

Briefing note on international migration of health professionals: levelling the playing field for developing country health systems

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Abstract

This briefing note provides an update on current issues surrounding international migration of health professionals. Historical, contemporary and future perspectives of migration are presented. Some of the world's richest countries benefit from international migration, whilst it has a generally negative impact on health services in some of the world's poorest countries. However, the influences on international migration are more complex than have often been portrayed: for example within a poor country some stakeholders see migration as a means of improving the balance of payments whilst others are concerned about the damage to health services. Responsibilities of both the source and recipient countries need to be made explicit before meaningful dialogue can take place. Despite the development of codes of practice on ethical international recruitment, the increased demand for health professionals seems inevitable. More radical strategies are therefore needed to protect health systems of the world's poorest countries.

This briefing paper is also available at www.liv.ac.uk/lstm/hsrhome.html

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Introduction

Health is a labour-intensive service employing an estimated 35 million people worldwide.¹ Because it is a population and client-oriented service, in general it cannot be moved to the sources of labour;² if there are shortages, labour must be attracted from elsewhere. There is a strong perception of global shortage of health professionals,³ though others prefer to talk of an imbalance of the global supply.⁴

The international movement of labour is greatest amongst those with a high level of skill. Current demands are for IT skills, teachers, social workers, though health professionals form the biggest group of skilled migrants.⁵ These movements are facilitated by the fact that within the profession there is a globally shared knowledge base.

There has been a general concern about the impact on poorer countries of the increasing level of globalisation – of which these labour movements form a part. This has been expressed in a recent DFID White Paper,⁶ though the concern of the impact on health systems in these countries goes back to the Edinburgh Commonwealth Medical Conference in 1965.

Whilst many have commented on the nature of international migration of health professionals and on the impact on health systems in poorer countries, much of what has been said is based on poor information or an oversimplification of the issues. Using available evidence we attempt in this paper to provide some clarity on the key issues surrounding the international migration of health professionals and the impact on health services in developing countries. However, for reasons that will become evident, we do not claim to be able to provide the full definitive picture.

Our information is drawn from an exploratory study of the literature supplemented by key informant interviews and review of documents from three countries: Ghana – a net exporter (or 'source' country); South Africa – an importer (or 'recipient' country) and exporter; and England – a net importer.⁷

As with all aspects of labour, the area of international migration has many stakeholders with differing agendas. Whilst we aim to shed some light on what the range of agendas might be, our major concern is the impact on the health services for populations in poorer countries.

¹ ILO (1999). 'Terms of employment and working conditions in health sector reforms'. Geneva, International Labour Office: p23.

² Though patients are beginning to move to the suppliers for reasons of cost and availability

³ Buchan, J. and F. O'May (1999). "Globalisation and Healthcare Labour Markets: a case study from the United Kingdom." Human resources for health development journal 3(3).; WHO (2001) World Health Assembly 54.12.

⁴ Mehmet, O. (2002). The emerging global labor market: some implications for international health (2nd draft). WHO consultation on imbalances in the health workforce. Ottawa 10-12 March 2002. (Unpublished)

⁵ Idem

⁶ Department for International Development (2000). Eliminating world poverty: making globalisation work for the poor. White paper on international development presented to parliament by the Secretary of State for International Development of the United Kingdom. London, Department for International Development.

⁷ The main interviews in South Africa and Ghana were carried out in October 2000, and UK interviews in the summer of 2001, but additional data collection on this highly dynamic subject has been ongoing.

We start with an overview of what is known about the extent of international migration, and the impact on health services in poorer countries. Current influences on migration are then explored. Finally, policy issues relating to different levels and different stakeholder groups are raised.

What is the extent of international migration?

Introduction

The subject of international migration of professionals has attracted the interest of many different types of analyst including labour economists, human geographers and human resource specialists. Yet it is clear that though much information is available, the overall picture is very patchy and no neat analysis of flows of health professionals between countries is available. This is partly because of the complex nature of the subject. Are we talking about 'temporary' or 'permanent' migrants? Can we compare a doctor in Canada with a doctor in Russia? In addition, 'migration' cannot be treated as a completely independent form of labour market movement. An international migrant from Ghana to England and an internal migrant within the United States could both be moving similar distances and could both be required to register with a new professional body. Within these data and definitional constraints we have tried to construct a rough sketch with highlights of past, current and future migration flows of health professionals.

Historical perspective

In the post-colonial period many developing countries started to expand their health services and to train their nationals to staff them. Initially the prospects looked good. However, from the 1960s there were already concerns that some of these professionals were being lost to richer countries which were expanding their own health services and lacked sufficient home grown professionals – thus widening the divide between developed and developing countries. In the 1970s WHO was prompted to study this phenomenon by looking at the global stocks and flows of physicians and nurses in the only study⁸ of its kind, hereafter referred to as the Mejia study.

Table 1: Physician flows in 1972

Countries	Stock	Inflow	Outflow	Change
Developed	1,746,000	118,000	52,300	+65,700
Developing	615,300	14,3000	67,100	- 52,800
Totals	2,361,300	261,000	119,400	

Source: Table compiled from Mejia and Pizurki, 1976

The physician flows (see Table 1), which represented about 16% of the global stock of physicians on the move, were mainly from Canada, Germany, Ireland, UK, India, Iran, Pakistan, Sri Lanka, the Philippines, Korea and Latin America to the USA and the UK. In the 1970s it was estimated that about 135,000 nurses (or 4% of the world total) were outside their country of birth or training, 92% of these were in Europe, North America and the developed countries of the West Pacific⁹. In 1970 more Filipino nurses were registered in the USA and Canada than in the Philippines. The migration of nurses was more multidirectional than that of physicians. Major countries of origin were Canada, Egypt, New Zealand, the Philippines and the UK, and major destinations were Canada, USA, UK, Germany and Australia. Of the foreign nurses newly registered in the USA in 1972, over 49% were from the

⁸ Mejia, A. and H. Pizurki (1976). "World migration of health manpower." *WHO Chronicle* **30**: 455-460.

⁹ Mejia and Pizurki (1976) op. cit.

Philippines, over 21% from Canada and the UK together and over 14% from India, Korea Thailand and the West Indies together.¹⁰ At times migration was like a 'carousel': when nurses emigrated from the UK, replacements were recruited from Ireland, the West Indies and Mauritius.¹¹

Besides the staff losses, there were also concerns about the investment that poorer countries were making in human capital was being lost. In 1971, there were at least 140,000 physicians in countries other than their own or where they had been trained representing 6% of the world's physician stock and about one-eighth of the world medical school output (excluding China). In the 1970s, 35% of all hospital physicians in the UK were trained overseas, 60% of them in developing countries. They filled, in general, positions unpopular amongst British physicians (only 19% in teaching hospitals compared to 39% in all other hospitals).¹²

At that time past colonial, language and cultural ties were very important in determining migration patterns and directions. For example, there was a high proportion of UK immigrants from Commonwealth countries, especially from India and the Caribbean. These ties extended to the nursing profession, and were evident in the nursing education structure, the textbooks, the curriculum etc.¹³

In the 1960s and 1970s there was an energetic movement to stem what was referred to as "brain drain" from developing countries, which included calls for compensation for the investment in education and training by developing countries.¹⁴ Concern about the level of international migration then seemed to evaporate. This might have been because it was assumed that demand in developed countries would ease off and the positive economic forecast for developing countries would attract health professionals to stay. Others have implied that this apparent loss of concern was due to the influence of the more powerful stakeholders who stood to lose out. As a result a more detailed follow-up study planned by WHO was shelved¹⁵ and until recently little information has been gathered on international migration of health professionals.

