Briefing

Development Research Centre on Migration, Globalisation & Poverty

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Skilled Migration: Healthcare Policy Options

Summary of Key Issues

The loss of skilled personnel to rich countries is a major concern for many developing countries today. However, large numbers of people from developing countries are also being trained overseas and, of those trained at home, many cannot be absorbed productively into their economies of origin. At the same time, the association between the presence or absence of health personnel and the health status of a population is seen as simplistic and a range of other factors are addressed. This Briefing examines the case for a two-tiered health training system, one for global markets and the other for local markets. It also examines options for 'outsourcing' healthcare to regional centres in poorer countries as a way to assist with retention and return.

Overview

A persistent tendency exists amongst policymakers and commentators to view the exodus of skilled people from developing countries as negative. Stopping that migration, and encouraging the retention and return of the skilled, therefore become major policy objectives. As a result, some governments, including the UK, have established ethical codes of practice for the recruitment of health professionals. Such programmes appear to be morally impeccable to the extent that they attempt to protect the interests of origin states against those of destination states but they are problematic and difficult to implement. They also exclude certain individuals from opportunities and therefore, if implemented, could be seen to be discriminatory on the basis of origin.

The health sector is often seen as "exceptional" in migration and development. The loss of key medical personnel is seen to deprive origin countries of access to a basic human right, that of adequate health care. At the same time care cannot be provided in destination countries without importing health personnel to meet the growing demand in ageing societies.

Health systems in parts of the developing world, and particularly in sub-Saharan Africa, are seen to be in crisis as their doctors and nurses opt to move to greater security and higher paid jobs in Europe, North America and Australasia.

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Ethical recruitment codes can be discriminatory

Complexity in Healthcare Mobility

There certainly is a problem in terms of mobility of health professionals, reflecting increasing demand for healthcare in developed and ageing societies. However, the situation is more complex than it first appears.

- In terms of the absolute numbers of health workers on the move, the major countries of origin are other developed countries or middle-income developing economies. Overseas nurses recruited to the UK have mostly come from The Philippines, South Africa, Australia, and India in recent years.

- Migration is only one factor in accounting for losses of personnel in the health sector of developing nations. South Africa features prominently in the flows of both doctors and nurses to the developed countries of Europe, North America and Australasia. Yet, the pool of all health professionals in the country, except nurses, continued to expand between 1996 and 2001 despite the outflow. Although the number of nurses in South Africa was virtually stagnant over the same period, and 32,000 vacancies existed in the public sector, the OECD estimated that,

within the country, there were another 35,000 registered nurses who were inactive or unemployed, pointing to other problems than migration affecting the health service.

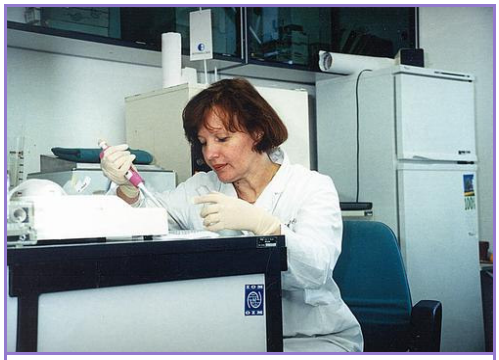
- Research evidence from Migration DRC partner ISSER in Ghana suggests that doctors and nurses migrate not only to fill demand, and to gain better wages and working conditions, but also, critically to gain further training. Of the 94 doctors and 447 nurses interviewed, around 58% of both groups intended to migrate, almost all of them immediately after graduation. Of those, 90% were waiting to complete their education before leaving. Of those who wanted to leave, 33% of doctors and 36% of nurses wanted to go to the US and 33% of doctors and 52% of nurses wanted to go to the UK. 38% of both groups put 'further training' as their primary reason for migrating; this was followed by 'improved working conditions' (28%), 'more money' (20%) then 'a better managed health system' (15%). Many of the foreign-born doctors in smaller developed countries receive advanced training overseas. The issue of accreditation is uppermost in the medical field, and doctors and nurses may have to complete "bridging" courses, required by local medical authorities, to bring them up to acceptable local standards. Opting to train in a medical school in a developed country obviates this problem.

Other Factors Affecting Healthcare

As well as diverse factors relating to the effect of and reasons for migration there are a range of other internal factors that affect the staffing of healthcare systems as well as the health status of the population of countries in general including:

- *Specific Places of Origin*

The internal distribution of health personnel needs to be taken into consideration. The origins of health professionals in developing countries are rarely to be found in the places of greatest deprivation, the rural areas. They come from urban areas and are likely to be from elite or at least wealthy families. It is often difficult to encourage medical personnel to serve in rural areas even in countries such as South Africa, which has resorted to importing doctors from Cuba to fill the void. The emigration of doctors is therefore unlikely to be fully responsible for any reduction of services in those areas of greatest need.



©IOM It can be difficult to encourage medical personnel to serve in areas of most deprivation

- *Relations Between the Health Sector and the Population's State of Health*

To relate the state of a nation's health to the increasing emigration of medical professionals or, conversely, to their presence, is to take too narrow a view of how health is delivered to a population. This is not to suggest that a country does not need doctors and nurses, simply that any crisis in the state of health in a country is unlikely to be the result of an exodus of skilled medical personnel alone. A number of other professional groups also need to be taken into consideration.

