

The brain drain: can it be stopped?

Enoch Powell, as minister for health in the 1960s, oversaw one of the first campaigns actively to recruit overseas health professionals to the NHS. Given Powell's status as doyen of the anti-immigration lobby, this may be surprising. But the UK likes migrants when they have something to offer us.

Forty years later and the health sector in the UK is still very demanding. The population is ageing, increasing pressure on health services; and there is intense political pressure on the Labour government to deliver on its promises to improve the NHS. To do this quickly it needs thousands of new staff and is turning to developing countries to recruit them.

Similar problems exist in other developed countries. The US, for example, estimates it will need a million more nurses by 2010.

Meanwhile, in developing countries wages are lower and working conditions worse. In 1999 a junior doctor in Zambia earned \$200 a month compared to \$3200 in the UK. Staff are dissatisfied because of poor management, a lack of career opportunities and, especially in the case of nurses, an undervaluing of their role. In some countries, HIV/AIDS is both increasing the burden of care and infecting health professionals.

Is it any wonder that so many health professionals are migrating from developing nations? It is

The answer is no, in the short term, but there is much more that can be done to relieve the problems caused by recruitment of health workers from developing countries, says Mike Rowson

estimated that South Africa loses 300 nurses a month overseas. In Ghana, Zambia and Zimbabwe, more than 50 per cent of recently trained medical students have either emigrated or plan to do so.

The problem is not confined to Africa. Significant skills drains are occurring from South and Southeast Asia as well as from the Caribbean and crisis-hit countries like Argentina.

Within countries, health professionals tend to migrate from rural areas to urban (or perhaps from public to private sector). They also migrate from very poor to less poor developing countries, leading analysts to describe a global 'conveyor belt' or 'feeding chain' of health professional migration. It starts in the public sector in rural areas in the poorest countries, ending in urban-based care in the rich world. Focus groups in Ghana have shown that

doctors often think about migrating to the UK with the intention of moving on to the USA, where salaries are even higher.

Greater demand from the developed world is combining with cheaper air travel and greater access to the internet enabling independent searching for job opportunities. There has been a proliferation of private recruitment firms facilitating the process of crossing borders.

Effects of the brain drain

What are the effects of the brain drain? Many rightly point out that skilled migrants send home substantial remittances to their families and communities from their highly paid jobs abroad. Indeed, total annual remittances from skilled professionals to developing countries now amount to more than total aid given by the rich world every year. A recent editorial in the journal *Africa Health* called for recognition of this phenomenon and suggested that the increasing export of health professionals to further enhance remittances should be looked at as a policy response.

Yet, although important, remittances go to families, not back into the health systems that have been depleted by the migration.

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In poor country health services the numbers of professionals are extremely limited and the loss of even a handful of them can have a major impact. For example, the Boxburg Centre for Spinal Injuries near Johannesburg was the referral centre for the whole region. However, in 2000, its two anaesthetists were recruited to work in a Canadian institute. The centre has since had to close.

Working out solutions

The problems caused by health professional migration have been increasingly recognised in the developed world. The NHS in England has been a world leader in implementing a code of practice that proscribes the active recruitment of health professionals from developing countries, unless there is an agreement between the UK and the developing country that explicitly allows it.

However, recent research has noted that nurses are still arriving in the UK from the proscribed countries. In 2002/03 one in four new nurse registrants was from the proscribed list. There is no

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evidence of direct active recruitment by the NHS; rather, it’s via the independent sector, where the code does not apply. There is evidence, however, that nurses recruited by the independent sector then go on to work in the NHS.

Should we attempt to strengthen the code further? Practically, it is difficult to see how

this could be done. The government seems reluctant to extend the code to the independent sector, and this would not reduce the numbers of people applying on their own behalf.

Even if the UK succeeded in blocking the inflow of health professionals, it is likely that they would go somewhere else instead. This might imply that an international code is needed, perhaps brokered by an agency such as the World Health Organization — but would this really be manageable?