Contemporary migration

Whilst there have been some temporary falls in demand from developing countries – sometimes in specific staffing groups where entry became more restricted e.g. physicians in the US – overall demand for health professionals has gradually increased. Since the 1970s the globalisation of markets and the development of free trade agreements have also facilitated international migration and reduced barriers to trade and mobility of services, products and people, including the skills of health professionals. Demand in many developed countries is increasing: for example, the UK currently needs 10,000 more doctors and 20,000 more nurses to meet the needs of the new health plan.¹⁶ At the same time the economies of most developing

¹⁰ Mejia, A. (1978). "Migration of Physicians and Nurses: a worldwide picture." International Journal of Epidemiology 7(3): 207-215.

¹¹ Abel-Smith, B. (1986). "The world economic crisis. Part 2: health manpower out of balance." Health Policy and Planning 1(4): 309-316.

¹² Abel-Smith (1986) op. cit.; Heller, T. (1979). Chapter 10: The patterns of medical practice in England and the Third World. The principles and practice of primary health care. Geneva, Switzerland, Christian Medical Commission, World Council of Churches.

¹³ Mejia, A (1978), op. cit.

¹⁴ Gish, O. and M. Godfrey (1979). "A reappraisal of the "brain drain"--with special reference to the medical profession." Soc Sci Med [Med Econ] 13C(1): 1-11.

¹⁵ Mejia (1976) op. cit.

¹⁶ Department of Health (2000). The NHS plan. A plan for investment. A plan for reform. London, Department of Health.

countries have become significantly weaker with the consequent fall in the value of salaries, and fall in morale of staff having to work in under-funded health services, making employment overseas all the more attractive to them.

Since the Mejia study of the 1970s the patterns of migration have changed. New entrants to the 'source' country for physicians include: the Caribbean and Egypt and sub-saharan African states, Cuba and the former Soviet Union for doctors. Many African doctors migrate within the continent - mostly to southern Africa where salaries are often higher (See Table 2). Since the harmonising of qualifications within the European Union, there has been a greater movement of physicians and nurses – particularly to the UK.¹⁷ China and Thailand are exporting more nurses now and whilst the actual numbers may be small, an ever-increasing number of nurses from sub-Saharan Africa are moving to developed countries.

Table 2: Average monthly salary levels for junior doctors in \$US equivalent c.1999

Sierra Leone	Ghana	Zambia	Lesotho	Namibia	South Africa
\$50	\$199	\$200	\$1,058	\$1,161	\$1,242

Source: Dovlo 1999b

An important new destination since the Mejia study are the Gulf States which recruited health professionals from all parts of the world including Europe. Most migrants are on fixed term contracts, though some academics have stayed on gaining very senior posts. India now provides a huge number of health professionals particularly from southern states like Kerala.¹⁸

Migration is possible for all health professionals who have marketable skills and besides doctors and nurses there has been a greater movement of other health professionals such as pharmacists and physiotherapists. We were even told of African Enrolled Nurses travelling to Canada and New Zealand.

As information on the size of these flows is patchy, it is only possible to give examples. The percentage of foreign trained doctors in UK hospitals has fallen to 31% (5% European Economic Area (EEA) trained; 26% trained outside the EEA).¹⁹ There has been a recent dramatic rise of nurses of certain nationalities coming to the UK (see Table 3), though the same table shows a corresponding fall in the supply from industrialised countries.

¹⁷ see Jinks, C., B. N. Ong, et al. (2000). "Mobile medics? The mobility of doctors in the European Economic Area." *Health Policy* 54(1): 45-64. [check]

¹⁸ Dr S Tata, Presentation to WHO International Consultation on Assessment of Trade in Health Services and GATS, 9-11 January 2002

¹⁹ Department of Health (2002). "Hospital, Public Health Medicine and Community Health Services Medical and Dental staff in England: 1991-2001." *Bulletin* 04.

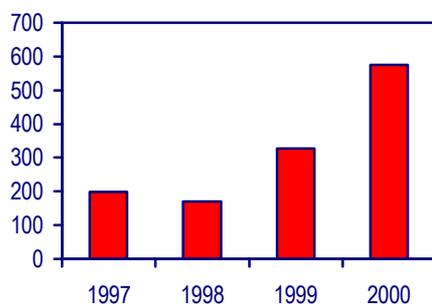
Table 3: Overseas trained nurses and midwives registering with the UKCC from selected countries by year

	98/99	99/00	00/01
Philippines	52	1,052	3,396
South Africa	599	1,460	1,086
Australia	1,335	1,209	1,046
New Zealand	527	461	393
Zimbabwe	52	221	382
Nigeria	179	208	347
India	30	96	289
West Indies	221	425	261
Ghana	40	74	140
Canada	196	130	89
Zambia	15	40	83
Kenya	19	29	50
Malawi	1	15	45

Source: UKCC

Evidence of outflow may also be available, and not surprisingly in some countries this is increasing. Though difficult to measure, health professionals registering in a new country need confirmation from the original registration body. The number of requests serves as an indication of intent to move, and Figure 1 shows a significant increase in Ghana. The outflow was about the same as the equivalent training output in this case, despite significant investment in training capacity.²⁰

Figure 1: Requests for confirmation of registration of nurses



Note: The data for 2000 covers 9 months only

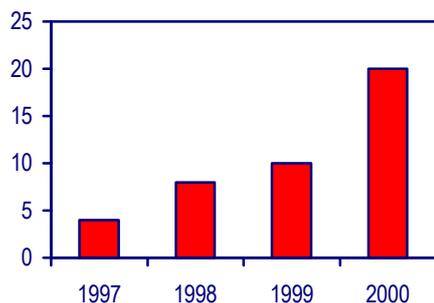
Source: Nursing & Midwives Council, Ghana, September 2000

Whilst the numbers of Ghanaian pharmacists wishing to work overseas (mostly the UK) is much smaller (see Figure 2), the impact on pharmacy services – particularly the 200 or so government pharmacists²¹ – is probably much greater than that of the larger staff group.

²⁰ Ministry of Health and Health Partners (2000). Chapter VIII: Human resource strategies. in Consolidating The Gains: Managing The Challenges. 1999 Health Sector Review, Government of the Republic of Ghana.

