Workshop On Human Resources For Health And Migration
MOBILITY, TRAINING AND THE GLOBAL SUPPLY OF HEALTH WORKERS
16th-17th May 2007, Sussex

THE MOVEMENT OF HEALTH PROFESSIONALS: A CONCEPT NOTE

The migration of trained health professionals from poorer developing countries to wealthier developed countries is still generally seen as negative for countries of origin and prejudicial for their social and ultimately economic development. This interpretation drives policy and while this workshop will not deliberately seek a revisionist approach, it does seem timely to re-examine what often appear to be easy assumptions. The principal purpose of the DRC workshop is to consider the movement of health professionals from several points of view:

1. The data upon which interpretations are based.
2. The causes of the movement, both the demand and the supply side.
3. The question of scale in the causes and consequences of the movement.
4. The alternative scenarios or likely future directions of the movement.
5. The potential for a "management" of the movement.

1. **Data**. It is all too easy to become preoccupied with questions of data, of their availability and adequacy. In the workshop we want to "move beyond the numbers". Nevertheless, we must surely start with the numbers, lest our interpretations lack empirical validity. How many are leaving, from where, and to where? Yet, the movement of health professionals is not a simple movement from an origin to a destination. It can involve a complex trajectory where place of training is often not the place of origin: centres of training will normally be in the larger cities in countries of origin but may also lie outside countries of birth. Hence, a migration to a place of training may be a precursor to a later movement for employment after the training is complete. Training itself may be split among several different places as health professionals complete basic training, perhaps at home, and then move overseas for more advanced qualifications. Place of origin, place(s) of training and place of employment can, theoretically, be at least three separate places in at least three different countries. Quite apart from the data on the trajectory of the migration of health professionals are data on the funding of training: whether it is by by state of origin, state of employment, private foundation, or the migrant, or family of the migrant, him or herself. Costs of training may be split among any one of these sources and the combination of sources has distinct developmental implications. For example, policy recommendations that might emphasise some form of compensation become complicated.

2. **Causes.** The fundamental cause of the movement of health professionals is the difference in earning potential as well as differences in working conditions between developing country of origin and developed country of destination. Nevertheless, the trajectory of movement of health professionals is not simply from developing to developed country. Much movement occurs among the developed countries themselves and also from the developed to the developing world. As with so much migration, training expands a person's horizons and increases their marketability and these variables, too, need to be taken into consideration.

However, the differential *demand* for health professionals among the ageing societies that make up the developed world will remain, at base, the driver of the movement of health professionals. The policies that influence domestic production of health personnel and whether self-sufficiency in health personnel is an achievable or even desirable goal for developed societies, seem critical to an understanding of flows of doctors and nurses. Current trends and policies in this area will be assessed. What is the likely demand for health positions going to be in the developed world and how can they be filled from domestic and external sources?

The *supply*, too, is critical to an understanding of the movement of health professionals. Some countries, following the law of comparative advantage, are specifically training their citizens for overseas markets. The extent to which state policy, private initiative or a combination of the two, drives this process needs to be examined. Here again, the sources for the funding of training are critical. Such strategies need to be set against domestic demand for the health services that will help countries to achieve the Millennium Development Goals. Hence, strategies of *retention* of health personnel appear relevant. Is it achievable or desirable to implement policies to retain key personnel at home? Integral to this question is the issue of appropriate type of training. Training for local rather than global markets may be more appropriate for certain countries, which, in turn, raises the issue of two- or multi-tier training systems appropriate for the needs of people in poor isolated parts of the developing world. Clearly, the issue of retention does not simply apply to migration from a country. Poor pay and conditions may cause a movement from the sector rather than the country: from the health sector into government or into business, for example, leading to skill wastage. The relative importance of this internal "migration" relative to international migration needs to be assessed.

3. **Scale.** In the literature on the impact of the exodus of skilled migrants in general, and health professionals in particular, rarely is the question of scale addressed directly. Size of country as well as location in the global system is going to affect both the volume of outflow, and its impact. The consequences of the loss of personnel from small isolated countries is going to be very different compared with those for a large developing country close to centres of dynamic development. Similarly, the capability of small countries to *train* and *retain* skilled personnel is going to be different relative to a large country. The location of that small country may also be important as far as the establishment of training facilities is concerned. Size and location are certainly not the driving factors of the movement of health personnel but they are significant and it may be possible to think of a relative impact factor that is largely a function of these two variables.

4. **Alternative scenarios.** Any assessment of the impact of the exodus of skilled personnel needs to be made in the context of a dynamic system. New source and destination areas emerge: what were once source areas may go though a transition to destination areas. In the workshop, we will want to look at where centres of service delivery are likely to emerge in the periphery. In part, this will reflect local and regional demand; in part, it will reflect global demand or where certain parts of the world can provide particular types of treatment more efficiently through comparative advantage. Rather than move the personnel to the service, the patients can be moved, or move themselves, to the service. That is, retention of health personnel can be based, in certain locations at least, on the provision of regional and global care However, if countries opt for such a strategy, what is the impact on the provision of services to the local population? The factors which decide any such location will be the subject of discussion. Other issues such as aftercare also seem apposite to the success of these alternative strategies.

5. **Management strategies.** Given the complexity of factors affecting the volume and direction of movement of health professionals, as specified in 2 above, together with the issues of scale and location, it is pertinent to ask whether it is possible to "manage" the flow in any way. While not wishing to pre-empt any interpretation, it does seem likely that non-proximate or indirect policies are more likely to meet with success than any direct attempts to limit (or encourage) the movement of health professionals. That is, policies that focus on types of training, improvement of working conditions, liberalization of the health sector, and so on are more likely to have a greater impact on

the migration of health professionals than attempts to restrict recruitment, close borders or otherwise limit health professionals leaving. Issues of accreditation and providing adequate channels for health professionals to move through will be critical if a *wastage of skills* is to be avoided. Ultimately, do viable policy approaches exist that can act in the interests of countries of origin, countries of destination, as well as the migrants themselves? International, governmental and non-governmental organizations will all have a role to play in the design and implementation of any effective management strategies and the extent to which they can be successful will be an underlying theme in the discussions of the workshop.

The above notes are in not meant in any way to provide a straitjacket for the discussions. Participants are expected to go their own way, suggest other issues or to elaborate and go beyond the points made above in what we hope will be wide and free-ranging discussions. We look forward to your active participation in what we hope will be a stimulating workshop.