International Movement of Skilled Health Professionals: Ethical Policy Challenges for Developed Nations

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The global migration of people that has taken place in the past few decades has been unprecedented. There are an estimated 175 million people living temporarily or permanently outside their country of origin. These figures include migrant workers, permanent immigrants, refugees and asylum seekers, but exclude irregular or undocumented movements, which are on the increase. Growing political instability and economic changes in tandem with complex humanitarian and environmental reasons have contributed to the large number of people moving. This mobility has important implications for individual migrants, as well as for those left behind.

Providing health care to populations is highly labor-intensive – the industry employs 35 million people around the world, as estimated by the International Labour Organisation in 1998. Human resources are cited as the most costly component of health budgets. In fact, it has been estimated that the wage costs in many countries represent 65% to 80% of health system expenditures. The World Health Report 2000 defines human resources for health as “the stock of all individuals engaged in the promotion, protection or improvement of population health.” Without this rich mix of human input, health services could not be provided to care for patients, diagnose, cure and treat, or pro-

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mote health and prevent disease in individuals and populations. The shortage of human resources in health has also been identified as a “constraint to achieving the Millennium Development Goals and to scaling up interventions on major health problems,” such as child mortality, maternal health, childhood nutritional status, malaria prevention measures, access to clean water, and HIV/AIDS. Yet planning the supply and demand for human resources in health care is often neglected or prone to methodologically weak forecasting and quick-fix policy solutions.

Many of the most developed countries of the world are currently experiencing shortages of skilled health professionals including nurses, doctors and allied health workers. These shortages are occurring in certain specialties such as intensive care, midwifery and in rural, remote or poorer urban geographical areas. Increasingly, trained professionals from developing countries are filling these gaps. It is not just an issue concerning the health workforce, but it is also part of the larger issue of skilled labor migration from low-income countries to high-income countries, commonly referred to as the brain drain.

What is the Brain Drain and how big is it?

Brain Drain has been described as a “conveyor belt-like movement” from poorer to richer regions, countries and areas of the health sector. This movement is visible not only between countries but also within the poorer and richer sectors of the health market within countries. Recent estimates of emigration rates of skilled workers, from almost all countries in the Organisation for Economic Co-operation and Development show that the greatest numbers of highly educated migrants come from European, Southern and Eastern Asian and Central American countries, while the highest rates of brain drain are occurring in the Caribbean, Central America and Western and Eastern Africa.

The migration of highly skilled professionals from poor countries to rich has been recognized internationally since the 1960s. In health care, concerns over the impact of these labor movements on the health systems and economies of poorer countries were expressed as long ago as 1965, at the Edinburgh Commonwealth Medical Conference. These concerns, expressed more explicitly in the 1970s, prompted the World Health Organization (WHO) to support a large Multinational Study of the International Migration of Physicians and Nurses, investigating stocks and flows of doctors and nurses in 137 countries.

Physician flows, then representing about 16% of the global migrant stock, were mainly from Canada, Germany, Ireland, UK, India, Iran, Pakistan, Sri Lanka, the Philippines, Korea and Latin America to the USA and the UK. It was estimated that in the 1970s 135,000 nurses were outside their country of birth or training, with more Filipino nurses registered in the USA and Canada than in the Philippines. Since the 1970s, the patterns of migration and source countries have changed; the new source regions for doctors str in the Caribbean, Egypt, sub-Saharan Africa, Cuba and the former Soviet Union; for nurses, increasing numbers are migrating from China, Thailand and sub-Saharan Africa.
Until recently, little systematic research or concerted action had been undertaken, and the migration of skilled health professionals from developing countries continues to increase. Indeed, many of the recommendations made for improving workforce planning in recipient countries, laid out in the landmark WHO study mentioned above, still hold.

**Increased Flows to Recipient Countries**

Some comparisons of available data on physician and nursing flows are given here for the major recipient countries – the United Kingdom, the United States of America, Canada and Australia. Data for newer recipient countries such as the Gulf States are not included, although their health systems are heavily reliant on foreign-trained workers from many countries.

In the UK, in the past few years, the number of overseas trained nurses and midwives from countries such as South Africa rose from 599 in 1998-99 to 2,114 in 2001-02, and those from the Philippines rose from 52 to 7,235 in the same period. Nurses registering from Zimbabwe, Nigeria, India, Ghana, Zambia and Pakistan also increased. At the same time nurses coming from Australia, Canada and the West Indies remained stable or declined. Most recent analysis shows that numbers from South Africa and the Philippines have declined in 2002-03, which may reflect changes in push-pull factors, recruitment practices or the lessening attractiveness of the UK as a destination and the increasing attractiveness of other countries. This highlights the need to look at global flows – are these nurses now going to other countries or are they remaining in their home countries?