²¹ Ministry of Health (Ghana) data, 1999

Figure 2: Requests for confirmation of registration of pharmacists going overseas



Source: Pharmacy Council, Ghana, 2000

Information on whether the migration is temporary or permanent is very difficult to get from source countries, partly because some migrants may choose to stay registered at home because of relatively low fees compared to the high nuisance factor involved in fresh registration. Nursing registration data in the UK can be used as an indicator of length of stay, and a recent review showed that less than half of non-EU registrants in 1995 re-registered²² indicating a high level of short-term migration. Similar data monitoring length of stay for physicians is not yet available in the UK. Some migration is extremely short-term; for example nurses from Jamaica 'commute' to the US to work there in their vacations. Similar cases were identified where consultant physicians travel from Africa and Asia to carry out short-term locums in the UK.

The carousel movement continues, and the demand is still largely for jobs that nationals are reluctant to take. Due to shortages of doctors in the USA from 1992 to 1997 around 450 Canadian doctors went to the US annually, and there are approximately 8,000 Canadian doctors practising in the USA.²³ Because of its insufficient training output in 1999 of all practising doctors in Canada 24 percent were foreign graduates, and Alberta and Saskatchewan have been recruiting actively in South Africa for general practitioners to work in remote rural areas. Until recently South Africa has been recruiting internationally to fill the same kind of posts; in 1999 78% of rural doctors were non-South African.²⁴

²² Buchan, J. and F. O'May (1999). Op. cit.

²³ Tyrrell, L. and D. Dale (1999). Physician workforce, Advocacy & Communications - Canadian Medical Association.

²⁴ Dovlo, D. (1999). Report on issues affecting the mobility and retention of health workers/professionals in Commonwealth African states. A consultancy report prepared for the Commonwealth Secretariat (unpublished).

Box 1

In Ghana it was reported that some 40 out of 43 final year medical students were intending to leave immediately after qualification and graduates were going overseas without completing the re-registration year.²⁵

A substantial number of physiotherapists are now leaving South Africa without even practising. We met a group at the University of Pretoria, just after they had completed their qualifying examinations. They told us that of their class of 46, 50% of them were leaving for the UK immediately after graduation.

Some health professionals are going overseas straight from training (see Box 1). In such cases the country may not recoup any of the human capital investment. We do not have a clear 'balance sheet' view of migration that Mejia and colleagues drew up in the 1970s. However, from what we know there appears to be a shift in the direction of the flows, with a greater polarisation towards flows from poorer to richer countries.

Future prospects

There are many signs that the pull from richer countries will increase over the next 10 to 20 years;²⁶ it is estimated that a further one million nurses will be needed over the next 10 years to meet the shortfall in the US.²⁷ In addition to the general expansion of health care provision based on previous trends, these countries will have to cater for an increasingly ageing population. For example, in the UK it is estimated that the over-sixty group will make up 25% of the population by 2020.²⁸ Of more immediate concern is the "greying" of the health workforce needed to bear this extra burden of care. In the UK projections show that by 2010 one in four nurses will be 50 or older.²⁹ In the US the predicted shortage of 550,000 nurses by 2005 will be exacerbated by a high average age, a low average retirement age and falling enrolments into training. In addition to these problems legislation has been introduced in some countries to reduce working hours,³⁰ lowering the Full-time Equivalent (FTE) value.

Some of the pull due to the changing demographics in richer countries could be addressed by more effective workforce planning. However, some demand is due to the structural design of the workforce e.g. a pyramid with a large number of junior and intermediate level doctors supporting a small number of consultants, with a limited flow to the high level of the pyramid. The structure works if foreign medical graduates fill the mid and lower level posts in hospitals. In the UK foreign medical graduates trained outside the EEA make up 65% of the staff grades (compared with

²⁵ Dovlo, D. and F. Nyonator (1999). "Migration by Graduates of the University of Ghana Medical School: A preliminary rapid appraisal." Human resources for health development journal **3**(1).

²⁶ Dixon, A. and E. Mossialos, Eds. (2002). Health care systems in eight countries: trends and challenges. London, European Observatory on Health Care Systems. This reports shortages in at least four of the countries reviewed.

²⁷ Buchan, J. (2002). International recruitment of nurses: United Kingdom case study. Report based on research funded by the World Health Organisation, the International Council of Nurses and the Royal College of Nursing. Unpublished document.

²⁸ Government Actuary's Department, 1998.

²⁹ Buchan, J. (1999). "The 'greying' of the United Kingdom nursing workforce: implications for employment, policy and practice." Journal of Advanced Nursing **30**(4): 818-826.

³⁰ For example, the EU Working Time Directive and the Australian Safe Hours Campaign.

17% of consultants) and 27% of the 'doctors in training'.³¹ The US and Canada use foreign medical graduates to fill less desirable jobs in rural or inner city areas.³² Such reliance, will continue to create demand for temporary physician migration.³³

Prospects for economic development in the poorest countries are much worse than they were when the alarm about brain drain was raised in the 1970s. The pull to better paid jobs abroad will therefore increase and in many source countries shortages such as those in South Africa will be exacerbated by long-term illness or death linked to HIV/AIDS which will hit health professionals in their prime working years.³⁴

Lessons from the past have shown that migration is highly unpredictable. New patterns of migration are already emerging e.g. Chinese and Spanish nurses coming to the UK, and international recruiters will continue the search for new source countries.³⁵ The constant monitoring of workforce imbalances is essential to keep track of these unpredictable trends.

What is the impact of international migration of health professionals?

The international migration of health professionals has both winning and losing stakeholders, both in the source and recipient countries. To further complicate this question we also need to distinguish between permanent and temporary migration, and short-term or longer-term benefits.³⁶

The focus in this paper is on the impact on health services in developing countries and the associated stakeholders. It is therefore essential to appreciate the impact on other organisations – in particular those who benefit, and to identify the incentives that continue to drive migration if the status quo is maintained.

We should note that hard information that will provide a rounded picture of the impact is unsurprisingly in shorter supply than that on migration itself.

Winners

Receiving countries naturally benefit from international migration. From a national perspective huge savings in training and education are made from this form of 'free riding'. The loss of political capital may be averted by ensuring that the level of health service provision can be maintained in times of national labour shortages. Whilst the workforce planning process can be made more accurate, it will always be better to underestimate the need, as the gap can be filled from overseas labour pools and the consequences of oversupply are much more disastrous. However, reliance

³¹ Department of Health (2002). op. cit.

³² This is possible through the J1 visa waiver scheme. The J1 visa scheme was originally conceived to ensure that foreign medical graduates returned home following completion of their training.

³³ Bundred, P. E. and C. Levitt (2000). "Medical Migration- who are the real losers?" *The Lancet* **356**: 245-246; Mullan, F. (1997). "The National Health Service Corps and Inner-city Hospitals." *The New England Journal of Medicine* **336**(22): 1601-1604..

