. (2005). *The millennium development goals and migration* (No. 20). International Organization for Migration.
- Kinuthia, J. (2002). *Trading in healthcare services in Kenya, are we prepared?* WEMOS and SOMO.

- Kirigia, J. M., Gbary, A. R., Nyoni, J., Seddoh, A., & Muthuri, L. K. (2006). The cost of health-related brain drain to the WHO African Region. *African Journal of Health Sciences*, 13(3), Article 3. <https://doi.org/10.4314/ajhs.v13i3.30830>
- Ključnikov, A., Popkova, E. G., & Sergi, B. S. (2023). Global labour markets and workplaces in the age of intelligent machines. *Journal of Innovation & Knowledge*, 8(4), 100407. <https://doi.org/10.1016/j.jik.2023.100407>
- Koivusalo, M. (2014). Policy space for health and trade and investment agreements. *Health Promotion International*, 29(suppl 1), i29–i47. <https://doi.org/10.1093/heapro/dau033>
- Kotlia, A. (1998). The concept of the labor market. *Problems of Economic Transition*, 41(3), 53–65. <https://www.tandfonline.com/doi/abs/10.2753/PET1061-1991410353>
- Krieger, N. (2001). Theories for social epidemiology in the 21st century: An ecosocial perspective. *International Journal of Epidemiology*, 30(4), 668–677. <https://doi.org/10.1093/ije/30.4.668>
- Kurowski, C., Wyss, K., Abdulla, S., Yémadji, N., & Mills, A. (2004). *Human resources for health: Requirements and availability in the context of scaling-up priority interventions in low-income countries: Case studies from Tanzania and Chad* (HEFP Working Paper 01/04). London School of Hygiene and Tropical Medicine. <https://researchonline.lshtm.ac.uk/id/eprint/12948>
- Labonte, R. (2007). Foreign Policy matters: The case of the G8 and population health. *Bulletin of the World Health Organization*. https://www.academia.edu/13220637/Foreign_Policy_Matters_The_Case_of_the_G8_and_Population_Health
- Loh, L. C., Ugarte-Gil, C., & Darko, K. (2013). Private sector contributions and their effect on physician emigration in the developing world. *Bulletin of the World Health Organization*, 91(3), 227–233. <https://doi.org/10.2471/BLT.12.110791>
- Mackintosh, M., Mensah, K., Henry, L., & Rowson, M. (2006). Aid, restitution and international fiscal redistribution in health care: Implications of health professionals' migration. *Journal of International Development*, 18(6), 757–770. <https://doi.org/10.1002/jid.1312>
- McPake, B., Maeda, A., Araújo, E. C., Lemiere, C., El Maghraby, A., & Cometto, G. (2013). Why do health labour market forces matter? *Bulletin of the World Health Organization*, 91(11), 841–846. <https://doi.org/10.2471/BLT.13.118794>
- McPake, B., Squires, A., Agya, M., & Araujo, E. (2015). *The Economics of Health Professional Education and Careers: Insights from a Literature Review*. The World Bank. <https://doi.org/10.1596/978-1-4648-0616-2>
- Mills, E. J., Kanters, S., Hagopian, A., Bansback, N., Nachega, J., Alberton, M., Au-Yeung, C. G., Mtambo, A., Bourgeault, I. L., Luboga, S., Hogg, R. S., & Ford, N. (2011). The financial cost of doctors emigrating from Sub-Saharan Africa: Human capital analysis. *BMJ*, 343, d7031. <https://doi.org/10.1136/bmj.d7031>
- Mooney, A., & Evans, B. (2007). *Globalization: The key concepts*. Routledge.
- Mwachofi, A., & Al-Assaf, A. F. (2011). Health care market deviations from the ideal market. *Sultan Qaboos University Medical Journal*, 11(3), 328–337.

