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Background Document
The Migration of Healthcare Providers

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Dear Delegates,

On behalf of the McGill International Health Initiative, the International Federation of Medical Students Associations Québec chapter, the International Relations Students Association of McGill and the entire conference secretariat, I would like to welcome you to the second annual McGill World Health Organization Simulation (McWHO). This year the conference will address the critical issue of the Migration of Healthcare Providers.

In our increasingly globalized world, healthcare providers, such as pharmacists, physicians, dentists and nurses, among others, have been migrating from their country of origin in order to pursue a better life. How can the intrinsic rights of these workers to relocate be balanced with the healthcare needs of their nation? How can these workers be fairly and ethically recruited to meet shortages abroad?

In your role as delegates to the Model World Health Organization, you will have to address these issues and more, while adhering to your respective countries' desires, established policies and biases. As within the real United Nations (UN), any solution will have to be acceptable to the majority. Negotiation, diplomacy and knowledge of the issue at hand will be critical to your success.

I have been involved in Model UN conferences for several years, and have worked hard with the organizing team to prepare a conference that poignantly presents global health issues and the manner in which they are resolved at the World Health Organization. We have also ensured that McWHO is an open and friendly event that is easily accessible to those who are attending their first Model UN conference. For newcomer and veteran alike, I hope that McWHO will prove to excite and inspire your interest in global health issues.

Should you have any questions or concerns during the conference, do not hesitate to talk to myself or any of the dedicated McWHO staff. I look forward to meeting you all on February 15th.

Sincerely,



Ben Albright

Executive Director - McGill World Health Organization Simulation 2008

The World Health Organization

The World Health Organization (WHO) is the guiding authority within the United Nations system, whose overall objective is to attain the highest level of health for all peoples. Its role involves providing leadership on many aspects relating to health. The following list is an excerpt from the WHO website, describing the organization's core functions:

- *providing leadership on matters critical to health and engaging in partnerships where joint action is needed;*
- *shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;*
- *setting norms and standards and promoting and monitoring their implementation;*
- *articulating ethical and evidence-based policy options;*
- *providing technical support, catalysing change, and building sustainable institutional capacity; and*
- *monitoring the health situation and assessing health trends*

These core functions demonstrate how the WHO achieves its overarching objective.

Currently, the WHO is composed of 193 member countries, all of whom have signed the WHO's constitution. The supreme decision-making body for the WHO is the World Health Assembly (WHA), which comprises delegations from all member states. The organization itself employs over 8000 individuals hailing from more than 150 countries, whose qualifications range from public health specialists, to scientists, to administrative staff. With employees in over 147 countries, the WHO has its main offices in Geneva, Switzerland.

The World Health Organization Simulation

Each of you has been assigned a member state or non-governmental organization (NGO) to represent for the duration of the conference. As a delegate, you will have the opportunity to help shape international health policy by working with your fellow delegates to draft resolutions on a particular topic within the McWHO General Assembly. This year, delegates will address the issue of the Migration of Healthcare Providers.

Prior to the conference, you should understand the important health policies of your member nation or NGO and reflect on how these policies can be used to frame your approach to the conference topic. Your research will prepare you to work with your fellow delegates to develop

strategies in response to the migration of healthcare providers, in a manner that reflects the particular views of your member state or NGO.

Prior to the General Assembly, you will be separated into working groups based on your country or NGO assignment: delegates representing nations will be separated into regional blocks that consist of member states within their geographic region; in contrast, delegates representing NGOs will form one separate working group. The working groups provide an important opportunity for delegates to recognize the particular health policy goals and interests that are common to their region. The purpose of the working groups is to have delegates draft working papers that outline the solutions or ideas that have been developed during their block committee sessions. These working papers must then be approved by the directorate to be presented during the plenary session which follows.