³⁴ Dorrington, R., D. Bourne, et al. (2001). The impact of HIV/AIDS on adult mortality in South Africa, Medical Research Council, South Africa

³⁵ Lowell, B. L. and A. M. Findlay (2001). Migration of highly skilled persons from developing countries: impact and policy responses. Draft synthesis report. Geneva, International Labour Office. [Section 4.2]

³⁶ Lowell and Findlay (2001) op. cit.

on foreign workers may hinder development of the domestic supply³⁷ and there may be tension between domestic interests of the country and its policy on international development. One British NGO³⁸ recently strongly complained about the recruitment of African teachers to the UK while it was trying to improve teaching capacity in those same countries. Sometimes this reliance may seem a deliberate form of free riding. According to Mullan, US hospitals hire approximately 5,000 foreign medical graduates each year to fill first-year residency positions. At the same time, US medical schools "turn away thousands of [US] applicants with high grade-points averages".³⁹

Employers benefit by getting much-needed staff. They may also benefit if they can pay lower wages to immigrant workers, as might be expected in a 'true' market economy.⁴⁰ However, social, political and union pressure in some countries will ensure that migrant workers receive equal pay. The downside is the extra cost of international recruitment (though this can be significantly reduced by 'batch' recruitment), delays in staff trained for other health systems getting fully up to speed and complaints from patients because of language problems.⁴¹ Over-reliance on a foreign source of labour can also cause problems as UK NHS managers discovered when many overseas workers wanted to go home to celebrate the Millennium.⁴² Because of the volatile nature of the international labour market, employers risk exposure to their source of overseas labour or even their own nationals being attracted to other countries, unless they can maintain competitive salary levels.

Employers may also benefit from migrants' flexibility of working, being more readily prepared to work in less desirable areas of work (for example, mental health), under less socially acceptable conditions (e.g. night shifts) and less desirable geographic regions (e.g. the rural areas of South Africa or Canada, or the inner cities of the US).

Source countries will benefit from the remittances from their expatriates – both the permanent and temporary migrants – enabling them to improve their balance of payments. The World Bank also suggests that developing countries might benefit from temporarily sending their health personnel abroad.⁴³ In 1996 India, the world's highest earner of remittances, received \$US7.6 billion – more than a three-fold increase from 1990.⁴⁴ Remittances account for the third largest inflow of funds to Ghana. Disaggregated data on remittances is not available, but it can be assumed that since health professionals form one of the most important group of migrants much of the inflow can be attributed to them.⁴⁵ There is little information on how remittances are used, but it is unlikely that much will filter back into the education sector to offset the loss in human capital investment.

³⁷ Lowell and Findlay (2001) op. cit. [Section 4.2]

³⁸ VSO EDUCATION AT WHOSE EXPENSE? UK teacher shortages filled at the cost of the world's poorest children warns VSO. **2002**. [http://www.vso.org.uk/media/aug2001_2.htm]

³⁹ Mullan, F. (2000). "The case for more U.S. medical students." *N Engl J Med* **343**(3): 213-7.

⁴⁰ Stalker, P. (2000). Workers without frontiers. The impact of globalisation on international migration. Boulder, Colorado, USA, Rienner Publishers.

⁴¹ Buchan, J. and F. O'May (1999). "Globalisation and Healthcare Labour Markets: a case study from the United Kingdom." *Human resources for health development journal* **3**(3).

⁴² Brindle, D. (1999). Operations stop as foreign nurses quit for millenium. The Guardian. London.

⁴³ World Bank (2001). *Global Economic Prospects and the Developing Countries: 2002*. Washington, World Bank, p76

⁴⁴ Nielson, J. (2002). *Service providers on the move: a closer look at labour mobility and the GATS*. Paris, OECD, p84

⁴⁵ Though there is some evidence that health professionals – particularly permanent migrants – remit less than lesser skilled short-term migrants.

The transfer of skills acquired whilst overseas is often cited as a benefit brought by returning temporary migrants, though no evidence has been found to substantiate this claim. Several assumptions could be made to qualify this claim: skills with commercial value are more likely to be used e.g. IT skills in the computing industry. 'High tech' skills will only be valuable in the health sector if the returnee has access to similar working conditions and equipment, which may only be available in middle income countries or private sector facilities. It is unlikely that a Zambian nurse working in an intensive care unit in the US will be able to transfer useful skills if she returns to a district hospital in her country.

Though this may be seen as a somewhat cynical view, migration may act as a welcome 'safety-valve' reducing pressures on national governments to provide employment opportunities and welfare services, especially where the number of public service employees is being trimmed. One Ghanaian respondent pointed out that if all 1,500 doctors working abroad were to return, the government would probably only be able to find jobs for about 200 of them.

There are clearly benefits for the individual migrants, otherwise they would not (in most cases) travel overseas, though many said that if economic conditions were different they would prefer to remain at home. The benefits are those things that they might not get at home which could include some or all of the following: higher salary, better and more satisfying jobs, better education for children, more skills and opportunity to get a better job on return. Some migration is planned around particular life-cycle points when benefit will be greatest, for example a financial boost before people start a family, or prior to retirement to supplement a meagre pension.

Losers

The most frequently reported loss to source countries is that of health personnel and the impact of understaffing of health systems. The measurement of these losses is problematic. We know of no personnel systems that record "migration" as a reason for resignation; a person might have moved to the private health sector, or have taken up a different career. We heard of cases where people simply take long leave in case they need to come back to the job again, which would not be recorded as a loss. However, there is plenty of anecdotal evidence used to attribute vacancies to migration. Sometimes the numbers are quite striking: 114 (60%) of the 190 registered nurses left a tertiary hospital in Malawi between 1999 and 2001.⁴⁶ Reasons for leaving are not recorded, but given the losses to migration reported by other institutions in the country it can be safely assumed that a significant proportion will have migrated. The impact of the loss of one or two staff with specialist skills may be just as significant as the loss of more general staff in greater numbers (see Box 2).

Box 2

The Centre for Spinal Injuries in Boxburg, near Johannesburg, South Africa was the referral centre for the whole region. On the same day in 2000 the two anaesthetists were recruited by a Canadian institution opening a new Spinal Injuries Unit. The Boxburg Centre has been closed ever since.

⁴⁶ Martineau, T., K. Sargent, et al. (2001). Institutional and Human Resources appraisal (Phase II) of Sexual and Reproductive Health Programme, Ministry of Health and Population, Government of Malawi. Mission Report. Liverpool, LATH.

The ultimate losers tend to be health services (and their users) in the remoter rural areas, as they come lowest in the pecking order of people's preferred working location. If a vacancy in an urban area is created due to the incumbent moving overseas, a re-shuffle (another form of carousel) takes place with the vacancy being filled by someone from a more rural area, and so on. Since the poorest citizens tend to live in the remoter areas, it is they who are most affected by migration.

Even in urban areas the increasing attrition of health professionals creates a downward spiral. Job satisfaction is still given as a major retention factor for health professionals. But this is fragile and could be damaged by substantial increases in workload. Some of the remaining 76 registered nurses in the Malawian hospital mentioned above may subsequently leave, thus further driving the downward spiral.

