“Pull” factors in international migration
of health professionals

An analysis of developed countries’ policies
influencing migration of health professionals.

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A minithesis submitted in partial fulfilment of the requirements for the degree of
Masters in Public Health in the School of Public Health,
University of the Western Cape.

Supervisor: Prof. David Sanders

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Abstract

“Pull” factors in international migration of health professionals

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MPH minithesis, School of Public Health, University of the Western Cape.

This secondary data study, framed in social constructionism theory, describes and analyses the “pull” factors influencing migration of health professionals from developing to developed countries.

The literature review sets the context within which international migration takes place and explores relevant aspects of the G8, globalisation, and the General Agreement on Trade in Services.

The research demonstrates that temporary or permanent international migration occurs for employment or study purposes. It further confirms that, despite the lack of accurate data from African countries, the number of health professionals leaving the continent has increased significantly during the 1990s. Because of developed countries’ continued high demand for and their failure to produce sufficient health professionals, recruitment from developing countries is expected to increase during the next 10 – 20 years. Africa will become a major source of migrants during the 21st century.

The analysis of international macroeconomic policies and the GATS demonstrates that these are influencing developed countries’ immigration policies and international migration from developing to developed countries, because of the ever-expanding need for skilled health professionals in an expanding global health services market.
Macroeconomic policies and trade-related agreements promoted by developed countries play a significant role in maintaining or exacerbating skills losses from developing countries, despite the numerous pledges by developed countries to build and strengthen health systems’ capacity in developing countries: this is described as the “development paradox”.

The discourse on international migration demonstrates that international migration is associated with substantial economic benefits and access to a significant reserve workforce mainly for countries that generate the pull. Developing countries are incurring important economic losses because international migration does not allow the public health sector to benefit from the investment in human capital, while a significant proportion of Overseas Development Assistance is used to substitute or develop capacity of human resources.

Proposed solutions to the brain drain include improved workforce planning in developed countries, compensation for lost investment and ethical recruitment. The continued high demand for health professionals in developed countries indicates that demographic changes and changes in career choices of school leavers have received inadequate attention in health workforce planning. Only increased production of health professionals for the domestic markets of developed countries would resolve the brain drain. The proposed compensation schemes and ethical recruitment will not solve the critical human resource shortages, but can contribute to mitigating the impact of international migration.
The research confirms that current macroeconomic and trade-related policies have the potential to undermine G8 commitments to capacity development of developing countries’ health sectors.

If the G8 and other developed countries are truly committed to strengthening African health systems, they should accept responsibility for creating the pull in international migration and acknowledge the existence of the brain drain by including the brain drain in international policies.

Comprehensive information systems should be established to provide accurate data on international migration and for health workforce planning.
Pull factors in international migration
of health professionals

Wilma Meeus

Key words

International migration
Pull factors
Health professionals
Brain drain
Africa
Health systems
NEPAD
GATS
Macroeconomic policies
G8
**List of abbreviations and acronyms**

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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>CMH</td>
<td>Commission on Macroeconomics and Health</td>
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<td>ECOWAS</td>
<td>Economic Community of West African States</td>
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<td>G8</td>
<td>Group of Eight industrial countries (United States of America, Canada, Japan, United Kingdom, Italy, France, Germany and Russia)</td>
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<td>GATS</td>
<td>General Agreement on Trade in Services</td>
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<td>GATT</td>
<td>General Agreement on Tariffs and Trade</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunisation</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>IOM</td>
<td>International Organisation for Migration</td>
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<td>NEPAD</td>
<td>New Partnership for Africa’s Development</td>
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<td>NHS</td>
<td>National Health Service (United Kingdom)</td>
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<td>ODA</td>
<td>Official Development Assistance</td>
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<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
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<td>SANSAL</td>
<td>South African Network for Skills Abroad</td>
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<td>TRIMS</td>
<td>Trade-related Investment Measures</td>
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<td>UNCTAD</td>
<td>United Nations Conference on Trade and Development</td>
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<td>UNDP</td>
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<td>UNECA</td>
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<td>UNESCO</td>
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<td>WHO</td>
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<td>WTO</td>
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Declaration

I declare that *Pull factors in international migration of health professionals* is my own work, that has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Wilhelmina Everarda Antonia Maria (Wilma) Meeus 23 April 2003

Signed:

[Signature]

UNIVERSITY of the WESTERN CAPE
Acknowledgements

During the many years I have worked on the African continent, I have been impressed by the commitment of colleagues to deliver health care. The many challenges they faced, either because of the country’s limited resources or because of conflicts, were met with courage and enthusiasm. Despite the fact that poverty and/or conflict often impacted directly on their own lives, their families’ survival and on their communities, they were committed to improve the capacity of the health sector. I wish to acknowledge the inspiration these colleagues have given me in conducting this research.

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Last but not least, I want to thank Steven for being there with me.

Cape Town, 23 April 2003.
“Pull” factors in international migration
of health professionals

An analysis of developed countries’ policies
influencing migration of health professionals

“... Thus the process of development begins by widening the gap between rich and poor in each country... What are developing countries to make of the rhetoric in favor of rapid liberalization when rich countries with full employment and strong safety nets argue that they need to impose protection measures to help those of their own citizens adversely affected by globalisation? ...” (Kissinger H, 1999)
Introduction

International migration of health professionals\(^1\) is not a recent development, but has increased significantly during the last decade. Although it occurs throughout the world, international migration of health professionals is conceivably more problematic where it concerns migration from developing to developed countries\(^2\), because it aggravates existing health personnel shortages and leads to “brain drain”. Health personnel shortages are common in many developing countries, in particular in African countries, and pose serious challenges to efforts that aim at strengthening health systems.

Current macroeconomic policies are ensuring the increasing integration of developing countries into the global economy. It is acknowledged that the benefits from such integration are unequally divided between developing and developed countries. The scant attention given in official policies of developed countries to the consequences of international migration of health professionals from developing to developed countries symbolises this increasingly unequal relationship. The resulting social injustice, i.e. the lack of basic health care for the world’s poorest populations and the inability of developing countries to meet the challenges of strengthening their health systems has motivated this study.

\(^1\) The term “health professional” refers to all categories of health personnel, i.e. doctors, nurses, midwives, pharmacists, dentists and allied health professionals.

\(^2\) In this report the terms “developing” and “developed” countries are used, despite the fact that these terms could suggest that developing countries are in a process of becoming developed. There is sufficient evidence to suggest that this will not happen: the process of overdevelopment in “developed” or “dominating” economies has created and is accompanied by underdevelopment in “developing” or “dominated” economies (Sanders & Carver, 1985: 64).
The main perspective of this study is that health is a basic human right. This right is, however, not afforded to many people on the African continent, partly because of the inadequate capacity of African health systems to provide for the most basic health care needs. This study will show the role of continued out-migration of health professionals in contributing to this situation, and examine the influence of international macroeconomic policies.

The study focuses on the consequences of international migration of health professionals for African countries’ health systems, although it is acknowledged that such migration has led to brain drain from developing countries worldwide. The fact that the study concentrates on pull factors and the economic and political aspects of international migration does not imply that push factors in international migration and freedom of movement as a basic human right are considered insignificant.

Analysts state that developing countries tend to focus on reducing the push factors, because they have the ability to influence these, while reducing the adverse effects of pull factors is considered beyond their control (Dovlo, 2001). However, given the extent of migration and its mostly negative impact on developing countries’ health systems, developing countries should engage with powerful nations to address the pull factors leading to international migration. The purpose of this research is to increase awareness of the pull factors influencing international migration and to persuade policy makers to give due attention to these factors by putting them on the international policy agenda.
Research problem

Human resources are key to health systems’ performance worldwide. Unfortunately, health personnel planning and retention remain problematic due to the instability of the workforce, especially in developing countries. International migration is an increasingly important factor in such instability and is influenced by both “push” and “pull” factors. The latter, which this study will demonstrate, are often the result of policies emanating from developed countries, which in their Official Development Assistance (ODA) prioritise “capacity development” and especially target human resource capacity. The apparent contradiction between stated development policies and global macroeconomic policies, which manifest, in this case, in the loss of health professionals from developing to developed countries, is the focus of this research.

The study was carried out to answer the research question:

To what extent do currently dominant macroeconomic and trade-related policies promoted by developed countries support or contradict commitments to capacity development in the health sectors of developing countries?

Research framework, design and methodology

The theoretical framework employed in this study is social constructionism. The research design is a qualitative, secondary data study. Data obtained through key informants have been used to triangulate data obtained from document sources.

Outline of the research report

The research report commences with the literature review that sets the context within which international migration from developing to developed countries takes place. This is followed by chapter 2 in which the methodological issues are clarified. The
results are presented in three separate chapters: chapter 3) the nature and extent of migration of health professionals; chapter 4) implications of international macroeconomic policies and the General Agreement on Trade in Services (GATS); and chapter 5) the discourse on and proposed solutions to international migration of health professionals. Each of these chapters ends with a number of discussion points resulting from the analysis. The final chapter provides a conclusion with recommendations for further action.
Chapter 1 - Literature review: the Context

This chapter sets the context within which international migration takes place. It provides an overview of health systems in Africa, explores current trends in migration and factors influencing this migration, and examines current thinking in health workforce planning. This is followed by a review of relevant aspects of the G8 and globalisation, and of general aspects of the General Agreement on Trade in Services. The final section addresses issues related to the theoretical framework utilised in this study as well as criteria employed in the analysis of qualitative data.

1.1 Health systems in Africa

The health status of populations is influenced and determined by a large number of factors, many of which are not directly linked to the health sector and its performance (Werner & Sanders, 1997; Labonte et al., 2002; Sanders et al., 2002), such as annual per capita income and income distribution, food security and access to water and sanitation.

The health status of African populations has improved significantly since the 1960s, although the rate of improvements has been slower than the gains achieved in health status globally (Social Watch, 2002; UNDP, 2001; World Bank, 2001; Sanders et al., 2002). This is partly due to the weakness of health systems in sub-Saharan Africa, which are not able to provide adequate services to their populations, as is suggested both by deteriorating health status indicators and specifically demonstrated by declining health service indicators such as vaccination coverage rates (Simms et al., 2001; Sanders et al., 2002; UNICEF, 1983, 1993 & 2000).
The emergence of new diseases such as HIV/AIDS and the increase in incidence of “old” diseases such as tuberculosis and malaria reinforce the need for strong health systems. Significant funding to target these diseases has been generated by the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI). For these initiatives to achieve their goals, an increase rather than a reduction in human resource capacity, in both qualitative and quantitative terms, is required on the African continent (Sanders et al, 2001; Sanders et al, 2002).

The public health system, generally wholly financed by governments, is the main provider of health services in sub-Saharan Africa. During the last decade, many sub-Saharan countries have seen a reduction in government’s health sector expenditure, often linked to Structural Adjustment Programmes (Bijlmakers et al, 1996), while the recently introduced Health Sector Reform process was developed, among other reasons, to address the need to contain costs (Sanders et al, 2002).