In terms of skilled workers, the agronomists who work to increase agricultural yields to improve the nutrition that will combat disease, the water engineers who work to supply safe drinking water, the sanitary engineers who build the sewerage systems, the transport engineers who improve communication that allow food to be taken from point of supply to where it is needed, and so on, are as critical as any skilled doctor in improving the health status of a population.

- *In-migration of Doctors & Return of Trained Nationals*

Movement of doctors from developed countries and other parts of the developing world to many poor countries also occurs. Currently, voluntary personnel are working in almost 70 countries and each year personnel are involved in more than 3,400 missions. These doctors often operate in the rural areas where local doctors are reluctant to take up positions. A critical dimension of the migration of the skilled is their return to their countries of origin. This return can either be of previous brains lost in the migration or of brains enhanced through training overseas in a "brain gain". They are unlikely to be *the* key factor in the development of their homeland, but they can play significant roles nevertheless.

It is all too easy to use emigration as a scapegoat for a lack of development, but to what extent can highly trained medical personnel truly make a difference in areas where basic facilities are lacking? Should countries

be opting for training systems more appropriate to the needs of the majority of poor rural people, producing medical personnel who are not marketable internationally but who are needed locally? What are appropriate policy responses that do not limit options for trained personnel but allow countries to provide appropriate healthcare for their populations?

Possible Policy Responses

Countries will not wish to introduce what might be perceived as a "second-rate" system of medical training. But some variant of a "two-tier" system of training could be considered in which doctors and nurses are trained to international standards and it is accepted that losses will occur, but many others are trained to more basic levels of health care in order to have the most appropriate personnel for poor rural areas.

Like labour-intensive industrial production, basic services such as health can also be outsourced. Ageing populations have patterns of recurrent and degenerative diseases, personnel shortages in the health sector, rising costs of medical care and increasing waiting times for non-emergency surgery. These are all factors favouring travel overseas for non-emergency treatment, as well as the incentive of lower costs for using the private sector in developing countries.

A global market in health care appears to be emerging with India, South Africa, Cuba, Costa Rica, Malaysia and Thailand all promoting medical care for patients from overseas. The principal market in India is its expatriate community who can combine non-emergency medical care with trips back home. However, regional markets are emerging, with people from the Middle East going to South and Southeast Asia for treatment, and hospitals in Bangkok serving patients from Hong Kong, Bangladesh and as far away as Australia. What began as medical services for expanding expatriate populations based locally, or the international develop-ment and diplomacy sectors, has evolved into supplying regional and even global medical care.

The extent to which programmes to outsource medical care can encourage migrant national doctors to return from overseas or can even retain local talent remains unproven. Nevertheless, the cases to date suggest that regional markets are emerging for health care, as middle-class or middle-income groups emerge in developing economies.

It is clear that not all countries will be able to adopt such outsourcing strategies. These alternatives are only possible where a number of conditions can be met:

- Where prior demand exists from an expatriate population.
- Where regional and, ideally, global networks of aviation transport are available.
- Where there is a local supply of high-quality health professionals
- Where government accepts the existence of a significant private sector in promoting health.

The combination of such factors is likely to be found only in the larger cities of middle-income developing countries: throughout Southeast Asia, coastal China, parts of India, Mexico, coastal Brazil and Argentina, South Africa, North African countries, and Nigeria and possibly Ghana in West Africa.

Medical Outsourcing : Bunmrungrad Hospital

Initially founded in 1990, Bunmrungrad became "Asia's first internationally accredited hospital" on 25 April 2002. It is a private company, listed on the Thai Stock market, that treats 850,000 patients a year, 300,000 of whom are international, from 154 countries, and an unspecified proportion of whom will be resident in Thailand. Its turnover in 2003 was $US114 million. Although the majority of its 600 health professionals have been trained in Thailand, most of them have overseas training and certification, mainly in the United States, and Bunmrungrad has an "American-led" management team. Like other hospitals, it has reached agreements with leading American and European insurance companies to cover the costs of its medical treatment. The hospital has representative offices in seven South or Southeast Asian countries plus the Netherlands. The Bunmrungrad Hospital Foundation is involved in a wide range of charitable activities to help poor Thais. These range from doctors providing free services in low-income areas to in-patient heart treatment for children, and the Foundation estimates that it has provided benefits to over 100,000 needy Thais since its inception, a tiny fraction of total treatment but at least demonstrating linkages back into the local community.

Not all countries will be able to deal with the flows of the skilled in the same way. Equally clearly, not all countries generate skills in equal numbers, not all countries have the same demand for skills and the impact of the movement of skills both in and out is variable. Location and size of labour market are critical in any assessment of the impact of the exodus of the highly skilled, and policy responses need to be adjusted accordingly.

Implications for Policy

There are five major policy implications for developed and developing nations when considering the implications of migration for healthcare:

- Migration is a symptom not a cause of failing health systems
- Most elite healthworkers would not provide basic healthcare to the most needy if they stayed
- Ethical recruitment policies can be discriminatory and unfair
- Training should be oriented towards the true needs of a country
- Creating regional centres of excellence supported internationally can help retain and attract back healthworkers

Further Reading

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Development Research Centre on Migration, Globalisation and Poverty

The Migration DRC aims to promote new policy approaches that will help to maximise the potential benefits of migration for poor people, whilst minimising its risks and costs. It is undertaking a programme of research, capacity-building, training and promotion of dialogue to provide the strong evidential and conceptual base needed for such new policy approaches. This knowledge base will also be shared with poor migrants, contributing both directly and indirectly to the elimination of poverty.

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