In the case of the longer-term migrant the gain of the country receiving trained health personnel is at the same time the lost educational investment to the sending country. Numerous attempts have been made to put a monetary value on these losses. For example it has been estimated that India has lost up to US\$5 billion in investment in training of doctors since 1951⁴⁷ and Ghana has lost around US\$60 million in investment in the training of health professionals according to one estimate.

Migration may impact on what one respondent referred to as "academic reproduction" or the continuous development of academics to provide quality training of new health professionals. A major migration of Ghanaian doctors to the Middle East in the 1980s left academia severely depleted. Though policy initiatives have restored the number of teachers to a reasonable level (though at the expense of the staffing of the health services), most of the research capacity – an important ingredient of academia in terms of quality and retention incentive – was said to have been lost.

From the perspective of the individuals (actual or would be migrants) there is a much evidence of exploitation and lost opportunities – or 'brain wastage' where the full potential of the migrant is not used. Despite the current high demand for migrant health professionals, the process of getting a job can be lengthy, costly and risky. Fees charged to migrants by recruitment agencies can be exorbitant.⁴⁸ Indian nurses were duped by a fictitious recruitment agency promising jobs in the UK but which only took the recruitment fees. Some nurses in Ghana had their registration fees stolen by a corrupt agency official. Immigrants may be paid below the going rate for the job. Highly qualified overseas-trained nurses arrive to find they are expected to carry out menial tasks.⁴⁹ Some health professionals attempt to get registration in country, but end up as 'assistants' in their profession (e.g. pharmacy assistants) working far below their potential.

Some young health professionals intend to work overseas for a short time and then return. However, they tend to start families and then are 'stuck' at least until their children have been through their education. By that time many will find it hard to get back into employment at an appropriate level in their home country.

⁴⁷ Nayak, S. (1996). International migration of physicians: need for new policy directions. European Association of Development, Research and Training Institutions (EADI) VIIIth General Conference, Vienna September 1996 quoted in Commonwealth Secretariat (2001) op. cit.

⁴⁸ 'Internationally recruited nurses pay up to £2,000 to care for patients.' RCN Online. 22 April 2002

⁴⁹ Browne, A. (2001). Abused, threatened and trapped - Britain's foreign 'slave nurses'. Guardian. London.

What are the influences on migration?

Prevailing policies and environmental factors as well as the actions of individuals will influence migration. These take place at various levels: international, national, employer and individual. Many of these factors are liable to change or could purposefully be changed to influence migration flows.

Individual level

The reasons for migration may depend on whether the move is intended to be temporary or permanent.⁵⁰ For those from poorer countries improved salary is frequently given as an important reason. For example a specialist nurse in India reported that she was earning £77 a month and in her job on a general medical ward in the UK earns £1,250 a month.⁵¹ A Zambian doctor might leave to work in a neighbouring country where the salary is not a lot higher, but good housing and perhaps a car is provided in the package. Migration may not be the choice of the individual, but rather the family, which may support the migration process financially as an investment. Migration from poor to richer countries cannot be explained simply by economics. An overseas job may provide a person with higher status (a sign of having “made it”) in his or her community or amongst professional colleagues. A lack of job satisfaction due to the inability to do what they had trained for and poor working conditions (including a high level of bureaucracy) come high on the list of reasons for leaving the country.

Having made the decision to migrate, there are many factors that both influence the final decision and the final outcome. Amongst the barriers to obtaining work in another country are: knowledge of vacancies, getting a work permit, getting appropriate professional registration, which may involve upgrading training. All of these have important financial implications to which travel, accommodation before the first pay packet is received must be added. Costs may be increased if the process is lengthy, as is often the case. Social costs such as separation from the family must be added. Some sort of crude cost-benefit analysis will be made by the individual – or possibly the family – before the final decision is made. The move may require a strategic approach. It was reported that nurses in the more rural Eastern Cape Province of South Africa were seeking more highly skilled jobs in hospitals in neighbouring Kwazulu Natal to improve their prospects of gaining work overseas.

Individuals may rely on recruitment agencies to negotiate the major barriers for them. However, the networks of the diaspora can be extremely effective for those who are plugged into them. These networks provide information (where the jobs are; what is the cost of renting a flat in Manchester, for example) and will often provide financial support for travel and the period of upgrading training before a wage packet is received. The support may be for altruistic reasons, but it also reflects the kind of support that these earlier migrants may themselves have received.

Employer level

The global health care market is expanding. Employers have to find health professionals to staff the services. When the local labour market is exhausted – perhaps because of poor planning in the past – they look abroad. This strategy may be part of a broader staffing strategy. In the UK international recruitment sits alongside strategies to get health professionals who have left the health sector to return, increasing the attraction into the labour market, and retention measures to

⁵⁰ See Buchan and O'May (1999) op. cit.

⁵¹ Marsh, B. and A. Loundon (2001). Half of NHS's new nursing recruits are from overseas. *Daily Mail*. London: 6.

stem the losses.⁵² In the more competitive and often unregulated private sector, the lower cost of migrant labour may also be an incentive to employers.

In a 'buyer's market' if the employer offers sufficiently attractive jobs, prospective migrants will find their own way to them. If the requirements for extra staff are greater than the unsolicited supply, then some form of organised recruitment is needed. International recruitment is expensive and to ensure the process is cost effective, bulk recruitment has often been carried out by employers, or by recruitment agencies on their behalf. This has led to accusations of 'poaching' and 'hoovering up'.

The losses of health professionals to the richer countries can be seen as the result of attraction strategies of the receiving countries being more effective than the retention strategies of the source countries. Whilst public sector employers in poorer countries are not going to be able to match salary levels of those in richer countries, some countries such as Namibia are reported to be offering generous end of service payments, subsidised house owning schemes, car ownership etc⁵³ and though Mozambique cannot compete with financial incentives of overseas employers doctors are afforded "considerable social status and professional respect".⁵⁴

Where the private sector is sufficiently developed, health professionals may be attracted to stay in the country, but this may be variable across the different groups. For example, whereas there may be sufficient business to retain pharmacists, the use of private general practitioner physicians may be insufficient, as is the case in Ghana, to retain many of those who would otherwise leave.

Some employers – in particular the more rigid civil services – make it difficult for people to re-join the service,⁵⁵ particularly at a level commensurate with the person's experience. There is also the practical difficulty of the potential returnee in finding out what vacancies are available. Attempts have been made to attract people back from overseas – particularly for more senior jobs as happened in the early years of the Zambian reforms. The International Organization for Migration had a programme (the Return and Re-integration of Qualified African Nationals) to assist returnees which provided both help with finding a job and financial assistance towards the move. However, we learnt that of about 250 Ghanaians assisted between 1986 and 1999 only about 14% were health professionals.