1.1.1 Human Resources for Health

Human resources are vital in the provision of health services and consume between 60 to 80% of recurrent public health expenditure (World Bank, 1994). Economic and social factors influence the retention and equitable distribution of human resources. In most sub-Saharan countries the majority of people live in rural areas, while health professionals are concentrated in urban areas, adversely affecting the provision of health services to rural populations. Data that capture doctor and nurse per population ratios are presented as aggregate figures that mask the unequal distribution of health professionals between rural and urban areas.
The physician and nurse to population ratios in sub-Saharan African countries are the lowest in the world. Some analysts indicate that there has been a further decline in doctor to population ratios between 1980 and 1996 (Dovlo, 2001; Martineau et al., 2002; Frommel, 2002). However, the aggregate data for African countries suggest that the ratios have improved between 1970 and the early 1990s (UNDP, 2000; World Bank, 1993; World Bank, 1994). Nevertheless, 31 of the 53 African countries have a physician to population ratio that is far below the average for sub-Saharan Africa (32 physicians per 100,000 people), and 41 African countries have a lower than sub-Saharan average nurse to population ratio (135 nurses per 100,000 people), as shown in annex 1. Malawi, Eritrea and Chad have one doctor per 50,000 people, while Uganda has one doctor per 24,000 people (Bundred & Levitt, 2000; UNDP, 2000; World Bank, 1993; World Bank, 1994), averages which do not reflect the physician to population ratio in rural areas. Vacancy rates for physicians in Ghana, Namibia and Malawi were 42.6%, 26% and 36.3% respectively in 1998 (Dovlo, 2001).

1.1.2 The brain drain

Migration of health professionals from developing countries is often referred to as “brain drain”, which can be defined as follows:

A “brain drain” can occur if emigration of tertiary educated persons for permanent or long-stays abroad reaches significant levels and is not offset by the “feedback” effects of remittances, technology transfer, investments or trade. Brain drain reduces economic growth through uncompensated investments in education and depletion of a source country's human capital assets. (Lowell & Findlay, 2001: 6)

Continued outward migration contributes to Africa’s health personnel deficit, results in economic losses to the continent, and hinders the development of and efforts to strengthen health systems in sub-Saharan African countries (Dovlo, 2001; Sanders et
International migration of health professionals is a problem that is increasingly being recognised globally: the World Health Organisation has made addressing professional migration a priority area because of “the damage to the health systems which serve poor communities [caused] by the relentless recruitment of skilled … health personnel … to places where the pay is better.” (WHO, 2000)

1.2 Trends in Migration

Migration is not a recent phenomenon. However, international migration increased dramatically during the last decade of the 20th century and is considered by some as a global challenge for the new century (Martin & Widgren, 2002; Stalker, 2001). The latest figures of the United Nations International Organisation for Migration (IOM) show that the number of migrants has doubled since 1975: at present 175 million people reside outside of the country where they were born, which represents approximately 3% of the world’s population (Moodie, 2002).

Socio-economic, demographic and political differences between regions have influenced migration patterns, as is shown by the different waves of migration during the nineteenth and twentieth centuries. Stalker (2001) suggests that “[I]nternational migrants have become the shock absorbers for the global economy” and introduces the concept of economic convergence as the reason for reduction in migration. Following the industrial and agricultural revolutions in the 19th century, large-scale migration occurred from Europe to North America. However, by the beginning of the 20th century wage differentials had become minimal which resulted in far fewer people migrating to the United States (Stalker, 2001). Similarly, the number of low-
skilled migrant workers from Italy, Spain and Portugal to address labour shortages in wealthier European countries during the 1960s declined or was even reversed during the 1970s, when the stark differences in income between poorer and richer European countries narrowed (Stalker, 2001; Martin & Widgren, 2002).

The current demographic and socio-economic changes in developed countries are having profound effects on the workforce and result in serious labour shortages. In this era of high technology labour shortages refer to professional rather than low-skilled workers (Martin & Widgren, 2002; Stalker, 2001) and influence migration patterns from developing to developed countries. The central promise of globalisation is that employment opportunities in developing countries will increase once they attract capital and can trade goods instead of people (Stalker, 2001). In the meantime, developed countries with critical labour shortages are provided with ready-made professionals, who move from poor to rich countries to have better career prospects and higher incomes (Sanders & Carver, 1985). Africa is set to become a major source of migrant workers during the 21st century (Martin & Widgren, 2002).

Migrants can be divided into two broad categories: migrants who leave their country of origin for economic reasons, mostly to seek employment, and non-economic migrants, such as refugees, asylum seekers, and people who leave to join family members living outside of their country of origin (Martin & Widgren, 2002; Stalker, 2001).
1.2.1 Importing countries

The United States has a migrant population of 35 million, while 56 million migrants reside in western European countries. Migrant flows into Asia are significant at 50 million, mainly to India, Saudi Arabia, Pakistan, Hong Kong, Iran and Israel (Lederer, 2002). Important destinations of either temporarily or permanently migrating professionals are the United States, Canada, the United Kingdom, Germany, France, Australia and New Zealand, and other member states of the Organisation for Economic Cooperation and Development (OECD). Australia, Canada, France, Germany, the United Kingdom and the United States account for approximately 93% of the total OECD migrant workforce (Carrington & Detragiache, 1999). Other countries with significant numbers of migrant workers are the different Gulf States and South Africa (The Economist, 2002; OECD, 2001; Commonwealth Secretariat, 2001; Dovlo, 2001; Stalker, 2001; Martineau et al., 2002).

Many of the importing countries have changed their immigration policies to facilitate the recruitment and entry of highly skilled workers (Stalker, 2001; Lowell & Findlay, 2001; Buchan, 2002). A disproportionately high percentage of migrants are well-educated people, and among this group many are health professionals, with over half of all physicians migrating to developed countries supplied by developing countries (Stalker, 2001; The Economist, 2002; Hilary, 2001).

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3 Various terms are used in the existing literature to distinguish between countries receiving migrants and countries from where migrants originate. In this study the term "exporting country" is used to indicate the country from where migrants originate, while "importing country" refers to the country receiving migrant workers.
1.2.2 Migration from Africa

Overall, the number of African migrants climbed to 33,800 people annually during the nineties, more than doubling the number of migrants during the 1980s. The majority are highly skilled professionals: during the sixties and the first half of the seventies, 27,000 skilled workers left the African continent, while during the next ten years (1975–1984), an estimated 40,000 professionals left. This increased to 60,000 between 1985 and 1990 and since then an estimated 20,000 skilled people leave the continent annually (UNECA, 2000; IRIN, 2002). This figure is corroborated by Pang et al (2002) who estimate that 23,000 qualified academic professionals emigrate from Africa annually.

The study of Carrington & Detragiache (1999) shows that 95,000 of the 128,000 Africans currently residing in the United States are highly educated workers. Most Africans who arrive in the USA are professionals (Stalker, 2001:104; Lobo, 2002). While the actual number of highly skilled professionals leaving Africa is small compared to figures from other continents and regions, the figures are high when compared to the total professional workforce: 60% of university graduates from the Gambia work abroad, and Sierra Leone, South Africa, Egypt and Ghana lost 25%, 8%, 8%, and 26% of their highly skilled workforce respectively (Stalker, 2001:104; The Economist, 2002). UNESCO estimates that approximately 30,000 Africans with a PhD degree are currently residing outside of the continent (quoted in: Stalker, 2001:106).

Although South Africa is still an importing country for migrants from the African continent, it is losing more professionals to Europe, Australia, New Zealand and the
USA/Canada than it receives (Ray, 2001). Data collected by Meyer et al (2000) show that a total of 41,496 professionals emigrated between 1987 and 1997 from South Africa, a figure that was 3.2 times higher than the 12,949 declared at exit. Natural scientists, engineers, and health workers are leaving in higher numbers than other qualified professionals. The latest figures for South Africa show that during the first half of 2002, an estimated 7,400 people officially declared themselves to be emigrating, almost 5,000 of these being graduates and professionals and 1,264 students and scholars. This loss of skills is not compensated by immigrants to South Africa: the total number of self-declared immigrants dropped from 4,832 during the first half of 2001 to 3,623 during the first half of 2002, with 81.5% of immigrants (2,956) classified as ‘not economically active’ (Dickson, 2002).

The growing loss of skilled workers through international migration has become a major policy issue for developing countries. African leaders refer to current international migration levels as “brain drain” and have made the reversal of the brain drain one of the priorities of the New Partnership for Africa’s Development (NEPAD, 2001; NEPAD Secretariat, 2002).

1.3 Factors influencing migration

Stalker (2001) introduces the concept of the individual and the structural approach to migration. The individual approach is also referred to as the ‘human capital’ approach, while the structural approach considers factors outside of the control of individuals, i.e. the economic, social or political factors that push people from one country and pull them to another country (Stalker, 2001: 21-22).
Push factors refer to the situation in the exporting country and include remuneration, capacity to produce adequate numbers of health professionals, support and supervision, work conditions, quality of life issues, personal safety, social and political security, post-colonial and cultural links, and a tradition of mobility (Dovlo, 2001; Commonwealth Secretariat, 2001; Martineau et al, 2002; Martin & Widgren, 2002).

Pull factors relate to conditions in importing countries and include the high demand for health professionals, job and career opportunities, remuneration differentials, training opportunities, personal safety and security, and perceived freedom from undue political and administrative influences on matters professional (Dovlo, 2001; Commonwealth Secretariat; 2001, IRIN, 2002).

Martin & Widgren (2002) consider three factors that influence migration patterns: pull or demand factors, push or supply factors and network factors. The significance of each of these factors is determined by prevailing intra-country and regional socio-economic, socio-political and demographic differences that can have profound effects on population movements.

1.4 Planning of the health workforce

The health sector is labour intensive (World Bank, 1994; Martineau et al, 2002; WHO, 2001). Health workforce planning involves the health and education sectors, as well

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¹ Network factors refer to information derived from a network of colleagues, friends or relatives already residing and/or working outside of their country of origin that influences the decision of a person to migrate (Martin & Widgren, 2002: 6-7).
as the legislature, labour and finance (Hall & Mejia, 1978). Political, cultural and ideological considerations influence decisions regarding health workforce planning.

Economic and social factors affect the retention and equitable distribution of human resources. In both developing and developed countries, adequate planning for health human resources is of crucial importance (Dovlo, 2001; Green, 1992; Sanders et al, 2002; Buchan & O'May, 1999).

At present, the health labour market is characterised by a significant imbalance in the demand for health services and the supply of health professionals, which concerns an undersupply in both developed and developing countries (Zurn et al, 2002; World Bank, 1994; Stalker, 2001). The global health workforce imbalance is arguably having the most negative impact on health care delivery in developing countries, and most dramatically on the African continent.

The undersupply in developing countries is related to a myriad of factors, the most significant being: 1) the underproduction of health professionals because of high costs of training and low educational capacity; 2) increased demand for health care and high attrition rates in the current health workforce because of HIV/AIDS; and 3) migration of health professionals from the public to the private sector, from low-income to middle-income developing countries and to developed countries (World Bank, 1994; Sanders et al, 2002; Simms et al, 2001; Stalker, 2001; Frommel, 2002).

The undersupply in developed countries is associated with: 1) the relative underproduction of health professionals; 2) the increased demand for health services partly due to a growing ageing population; 3) a high turnover of in-patients resulting
in increased intensity of care; and 4) the expectations of people with regard to quality of health care that include access to recently introduced, life-sustaining technologies (Zurn et al, 2002; WHO, 2002). Between 1970 and 1992, the physician per population ratio in OECD countries increased from 150 to 245 per 100,000 people (Bundred & Levitt, 2000). To maintain the current ratios, OECD countries agreed to increase their Medical School outputs by 26% between 1985 and 1994. However, not all member states achieved this: the output increases in the United Kingdom, the United States and Canada were only 14%, 10% and 18% respectively (Bundred & Levitt, 2000). At present, the replacement of the current workforce is lagging behind, which is evident in the increased average age of health workers (Buchan, 2002). However, developed countries also have to deal with an outflow of their health professionals. Canada and the United Kingdom are both losing health professionals to the United States and make up the shortfall caused by emigration through recruitment of health professionals from South Africa, the Philippines and Australia (Nadeau et al, 2000).