There are deeper problems with the code. First, it doesn’t address the factors that are pushing people to migrate in the first place. A better response might be to build policy responses around the incentives people say would make them stay, rather than prevent them from coming.

Second, the code implicitly restricts the freedom of movement of health professionals from proscribed countries. Is it fair that a Norwegian or Indian nurse should be allowed to be recruited by the NHS, but not a Zambian or a South African one?

A response to the problem of health professional migration has to balance two basic entitlements: the freedom of health professionals to move and the rights of communities to have a functioning health service.

Two alternative approaches to ethical codes are frequently discussed. The first is compensation for countries that have suffered loss of health workers. The second is forming partnerships between developed and developing country health systems that encourage some form of skill circulation.

Compensation

The issue of financial restitution is a political minefield. The UK government reportedly would not sign up to the Commonwealth code on recruitment because it contained references to compensation. There are also problems with defining how much might be owed to a source country.

Most calculations revolve around training investments lost. Calculations of direct financial losses in training costs alone to South Africa are estimated at US\$37 million annually. This exceeds the combined (multilateral and bilateral) estimated education assistance for all purposes, not just health professional training, received by South Africa in 2000.

More difficult to calculate are the lost service benefits including the cost of less effective health systems and higher disease burdens. A study commissioned by the WHO is currently attempting this type of costing.

If a realistic figure could be calculated, and the political will to compensate were present, the idea of some form of restitution is an interesting one.

For a start, extra money directly for health systems is desperately needed to address the push factors of low pay, job dissatisfaction and poor living and working conditions — the incentives that professionals regularly say they need to be in place for them to stay at home.

However, direct compensation is rarely tried. Compensation could produce a culture of production for export — training extra health professionals specifically for migration. The Philippines already trains nurses for export on the basis that remissions prop up a flagging economy. The danger is that this may distort health system priorities — including the use of public funding for training — in the source country.

Skill recirculation

Partnerships allowing some form of skill recirculation are also interesting from a policy perspective. These might aim at managing migration so that freedom to move is respected alongside responsibilities for the delivery of health care.

The Caribbean Nurses Organisation and the Pan-American Health Organisation joined forces to try to prevent quite harmful forms of random migration where nurses leave the



Moving skills: students at work at the University of Harare, but where in the world will they end up?

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health service in an unplanned and unpredictable manner. They hope to encourage retention by providing incentives to stay — improving terms and conditions of employment, education and training, improving management and enhancing the respect accorded to nurses.

In parallel, some islands are attempting to structure agreements with US health care institutions that would offer educational opportunities for migrating staff or compensation for the source country.

Another initiative is bringing skill circulation to its logical conclusion by importing staff from recipient countries (such as the UK, Canada and the USA) to provide post-basic specialty training with the host country providing financial support at local levels of pay. An International Organization for Migration project has supported the return to Ghana of health professionals in the diaspora with the aim of helping to support the Ghanaian system.

Imagination could be used to develop closer links between the UK NHS and developing countries that can support the development of health systems in poor circumstances.

There are dangers that the support may be inappropriate (in terms of medical skills transferred), even costly for the poor country, and that initiatives will be uncoordinated. However, it should be possible to minimize such problems.

The brain-drain may not be stoppable — at least in the very short-term — but it may be manageable. In particular, there is a great deal more that developed countries should be doing to support collapsing health systems in poorer countries and improving incentives for health staff to stay. [link](#)

Sources and resources

1. This article draws on background research by Matt Gordon for Medact as well as work by Buchan and Dovlo and others.

2. Buchan, J., Dovlo, D. *International Recruitment of Health Workers to the UK: a Report for the Department for International Development*. DfID: Lonon, 2004. It can be downloaded from the Health Systems Resource Centre at www.dfidhealthrc.org/shared/publications/reports/int_rec/int-rec-main.pdf
3. Further resources are available in the health, poverty and development section of the Medact website www.medact.org. Medact, alongside research and advocacy partners in Southern Africa, Australia, and Canada, is developing further work around these issues. A paper on compensation and partnership will be published later in the year and we will be campaigning for enhanced government action.

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