National/international level

International migration is influenced by national governments in a variety of ways. Receiving countries can facilitate or control movement by imposing or removing barriers. For example with the global economic recession in the 1980s there was a need to reduce inflows: the US government tightened up entry requirements for physicians and the UK put a limit on the stay of medical graduates.⁵⁶ Such controls may be specific to particular source countries: for example, the UK recently derecognised the dental qualifications of the University of Witwatersrand in South

⁵² Buchan, J. (2002) op. cit.

⁵³ Dovlo, D. (1999). op.cit.

⁵⁴ Pavignani, E., A. Colombo, et al. (1998). The case of Mozambique. International trade in health services. A development perspective. S. Zarrilli and C. Kinnon. Geneva, UNCTAD & WHO.

⁵⁵ Dovlo, D. and F. Nyonator (1999). op. cit. p.50

⁵⁶ Abel-Smith (1986) op. cit.; Doan, B. D. H. (1987). Health manpower imbalances in the 90's; a worldwide panorama. Health manpower out of balance: conflicts and prospects. Z. Bankowski and A. Mejia. Geneva, Council for international organisations of medical sciences, WHO.

Africa. Barriers may be removed or reduced to increase inflows. For example, the UK fast tracks the issue of work permits in the IT sector.⁵⁷ Middle Eastern countries will closely link the visa to the contract, so migrant workers are forced to return. Some countries are reacting to moral pressure on recruiting from poor countries with apparent staff shortages. England – which has perhaps come in for some of the severest criticism – led the way with the development of an ethical nurse recruitment policy in 1999. A new policy now covers all NHS staff,⁵⁸ and policies are also being developed by health professional unions (RCN) and private sector employers.⁵⁹ Other countries (the Netherlands, Ireland and some Scandinavian countries) are developing similar policies.⁶⁰

Source countries – or potential source countries – may seek to increase or decrease flows. China has approached the UK to take health professionals as it has a surplus and the remittances are considered important. India is pushing for more open access to employment for its nationals as remittances are an important inflow of funds. However, the major push may be from ministries of finance and trade of those countries, rather than from the ministry of health that bears the consequences of these losses. Strong protests have been made by those defending health services in their country, notably one believed to have been made personally by Nelson Mandela to the UK in 1996⁶¹ and more recently by health ministers from Ghana. Some countries may control the length of period of temporary migration through bilateral agreements to ensure their nationals return – Cuba and China, for example.

Countries often have mechanisms to ensure they at least get some return on their investment in an individual's training. Bonding schemes, which are quite common, require graduates to work for the government for say three years, or otherwise buy back the bond. Often this is poorly policed, or unless the bond is linked to inflation which is very high, the value of the bond soon loses its deterrent effect. In Ghana we learnt that the father of a nurse who wanted to emigrate turned up at the Ministry of Health with a sack full of money to pay off the bond as this would quickly be recouped through remittances from his daughter.

Most national governments – both source and recipient – have difficulties in monitoring in and out migration due to insufficient data, which hampers the development of appropriate policies. The issue of visas can be monitored, but not all immigrants will need them (for example, citizens of some Commonwealth countries coming to the UK⁶²). Professional registration seems to be the best source of data, though in many cases the data capture and the database systems need substantial improvement.

Regional and global initiatives are also influencing flows of health professionals. South Africa was criticised for taking a large number of professionals from other sub-Saharan countries and agreed to stop employing foreign doctors. Caribbean countries have agreed to the freer movement of their nurses within the region. The World Health Organization has again made professional migration a priority area stating that “the damage to the health systems which serve poor communities by the

⁵⁷ Nielsen (2002) op. cit., p45

⁵⁸ DoH (2001). Code of Practice for NHS employers involved in the international recruitment of healthcare professionals. London, Department of Health (England).

⁵⁹ For example, the Independent Health Care Association, December 2001

⁶⁰ Buchan, J. (2001). "Editorial: Nurse migration and international recruitment." *Nursing Inquiry* 8(4): 203-204.

⁶¹ Brindle, D. (1999). Curb on poaching foreign nurses. *Guardian*. London.

⁶² Buchan and O'May (1999) op. cit.

relentless recruitment of skilled health personnel ...to places where the pay is better".⁶³ The Commonwealth has taken an important stance on the migration of health professionals, commissioning a specific study on the situation.⁶⁴ On the basis of the findings of the study the Commonwealth health ministers requested the development of a Code of Practice for the international recruitment of health professionals. The Commonwealth's draft Code⁶⁵ – which was approved at a meeting of Commonwealth Health Ministers in Geneva in May 2002 – suggests that the code "should not be limited to Commonwealth countries" but also include major recruiting countries and as such is therefore a proposed global code. The International Council of Nursing⁶⁶ and more recently WONCA⁶⁷ have developed their own statements on or codes of practice for international recruitment. Whilst the codes would have no legal status, the WTO's General Agreement on Trade in Services (GATS) does bind countries. However, to date the section of the agreement dealing with movement of professionals (known as Mode 4) has been little used – especially by developing countries. India is an exception and is working hard to take advantage of GATS to export its skills.⁶⁸

The issues of denying the individual their rights to leave the country, as a means of controlling migration, purely on the grounds of their profession has been raised in the past and again more recently.⁶⁹ This deserves further exploration, though this has not been possible within the scope of this paper.

What are the policy issues?

Introduction

We need to work on the assumption that the international migration of health professionals will continue. There are therefore a number of key policy issues⁷⁰ around protecting the interests of the health services in the poorest countries. These policy issues are even more pertinent given the risks to the proposed massive new investments in their health care systems⁷¹ posed by staff shortages. These policy issues can be organised in terms of levels of responsibility: global; source country; recipient country; and the development partners of many of the industrialised recipient countries.

⁶³ Address by Dr Gro Harlem Brundtland, Director-General, to the Fifty-fifth World Health Assembly, Geneva, Monday 13 May 2002

⁶⁴ Commonwealth Secretariat (2001a). Migration of Health Workers from Commonwealth Countries. Experiences and Recommendations for Action. London, Commonwealth Secretariat.

⁶⁵ Commonwealth Secretariat (2001b). Commonwealth code of practice for international recruitment of health workers. Agenda Item 3 (b). 13th Commonwealth health ministers meeting. Christchurch, New Zealand, 25-29 November 2001.

⁶⁶ ICN (2001). Ethical Nurse Recruitment. [www.icn.ch/psrecruit01.htm; accessed 29/04/02]

⁶⁷ WONCA (2002). A Code of Practice for the International Recruitment of Health Care Professionals: THE MELBOURNE MANIFESTO Adopted at 5th Wonca World Rural Health Conference Melbourne, Australia. 3 May 2002.

⁶⁸ Nielsen (2002) op. cit., p58

⁶⁹ Mejia, A. (1978). "Migration of Physicians and Nurses: a worldwide picture." International Journal of Epidemiology 7(3): 207-215.; Mejia, A. (1978). "Migration of Physicians and Nurses: a worldwide picture." International Journal of Epidemiology 7(3): 207-215.; WONCA (2002) op. cit.