The United States authorities are currently developing a recruitment campaign for an additional 1 million nurses by 2010 (Carwel, 2002). The recently announced budget increase for the UK’s National Health Service (NHS) should result in a significant expansion of public health service delivery and requires the recruitment of an additional 80,000 staff between 2002 and 2008. International recruitment is expected to increase, given the already existing shortfall in supply (Guardian Reporters, 2002; Buchan, 2002; Martineau et al, 2002).
1.5 The G8, globalisation and the GATS

1.5.1 The G8

In November 1975, the United States, the United Kingdom, France, Germany, Japan and Italy met in Rambouillet, France to discuss the ramifications of the oil crisis for the world economy. This group of six was joined by Canada in 1976, by the European Union in 1977 with a different status from national governments, and by Russia in 1998 to form the G8. The G8 took it upon itself to provide management of the world economy, to reconcile tensions between members resulting from globalisation, and to create global political leadership (Labonte et al., 2002). The G8 economies are powerful, as they account for 48% of global economic activity and 49% of global trade, and dominate the World Bank and International Monetary Fund (IMF).

Decision-making in these financial institutions is based on the ‘one dollar, one vote’ system. The G8 also have considerable power in the World Trade Organisation (WTO), the ‘successor’ to the General Agreement on Tariffs and Trade (GATT), which established rules on trade that aimed to reduce trade barriers. The final round of GATT negotiations, the Uruguay Round, started in 1986 (Ellwood, 2001:32) and resulted in the establishment of the WTO in 1994. The WTO has 145 members, is a United Nations agency and has adopted the ‘one nation, one vote’ principle for decision making, as is the custom in the United Nations (Ellwood, 2001; Bettcher et al, 2000).

1.5.2 Globalisation

Globalisation refers to the process of increasing economic, political, and social integration, signified by the flow of capital, traded goods, persons, concepts, culture, norms and values across international borders. This process, driven by industrialised
countries, has accelerated dramatically during the last 25 years because of the rapid developments in communication and information technology in conjunction with trade liberalisation and the increasing political and economic power of multinational corporations (Ellwood, 2001:12; Gould & Jóy, 2000; Hong, 2000; Hilary, 2001).

The General Agreement on Trade in Services was designed to facilitate the globalisation process and expand trade beyond the traditional trade in goods, i.e. trade in raw commodities and manufactured goods (Hilary, 2001).

1.5.3 The General Agreement on Trade in Services (GATS)

The GATS was developed during the different trade negotiation rounds and was formally adopted in 1995 (WTO, 1995; Ellwood, 2001; Hilary, 2001). The GATS sets out to liberalise trade in services, including trade in health services (WTO, 1995; Hong, 2000; Bettcher et al., 2000; WHO, 2001, Adhun & Carzaniga, 2001; Hilary, 2001). Together with the Trade-Related Investment Measures (TRIMs) and Trade-Related Intellectual Property Rights (TRIPS), the GATS is one of three international trade instruments that are promoted by developed countries and international institutions such as the World Bank and IMF (Hilary, 2001; Hong, 2000).

The GATS includes four different modes of supply for trade in (health) services:

- Mode 1: Cross-border supply (e.g. telemedicine, internet services)
- Mode 2: Consumption abroad (e.g. postgraduate training in a foreign country, health service delivery to foreign nationals)
- Mode 3: Commercial presence of foreign company to deliver services locally (e.g. private hospitals and clinics, private health insurance companies)
The GATS is associated with increased migration of health professionals, as will be demonstrated in chapter 4.

1.6 Theoretical framework of this study

The paradigm employed in this study is social constructionism. This paradigm emphasises political constructions of social problems and intends “to show how understanding and experiences are derived from discourses” that interpret the social world as a system of meanings and practices that construct social reality (Terre Blanche et al, 1999). Social constructionist research draws on qualitative methods and considers interventions such as policies and plans accepted units of analysis. A secondary data study is an appropriate research design to describe the key debates on migration (Babbie & Mouton, 2001).

Data collection methods commonly used for social constructionist research are interviews and documentary sources. Documentary sources are considered to be particularly suitable for constructionist analysis, because they are “a means by which ideas and discourses are circulated in our society” (Terre Blanche et al, 1999). Policy analysis involves initial “issue searches” to make policy makers aware of key problems and their ramifications before a crisis occurs, or to raise questions about power and legitimacy in society. Issue searches may involve purposeful identification of information sources, such as documents and people with specific information on the issue (Walt, 1994: 64; Hogwood & Gunn, 1984; Wildavsky, 1979).
The trustworthiness of the findings of qualitative research depends on the rigour with which data are analysed and on the findings being convincing (Lincoln & Guba, 1985).
Chapter 2 - Research design and methodology

This chapter describes the aim and objectives of the study, and the research design and methodology utilised in this study. It further indicates how data analysis was carried out and describes the limitations of the study.

2.1 Aim of the research

To explore the external or “pull” factors in migration of health professionals from developing to developed countries, the main policies influencing this, and possible actions to mitigate the impact of such migration.

2.2 Objectives of the research

- To describe the nature and extent of migration of health professionals from developing to developed countries.
- To determine and describe the main thrust of international macroeconomic policies and trade-related agreements relevant to pull factors in migration of health professionals.
- To critically engage with current debates on and proposed solutions to international migration of health professionals.

2.3 Research design and methodology

2.3.1 Design

The research design is a secondary data study using a social constructionist framework in its analysis. This framework has been chosen because the political
context and power relations between developed and developing countries influence health professionals’ migration as well as perceptions of the issue of migration.

2.3.2 Methodology

While this study attempts to quantify the extent of health professional migration from developing to developed countries, the data collection methods are qualitative and have focused on the documented key macroeconomic policies and current debates related to the pull factors of migration as units of analysis. Data from key informant interviews, an additional unit of analysis, have been used to triangulate the data derived from document sources.

2.3.3 Sample size and sampling procedure

Documents were purposefully identified using a variety of sources. The brain drain is a topic that is receiving a great deal of attention and is generating a large volume of literature. Incorporating all available literature would have exceeded the scope of this research project and, consequently, only the most recent articles and publications have been reviewed. The identification of documents was halted once the sources had provided a sufficient range of opinions and positions on the main themes.

Key informants were identified on the basis of acknowledged expertise in human resource development and planning for health human resources, or on the basis of an established interest in the research topic. Of the nine (9) key informants contacted, eight (8) contributed to the study.
2.3.4 Data collection methods

Two data collection methods were utilised in this study: existing documents and key informant interviews. Document sources consisted of books, reference journal articles, research reports, daily and weekly newspaper articles, and documents located through electronic searches using general search engines and websites of international organisations and agencies. In addition, a total of ten (10) G8 Summit documents were used in this study, covering the outcome of the last four meetings (1999 – Köln, 2000 – Okinawa, 2001 – Genoa and 2002 – Kananaskis) as well as the preparatory Labour Ministers’ meetings in Washington DC in 1999 and Turin in 2000.

2.3.5 Data analysis

During the first round of analysis the different pull factors in migration and statements related to the health workforce, human resource capacity, health systems and other relevant statements were classified, grouped and linked in themes. These statements were subsequently re-organised around the three main themes: 1) the nature and extent of international migration; 2) the implications of macroeconomic policies, with a particular focus on the global workforce, investment in human capital, capacity building and technical assistance, health systems, and of the General Agreement on Trade in Services; 3) the discourse on issues pertaining to international migration.

This process was repeated until sufficient understanding of the linkages as well as the contradictions was achieved. The classification of issues and themes is presented in chapters 3, 4 and 5, each ending with discussion points that resulted from the document analysis. These points were subsequently used in key informant interviews.\(^5\)

\(^5\) See annex 2: Discussion points for key informant interviews.
conducted either face-to-face or by e-mail, to ensure and enhance validity, also referred to as data triangulation.

Reflection on the criteria used to classify the pull factors and G8 statements occurred throughout the analysis and interpretation process. Data from document sources and key informants that provide contradictory explanations have been included in the interpretation of data as negative cases. Specific positions taken by the researcher in understanding the value of the classified issues have been made explicit where required.

2.4 Limitations of the study

The use of recently published documents might have biased the outcome of the study. It is acknowledged that important documents might have been overlooked due to the limitation in the volume of literature that could be analysed. Furthermore, the assumptions made by and the perspective of the researcher might have influenced the way statements were analysed and classified.
Chapter 3 - The nature and extent of migration of health professionals

This chapter details the findings of the document analysis regarding the nature and the extent of international migration. It begins with an overview of the nature of migration of health professionals, followed by a description of the extent of international migration and ends with a discussion.

3.1 The nature of migration of health professionals

Health professional migrants can be divided into three main groups, i.e. professionals moving from the public to the private health sector, health professionals moving temporarily or permanently abroad for employment, and health professionals moving for study purposes.

3.1.1 Movement from the public to the private health sector

The movement of health professionals from the public to the private sector is generally excluded from the debate on the brain drain, because these health professionals remain in the country and are available as a health resource. This movement occurs in many African countries, but is only significant in countries that have a thriving private health sector, such as South Africa. In many African countries health professionals are permitted by law to provide private health services while employed in the public health sector, an example of a retention strategy used to avoid the brain drain (Commonwealth Secretariat, 2001; Dovlo, 2001).

Some analysts refer to the movement from public to private sector as the “internal” brain drain. This movement has the potential to increase significantly because of the
drive to privatise the provision of health services and the expansion of the trade in health services under the GATS (Chanda, 2002; Hilary, 2001). In countries such as Canada, the United States and the United Kingdom, the movement from the public to the private health sector has led to an increased demand for foreign nationals to provide public health services in rural and other areas unpopular with nationals. This is said to influence migration of health professionals from developing to developed countries (Stalker, 2001:105; Martineau et al, 2002; Commonwealth Secretariat, 2001).

3.1.2 International migration for employment purposes

This movement dominates the flow of migrants. Some analysts refer to this phenomenon as “the medical carousel”: health professionals move from least developed to middle income countries, while professionals from middle income countries move to developed countries (Bundred & Levitt, 2000; Martineau et al, 2002). For instance, doctors from poor African countries move to South Africa; South African doctors move to the UK and Canada; British and Canadian doctors move to the USA.

Available information from immigration departments and/or professional registers in either the exporting or importing country indicates that the majority of health professionals leave their country of origin on a temporary basis (Meyer et al, 2001; Buchan & O’May, 1999; Buchan, 2002). Professionals leaving on a permanent basis tend to be physicians and dentists rather than nurses, midwives and allied professionals, who are often recruited for a limited period of stay in the importing country (Buchan & O’May, 1999).
3.1.3 International migration for study purposes

Professionals who seek to further their formal education abroad are generally not considered as part of the migrant workforce. However, OECD countries with extensive training capacity are promoting their training programmes in developing countries. For instance, the United Kingdom provides training to 266,000 foreign nationals, which in 1998 accounted for US$600 million in tuition fees, while 130,000 foreign nationals were enrolled in France during the same year (Stalker, 2001).

Postgraduate training of foreign nationals is a source of income for developed countries, contributes to the brain drain because significant numbers of students do not return home after completion, and leads to under-reporting of the brain drain (Meyer et al., 2000; Stalker, 2001, Martin & Widgren, 2002; Dovlo, 2001; Commonwealth Secretariat, 2001; UNECA, 2000).