In the USA, the number of international medical graduates (IMGs) has risen from 10% of the physician workforce (26,048 people) in the early 1960s to 18% (57,217) in 1970, and to 25% (196,961) in 2002. In 1998, over half of the IMGs in the graduate medical education programs were either permanent residents (33%) or citizens (20%); 43% were temporary workers – 27% on exchange visas; 13% classified as refugees and 7% on other visas. Over 39% of IMGs undertaking graduate medical education came from Asia – 20% from India, 11% from the Philippines, 5% from Pakistan and 3% from South Korea.

In a study of human resources in health performed by Health Canada, IMGs comprised between 20 and 30 percent of Canada’s physician workforce between 1969 and 1999; they are currently about 23%. Over the last 25 years, the origin of IMGs has changed from primarily Commonwealth countries and Ireland to countries in the Middle East, Asia and Eastern Europe. Although the content and quality of post-graduate training in Commonwealth countries is generally well known, this is not the case in newer source countries. Consequently, an increasing number of landed immigrants to Canada intending to practice medicine require in-depth assessment and additional training. Canada’s supply of nurses has also been enhanced through immigration. In 2002, almost 7% of Canada’s registered nurses graduated from a foreign nursing program, with the highest proportion coming from the Philippines (27%) and the United
Australia shares many demographic features and policy challenges with the USA, UK and particularly, Canada, with respect to its medical and health labor force, population trends and geographical imbalances in medical labor supply. Australia relies heavily on overseas-trained doctors, with approximately 2,000 temporary migrant doctors being recruited over the 2000-01 period. The Australian Health Minister’s Advisory Council emphasized that “Australia remains highly dependent on overseas-trained doctors.”

Furthermore, there are indicators that a considerable number of these doctors are from the developing world. Recent statistics show that 2.4% (1,249) of the Australian medical workforce were born in Sub-Saharan Africa, with as many as 16% (8,348) of Australia’s doctors being born in Asia. Nonetheless, these statistics do not show in which country staff were trained or the year in which they entered Australia.

Recent research on overseas-trained doctors in regional practice in the state of Victoria, Australia has highlighted the “hypermobility” of this group of doctors. Doctors of Asian origin, in particular, reported multiple relocations prior to reaching Australia. In the ten-year period ending in 2001, doctors born overseas rose from 40% to 47%. East and South East Asia have come to dominate medical migratory flows to Australia surpassing the UK and Ireland as the major sources of medical migrants to Australia. Changes in the profile of Australia’s general practice (GP) workforce showed the proportion of Australian graduates between 1991 and 2003 falling from 81.4% to 72.2%, with the proportion of GPs graduating in Asia increasing from 5.8% to 9.8% over that same period. Meanwhile the proportion of African graduates rose threefold from 1.4% to 4.2% between the years 1999 and 2003.

This broadening of source countries is also evident for nurse migration to Australia. It has recently been estimated that four to five thousand overseas-trained nurses enter Australia annually. Many of these come from other wealthy countries such as the UK, New Zealand, Canada, Ireland and Norway, but source countries in the developing world such as the Philippines and South Africa are also major contributors. In fact, a recent profile of the Australian nursing workforce showed that a quarter of nurses are born outside of Australia.

While the UK and Ireland continue to dominate nurse migratory flows, new patterns are emerging when data is analyzed at the state level. For example, the top five countries providing nurses to the State of Victoria show an increase in nurse registrations from the Philippines and South Africa by 52% and 78% respectively. Meanwhile, in New South Wales, Zimbabwe became a significant source country of nurses in 2002.

Immigration Policy Changes – towards temporary visas

Many countries have changed their immigration requirements and regulations to encourage temporary migration of skilled workers. For example, the entry of permanent workers into the USA declined from over 100,000 to about 70,000 from
1992 to 1998, with a corresponding rise in the entry of temporary workers during the same period from about 120,000 to nearly 400,000. Figures provided for Australia also show a decline in permanent migrant entries, from about 50,000 to 25,000 between 1992 and 1998, with temporary immigration entries increasing during the period from 40,000 to 100,000.