- Nielson, J., & Taglioni, D. (2003, November 12–14). *A quick guide to the GATS and Mode 4*. [Paper presentation]. OECD-World Bank-IOM Seminar on Trade and Migration, Geneva, Switzerland.
- OECD. (2004). *'The international mobility of health professionals: An evaluation and analysis based on the case of South Africa'* [Chapter 3, Trends in Migration]. <https://equinetafrica.org/sites/default/files/uploads/documents/OEChres200208.pdf>
- OECD. (2015). *International migration outlook 2015*. OECD Publishing. https://doi.org/10.1787/migr_outlook-2015-en
- OECD. (2017). *Health at a glance 2017: OECD indicators*. Organisation for Economic Co-operation and Development. https://doi.org/10.1787/health_glance-2017-en
- OECD. (2020). *Contribution of migrant doctors and nurses to tackling COVID-19 crisis in OECD countries*. <https://doi.org/10.1787/2f7bace2-en>
- OECD. (2024a). *Health workforce migration*. [https://data-explorer.oecd.org/vis?lc=en&df\[ds\]=dsDisseminateFinalDMZ&df\[id\]=DSD_HEALTH_WFMI%40DF_HEALTH_WFMI&df\[ag\]=OECD.ELS.HD&df\[vs\]=1.0&dq=A..PT_WR_PRF_HLTH...&lom=LASTNPERIODS&lo=5&to\[TIME_PERIOD\]=false&pg=0](https://data-explorer.oecd.org/vis?lc=en&df[ds]=dsDisseminateFinalDMZ&df[id]=DSD_HEALTH_WFMI%40DF_HEALTH_WFMI&df[ag]=OECD.ELS.HD&df[vs]=1.0&dq=A..PT_WR_PRF_HLTH...&lom=LASTNPERIODS&lo=5&to[TIME_PERIOD]=false&pg=0)
- OECD. (2024b). *International Migration Outlook 2024*. <https://doi.org/10.1787/50b0353e-en>
- Olufadewa, I., Adesina, M., & Ayorinde, T. (2021). Global health in low-income and middle-income countries: A framework for action. *The Lancet. Global Health*, 9(7), e899–e900. [https://doi.org/10.1016/S2214-109X\(21\)00143-1](https://doi.org/10.1016/S2214-109X(21)00143-1)
- Opoku, S. T., & Apenteng, B. A. (2014). Seeking greener pastures? The relationship between career satisfaction and the intention to emigrate: a survey of Ghanaian physicians. *International Health*, 6(3), 208–212. <https://doi.org/10.1093/inthealth/ihu030>
- Packer, C., Labonté, R., & Spitzer, D. (2007a). *Globalization and health worker crisis*. Globalization Knowledge Network, Institute of Population Health.
- Packer, C., Labonté, R., & Spitzer, D. (2007b). *Globalization and health worker crisis*. Globalization and health knowledge network research paper. WHO Commission on Social Determinants of Health.
- Padarath, A., Chamberlain, C., McCoy, D., Ntuli, A., Rowson, M., & Loewenson, R. (2004). Health personnel in Southern Africa: Confronting maldistribution and brain drain. *EQUINET DISCUSSION PAPER NUMBER 3*. <https://www.semanticscholar.org/paper/Health-personnel-in-Southern-Africa-%3A-confronting-Padarath-Chamberlain/8007fd5f306f3e8bfa025ac4a3000c578bbf2bfa>
- Pang, T., & Guindon, G. E. (2004). Globalization and risks to health. *EMBO Reports*, 5(Suppl 1), S11–S16. <https://doi.org/10.1038/sj.embor.7400226>
- Pardo, I. (2020). A social anthropologist in lockdown. *Urbanities, City Life and Beyond in Times of Pandemic*, 10 (Special Issue – Edited by G. B. Prato).
- Physicians for Human Rights. (2004). *An action plan to prevent brain drain: Building equitable health systems in Africa*. PHR.org. <https://phr.org/our-work/resources/an-action-plan-to-prevent-brain-drain>