The United Nations Economic Commission for Africa (UNECA, 2000:3) states that "Scholarship programmes for study abroad, aimed at the development of Africa’s human resources and indigenous capacity coupled with the lack of training institutes of higher learning have been another channel of brain drain." Seventy percent (70%) of health workers, who received a WHO scholarship to study abroad, did not return to Lesotho after completion (Commonwealth Secretariat, 2001). A UNECA statistic indicates that 33% of foreign students entering the USA do not return after completion of studies (UNECA, 2000). Furthermore, training of developing countries’ nationals in developed countries is associated with the introduction of inappropriate technologies, as the orientation of such training is often on health care delivery in developed countries (Sanders & Carver, 1985; Dovlo, 2001; Commonwealth Secretariat, 2001).
3.2 The extent of international migration

3.2.1 Availability of data

Accurate data on international migration of health professionals are not available. That this is the case for Africa has been recognised by the authors of the original NEPAD document (NEPAD, 2001), who propose the establishment of "a reliable database on the brain drain, ... to determine the magnitude of the problem ...." (NEPAD, 2001 ¶ 122). A recent meeting in Dakar, organised by the International Organisation for Migration (IOM) and the Economic Community of West African States (ECOWAS), has taken the first steps towards supporting this call by establishing a Migration Statistics Unit for West Africa (IRIN, 30 September 2002).

There is consensus that it is difficult to estimate the extent of the brain drain at global level. Official records only reflect permanent departures, but exclude people who migrate temporarily (Stalker, 2001; Meyer et al., 2000). Comparison of data of different countries is also problematic because of the use of different systems to record people who leave the public health service (Martineau et al., 2002; Stalker, 2001; Buchan & O'May, 1999; Meyer et al., 2000; Buchan, 2002).

Professional registration is required in virtually all countries for health professionals to be licensed to practice. However, the use of professional registers to determine the extent of in-migration has its limitations, as they do not always reflect actual migration, because of the need to apply for registration before migration can take place (Buchan, 2002).

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* The symbol ¶ refers to the number of the paragraph in the referenced document.
The data that are available mainly deal with flows of physicians and, to a lesser extent, with nurses. Other health professionals, such as dentists, pharmacists, and members of the allied health professions are rarely included. A WHO study carried out in the 1970s recorded the loss of health professionals trained in developing countries to richer countries. It provided the following data for physicians and nurses (Mejia & Pizurki, 1976, quoted in: Martineau et al, 2002):

- In 1972 an estimated 16% of the global physicians’ supply was on the move. The main importers were the USA and the UK; the main exporters were Canada, Germany, Ireland, UK, Asian and Latin American countries.

- In 1970 approximately 135,000 nurses, estimated at 4% of the global nurse workforce, were working/living outside the country where they were born or trained. Europe, North America, Australia and New Zealand together received 92% of these nurses.

International migration of health professionals from Africa was not specifically mentioned and might have been small. However, this WHO study and publications during the 1980s even then referred to this movement of health professionals as a brain drain from developing countries (Sanders & Carver, 1985: 93).

3.2.2 Data on migration of health professionals

Recent figures from the OECD suggest that the number of foreign trained health professionals residing in OECD member states is substantial. In the United Kingdom’s National Health Service (NHS), 31% of physicians and 13% of nurses are foreign nationals, mostly from outside the European Union. Of the 4,981 foreign
trained nurses registered in 1998/1999 in the UK, 27% were from Australia and 12% from South Africa (Buchan & O'May, 1999).

Frommel (2002) reports that France employs approximately 8,000 foreign trained physicians, more than 50% from outside Europe. An estimated 24% of physicians in the Canadian health service are foreign trained to make up for the shortfall caused by emigration to the USA (Stalker, 2001; Martineau et al, 2002). Between 1970 and 1993, the number of foreign medical graduates working in the USA rose from 57,000 to 150,000, the majority from Asia (Chanda, 2002).

The majority of migrating physicians, 56%, originate from developing countries, while developing countries themselves import 11% of physicians (World Bank, 1993: 141). India and the Philippines are leading exporting countries, with the latter and South Korea specifically producing an excess of health professionals for the export market (Stalker, 2001; Martineau et al, 2002).

South Africa has lost significant numbers of physicians and nurses to the USA, Canada, the UK, Australia and New Zealand. However, South Africa is also an importing country, as evidenced by the fact that 22% of physicians in South Africa are foreign trained: in 1999, 78% of its physicians working in rural areas were non-South Africans (Martineau et al, 2002; Commonwealth Secretariat, 2001).

3.2.3 Data on health professionals’ migration from Africa

Data from the African continent are scarce and often lack precision regarding the period over which the loss occurred. The data that exist are used extensively in the existing literature. Commonly quoted data are:
• Ghana lost, between 1985 and 1995, approximately 60% of its medical graduates (Dovlo, 2001; Commonwealth Secretariat, 2001; Martineau et al, 2002).

• Zimbabwe lost 840 of the 1,200 doctors who graduated during the nineties (Frommel, 2002).

• Approximately 18,000 nurses from Zimbabwe left for the UK during 2000/2001 (Dube, 2001).

• Ethiopia and Zambia have lost about 50% of their physicians7 (Frommel, 2002).

• South Africa lost 2,114 nurses to the UK during 2001 (Anonymous, 2002). During the first half of 2002, 104 South African doctors and dentists officially emigrated (Dickson, 2002).

• Between 1999 and 2001, a tertiary hospital in Malawi lost 114, equivalent to 60%, of its registered nurses (Martineau et al, 2002).

• The Sudan has lost 17% of its doctors and dentists to developed countries7 (UNECA, 2000).

• Nigeria has lost 21,000 doctors to the USA7 (UNECA, 2000).

• Kenya has more than 5,000 registered doctors, but only 600 doctors work in the public health sector (Pang et al, 2002).

• In Namibia and Lesotho, 50% of physicians are foreign nationals (Dovlo, 2001; Commonwealth Secretariat, 2001).

3.3 Discussion

The current trends in movement of health professionals, either internally from the public to the private health sector or internationally for employment or study purposes,

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7 This reference does not specify the time period over which these losses occurred.
exacerbate staff shortages of African public health systems. These trends contribute to inadequate access to health care, particularly for rural African populations, and are associated with an increase in the existing inequity and inequality in health, reflected in poor health status and access to health service indicators.

Most analysts and key informants agree with NEPAD’s statement that current international migration levels lead to a net brain drain from developing countries and support the initiative to establish comprehensive information systems to record this. However, NEPAD’s proposals to reverse the brain drain focus on addressing the push factors, but fall short of strategies to address the pull factors (NEPAD, 2001: ¶121-122).

The demand for foreign health professionals in developed countries has led to recruitment practices that entice health professionals from developing countries. Key informants agree with this statement. UNECA (2000) and Stalker (2001: 66-67) suggest that the drain of developing countries’ physicians is the most striking, because of the difficulties in producing adequate numbers. This position is supported by Carrington & Detragiache (1999), who indicate that the extent of health professionals’ migration from African countries might not be important in terms of actual numbers, but that the proportion of skilled people migrating and the gaps this migration leaves behind are far more significant in Africa than can be derived from looking at actual numbers only. Key informants point out that African countries with adequate information systems have sufficient evidence to demonstrate that international migration has increased over the past few years.
Chapter 4 - Implications of international macroeconomic policies and the GATS

This chapter describes the implications of international macroeconomic policies and categorises G8 statements and commitments relevant to international migration. It explains the General Agreement on Trade in Services, and considers the different modes of supply of trade in health services and the implications of these for international migration. This chapter further elaborates on the debate on the GATS and its expected impact on developing countries' health sectors. The chapter ends with the main discussion points extracted from the analysis of G8 commitments and the GATS in relation to international migration of health professionals.

4.1 International macroeconomic policies

Current macroeconomic policies emanating from developed countries aim at expanding the global economy and particularly emphasise the inclusion of developing countries' economies, by promoting trade, tariff and import control reductions, elimination of restrictions on foreign investment and capital flows, privatisation of state assets, lifting of exchange controls, and increased labour market flexibility, including mobility of the global workforce. The current policies have profound effects on developed and developing countries (CMH, 2001), although the latter group of countries have far less influence in the development of these policies:

Many of the benefits of global trade and its liberalization depend on the ability of developing country producers to respond to new opportunities for production and trade. ... the concerns of developing country producers are not always reflected in international agreements.... (IMF, 2002: 7)

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8 The spelling of the statements quoted in the text has not been altered. The spelling used in the research report is UK English, while most G8 and IMF documents use US English.
4.2 G8 summit statements

G8 summits deliberate domestic and international issues considered priorities for their members. Summit documents have been analysed to examine whether international macroeconomic policies developed and/or promoted by the G8 contribute to the "pull" in international migration of health professionals and whether these policies support or contradict the international development agenda.

4.2.1 G8 statements related to the global workforce

The G8 commits itself to "...address labour and skills shortages" (G8, 2000 - Labor Ministers Conference, Turin ¶ 4), because "...a skilled workforce enables countries to benefit from the transfer and adaptation of technology which is a key engine of development." (G8, 2001 - Debt Relief and Beyond ¶ 33)

*The knowledge based economy requires adaptability, firstly by work organisations, but also by the labour force and public policy. ... Engaging business and labour in the development of a highly skilled workforce is key to supporting the growth of productive employment opportunities and to attaining sustained economic growth.* (G8, 2000 - Labor Ministers Conference, Turin ¶ 9)

Other G8 summit statements also include references to the growing need for skilled labour in developed countries, but regularly use vague descriptions to indicate how workforce problems in G8 countries can be addressed. For example, wordings such as "equal access to the labour market for all" and "connecting people to the labour markets" could be expressions of concerns about domestic unemployment rates, but could also be understood to imply international migration of professionals as a way of addressing labour shortages (G8, 1999 - Labor Ministers Conference ¶ 6 & 7).

The G8 regularly refer to the need for increased mobility of the global workforce (G8, 1999 - Köln Final Communiqué ¶ 17; G8, 1999 - Köln Charter: Aims and Ambitions

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for Lifelong Learning ¶ 2), but make no mention of international migration to G8 countries.

4.2.2  **G8 statements related to investment in human capital**

Investment in human capital covers a wide range of issues and sectors and includes investment in health, education and skills development, social welfare, environment, food security and biodiversity. The following statements show that the G8 recognise the value and importance of investment in human capital for their members as well as for developing countries:

*Effective investment in human capital is a key component of long-term economic growth and increased productivity. A healthy, able and well-educated population is ... a conduit to accelerated social and economic development. The challenge faced by the poorest countries in upgrading their human capital through education and skills development and improvements of health conditions often exceeds national capacities and requires enhanced support from the international community.* (G8, 2001 - Debt Relief and Beyond ¶ 27)

*The rewards for investing in people have never been greater and the need for it has never been more pressing. It is the key to employment, economic growth and the reduction of social and regional inequality.* (G8, 1999 - Köln Charter: Aims and Ambitions for Lifelong Learning ¶ 4)

The G8 link education and skills development to “ ...achieving economic success, civic responsibility and social cohesion” (G8, 1999 - Köln Charter: Aims and Ambitions for Lifelong Learning ¶ 1) and state that “Investing in education is critical to economic and social development in Africa.” (G8, 2002 - Kananaskis G8 Africa Action Plan ¶ 5).

4.2.3  **G8 statements related to capacity building and technical assistance**

The G8 statements pertaining to capacity building and technical assistance are mostly related to the capacity of developing countries in issues of governance, trade, and
infrastructure. While statements refer to the need to support and assist developing countries in strengthening capacity, the G8 does not specify sectors that should be targeted, but covers broad areas such as public financial management, accounting and auditing systems, corporate governance, monetary and financial systems, and infrastructure projects (G8, 2002 - Kananaskis G8 Africa Action Plan ¶ II.2.2 & ¶ III.3.2).

Specific reference is made to Africa’s limited capacity to benefit from trade liberalisation. To address the continent’s capacity constraints, the G8 propose increased funding for trade-related technical assistance and capacity building:

... *We are committed to the Doha development agenda ... (and) to improving the quality of support for trade-related technical assistance and capacity-building in Africa – including by supporting the establishment and expansion of trade-related technical assistance programmes in Africa ... and providing technical assistance to help African countries engage in international negotiations, and in standard setting systems.* (G8, 2002 - Kananaskis G8 Africa Action Plan ¶ III.3.4)

### 4.2.4 G8 statements related to health systems

The G8 recognise that health is essential to development. When addressing health, the G8 give considerable attention to the health sector, only one of the many determinants of health (Labonte *et al*, 2002).