This pattern is reflected in the data on medical migration to Australia. A significant trend in the data on medical migration to Australia shows the decline in the numbers of persons holding medical qualifications permanently migrating to Australia, from 639 in 1991-92 to 292 in 1999-2000. Likewise, temporary migration of doctors has been on the increase; the increase in long-term temporary visas (one year) went from 241 in 1992-1993 to 839 in 1999-2000; and short term (less than a year), from 426 in 1992-1993 to 1,533 in 1999-2000. The increase in temporary medical migration has been specifically targeted to what are called in Australia, Areas of Need, i.e. geographical areas characterized by insufficient numbers of doctors as well as areas of medicine characterized by critical workforce shortages.

With the introduction of Medicare Plus in Australia in 2004, additional initiatives to intensify recruitment of overseas-trained doctors have been introduced by the federal government. These measures include initiatives to assist temporary resident doctors in changing their visa status to that of permanent residents. For example, in 2002-03 the number of category 422 visa holders (temporary residents) who were sponsored under the permanent residence employer nomination scheme increased to 225 from 54 in 2001-02, while the numbers sponsored under the Regional SponsoreMigration Scheme rose from 26 in 2001-02 to 176 in 2002-03. These and other conditions for changing visa status, such as serving in an Area of Need for a period of five years (instead of ten previously) have all been introduced to increase the attractiveness of Australia as a destination for overseas trained doctors.

Temporary migration is an option that has the potential to deliver some benefits to source countries; however, data systems are unable to assess whether this in fact occurs. Do temporary migrants return to their home countries and if so, to what do they return? Anecdotal evidence suggests that few nurses from developing countries, particularly those from sub-Saharan Africa, ever return to their countries of origin.

**Areas of need and underserved areas**

In high-income countries, just as in low-income countries, the burden of shortages of health professionals is concentrated among certain populations, particularly rural and poor inner city areas. Foreign-trained doctors are more likely than American doctors to practice in rural areas and inner cities. IMGs in the USA serve in relatively largely numbers in Areas of Need, as is also a global trend. For example, in the UK, “foreign graduates have frequently obtained employment in areas of the country in which British doctors would not live.” A similar reliance on overseas trained health professionals applies in Canada. In the rural Canadian province of Saskatchewan, more
than 50% of doctors are foreign trained and at least a fifth of the 1,530 doctors there earned their first medical degree in South Africa. Canada’s medical association reports that Canada’s rural areas are short of 1,600 physicians. The situation in South Africa is also complex, with shortages in their rural areas filled by doctors from other African countries.

In Australia, the Australian Health Ministers’ Advisory Council stressed that access to health services in many rural and remote areas will be dependent on Australia’s recruitment of overseas trained doctors. This dependence underpins Australia’s current strategy of recruiting overseas trained doctors to work in Areas of Need, which are mostly in rural and remote settings. The number of overseas doctors working in these Areas of Need has increased over the last decade, from 667 in 1992-93 to 2,899 in 2001-02. In New South Wales, many currently registered Areas of Need doctors are from the following four countries: India, South Africa, Egypt and the UK. Data from the Queensland Rural Medical Support Agency show 41.7% of the current rural and remote medical workforce in that state obtained their basic medical qualifications overseas.

Determinants of Migratory Flows – Push-Pull Factors

A variety of push and pull factors are implicated in the movement of health professionals internationally. These also relate to other areas between which maldistribution of health personnel can be found, including public and private, urban and rural and tertiary and primary levels of the health system. While conditions precipitating the outflow of health professionals from their own countries may vary in nature, scope and purpose, the push factors out of the public system in developing countries have generally been well-documented. The decisions of health personnel to migrate occur at multiple levels. These relate to:

- Dissatisfaction with conditions of work (poor remuneration, inflexible working conditions, lack of prospects for career advancement, limited training and educational opportunities for professional development, lack of supplies and equipment and poor work environments)
- Social pressures (family and friends abroad and the needs and expectations of extended family and kin for remittances from greater earnings)
- Impact of HIV/AIDS on health professionals and morale
- Concerns about personal security
- Political conflicts
- Economic instability and stagnation

The research conducted by the Regional Network for Equity in Health in Southern Africa (EQUINET) notes the difficulty in generalizing exactly which balance of push-pull factors influence the migratory flows in different countries. However, greater investments by source country governments and donor agencies in health infrastructure, remuneration and
health professional development generally are imperative as a starting point for addressing common push factors. 45