During this General Assembly, all delegates will be grouped together. The General Assembly is an opportunity for delegates to turn their working papers into formal draft resolutions that can then be discussed, debated and voted on. Delegates may also draft amendments to the draft resolutions. Delegates representing member states will be allowed to vote on both procedural and substantive motions. In contrast, delegates representing NGOs can only vote on procedural motions. As a general rule, substantive motions involve voting on draft resolutions and their amendments, whereas procedural motions involve voting on everything else (i.e. motions for moderated/unmoderated caucuses, closure of debate, etc.). Upon closure of debate, all draft resolutions and their amendments will be voted on sequentially and separately. Those that pass will be combined to write a Declaration of Principles outlining the view of the simulated WHO on the issue of the Migration of Healthcare Providers. This declaration will be sent to the actual World Health Organization.

The Migration of Healthcare Providers

It is estimated that there are 2 360 000 less healthcare providers (HCPs) worldwide than are needed to meet current global health needs (WHO, 2006a, p.13; WHO, 2006b). Within the context of this generalized scarcity, HCPs are not equally distributed between the world's countries, with the imbalance favoring more developed countries. Less developed countries suffer from a lack of HCPs, especially in rural areas. The shortage is more pronounced in Africa and Asia, often to the point of crisis.

Today, there are approximately 57 countries with critical shortages of HCPs, amounting to a global deficit of 2.4 million doctors, nurses, and midwives, with the bulk of deficits falling in sub-Saharan Africa and South-East Asia (WHO, 2006a, p.18). The World Health Organization estimates that sub-Saharan Africa suffers from a shortage of approximately 1.5 million health workers, including a lack of over 800,000 doctors, nurses, and midwives (WHO, 2006a).

Although Africa holds over 24% of the global burden of disease, African countries only have access to 3% of the world's 59.2 million paid, full-time health workers (WHO, 2006a, p.16). In contrast, the region of the Americas, including Canada and the United States, holds access to 37% of the same workforce to combat only 10% of the global disease burden (WHO, 2006a, p.36). Furthermore, the World Health Organization recommends a minimum of 20 physicians per 100,000 people. Unfortunately, only 9 of the 47 sub-Saharan African countries meet this standard and 13 sub-Saharan African countries have devastatingly low 5 or fewer physicians per 100,000 people (WHO, 2006a). The alarmingly low density of HCPs in some of the world's poorest countries can be partly explained by the migration of health workers from developing countries to developed countries.

Patterns of Migration

HCPs leaving developing nations for developed nations account for 56% of the total migrating workforce whereas only 11% migrate in the reverse direction (Chanda, 2002). However, data concerning the flux of health professionals remains largely incomplete, and is generally limited to registered doctors and nurses, thereby overlooking pharmacists, occupational therapists, and other types of HCPs. The lack of important statistics makes it difficult to understand the scale of the problem, and map out potential solutions (WHO, 2006a, p.126).

Data from the World Health Organization indicates that a large percentage of doctors and nurses trained in sub-Saharan Africa are currently practicing medicine in more developed countries such as Australia, Canada, Finland, France, Germany, Portugal, the United Kingdom and the United States of America (WHO, 2006a, p.127). An average of 23% of doctors trained in sub-Saharan Africa are now practicing medicine abroad, ranging from 3% of doctors in Cameroon, to an overwhelming 37% in South Africa. An average of 5% of nurses and midwives trained in sub-Saharan Africa are now working abroad, ranging from as low as 0.1% in Uganda,

to an astonishingly high 35% in Zimbabwe. These patterns are creating huge healthcare deficits in sub-Saharan Africa (WHO, 2006a, p.127).