*Health is key to prosperity. ... Only through sustained action and coherent international cooperation to fully mobilise new and existing medical, technical and financial resources, can we strengthen health delivery systems and reach beyond traditional approaches to break the vicious cycle of disease and poverty.* (G8, 2000 - Okinawa Final Communiqué ¶ 26)

The Okinawa meeting called for “priority to the development of equitable and effective health systems,...” (G8, 2000 - Okinawa Final Communiqué ¶ 30), while the Genoa meeting concluded that:
Strong national health systems will continue to play a key role in the delivery of effective prevention, treatment and care and in improving access to essential health services and commodities without discrimination…. (G8, 2001 - Genoa Final Communiqué ¶ 17)

The state of African health systems was specifically emphasised during the 2002 Kananaskis Summit, where NEPAD was formally introduced. The G8 state that “Substantial efforts are needed to confront the health challenges that Africa faces…. ” (G8, 2002 - Kananaskis G8 Africa Action Plan ¶V1) and specifically calls for support to African efforts in addressing HIV/AIDS, tuberculosis and malaria.

However, the G8 statements lack clear indications as to the different components constituting a strong health system. No reference is made to health personnel as the critical component of health systems with the exception of the Genoa “Debt Relief and Beyond” document (G8, 2001 ¶ 30) that highlights “...education, further training of medical and other personnel,...”

4.3 The GATS

The services industry includes transport and the required infrastructure, such as roads and telecommunication, banks, tourism, and service sectors such as health and education and is an important export earner for developed countries: in the European Union the services sector accounts for two-thirds of the economy and employment, half of all foreign investment, and an estimated 25% of exports, while a third of the United States’ economic growth is related to services exports (Hong, 2000).

The GATS has been designed to expand the trade in services as part of the on-going process of globalisation, with a focus on the integration of developing countries as trading partners in the services sector (Bettcher et al, 2000; Hilary, 2001; Hong, 2000;
Gould & Joy, 2000). Many commentators suggest that the GATS was designed by multinational corporations rather than governments of WTO member states and that it will mainly benefit developed countries:

*It has been argued that the export interests of large OECD industries, including banks, insurance companies and telecommunications operators, provided most of the negotiating momentum that helped to bring the Uruguay Round to a successful conclusion and to shape current commitments in services.* (Adlung & Carzaniga, 2001)

*Without the enormous pressure generated by the American financial services sector, particularly companies like American Express and Citicorp, there would have been no services agreement.* (David Hartridge, former director, WTO Trade in Services Division, quoted in: Hilary, 2001: 20)

4.3.1 *The GATS and trade in health services*

The GATS includes trade in health services, considered insignificant in comparison to trade in other services sectors (Hilary, 2001; Ellwood, 2001). The World Health Organisation estimates that only 1% of the services trade concerns trade in health services. However, the health sector is a rapidly expanding sector, which generates an estimated US$ 3 trillion annually in OECD countries alone (Chanda, 2002:158; WHO, 2001). In real figures the 1% translates into US$ 30 billion, a not insignificant amount of money.

The lack of capacity of developing countries’ public health systems is likely to become more acute as a result of trade in health services. The United States is possibly the best example of what occurs when the sector is completely privatised:

*The US, the world’s richest nation has the highest health spending as a percentage of GDP. The US health system dominated by the profit hungry private sector is not only the most expensive in the world: the US health statistics are among the worst in the North. The US health care system is illustrative of what can develop when GATS is implemented: the global trade in health and social services and the privatisation of healthcare will lead to costlier and inequitable health systems which will adversely affect the health and well-being of the majority of people everywhere.* (Hong, 2000)
The government as public provider of health services will have to compete with private providers if the country has not excluded the private provision of certain services in its final health service trade commitments. On the African continent, 21 countries have signed the GATS agreement that allows private companies to compete for the provision of health care (Hilary, 2001). The presence of foreign health insurers is allowed in most countries, while several have made commitments that allow foreign companies to provide hospital and other professional services.

4.3.2 The GATS' modes of supply

Each WTO member state negotiates the extent of liberalisation of the health sector and the limitations under each of the four modes of supply.

Mode 1: Cross-border supply

Mode 1 refers to the provision of health services through the use of health service providers by means of telephone (telemedicine) or internet. The use of the internet often concerns the procurement of pharmaceutical products. Telemedicine, mostly used for diagnostic purposes and for medical education, could become an important mode of supply, but requires that the necessary infrastructure is developed (Hilary, 2001; Chanda, 2002).

It is unclear how important this mode of supply is at present. However, if there is a significant market, the telemedicine system could attract skilled health professionals from public service delivery and influence the capacity of the public health service (Hilary, 2001; Sein & Rim, 2001).
Mode 2: Consumption abroad

This mode refers to training of health professionals outside of the country of origin and the provision of health services to foreign nationals.

The provision of education abroad is a contributor to migration: some data indicate that as many as 50% to 70% of persons who received such training opportunities failed to return home after completion (Dovlo, 2001; Hilary, 2001; Adlung & Carzaniga, 2001; UNECA, 2000).

The provision of health services to foreign nationals is considered to be relatively small (WHO, 2001), although not insignificant in countries such as Cuba, India, Singapore, Thailand, South Africa, as well as the US and France (WHO, 2001; Chanda, 2002). India, Cuba and South Africa provide health services to nationals from developed as well as other developing countries that lack the infrastructure to provide high technology specialist care, and have seen an increase in ‘medical tourism’, particularly in cosmetic surgery and dental care (Chanda, 2002).

This mode contributes to the brain drain, by drawing health professionals to the private sector, also referred to as ‘internal’ brain drain (Chanda, 2002; Sein & Rim, 2001; Hilary, 2001; Adlung & Carzaniga, 2001).

Mode 3: Commercial presence of a foreign company to deliver services locally

The commercial presence of foreign owned companies relates to the take-over or establishment of privately run and managed hospitals, insurance companies, diagnostic and education facilities. The negotiations can restrict the number of foreign
nationals involved in the actual management of the facility and require that national professionals are employed for this purpose.

There is evidence and consensus that this mode of supply can lead to a two-tiered system and to an increase in inequity because it aggravates existing staff shortages in the public health sector (Chanda, 2002; Sein & Rim, 2001; Bettcher et al, 2000; Adlung & Carzaniga, 2001; Hilary, 2001). It is further argued that this mode of supply can lead to ‘cream skimming’: private companies attracting patients who are in good health, with the public health sector having to provide for people who are generally more in need of health care but cannot afford to pay for health services (Chanda, 2002; Adlung & Carzaniga, 2001; Bettcher et al, 2000; Sein & Rim, 2001)

Foreign commercial presence in medical education or in hospitals may ... distort the health care market by inducing an internal brain drain ... siphon off trained staff from public facilities to the highly paid private hospitals and practices. These factors may lead to lesser availability of essential health services for those who need them most. (Sein & Rim, 2001:3)

**Mode 4: Presence of natural persons**

This mode of supply refers to cross-border movement of health professionals to provide health services outside of their country of origin. This mode therefore directly contributes to international migration and the brain drain.

There are opposing views as to the importance of this mode of supply and the impact on international migration:

A comparison across all schedules and sectors reveals that trading conditions are considerably more restrictive for mode 4 than for other modes. Reflecting the political constraints involved, many [WTO] Members have limited the entry of natural persons to intracorporate transfers or to experts with special skills that are not domestically available. (Adlung & Carzaniga, 2001: 357)

For example, despite strong barriers to the migration of labor, the international market for health professionals contributes to a steady flow of
skilled doctors and nurses from developing to developed countries. Countries vary in how they view this issue. India, Cuba, and the Philippines are strong 'exporters' of health personnel; as such they want easier access to developed country labor markets to maintain or increase the flow of worker remittances. Countries with severe shortages of health professionals, however, are very concerned about the loss of trained health workers to the international market. ... For their part, 'importing' countries have little incentive to restrict medical immigrants, because such workers fill critical staff shortages. (WHO, 2001)

4.3.4 The debate about the implications of the GATS

The arguments as to who stands to win or lose from the GATS are closely linked to the debate about who benefits from globalisation and current international macroeconomic policies. The flow of human capital, i.e. professionals and other skilled workers, referred to as increased mobility of the workforce by some and brain drain by others, is now an integral part of this debate. The GATS is an instrument that influences this mobility of professionals.

The World Health Organisation and others argue that the economic value of health services trade and who will benefit from liberalisation of health services trade is as yet unclear (WHO, 2001; Betchter et al, 2000). Nevertheless, there is little doubt that developed countries are the primary promoters of, and presumably expect to gain from, liberalisation of trade in health services:

The divisions of the World Bank appear to be very significant forces driving privatisation in health care, both through projects, investments, and institutional support for the multinationals. (Hall, 2001: 15)

At the international level, there is consensus that the greatest gains [of the GATS] ... have accrued to the most powerful economies, ... predicted by both UN and OECD estimates at the conclusion of the Uruguay Round of GATT in 1994. (Hilary, 2001)

However, the debate also suggests that developing countries have exerted considerable pressure on developed countries to increase trade in health services, and

Trade in health services will, according to some, lead to an increase in foreign investment that creates employment, access to new technologies, general upgrading of skills, and will generate overseas remittances that will offset the loss of health professionals and the freeing up of resources for use in the public health sector (Adlung & Carzaniga, 2001; Bettcher et al, 2000; Sein & Rim, 2001). Others, however, question this:

\[\text{Will trade in health services prove to be a source of much-needed revenue for developing countries, or will commercial interests take precedence over the protection of people's health?... Particular problems faced the least developed countries, which were suffering from a "brain drain" as the outflow of nationals could not be compensated by the inflow of foreigners. (UNCTAD / WHO, 1998)}\]

\[\text{... a study from Thailand suggests that the entry of foreign-owned private health providers has lured physicians away from the public sector, exacerbating staff shortages and unequal access to care by different socio-economic groups. (WHO, 2001: 4)}\]

4.4 Discussion

International macroeconomic policies and trade agreements, promoted mainly by developed countries and multilateral institutions, are having a profound effect on global labour markets. Developed countries’ demand for skilled labour has influenced immigration policies and has increased international migration from developing to developed countries resulting in brain drain. Key informants agree with this statement and qualify this as follows:

\[\text{One cannot speak about true free trade, because the focus is on trade in highly skilled professionals who are in high demand. People migrating for economic reasons, but with skills that are not in high demand are not accepted in many}\]
developed countries. Freedom of movement as a human right is used as an argument where it concerns professionals, while this freedom is not necessarily afforded to lesser skilled people from developing countries. (Key informant)

The further liberalisation of trade that includes trade in health services influences the brain drain as it draws health professionals from the public to the private health service (internal brain drain) and, more importantly, from developing to developed countries because of the ever growing demand for skilled health professionals in an expanding global health services market.

The G8 does not explicitly acknowledge the existence of the brain drain. However, key informants indicate that some individual member states, for instance the United Kingdom, do acknowledge this phenomenon: the UK Department of Health recently issued a Code of Conduct on Ethical Recruitment (Department of Health, 2002). The G8 mention the need for mobility of the workforce, without specific reference to mobility between developing and developed countries and recognise the need for investment in human capital as vital in the pursuit of its macroeconomic policies. This raises questions as to how issues relevant to developing countries are considered in the development of international macroeconomic policies (WHO, 2001).