Shortages in developed countries are the major pull for skilled health professionals from other parts of the world. According to a US Department of Health and Human Services study, the country was facing a shortage of 111,000 registered nurses in 2000, which was predicted to rise to 275,000 by 2010 and 808,000 by 2020. 46 The nursing shortage is also being experienced by British, Canadian and Australian health systems. In 2002, the UK’s Department of Health set and met a target of adding 20,000 new nurses by 2004, and set another goal of adding 35,000 by 2008. 47 In 2002, the Canadian Nurses Association warned of a possible shortfall of 78,000 nurses by 2010. 48 By contrast, the USA is actually producing more physicians per year than it needs, but too few general practitioners and over 4,000 more specialists than required. 49 The UK, Australia and Canada face maldistribution causing doctor shortages in certain areas. Some European Union countries also suffer severe shortages of doctors and nurses.

There is little doubt that active recruitment by agencies in destination countries as well as government workforce policy initiatives aimed at increasing the supply of overseas trained health professionals to areas of critical workforce shortage act as significant ‘pull’ factors for health professionals from developing countries. The USA and UK have been accused of “aggressive recruitment and stealing of staff with no return for the resources that the countries had spent on training them.” 50 In Australia, it has been argued that government policy initiatives recently introduced aim to “pull out all the stops” to augment the medical workforce, of which international medical recruitment, increasingly from developing countries, is a substantial component. 51

**Concerns about Brain Drain and effects on source countries**

Most studies on the topic of brain drain in healthcare have focused on the doctors and nurses, with little emphasis on flows of other health personnel, such as research scientists, academics, laboratory technicians and radiographers, as well as allied healthcare personnel, including speech therapists, physiotherapists and occupational therapists. The public health impact in source countries of health human resource flows has not been well documented. However, available data relating to skilled health professional migration is currently being reviewed by the EQUINET. 52

Concerns have been especially marked in relation to the serious effects this migration has had on the delivery of health services in Sub-Saharan Africa, where the brain drain of health professionals is severely limiting the ability of countries to provide even basic health services. 53-56 WHO has expressed concern that brain drain from Africa is severely limiting the ability of health workers to combat the HIV/AIDS epidemic and achieve any substantial progress towards the Millennium Development Goals. 57

In addition to the consequences for the health of source country populations, it has been estimated that developing countries spend about US$500 million annually on
training health professionals who migrate to developed countries. The Democratic Nurses Organization of South Africa has reported frustration and demoralization among nurses remaining in South Africa, along with loss of skills, reduction in quality of services and increased staff shortages, with 60% of institutions surveyed reporting difficulties replacing nurses who had left. In small and resource-poor regions like the Pacific Island countries, the impact of migration centers on their unique demographic and geographic characteristics, since even relatively small numbers of health personnel migrating may have a disproportionate effect on the country and its health services. The capacity for replacing health personnel is limited and problematic in cultural and resource terms. While remittances from such migration back to home countries are reported to be considerable, little of this income is directly invested in health service provision or training.

It is the cumulative impact of the current and future shortages and recruitment targets for nurses and other health professionals by the wealthier countries of the developed world that threatens the availability of health professionals in developing countries to service their own populations. One of the critical policy challenges for both destination and source countries is addressing the push factors – the deficits in country health systems and in particular, developing and strengthening human resource capacity through investments in local solutions. It is this local focus that is a prerequisite for a global equity problem.

Ethical dimension and Codes

As the consequences of health professional brain drain for the developing world are becoming recognized, the ethics of national policies that allow rich countries to recruit the most qualified health professionals from their poorer counterparts, at no cost or penalty to themselves, are being questioned. Various governments and professional bodies have developed codes of practice, guidelines and statements. The recently adopted voluntary Commonwealth Code of Practice for the international recruitment of health workers indicates a growing concern in the international community that the active recruitment of health professionals from certain developing countries is both unfair and unethical. The International Council of Nurses published a policy on Ethical Nurse Recruitment in 2001 based on a 1999 document, “Nurse retention, transfer and migration.” The World Organisation for Family Doctors published the Melbourne Manifesto that also addressed ethical recruitment of health care professionals. Yet the effectiveness of aspirational and voluntaristic codes remains questionable.

The ethical concerns of national and international professional bodies that underscore codes of practice and guidelines and policy statements necessitate debate about difficult ethical issues in public and professional forums. These relate mainly to:

• Questions of political will (such as, a willingness of destination and source governments to seek solutions to the problem, especially in
light of the financial gains from foreign earnings).