⁷⁰ For more suggested strategies see Commonwealth Secretariat (2001a) op. cit. and Lowell and Findlay (2001) op. cit.

⁷¹ see WHO Commission on Macroeconomics and Health (2001). Macroeconomics and Health: investing in health for economic development. Report of the Commission on Macroeconomics and Health. Geneva, World Health Organization.

Global level

Information. Despite Mejia's recommendations in the 1970s we still lack comprehensive and reliable information on migration flows and related issues. This prevents effective monitoring and identification of the impact, which in turn hampers appropriate and effective policy development. The unpredictable nature of migration flows makes this information all the more essential. Numerous recent and ongoing initiatives are now helping to build a much clearer picture (see Table 6)⁷². As the results of these different studies become available they need to be synthesized into a single body of knowledge. The search for a methodology to produce a kind of balance sheet exercise initiated by Mejia and colleagues must continue. However, participants at a recent meeting⁷³ stressed that though such monitoring systems are necessary at a global level, they will only be sustainable if countries providing the information also use it for their own purposes.

Table 6: Contemporary studies on migration of health professionals

Name of study & date	Researchers/institution
International recruitment of nurses: a report for the Department of Health (UK), 1999	Buchan and O'May, Queen Margaret University College, Edinburgh
International Recruitment of Physiotherapists (UK), 2000	Buchan and O'May. Queen Margaret University College, Edinburgh
Migration of health workers from Commonwealth Countries, 2001	Various/Commonwealth Secretariat
The migration of skilled health personnel in the Pacific Region, November 2001	John Connel/WHO Western Pacific Regional Office
Study of international migration and mobility of nurses. 2001-2 (ongoing)	James Buchan, Queen Margaret University College, Edinburgh & Julie Sochalski/ University of Pennsylvania. UK/ USA. Supported by WHO/ICN/RCN
The migration of skilled health personnel in the African region 2001-2002	WHO/HQ/AFRO
Migration of highly skilled persons from developing countries: impact and policy responses, 2001	Lowell and Findlay, ILO

Source: compiled by the authors

Negotiation/dialogue. Despite the current insufficiency of data, the advocates for revisiting the migration issue appear to have been successful. The move to the Codes of Practice, and the constructive bilateral and multilateral agreements bear testament to this. However, the danger is that the cause will once again fall (or be pushed) out of fashion and the codes of practice and agreements will be forgotten. Hence strenuous efforts are needed to sustain the dialogue at an international level.

Negotiation between different national stakeholders must also be strengthened, particularly with increasing trade liberalisation. But it must be recognised that the dialogue should not simply be on a North-South axis. Ministry of Health negotiators representing the health service interests of a country need to be able to stand up to the government representatives on trade whose interests are in improving the balance of payments from the remittances of migrant professionals. Senior health officials have to get to grips with the language of trade and GATS. Development agencies that best understand the situation in the world's poorest countries need to need to represent stakeholder interests in those countries in the face of demands for better health services in their own countries. Because of their greater neutrality, there is surely an important role for civil society organisations in both developed and

⁷² South Africa has recently carried out a number of studies on migration of its health professionals. Source: Dr Steve Reid, Personal Communication, August 2002

⁷³ International Consultation on Assessment of Trade in Health Services and GATS: Research and Monitoring Priorities 9-11 January 2002, WHO Geneva, Switzerland

developing countries in engaging in dialogue on behalf of the poorest health service users.

Responsibilities of source countries

Those countries, encouraged by the World Bank, that see increasing globalisation as an opportunity to actively export their skilled health professionals need to ensure that this is not to the detriment of health service provision – particularly in the world's poorest countries.⁷⁴

Whilst it is reasonable for those poor countries that are losing their health professionals to richer countries to complain about poaching, they must also accept their own responsibilities as effective gamekeepers - improving strategies for attracting and retaining staff. They should aim to develop comprehensive strategies to deal with all aspects of the labour supply e.g. attrition from rural to urban areas, public to private sector, as well as international migration (regional and further abroad).⁷⁵ It has been suggested that the neglect of these responsibilities has been the cause of the migration.⁷⁶

In a competitive labour market all organisations that recognise the value of their staff will have some kind of attraction and retention strategies which revolve around pay, conditions of service, working conditions and – especially in the “caring professions” – job satisfaction. Those that do not have any such strategies put themselves in a weak position when complaining about losses the private sector or international recruiters. In government organisations, pay and conditions of service are usually the responsibility of central government; the Ministry of Health as the employer may be limited to making small improvements to the working conditions and job satisfaction.

If the competition for labour is so great, or resources so constrained, governments will have to reconsider their staffing strategies. In evolving post-colonial health services the use of substitute health cadres was common (e.g. Clinical officers in Zambia, Medical Assistants in Malawi). Some current proposals for combating losses through international migration include the use of types of staff whose qualifications are not internationally recognised.⁷⁷

Losses can be high when people go overseas for further training. Ghana has attempted to deal with this problem by introducing shorter specialist training provided in-country.⁷⁸ Bonding systems have been traditionally used to ensure that people put something back into the service following initial training, and further training. These only work in countries where the institutions are strong enough to enforce such policies. Where inflation is high the bond figure needs to be regularly re-assessed. As an alternative strategy South Africa has successfully introduced a form of community service for most health professionals which ensures some repayment to the system in kind, but only one year.

⁷⁴ Hilary, J. (2001). *The Wrong Model GATS, trade liberalisation and children's right to health*. London, Save the Children.

⁷⁵ The Commonwealth Secretariat, WONCA and ICN codes of practice on international recruitment all emphasise this responsibility.

⁷⁶ Lowell and Findlay (2001) op. cit.

⁷⁷ See Dovlo, D. and F. Nyonator (1999). "Migration by Graduates of the University of Ghana Medical School: A preliminary rapid appraisal." *Human resources for health development journal* 3(1).; and Commonwealth Secretariat (2001a) op. cit.

⁷⁸ Dovlo and Nyonator (1999). Op. cit. p50

In Ghana employment in the private sector appeared to be a factor in at least retaining pharmacists in the country. Private care involving doctors and nurses has not been well-developed in that country. However, it has been proposed that public sector hospitals develop private wings where government doctors could provide services in a private capacity outside working time.

However well designed the strategies for attracting and retaining health personnel, the pull towards jobs overseas will remain very strong in some countries. The demand looks as if it will continue and in many developing countries the level of salaries looks unlikely to rise dramatically. Perhaps it should be accepted that in such a situation, migration is inevitable, and the opportunities should be actively yet responsibly managed even in countries with serious shortages. If so, the policy debate should move on to ensuring that in broad terms the needs of stakeholders in source countries are met. This requires more flexible employment to enable people to work abroad and then come back into their employment at home on at least the grade they left. It may mean helping people to find overseas work – perhaps by setting up bilateral agreements with recipient countries. These agreements should be time-limited, to ensure that both the health professionals return and that others get the chance too.⁷⁹ A properly managed process would also protect people from unscrupulous recruitment agencies and ensure that people got jobs that made reasonable use of their skills.⁸⁰ Agreements could be made so that the temporary migrants truly relevant gained skills - not just any skills but those that the health service most needs – thus providing a win-win situation for the recipient employer, the original employer and the health professionals involved.