However, developing countries are also partly responsible for the continued brain drain. They, especially South East Asian countries, have lobbied for the lifting of developed countries’ restrictions on migration without considering that their public health sectors are experiencing staff shortages and can ill-afford to lose its health professionals in the pursuit of revenue generation. This would suggest that the interests and concerns of their health ministries have not been considered adequately in the deliberations on the GATS.
The impact of international macroeconomic policies and the GATS will almost certainly increase shortages of health professionals in developing countries at a critical juncture. The calls for increased funding for health systems and research capacity strengthening in developing countries are closely linked to the recognition that the fight against diseases such as HIV/AIDS, tuberculosis and malaria is a critical strategy towards sustainable development. The Commission on Macroeconomics and Health (2001) suggests that Official Development Assistance of US$ 22 billion is required annually until 2007 and US$ 31 billion annually by 2015 to expand coverage of health services in sub-Saharan African countries. However, for such amounts of money to have any impact, the health workforce must have adequate capacity, both qualitatively and quantitatively. Key informants suggest that addressing the brain drain is, similar to the fight against HIV/AIDS, in the interest of all countries because of the damage to economies if people are unable to access adequate health services.

The UNECA (2000) uses the term “development paradox” to describe the contradiction between the continued pull resulting in brain drain and the need to build capacity:

It can be extrapolated that between 1985 and 1990, on the 60,000 professionals who emigrated, the continent lost US$ 1.2 billions. This represents the reverse of what development aid tries to achieve through “transfer of technology and human resources”. This development paradox, combined with the inability of the African countries in building, retaining, and utilising indigenous capacities critical to Africa’s growth and development will deprive Africa of its vital development resources and make it more heavily dependent on foreign expertise. (UNECA, 2000)

Current macroeconomic policies and the GATS are good examples of the development paradox.
Chapter 5 – The discourse on and proposed solutions to international migration of health professionals

This chapter details the issues that are most often addressed in the current debate on international migration. It further summarises the strategies and solutions proposed to deal with the resultant negative effects of, and emphasises strategies and solutions related to, pull factors in international migration. The chapter ends with a discussion.

5.1 International migration and its effects on health service delivery

The recent increase in attention to international migration is related to the skills shortages experienced in developed countries, closely linked to significant demographic changes and the size of the workforce. This focus is further sparked by the current debate on the effects of globalisation and trade liberalisation, in which international migration is presented by some as a means to economic growth and by others as brain drain and reverse aid, and as such a contributing factor to increasing inequalities between rich and poor.

The 1970s’ proposals to address the brain drain included paying of compensation to developing countries for the loss in investment in training and human capital, which were shelved because of the “influence of powerful stakeholders” (Martineau et al, 2002). However, the issue of the brain drain is on the agenda again: the flow of health professionals from developing to developed countries has recently increased and is expected to further increase significantly over the next 10 to 20 years due to developed countries’ health personnel shortages (Martineau et al, 2002; Dovlo, 2001; Bundred & Levitt, 2000; Commonwealth Secretariat, 2001; Buchan, 2002; Zurn et al, 2002).
In contrast to earlier shortages, the present shortage [in developed countries] is characterised by a decline in the absolute numbers of people entering the nursing profession and a reluctance of inactive nurses to re-enter governments' health services, thus increasing the difficulties of recruitment for domestic markets. At the same time the existing nursing workforce is ageing, and many will leave in the next ten years. (Commonwealth Secretariat, 2001)

5.2 Is the brain drain one of the effects of globalisation and trade liberalisation?

There is little doubt among analysts that the current levels of international migration constitute brain drain for exporting countries and that globalisation and trade liberalisation are influencing the levels of migration. The Commonwealth Secretariat (2001) suggests that the increase in mobility due to the development of free trade blocs will have adverse effects on the existing inequalities in the distribution of health professionals in developing countries, in particular in light of the HIV/AIDS pandemic (Commonwealth Secretariat, 2001). The OECD (2002) states that there is a:

...booming demand for skilled labour and growing shortage of skilled workers in OECD countries. To meet these shortages, an increasing number of countries are implementing measures to facilitate the recruitment of foreign skilled workers. (OECD, 2002)

However, the OECD (2002) adds that the brain drain “...has been overestimated in developing countries, notably because the return rate is high.”

5.3 The “pull” factors in international migration

It should be stressed that the pull factor is likely to continue to be a dynamic in the UK nursing market. [International] Recruitment is likely to remain an option considered by many UK trusts. (Buchan & O'May, 1999)

The increased demand for skilled labour in general, and for health professionals in particular, in developed countries is recognised as a “pull” factor. Perceived or real improvement in the quality of life, and personal safety and security are also factors that influence individuals in their decision to migrate. However, the most commonly

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quoted pull factors are 1) remuneration differentials, 2) scholarship opportunities in developed countries, and 3) professional development and career opportunities (Dovlo, 2001; Commonwealth Secretariat, 2001; Martin & Widgren, 2002).

5.3.1 The increased demand for health professionals in developed countries

Many developed countries have seen an important increase in the proportion of people aged over 65 and significant declines in fertility rate. The changing age structure of developed countries' populations has received inadequate attention in the planning of the health workforce, despite the fact that the growing ageing population increases the demand for health services because of the higher prevalence of chronic diseases, while fewer young people enter the labour market to support and provide care to the elderly (Stalker, 2001; Walt, 1994). A number of importing countries have eased immigration restrictions for (health) professionals, which is evidence of this high demand. The diversity visas in the United States are an example of this. These visas, also referred to as 'lottery visas', are specifically issued to people from countries underrepresented in the immigration flow to the United States once the prospective employer has shown that suitable employees are not available on the local labour market (Lobo, 2001; Stalker, 2001). Similar provisions have been made in European countries to facilitate the recruitment of foreign skilled workers (Stalker, 2001; Commonwealth Secretariat, 2001; Dovlo, 2001; Buchan, 2002).

5.3.2 Remuneration differentials

There is agreement that the competitive salaries and benefit packages offered by developed countries are the most important pull factor (Martineau et al, 2002; Dovlo, 2001; Commonwealth, 2001; Stalker, 2001; Bundred & Levitt, 2000; Buchan &
O'May, 1999). Remuneration differentials affect migration trends, also in developed
countries. However, the economic outlook of most developing countries is bleak,
especially in Africa, and it is therefore unlikely that African countries can make any
significant progress in solving the problem solely by paying higher salaries.

*Prospects for economic development in the poorest countries are much worse
than they were ... in the seventies. 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.*
(Martineau et al, 2002:8)

5.3.3 Scholarship opportunities in developed countries

Developed countries provide scholarships for postgraduate training as a component of
bilateral development programmes. Such training can be considered as a mutual
benefit, although it has become a significant factor in international migration. Many
students do not return after completion, which is acknowledged by the OECD:

*As regards the mobility of students and researchers, several contributions
showed that OECD countries increasingly seek to attract specialised foreign
students, particularly in the field of science and technology, and to facilitate
their access to the labour market. This is not only because their tuition fees
are of direct financial benefit to the universities concerned but also because
they provide a potential highly qualified reserve of labour that is familiar with
prevailing rules and conditions in the host country.* (OECD, 2002)

5.3.4 Professional development and career opportunities

The need for highly specialised health professionals in developing countries is limited.
Only a selected few will be able to fulfil their ambition to become specialists given
the low number of institutions offering specialised health care. This is closely related
to the limited budgets for public health care in many developing countries and results
in many young professionals leaving for countries where such opportunities do exist
(Commonwealth Secretariat, 2001; Dovlo, 2001).
5.4 "Winners" and "losers"

By and large, there is agreement that international migration can benefit both developed and developing countries, in particular where it concerns the benefits to national economies and to individuals and their families. Increased flows of professionals from developing to developed countries create "winners" and "losers".

5.4.1 The winners

There is little doubt that importing countries benefit significantly from international migration. These benefits have both economic and political significance and have a bearing on continued economic growth. This is explained by the gains in skills and the reduction in crucial labour shortages, both linked to satisfying domestic demand and increasing productivity, and the savings in training and education (OECD, 2002; Frommel, 2002; Stalker, 2001; Martineau et al., 2002; Bundred & Levitt, 2000; WHO, 2001).

As far back as the early 1970s, the United States government calculated that it gained US$ 20,000 for every skilled worker from a developing country. The United Nations Conference on Trade and Development (UNCTAD) estimates that for each professional aged between 25 and 35 years, US$ 184,000 is saved in training costs by developed countries (UNECA, 2000). The actual costs of training doctors in African countries are considerable: in Ghana, tuition for medical school attendance costs the government an estimated US$ 20,000 per student (Bundred & Levitt, 2000), Nigeria spends an estimated US$ 30,000 to train a physician, while South Africa’s undergraduate medical training costs are approximately US$ 61,500 per student (Dovlo, 2001).
The 27 OECD countries have a workforce of approximately three million professionals educated in developing countries. Based on an estimated cost of US$20,000 per person educated outside of the OECD, the transfer of wealth from developing to developed countries would amount to approximately US$60 billion (Stalker, 2001: 107). If the UNCTAD figure of US$184,000 is used to calculate the total savings for OECD countries this figure would be 9.2 times higher, a staggering US$552 billion, which supports Emeagwali’s (2002) statement that “In essence, Africa is giving development assistance to the wealthier nations, which makes the rich nations richer and the poor nations poorer.”

Individuals benefit because of higher remuneration, a higher level of job satisfaction, better living standards and working conditions, improved opportunities for professional development, and a perceived or real increase in status back home (Pang et al., 2002; BMJ, 2002; Martineau et al., 2002; Dovlo, 2001; Commonwealth Secretariat, 2001; BBC News, 1999).

Exporting countries benefit from international migration because of remittances, the increase in investment in the home country’s economy, in trade and networking with foreign companies (Martineau et al., 2002; Commonwealth Secretariat, 2001; Dovlo, 2001). Lowell & Findlay (2001) suggest that “International migration is in the best interest of developing countries, therefore immigration policies should facilitate movement when there is high demand.”
5.4.2 The losers

The loss of much needed human capital or in investment in education is the most significant for exporting countries. This is felt more in developing countries which are experiencing critical staff shortages in the health sector, with disadvantaged populations in remote rural areas the ‘ultimate losers’ (Martineau et al, 2002).

The United Nations Development Programme (UNDP, 2001) calculated that India loses US$ 2 billion annually in human capital investment because of migration to the United States alone. Researchers in Africa have estimated that the loss of approximately 20,000 skilled workers per annum results in an annual loss of US$ 4 billion to the continent (IRIN, 30 April 2002). They further estimate that Africa has had to spend 35% of Official Development Assistance (ODA) annually, approximately US$ 4 billion, on salaries of 100,000 foreign experts (all sectors, not only health) to replace lost capacity, to ‘build capacity’ and/or provide technical assistance (Pang et al, 2002; UNECA, 2000).

Developing countries’ capacity to train adequate numbers of health workers is also significantly reduced by the brain drain, and adversely affects the production of new health professionals. This reduced human resource base, in turn, further undermines the capacity to provide support and supervision of health personnel, considered essential in health human resource development (Martineau et al, 2002; Dovlo, 2001; Commonwealth Secretariat, 2001).

5.4.3 Winners or losers?

Exporting countries benefit, according to some, from the transfer of skills upon return of migrants (OECD, 2002; Lowell & Findlay, 2001; Lobo, 2001). However, others
suggest that there is little evidence that these skills are appropriate in the settings to
working in an ICU in the US is unlikely to use her skills when working in a district
hospital.”

The debate on remittances is equally divided. Evidence suggests that remittances by
health professionals are limited, and certainly do not offset the loss in investment in
education. A comparison between doctors and nurses show that nurses are more likely
to migrate for a limited period of time over shorter distances and that they remit more
of their earnings. Doctors are more likely to emigrate, i.e. leave permanently with
their families and assimilate into their adopted home country. In the latter case,
remittances are insignificant (Commonwealth Secretariat, 2001; The Economist, 2002;
Stalker, 2001).