- What are acceptable standards and methods for international recruitment (recruitment trips/advertising, incentives)?
- What criteria are used to determine developing country status?
- What kind of mandate do governments have for regulating and monitoring international recruiting for both public and private health services?

The continued recruitment and employment of overseas-trained health professionals highlights some of the inconsistencies in government policy in relation to effective systems for monitoring and implementation of ethical recruitment guidelines. A review of eight national and international level codes of practice in 2002 showed that while the policy instruments had been effectively disseminated, the corresponding systems for the effective implementation of such policies were inadequate or unplanned. Yet despite efforts to avoid active recruitment from developing countries, the increasing presence of such doctors and nurses in developed countries illustrates the complexities of controlling recruitment. The story is further complicated by the problem of who initiates the recruitment and the lack of linear flows from country A to country B.

In the UK’s National Health Service (NHS), for example, the introduction of a code of practice in 1999 for the recruitment of international nurses heralded a substantial increase in the number of developing country nurses arriving in the country, in particular from Sub-Saharan Africa, although this trend has decreased in the past year. The case of the UK, which is committed to recruiting 7,500 more consultants, 2,000 more general practitioners and 20,000 more nurses by 2004, underscores that the pressures to achieving workforce targets may subsume ethical codes. While there is some evidence that the UK Code is working within the NHS, it does not apply to private sector recruitment. Other initiatives have been taken in the UK, such as specific agreements with particular countries. For example, India has an agreement with Britain that prohibits NHS recruitment of nurses from the four Indian states that receive aid from the British Department for International Development.

The fine separates active recruitment from simply ensuring that unnecessary barriers are not preventing foreign-trained professionals who are already in developed countries from working in the health field. A report by the Physicians for Human Rights articulates a number of recruitment practices that are a cause for concern.

Ethical aspects of this recruitment can no longer be overlooked. Ethical dilemmas arise if one were to impose restrictions upon skilled health professionals seeking to work abroad. It could be argued that skilled health professionals are an export industry for some low-income countries, given the high level of remittances that often accompany such migration.

The issue can be characterized as a complex interplay between ethics, personal freedom of choice, economics and the instrumental needs of health systems to attract and retain skilled health workers. There are a number of rights arguments that are in tension – the freedom of move-
ment is an essential right particularly when people are seeking work beyond national boundaries due to political and economic hardships. However, the exercise of that right should not occur at the cost to the right to healthcare.

If developed countries simply focus upon the health system gains that international migration brings, then economic incentives will guarantee an unflagging supply of foreign labor that can be used to plug the gaps in the health systems of wealthy developed countries. Unless the ethical dimensions are raised, discussed and subsequently addressed, the conveyor belt of global migration will ensure that developing countries continue to lose some of their most valuable and essential staff.

Policy Options

It is important to recognize that the current shortages have essentially been policy driven and related to health reforms and downsizing in the health workforce that took place in many countries through the 1980s. In addition, many countries got their workforce planning projections wrong, failing to take into account changes in the nature of work, including the feminization of the professions and changing workplace arrangements to limit hours of work. Also related to this are reports that healthcare professionals are not happy with their workplaces and that retention and absenteeism are increasingly affecting the provision of health services. A link also needs to be made to how developed countries monitor the performance and activities of health professionals, and whether there are shortages because of variations in practice or over-servicing rather than an actual lack of care and servicing. An analysis of five developed countries, Australia, France, Sweden, Germany and the UK, highlighted the deficiencies in national workforce planning leading to what was termed “cycles of shortages and surpluses.” Medical workforce planning in four of the countries was found to be determined by a “relatively crude forecasting method, based on the existing supply of doctors, changes in the supply such as likely retirements and other losses to the professions, and a prediction of the future demand for health care…based on demographic change, assuming that the same doctor/patient ratio is required for future generations.”