- Piketty, T. (2020). *Capital and ideology*. Harvard University Press. <https://doi.org/10.4159/9780674245075>
- Raphael, D. (2015). The political economy of health: A research agenda for addressing health inequalities in Canada. *Canadian Public Policy*, 41(Supplement 2), S17–S25. <https://doi.org/10.3138/cpp.2014-084>
- Raphael, D., & Bryant, T. (2006). Maintaining population health in a period of welfare state decline: Political economy as the missing dimension in health promotion theory and practice. *Promotion & Education*, 13(4), 236–242. <https://doi.org/10.1177/175797590601300402>
- Regmi, K. D. (2025). Five decades of neoliberal developmentalism in “Least Developed Countries”: A decolonial critique. *Journal of International Development*, 37(1), 68–86. <https://doi.org/10.1002/jid.3951>
- Robertson, R. (1992). *Globalization: Social theory and global culture*. SAGE.
- Robinson, R. (2007). *The costs and benefits of health worker migration from East and Southern Africa: A literature review*. EQUINET DISCUSSION PAPER 49. Regional Network for Equity in Health in east and southern Africa.
- Saleem, J., Ishaq, M., Zakar, R., Suddahazai, I. H. K., & Fischer, F. (2021). Experiences of frontline Pakistani emigrant physicians combating COVID-19 in the United Kingdom: A qualitative phenomenological analysis. *BMC Health Services Research*, 21, 291. <https://doi.org/10.1186/s12913-021-06308-4>
- Saluja, S., Rudolfson, N., Massenburg, B. B., Meara, J. G., & Shrim, M. G. (2020). The impact of physician migration on mortality in low and middle-income countries: An economic modelling study. *BMJ Global Health*, 5(1), e001535. <https://doi.org/10.1136/bmjgh-2019-001535>
- Sepulveda, C. F. (2020). Explaining the demand and supply model with the cost-benefit rule. *International Review of Economics Education*, 35, 100194. <https://doi.org/10.1016/j.iree.2020.100194>
- Smith, R. D., Chanda, R., & Tangcharoensathien, V. (2009). Trade in health-related services. *The Lancet*, 373(9663), 593–601. [https://doi.org/10.1016/S0140-6736\(08\)61778-X](https://doi.org/10.1016/S0140-6736(08)61778-X)
- Southern African Development Community. (2005). *Protocol on the Facilitation of Movement of Persons*. https://www.sadc.int/sites/default/files/2021-11/Protocol_on_Facilitation_of_Movement_of_Persons2005.pdf
- Stubbs, T., Kentikelenis, A., Gabor, D., Ghosh, J., & McKee, M. (2023). The return of austerity imperils global health. *BMJ Global Health*, 8(2). <https://doi.org/10.1136/bmjgh-2022-011620>
- Tomlinson, J. (1999). *Globalization and culture*. University of Chicago Press.
- Trewby, P. (2017). Migrating doctors. *Clinical Medicine*, 17(1), 4–5. <https://doi.org/10.7861/clinmedicine.17-1-4>
- USAID. (2003). *The health sector human resource crisis in Africa: An issues paper*. Bureau for Africa, Office of Sustainable Development.

- Vhumbunu, C. H., Adetiba, T. C., & Mawire, C. (2024). The Free Movement of People in SADC: Reflecting on the Experiences, Dilemmas and Strategic Considerations. *African Journal of Political Science*, 11(1), 12–29. <https://doi.org/10.36615/2j0fs582>
- Waitzkin, H. (2007). Political economic systems and the health of populations: Historical thought and current directions. In S. Galea (Ed.), *Macrosocial Determinants of Population Health* (pp. 105–138). Springer. https://doi.org/10.1007/978-0-387-70812-6_5
- WHO. (2010, April 15). *International recruitment of health personnel: Draft global code of practice. Report by the Secretariat* (Provisional Agenda Item 11.5, Document A63/8). https://apps.who.int/gb/ebwha/pdf_files/wha63/a63_8-en.pdf
- WHO. (2011, May 19). *World Health Statistics 2011*. WHO.int. <https://www.who.int/publications/i/item/9789241564199>
- World Bank. (2025). *World Bank Country and Lending Groups*. World Bank Data Help Desk. <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>
- Zehnati, A. (2024). L'émigration des médecins, en particulier vers la France, et la desserte médicale au Maghreb. *Belgeo – Revue belge de géographie*, 1, Article 1. <https://doi.org/10.4000/12ihd>

POVZETEK

IZSELJEVANJE ZDRAVNIKOV IN GLOBALIZACIJA: PERSPEKTIVA TRŽNE LOGIKE IN POLITIČNE EKONOMIJE

Taqiyeddine Benfifi, Naima Outaleb

Globalizacija je znatno prispevala h kompleksnim spremembam v sodobnem svetu. Omogočanje potovanja med državami je danes trdno vgrajeno v okvir sodobnega mednarodnega sistema, posledica česar je bolj dinamičen in prilagodljiv trg dela kot kadar koli doslej. Zaradi globalizacije se je po vsem svetu povečalo povpraševanje po usposobljenih kadrih, zlasti na medicinskem področju. Na ta način se je vzpostavil globalni trg, na katerem se zdravniki v iskanju boljših življenjskih in poklicnih pogojev selijo iz svojih matičnih držav v države z visokim dohodkom.