5.5 Strategies and solutions
The strategies proposed to reduce the brain drain resulting from international
migration relate to both push and pull factors. The global debate and action plans
focus primarily on strategies dealing with push rather than pull factors, whether these
originate in developed or developing countries, multilateral organisations or
organisations such as the OECD. Most analysts agree that there is a need to develop
policies and strategies to reduce the current levels of migration, and international
organisations such as the IMF received such advice:

Another important issue is the extent to which the benefits of education
acquired by citizens of developing countries are externalities that individuals
cannot be expected to take into account when making their private decisions.
If such externalities are substantial,... then policies to curb the brain drain
may be warranted. (Carrington & Detragiache, 1999)
The most effective strategy that deals with pull factors directly is workforce planning. Two other proposed strategies, compensation for loss in investment and a Code of Conduct for ethical recruitment, are responses that could mitigate the effects of the pull in international migration for developing countries.

5.5.1 Planning of the workforce

The strategy most often referred to in the debate is that which improves workforce planning, in particular in developed countries which create the most significant pull. This strategy stresses the need to recognise the adverse effects of the continued pull to health systems in developing countries and the resulting problems in access to health services for the poorest populations (Dovlo, 2001; Lowell & Findlay, 2001; Commonwealth Secretariat, 2001; Martineau et al, 2002; The Economist, 2002). The Indonesian Mission to the United Nations articulated this as follows:

Not only is there a need to increase the number of health care and education professionals trained in the developing countries, but the developed countries must step up their efforts to fulfill their own needs without draining these vital and scarce resources from poorer countries. (Djumala, 2002)

This view on workforce planning is supported by others:

Prediction of human resource needs probably requires more prescience than science, being influenced as it is by factors such as changing demographics and expectations, health sector reforms, the balance between public and private health care, liberalisation of trade, and new laws such as the EU directive limiting overtime work. Highly developed countries need to look for more innovative ways of providing adequate human resources for their health systems to ensure that the countries that have borne the cost of training, and devoted precious resources to that training, retain their health professionals. ... By actively enticing medical graduates from the less-developed world to work in situations in which local doctors will not work, health planners are looking for an inexpensive solution to inadequate human resource planning. (Bundred & Levitt, 2000)
5.5.2 Compensation for loss of investment

This proposed strategy only indirectly impacts on the pull to developed countries (Frommel, 2002; Martineau et al, 2002; Bundred & Levitt, 2000; Pang et al, 2002). If implemented, it would reduce the economic benefits of international migration for developed countries and might trigger improved workforce planning in importing countries. Exporting countries would, at the very least, receive financial compensation for investments made and lost.

Questions are raised, however, as to who should be compensated and by whom? Should it be the responsibility of the government that imports or the private company that employs foreign health professionals? Furthermore, the value of the 'price tag' and mechanisms to enforce compliance are additional complex and challenging issues that need to be answered for this strategy to have a beneficial impact.

5.5.3 Guidelines / Code of Conduct on international recruitment

This strategy proposed by, among others, the Commonwealth, some Scandinavian countries and the Southern African Development Community (SADC), does not consider pull factors in international migration, but rather the ethics of recruitment. It proposes to restrict recruitment of health professionals from countries that are themselves experiencing health personnel shortages, and to set standards with regard to the openness of procedures in recruitment (Bruinsma & de Visser, 2002; Commonwealth Secretariat, 2001; Dovlo, 2001; Altenroxel, 2002; SAPA, 2002; Martineau et al, 2002; Bundred & Levitt, 2000; Lowell & Findlay, 2001; Frommel, 2002).
The challenges posed by the introduction of a code of conduct relate to enforcement and the sensitive issue of who should be mandated for this purpose. Should it be the International Labour Organisation, the World Health Organisation, OECD member states, Commonwealth member states, the G8 member states, or NEPAD? These questions remain unresolved.

5.5.4 Additional proposals to reduce and/or reverse the brain drain

Many analysts consider the following proposals as possible strategies to reduce and/or reverse the brain drain:

- The establishment of a comprehensive and reliable information network to generate accurate data on the extent of international migration, and to monitor and identify the impact of continued migration on the health sector (Martineau et al., 2002; WHO, 2001; NEPAD, 2001; NRF, 2002).

- Study the impact of the trade in health services with particular emphasis on the identification of intended and unintended health system effects (WHO, 2001; Hilary, 2001; Chanda, 2002; Adlung & Carzaniga, 2001; Lowell & Findlay, 2001; Carrington & Detragiache, 1999).

- Programmes to assist the return of highly skilled workers from developed countries (Martineau et al., 2002).

- The Africans in the Diaspora (AIDs) initiative, which relates to using skills of professionals who migrated to developed countries by forging links and creating networks of benefit to their countries of origin. This initiative is supported by NEPAD, the South African Network of Skills Abroad (SANSA) and others (NEPAD Secretariat, 2002 - Initial Action Plan ¶56; NRF, 2002; The Economist, 2002; Lowell & Findlay, 2001; Selassie, 2001; BMJ, 2002).
• Various retention strategies that include, among others, improvement of work and living conditions, the introduction of hardship allowances for practitioners in rural areas, and opportunities to increase income through private sector work (Martineau et al., 2002; Commonwealth Secretariat, 2001; The Economist, 2002; Dovlo, 2001; Pang et al., 2002).

• Adaptation of the training curriculum of health professionals and training of substitute cadres such as medical assistants and auxiliary nurses, who are less attractive on the international labour market (Dovlo, 2001; Commonwealth Secretariat, 2001; Martineau et al., 2002; Pang et al., 2002).

• Measures to control movement of health professionals, such as bonding schemes, community service, tax levied on departing professionals, and bilateral agreements (Dovlo, 2001; Commonwealth Secretariat, 2001; Martineau et al., 2002; Chanda, 2002; Pang et al., 2002; Frommel, 2002; The Economist, 2002).

Of the above proposals, the establishment of an information system, research on the impact of GATS, measures to control movement and retention strategies all have merit, but only if effectively implemented following in-depth research.

5.6 Discussion

International migration is associated with significant economic benefits primarily for countries that generate the pull, i.e. developed countries, and is the cause of significant losses for developing countries. Using the conservative figure of US$ 20,000 to train a medical doctor, Zimbabwe lost US$ 16.8 million in investment through the loss of 840 doctors. Using the same conservative estimate Nigeria incurred a loss of US$ 420 million due to the migration of 21,000 physicians to the
United States. If, however, the UNCTAD figure of US$ 184,000 per professional is used to calculate savings for developed countries, the United States saved the not insignificant amount of US$ 3.86 billion.

It is crucial that appropriate strategies to provide for the high demand of health professionals in developed countries are identified and implemented. This continued demand would indicate that workforce planning in developed countries is woefully inadequate. Some of the key informants support this analysis. Others suggest that, for economic reasons, developed countries deliberately factor in the recruitment of foreign trained nationals in their workforce planning strategies or suggest that "Governments are not necessarily involved in planning and have no control over recruitment of foreign trained nationals, in particular in countries where the private sector is poorly regulated or where regulation is poorly enforced." Key informants further indicate that health and health workforce planning are sensitive political issues:

*Planning for human resources for health is a good example of policy conflict: Departments of International Cooperation will generally attempt to support health systems development in developing countries, while other government departments will focus on ensuring delivery of health services and if necessary will recruit from countries supported by its Department of International Cooperation for the benefit of achieving its policy goals at domestic level. (Key informant)*

The debate on compensation for losses in investment in human capital is incomplete. Compensation alone will not solve the immediate effects of international migration, i.e. increased staff shortages and the consequent negative effects on the delivery of health services. The issue of compensating developing countries for incurred losses is complex and a long way from being realised. In the interim, however, rich countries
will continue to be significant beneficiaries of developing countries’ investment in human capital and this must be acknowledged as such by developed countries.

Most key informants agree with the proposal that exporting countries should be compensated for the loss of investment. This compensation should be no less than $184,000 per health professional, as calculated by UNCTAD. One key informant, however, suggests that compensation should rather be provided in the form of investment in training institutions that focus on the production of medical assistants and auxiliaries who are able to meet local health needs and who are not in demand in developed countries.

Most key informants indicate that, if implemented, compensation should preferably go to the National Treasury to ensure equitable distribution. In addition, key informants stress that such funds should not be utilised to increase the output for export and should only be provided to ministries of health to implement staff retention strategies.

Key informants further emphasise the need for efficient database and information systems to administer compensation schemes and suggest the International Labour Organisation (ILO) or the International Organisation for Migration (IOM) as the most appropriate implementing organisations.

While the need for networking to benefit from technological and scientific skills of returning professionals and Africans in the Diaspora is relevant to many sectors, the same cannot be said for the health sector. These initiatives are in fact of questionable value, given that a higher status is afforded to health professionals who work abroad
than to professionals who remained at home. Furthermore, they run the risk of introducing inappropriate technologies that might influence the future size, shape and orientation of health services in the home country. Returning professionals are more likely to focus on hospital-based, doctor-driven health care requiring sophisticated equipment and drugs rather than on providing basic health care. African health systems have not been undermined because of lack of access to new technology, but because of insufficient financial and human resources to provide basic health services.

Most key informants agree that NEPAD should be encouraged to reconsider the AID strategy for sectors experiencing serious staff shortages and suggest that this initiative will only offer small scale, temporary solutions and be limited to addressing the provision of specialised clinical care.
Conclusion and recommendations

Conclusion

This secondary data study has analysed a large volume of documents that provide insights into the nature and extent of international migration, current international macroeconomic policies and the GATS, and the implications of these for the global health workforce and the pull in international migration of health professionals.

The analysis of the document sources, triangulated with data from key informant interviews, provide sufficient evidence to confirm that: 1) the extent of international migration is inadequately documented; and that 2) current macroeconomic policies and trade-related agreements are likely to aggravate the pull of health professionals and lead to substantial economic gains for developed countries while adversely affecting health service delivery in developing countries.

The study findings show that current macroeconomic policies contradict G8 commitments to the development of developing countries’ health sector capacity.

Significant pledges and commitments have been made by the G8 and other OECD member states to increase public health expenditure in developing countries to achieve the international development goals, with particular emphasis on the fight against HIV/AIDS, tuberculosis and malaria. However, inadequate resources have been pledged to strengthen health systems and, more specifically, the urgent need to address health workforce shortages.
The G8 members and other OECD member states acknowledge that improving their workforce planning is required, but they do not acknowledge that current trends in migration of health professionals from developing to developed countries constitute brain drain. By contrast, African leaders have made the reversal of the brain drain one of their priorities in the recently developed and introduced New Partnership for Africa’s Development.

While the OECD recognises that the enrolment of foreign students in their tertiary education facilities is creating direct economic benefits as well as a reserve workforce, the G8 and the OECD fail to recognise the harmful consequences of continued international migration of health professionals on health service delivery in developing countries.