In summary, we have presented some data on increased flows from developing countries to developed countries, although we acknowledge the deficiencies. Some action by Commonwealth countries has already taken place, but the effect of this has not yet been evaluated. What is becoming apparent is the need for policies that address push factors, as well as pull factors. Managed migration is one option that could be more explicitly modeled. For example, temporary migration is an option that can deliver some benefits to source countries. However, data systems are lacking to assess whether health professionals return to their countries of origin, and if so, what do they return to? While destination countries provide incentives for health professionals to migrate to areas of critical workforce shortage in the wealthier countries of the world, corresponding incentives for people to return to their home countries need to be supported if more equitable migration arrangements are to be taken seriously. Workforce planning and
1. Develop, promulgate and implement a national code of conduct for ethical recruitment. Such codes seek to differentiate those countries from which recruitment may be less harmful, to identify more acceptable forms of recruitment within poor countries, and to apply other elements of good practice listed in Tables 1 and 2.
   • Effective if adhered to by both public and private sector recruiting bodies
   • Limited impact if voluntary
   • Limited impact if private sector recruitment agencies exempt
   • Demands adequate monitoring of all recruitment activity
2. Provide adequate supply of human resources and appropriate workforce distribution within the developed country’s own professional education and health systems.
   • More sustainable solution to a fundamental cause of skilled migration
   • Recognizes need for a concerted whole-system approach.
   • If human resources within wealthy countries were better deployed, areas of need would be fewer and the search for skilled migrants to fill the gap would be diminished.
3. Selectively limit proactive approaches by public and private recruiters in recruiting skilled health professionals from developing countries.
   • Involves restricting proactive approaches made by governments and recruiting agencies to poach staff from the developing world through advertising and recruitment visits
   • Recognizes differences between countries as potential sources of imports, e.g., Sub-Saharan African countries as compared with China, India and the Philippines
   • Imposing blanket bans likely to be unenforceable and counterproductive.
4. Issue non-extendable visas that enable personnel from developing countries to undertake training and widen their professional experience in developed countries.
   • Australian Government has enabled foreign medical students graduating from an Australian medical school to undertake internships in Australian hospitals on temporary visas lasting up to two years.
5. Pay compensation to source countries for their loss of trained personnel
   • Calculation of loss may include cost of training replacement personnel in the source country
6. Recipient countries to invest in enhancing training and skills development in the countries exporting skilled staff.
   • Requires commitment to capacity enhancement and institution-building.

Table 1. Suggested national strategies addressing the ethics of skilled health professional migration.

modeling subsequent numbers of health professionals to be educated in developed countries could be improved. Further, the possibilities for technical, professional and service linkages in health provision across regional and international boundaries is an emerging area worthy of exploration.

The following boxes highlight some of the national and international strategies that have been proposed to address health professional migration.

The strategies offered here represent examples of approaches to stemming the brain drain of the developing world’s skilled health professionals. While none of these strategies is the solution, a com-
Combination of these approaches may go some way to alleviating the pressure this attrition imposes upon the health systems of poorer countries. The critical issue is addressing the deficits in source country health systems. However, the complexity of finding and implementing solutions underlines the limitations inherent in treating the symptom rather than the cause of the extensive inequities in wealth between developing and developed countries. Furthermore, as globalization intensifies, and the personal freedom of movement between countries becomes even more of a prerequisite for the international skilled employment market, the prospects of poorer countries retaining their key health professionals will be further undermined. Freedom of movement is a given but it creates critical rights challenges that force people to rethink the right to health in a global marketplace. Implementing long-term solutions depends upon ensuring this issue stays on the agenda; gathering additional data from developing and developed countries to better inform policy-making; and debating the gains and losses from the migration of skilled health professionals. When the global community can visibly perceive the serious consequences that the loss of health staff is having upon combating the HIV/AIDS epidemic in Sub-Saharan Africa, coordinated action from the world’s richer countries is more likely to occur. If, however, the issue slips away from the international spotlight, the chances of any concerted collective approach become even more remote. Ensuring human re-

Table 2. International cooperative strategies addressing the ethics of skilled health professional migration.

1. Coordinated international investment in building healthcare human resource capacity in the developing world.
   • Aimed at some of the fundamental reasons that developing countries lose the few health professionals they presently train
   • Requires concerted long-term commitment by wealthy countries to improve the training and education systems in the developing world
   • Would improve the present fragmented approach, e.g., Africa spends an estimated $4 billion a year on the salaries of 100,000 foreign development assistance experts, while wealthy countries recruit the continent’s sparse skilled expertise).
2. Implement a Code of Conduct, similar to the recently adopted code signed by Commonwealth countries, at a wide international level.
   • The Commonwealth Code focuses on agreement over a set of ethical principles to address the issue of brain drain
   • Feasibility depends on developed countries adhering to what is essentially a voluntary concordat
   • Difficult to be confident that voluntary international codes will make a real difference.
3. Developed countries to pay compensation to developing countries from which individual skilled health professionals are recruited.
   • Requires high-level international cooperation and probably oversight by an international body such as the World Health Organization.
   • Essentially a multilateral version of item 5 in Box 1.
source capacity is a critical policy challenge for the right to health in the future.

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