Namen avtorjev prispevka je proučiti vpliv globalizacije, politične ekonomije in trga dela v zdravstvenem sektorju na mobilnost zdravnikov. Številne študije kažejo, da na migracijo zdravnikov iz držav z nizkimi in srednjimi dohodki v države z visokimi dohodki vplivajo zlasti veliko povpraševanje po zdravstvenih storitvah, večje mobilnostne možnosti ter strategije zaposlovanja držav gostiteljic. Posledica teh dejavnikov je izčrpavanje zdravstvenih virov in zmožljivosti zdravstvenega sistema v državah izvora. Študije kažejo, da obstaja znatna povezava med gostoto zdravnikov in razumevanjem razlik v zdravstvenem stanju med posameznimi državami.

Številni strukturni, zgodovinski in kulturni dejavniki prispevajo h krepitvi migracij, ki še dodatno povečujejo razlike v zdravju prebivalstva med državami izvora in ciljnimi državami. Na zdravstvene sisteme v državah z nizkimi in srednjimi dohodki so znatno vplivale neoliberalne politike, kot so varčevalni ukrepi, privatizacija, večja zadolženost in druge, ki dodatno vplivajo k povečani migraciji in poglobljajo razvojne neenakosti med državami.

Zaradi globalizacije trga dela v zdravstvu in povečanega povpraševanja po zdravnikih vlade v ciljnih državah posvečajo manj pozornosti širitvi pravice do zdravja v državah izvora. Poleg tega je vse težje doseči dogovor o nadomestilu, ki bi ga morale dobiti države izvora za izgubo svojih zdravstvenih delavcev. Neustrezno naslavljanje izseljevanja zdravnikov iz držav, ki se soočajo s pomanjkanjem tovrstnih kadrov, bo škodovalo zdravstvenim sistemom teh držav in še dodatno otežilo prizadevanja za pravičnost.

Številne mednarodne organizacije v prizadevanju za zaščito suverenih pravic držav izvora poskušajo urediti vprašanje migracij z dvostranskimi in regionalnimi sporazumi. Vendar pa so bile do zdaj tovrstne pobude zaradi različnih dejavnikov – prostovoljnega značaja pobud, nezadostnega usklajevanja med državami, pomanjkanja podatkov ter premajhnih prizadevanj ciljnih držav za izvajanje sporazumov – v veliki meri neuspešne.

ČLANKI / ARTICLES

Janja Žitnik Serafin

Uvodnik: Inštitut za slovensko izseljenstvo in migracije to jesen praznuje štiridesetletnico priključitve k ZRC SAZU

Urh Šelih

Med odgovornostjo in solidarnostjo: novi solidarnostni mehanizem EU in njegove meje pri prerazporejanju bremen

Alenka Vrbinc, Donna M. T. Cr. Farina, Marjeta Vrbinc

Oglasi v slovarjih za slovenske priseljence v ZDA na začetku 20. stoletja

Mateja Curk

Alternacija kodov v proznih delih Gorana Vojnovića

Urh Frlež

Podoba domovine v delih Franceta Papeža

Maja Ramuš

Ruski general Ivan T. Beljajev v Zelenem peklu

Mojca Vah Jevšnik, Sanja Cukut Krilič

Emerging Diversifications of Labor Migration to Slovenia: From the Western Balkans to Asia

Luděk Jirka

Undesirable Reverse Remittances: The Case of Young Ukrainian Students in Czechia

Juraj Pokos, Rebeka Mesarić Žabčič, Nenad Pokos

The Croatian Population Among the Oldest in the World: Shifts in Age Structure, 1991–2021

Nina Bilokopytova, Karim El Guessab, Volodymyr Bilokopytov

The Phenomenon of "Balkan Islam" as a Factor of Intercultural and Ethno-Social Dialogue

Taqiyeddine Benfifi, Naima Outaleb

Physician Emigration and Globalization: A Market Logic and Political Economy Perspective

KNJIŽNE OCENE / BOOK REVIEWS

Florian Tissot, *Doing Family on the Move: Highly-Skilled Migrants in Switzerland and Germany* (Juan Paulo Gabriel Amurao)

ISSN 0353-6777



9 770353 677013

ISSN 1581-1212



Založba ZRC