**Recommendations**

a) First and foremost, developed countries should acknowledge that the pull of health professionals to developed countries adversely affects developing countries’ ability to strengthen their health systems.

b) The G8 should follow the example of African leaders by recognising the severity of the brain drain and ensuring its rightful place on the international policy agenda.

c) A comprehensive system should be established to provide accurate data on the extent of international migration and the brain drain.

d) A transparent global health workforce planning system should be established to determine needs and targets of the health sector. This system should provide
workforce planning figures from different countries that include the actual and required workforce size and furthermore stipulate the organisations to be involved in health workforce planning.

e) The G8 and other OECD member states should, in close collaboration with developing countries' governments, determine how the loss of investment in human capital as well as health professionals' training can be compensated.

f) The World Trade Organisation should, in close collaboration with relevant multilateral and bilateral agencies and developing countries themselves, ensure that all government departments are cognisant of the implications of trade liberalisation on the implementation of sectoral policies.

g) The G8 and other OECD member states should, in close collaboration with developing countries' governments, commission research from independent institutions to determine the effects of the trade in health services, particularly focusing on international migration trends and equity in access to health care.

h) The NEPAD initiative to utilise Africans in the Diaspora should be reconsidered, as it is an inadequate response to address African health sectors' inability to meet basic health needs and may indeed aggravate some of the existing inappropriate biases in health care provision in developing countries.
References and bibliography


IRIN. 2002. West Africa: Migration statistics unit to be created. United Nations Office for the Coordination of Humanitarian Affairs, Nairobi (Online, 30 September, IRIN@irinnews.org).


IRIN. 2002. Africa: Brain drain reportedly costing $4 billion a year. United Nations Office for the Coordination of Humanitarian Affairs, Nairobi (Online, 30 April, IRIN@irinnews.org).


Martineau T, Decker K, Bundred P. 2002. Briefing note on international migration of health professionals: levelling the playing field for developing country health systems. Liverpool School of Tropical Medicine, Liverpool.


Moodie G. 2002. Many happy returns. An increasing number of South African emigrants are bucking the brain drain by returning to their roots. Sunday Times, 8 December: 19.


Sanders D, Chopra M, Lehmann U, Heywood A. 2001. Meeting the challenge of health for all through Public Health education; some responses from the University of the Western Cape. SAMJ; 91(10): 823-9.


## Annex 1

### Physician and Nurse per population ratios

#### African countries

<table>
<thead>
<tr>
<th>Name of country</th>
<th>Physician / 100,000 population ratio</th>
<th>Nurse / 100,000 population ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seychelles</td>
<td>22.2</td>
<td>—</td>
</tr>
<tr>
<td>Gabon</td>
<td>19.0</td>
<td>—</td>
</tr>
<tr>
<td>Libya</td>
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<td>—</td>
</tr>
<tr>
<td>South Africa</td>
<td>—</td>
<td>57.1</td>
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<td>Botswana</td>
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<td>19.4</td>
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<td>Mauritius</td>
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<td>Tunisia</td>
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<td>Morocco</td>
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<td>Cape Verde</td>
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<td>Egypt</td>
<td>52.6</td>
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</tr>
<tr>
<td>Republic of Congo</td>
<td>10.5</td>
<td>—</td>
</tr>
<tr>
<td>Cote d'Ivoire</td>
<td>6.4</td>
<td>—</td>
</tr>
<tr>
<td>Djibouti</td>
<td>25</td>
<td>—</td>
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<td>Cameroon</td>
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<td>5.7</td>
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<td>Guinea</td>
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<tr>
<td>Comoros</td>
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<td>—</td>
</tr>
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<tr>
<td>Lesotho</td>
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<td>—</td>
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<td>S. Tome &amp; Principe</td>
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<td>—</td>
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<td>Central Afr. Republic</td>
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<td>5.1</td>
</tr>
<tr>
<td>DRC</td>
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</tbody>
</table>

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9 Countries have been listed according to their per capita GDP and starting at the highest GDP.


Data refer to the most recent year during the period specified in the column heading.

14 Data source: World Bank. 1994. Better Health in Africa. Data refer to the most recent year during the period specified in the column heading.

15 This data appears to be incorrect. Data from another source have been added in the next column.
<table>
<thead>
<tr>
<th>Name of country</th>
<th>Physician / 100,000 population ratio</th>
<th>Nurse / 100,000 population ratio</th>
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<td>Niger</td>
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<td>Burkina Faso</td>
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<td>Guinea-Bissau</td>
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<td>Burundi</td>
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<td>Mozambique</td>
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<td>Eritrea</td>
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<td>Liberia</td>
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**Averages:**

<table>
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<th>Low-income countries</th>
<th>Sub-Saharan Africa 18</th>
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<td>Nurse</td>
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</tbody>
</table>

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16 Eritrea was established as a sovereign state in the early 1990s. Prior to that, it formed part of Ethiopia.

17 Organisation for Economic Cooperation and Development. The OECD comprises 27 developed countries.

18 Sub-Saharan Africa comprises 48 of the 53 African countries. It excludes Egypt, Libya, Algeria, Tunisia and Morocco.
Annex 2

Discussion points for key informant interviews

Introduction

The study in which you have been asked to participate as a key informant examines the pull factors in international migration of health professionals. This qualitative secondary data study describes the nature and extent of international migration, the macroeconomic policies and trade agreements that influence migration patterns and engages in the current debate about international migration.

You are kindly requested to give your opinion on a number of issues that are considered to be of relevance in the search for solutions to what many define as brain drain of health professionals from the African continent.

Below you will find four (4) discussion points that resulted from the document analysis. You are requested to give your position / opinion on the discussion points you feel comfortable with and can contribute to. You are of course free to provide your opinion on all discussion points.

Your cooperation is highly appreciated.

Please find attached a statement guaranteeing confidentiality of information obtained through the interviews. Because of the means of communication used, this statement cannot be signed. If you wish to receive a signed statement, I can fax this to you. However, in the latter case I would appreciate receiving correct fax details.
Discussion point 1.  *Trade in health services*

The further liberalisation of trade that includes trade in health services influences the brain drain as it draws health professionals from the public to the private health service (internal brain drain) and from developing to developed countries because of the ever growing need for skilled health professionals in an expanding global health services market.

The G8 does not acknowledge the existence of the brain drain. However, mention is made of the need for mobility of the workforce, without specific reference to mobility between developing and developed countries. The G8 recognises the need for investment in human capital as vital in the pursuit of its macroeconomic policies. This raises questions as to how issues relevant to developing countries are considered in the development of international macroeconomic policies.

Developing countries are said to have insisted that movement of ‘contract workers’ be included in the GATS. This is said to be closely linked to the potential of remittance earnings through the migrant workforce. The GATS negotiating teams have consisted of representatives from Ministries/Departments of Trade and Industry, Economic Affairs, and others with a general portfolio. It is unclear whether national governments have deliberated presence of natural persons (mode 4 of supply) with ministries responsible for specific sectors, such as the health ministry. It would seem, however, that a number of issues have been overlooked in the negotiations. One of the most important issues that has been overlooked is of course the existing staff shortages in the health (and other) sectors in most developing countries. It is further possible that developing countries have not limited the ‘presence of natural persons’ in the health services trade, because they want to allow foreign health professionals to provide health services in their countries. The other side of the coin then is that they have to allow movement of their professionals across international borders. This should have been pointed out!

Furthermore, it would suggest that Ministries/Departments of Health have to be informed about the contents of the GATS and its possible implications for the health workforce. Regional and/or national offices of multilateral agencies such as the World Health Organisation, the United Nations Development Programme and the World Bank are in a position to ensure that relevant ministries and departments are fully informed about newly introduced policies that could have far reaching consequences for sectoral policies and, more importantly, for its implementation.

A separate issue in the debate about the GATS concerns migration for study purposes. The data available suggest that in this area significant economic benefits are made by countries with the capacity to provide quality undergraduate and postgraduate education. The countries benefiting most are, as with international migration, industrialised countries. It is clear that developing countries benefit from this investment in human capital, if students return home after completion of studies. There is substantial evidence that this is not the case.

G8 countries have to publicly acknowledge that the policies and trade-related agreements they promote have first and foremost been developed to ensure economic growth of their economies, not necessarily the economies of developing countries.
The G8 propose technical cooperation on trade with developing countries, and especially they commit to provide trade-related technical assistance. Such technical assistance should include examining the effects of expansion of trade in health services on the health workforce in developing countries with a particular focus on the resulting brain drain, a loss in human capital that most developing countries can ill-afford.

They should further accept to finance research that allows establishing what the implications of the introduction of the GATS are for health service delivery in developing countries and act according to the findings of such research.

**Discussion point 2. Workforce planning in developed countries**

A crucial issue that needs to be addressed is the continued demand for health professionals in developed countries, which would indicate that workforce planning is either not taken seriously or that the capacity to plan for health human resources is inadequate. The available information on the health workforce in developed countries does not clearly indicate what the real shortfall of health professionals is and why this shortfall is occurring.

What are the figures used in the workforce planning process, on the basis of which policies and data are these figures determined, and who is involved in workforce planning? Could WHO Regional Offices play a more prominent role in determining workforce planning figures?

One can of course take a more cynical view as to why health workforce planning is not given due attention, which is that many professionals from developing countries want to enter the developed countries’ labour market and that developed countries’ economic gains are the only driving force. This would suggest, however, that contributions by developed countries to discussions on sustainable development and equity are insincere given that these do not consider the much needed skills in and loss in investment by developing countries and the unfair competition on the global labour market that mostly benefits developed countries.

**Discussion point 3. Compensation for loss in investment in human capital**

The debate on compensation for losses in investment in human capital suffered by developing countries is incomplete. It is clear that compensation does not solve the effects of international migration of health professionals, which are the increasing staff shortages and its detrimental effects on the delivery of even basic health services in developing countries. There are indeed many questions regarding compensation which have been highlighted that need answering. For example, health professionals might first move from a “least developed” to a developing country in the region, from where they move to a developed country. This would mean that South Africa, for instance, would have to pay significant amounts to other countries in the region.
While it is true that establishing a compensation system might not be easy and straightforward, it is also true that rich countries are now the main beneficiaries of investment in human capital made by developing countries. African countries are experiencing far more significant staff shortages in the health sector than developed countries. This has to be acknowledged by developed countries and they should be forced to finding solutions for their (and consequently developing countries') staffing problems, or they should be forced to pay the price for “purchasing” health professionals, preferably using the UNCTAD price tag of US$ 184,000 per professional.

Surely creative solutions can be found. For instance, developed countries could compensate developing countries through a massive investment in education, i.e. primary, secondary and tertiary education. This would increase the capacity of education facilities of developing countries, and would enable these institutions to produce adequate professionals both for the domestic and the global labour market.

- Is it possible to determine how many years a health professional should work in his/her country of origin to ‘repay’ the investment made by the government in that individual’s training? Can this be calculated on a ‘per annum’ basis?
- What kind of system would be required to administer such compensation and who should be mandated to administer such system?
- Which ministry should be the recipient of the compensation: the education department, the health department?
- Which amount should be used? The UNCTAD figure of US$ 184,000 per lost professional?

The unfortunate drawback of compensation in whatever form is that health professionals are becoming a resource that can be traded, a commodity, which is an offence to people’s dignity.

**Discussion point 4. Africans in the Diaspora**

While the need for networking to gain from technological and scientific skills of Africans in the Diaspora is relevant for many sectors, the same cannot be said for the health sector. African health systems have not been undermined because of lack of access to new technology, but because of lack of financial and human resources to provide basic health services. It is the application of now more or less common procedures, standards and protocols that is inadequate because of the weak human resource base of African health systems. The Africans in the Diaspora option can therefore be considered of little relevance to ailing health systems on the continent.

Surely, African health systems first and foremost need to address its critical staff shortages without the introduction of inappropriately skilled AIDS. Will AIDS work in the ‘basic’ conditions and focus on delivery of essential health services or will they focus on introducing new technologies used in rich countries that will again benefit the economies that have patents on these technologies?
Statement concerning confidentiality of information gathered through key informant interviews.

I, Wilma Meeus, principal researcher in this study, hereby guarantee that all information you provide through your participation in the key informant interviews will be treated as confidential.

You agree that the researcher can analyse and publish the analysed data in her minithesis and possible subsequent publications without reference to details that would breach this confidentiality.

Cape Town, 18 November 2002.

Wilma Meeus, MD
MPH student
School of Public Health
University of the Western Cape.