Whilst this form of “managed migration” is a logical option, it does carry risks. This appears to be effectively handled by Cuba and China, but they are able to enforce their policies. Many other governments neither have the discipline nor the capacity to manage such a process, so the initiative could get out of control and end up actually increasing the net outflow of staff. Nevertheless, in the absence of better alternatives, it is worthy of consideration.

The starting point for all human resource planning and management is good information. At present the existing information is incomplete and is often only accessed when questions are asked in parliament.⁸¹ A set of suggested indicators and data sources provided by the Commonwealth Secretariat publication provide a good start. Ideally, just as countries recruiting internationally gather information on where there are surpluses of health professional, source countries would also have information on likely future demands – either to prepare to meet those needs, or to identify possible ways to protect themselves.

Responsibilities of recipient countries

All recipient countries that are members of the ILO have responsibilities to ensure that their health service employers and recruitment agencies follow accepted practices. These may be spelt out more clearly by developing Codes of Practice that include accreditation of recruitment agencies, equal treatment by employers, etc.

⁷⁹ ILO 2001 op. cit. 6.2.1; Dovlo, D. (2002). Retention and deployment of health workers and professionals in Africa. Consultative meeting on improving collaboration between health professions and governments in policy formulation and implementation of health sector reform, Addis Ababa, Ethiopia, January 28 - February 1, 2002., p.25

⁸⁰ Findlay, A. M. (2001). A development policy perspective on the General Agreement on Trade in Services in relation to temporary skilled migration. Dundee, Centre for Applied Population Research, University of Dundee. [pp 9, 22,23]

⁸¹ Examples of this were found both in Ghana and South Africa.

Whilst none of the codes of practice seen by us is legally binding, countries with national health systems can ensure that all public sector employers abide by the codes. Pressure could be put on private sector employers, especially if the government purchases services from them. Countries that have made the effort to develop Codes of Practice should not let the ethical glow prevent them from ensuring that employers are not just bringing in staff through the 'back door'.⁸²

It has been suggested that GATS should have Code of conduct that would then be enforceable under the term of the agreement.⁸³ This would ensure that countries who neither have ethical recruitment codes of their own, nor are members of wider clubs that have one e.g. the Commonwealth, can be held to account on international recruitment practices.

Agenda for development partners

The issue of reparations to counter losses to source countries raised in the 1970s has made a minor reappearance on the scene.⁸⁴ However, serious consideration would have to be given to who makes the reparations? to whom? and how?. A hospital in an industrialised country will probably not be best equipped to provide appropriate assistance to institutions in resource-poor countries. This work is much better handled by aid agencies, or development partners (regardless of whether they are recipients of health personnel from developing countries) who already have extensive experience in this area. This is another area where practicalities are in danger of being obscured because of political sensitivities.

Source countries need support in the development of broad human resource strategies described above including, but not exclusive to, international migration. Help in many countries is needed with developing expertise in human resource planning and management; funding the planning process, which involves many different stakeholders; help with developing appropriate information systems; and providing exposure to other health systems (developed and developing) and how they manage similar challenges. There are useful lessons that could be drawn from the successes in the UK⁸⁵ and Western Australia,⁸⁶ for example, with improving attraction and retention of nurses.

Within these human resource strategies there may be elements that development partners could support financially. This could include funding to training – often associated with the reparations demands – but it would only make sense to do this if it fitted in with a wider strategy for improving the staffing of health services. For example, the impact of investment in postgraduate training, which would be attractive to many stakeholders, would need to be weighed up against competing needs such as improvements to working conditions.

With the change in modes of providing aid – from projects to partnerships⁸⁷ - development partners have a more powerful voice that can be used to lobby developing country governments to better invest in human resources by developing

⁸² See BBC News (2001). UK 'draining third world nurses'. [BBC Online Network](#).

⁸³ ILO (2001) op. cit. 6.3.2

⁸⁴ see Findlay (2001) op. cit.; Commonwealth Secretariat (2001b) op. cit. [para 34]; and Pang, T., M. A. Lansang, et al. (2002). "Brain drain and health professionals." [BMJ](#) 324(7336): 499-500.

⁸⁵ see for example the UK's "Improving Working Lives" strategy at <http://www.doh.gov.uk/iwl/>

⁸⁶ Described in a presentation by Dr Phillip Della, Department of Health, Western Australia, on an Overview of nursing workforce education and planning in Australia at the 6th International Medical Workforce Conference, Ottawa, 25 – 28 April, 2002

⁸⁷ Through budget support or sector wide approaches

better human resource strategies, providing targeted incentives or even providing more realistic salaries. The level of the debate is also likely to be infinitely higher than some of the 'blame and shame' tactics used to date.

For many years certain development partners have funded some salaries or provided top-ups for key government posts in projects. Though there has been a reluctance to fund salaries on a wider scale, this issue could be revisited as an important staff retention measure as these new forms of development aid are introduced.

The interest of development partners will primarily be the improvement of developing country health systems. They will therefore be natural allies to lobby on behalf of developing countries. An important form of support will be to ensure that the codes of practice that have received such acclaim are implemented and that implementation is sustained. For example, much effort has been put into developing the UK Code of Practice on International Recruitment, but managers who are responsible for implementing it now face a much wider challenge of current structural reforms and the government's promise in the budget speech of April 2002 of yet greater staff increases. The UK's Department of International Development needs to ensure the pressure is maintained to ensure the good practice becomes properly embedded.

Conclusion

The negative impact on health services in poor countries of mass recruitment of health professionals from those countries seems in many cases beyond dispute. Some positive measures are being taken to curb this, but there is a danger of the small successes leading to complacency. The pressure from richer nations on the international labour market is clearly set to increase. It is therefore imperative that the issue of migration of health professionals remains on the international agenda.

Acceptance of responsibilities by all major stakeholders, not just the poachers, is a prerequisite to useful debate and a fruitful search for solutions. A recognition of the complexity of stakeholder interests – both within and between countries – is a necessary ingredient of progress.

Better information will assist the development of more effective policies, and the recent spate of studies will provide an important contribution. Better human resource planning and management strategies will improve attraction and retention in poorer countries.

However, some countries may need to consider much more radical solutions to their staffing problems – "managed migration" and a re-design of the workforce structure have been put forward as possibilities.

If there is to be any meaningful partnership between richer and poorer nations, the dialogue must get beyond the political posturing and defensiveness and be better informed by an understanding of the real drivers of professional migration.

Whilst the measures proposed in this paper will not solve all the problems of international migration, they may go some way towards levelling the playing field for developing country health systems.