Within both developed and developing countries, internal migration occurs from rural to urban areas. In general, urban centers are sites for teaching hospitals and populations that can afford to pay for health services. As a result, urban areas generally attract more HCPs than regions without such facilities or financial support (WHO, 2006a, p.36). However, while developed countries can import HCPs to fill these gaps, developing countries experience great difficulty in filling their rural care gaps due to loss of personnel to developed countries, resulting in a markedly uneven distribution of HCPs. Indeed, loss of HCPs from urban areas to other countries leaves vacancies which are then filled by rural HCPs. This stepwise migration pattern leaves rural regions in poorer countries facing a critical lack of HCPs. While only 55% of all people live in urban areas, over 58% of healthcare workers, 60% of nurses, and 75% of doctors live in urban areas, leaving rural healthcare systems even more vulnerable (WHO, 2006a, p.36). For example, 37 of Viet Nam's 61 provinces fall below the nation average of just over 1 healthcare provider per 1000 people, while the most urbanized province holds almost 4 healthcare providers per 1000 people. Similar variations have been observed in other countries (WHO, 2006a, p.36).

Factors Affecting Migration

A wide range of economic, professional, social and political factors have been identified as reasons for the migration of HCPs from developing to developed countries (WHO, 2006a, p.99). Multiple factors are involved in each migrant's complex decision to work abroad and the relative importance of each factor varies widely among HCPs. These motives can be classified as being either circumstances in the exporting country that persuade their departure or conditions that attract migrants to an importing country, which are often referred to as "push" and "pull" factors, respectively.

Push Factors

The most frequently cited factors that drive HCPs from their homelands are low wages, hazardous working conditions, lack of basic medical supplies, and limited career opportunities (Buchan *et al.*, 2003; WHO, 2006a, p.99), many of which can be attributed to the underfunding of health services in exporting nations. These conditions breed low morale because HCPs are

unable to deliver their services due to a lack of proper medical facilities and equipment. Additionally, the burden of AIDS, fear for personal safety, economic instability and political turmoil also play a significant role in the migration of HCPs (Organization for Economic Cooperation and Development, 2002). It has also been suggested that some medical schools in exporting countries have become too “Westernized”, leading to the production of graduates that are dissatisfied with work in their homelands because they have been trained to work in conditions that are found in more developed countries and not within their local environments (Loefler, 2000). The lack of opportunities for postgraduate training in their home countries can also drive professionals away.

Pull Factors

Inadequate planning to meet the healthcare needs of their growing ageing population, has led to a demand for healthcare personnel in developed countries that is being filled by workers from developing countries (Findlay, 2002). As one would predict, the pull forces that attract migrants to exporting countries are essentially the reverse of those that push HCPs from their homeland. Increased income, which may be up to 24 times higher in developed than in developing countries (Vujicic *et al.*, 2004), stable employment, improved work environments, social and retirement benefits and access to greater continuing education opportunities are factors that encourage migration to more developed countries (WHO, 2006a, p.99). Furthermore, in a recent survey of migrant physicians (Astor *et al.*, 2005), 78% of respondents stated the aspiration for a better life for their children as a motivating factor. In addition, this study showed that economic stability and increased general safety were also significant factors that attracted migrant physicians to a specific country. Finally, active recruitment by wealthier countries and “less strict immigration requirements” (Forcier *et al.*, 2004) play a role in pulling foreign physicians to work abroad (Findlay, 2002) .

Effects of Migration

The current HCP migration pattern has resulted in a skewed global distribution of HCPs. This imbalance has had devastating repercussions on exporting countries while predominately favoring the wealthier importing countries.

Effects of Migration on Exporting Countries

a) Positive Effects:

The export of HCPs may provide a nation with a secure source of external finance via the remittances workers abroad send back to their country of origin (Ahmad, 2005). However, many believe that these funds do not play a significant role in aiding the fragile healthcare systems of developing nation as they do not compensate for the loss of human capital. These funds are also unlikely to be funneled into the healthcare system of the exporting country (Martineau *et al.*, 2002; Astor *et al.*, 2005). Moreover in a survey of physicians, the only benefit to exporting countries was believed to be the gain of educational relations and medical knowledge if migrants return (Astor *et al.*, 2005). Unfortunately, few migrant HCPs return to developing countries (Martineau *et al.*, 2002).

b) Negative Effects:

With the exception of Cuba, India and the Philippines, which deliberately train a surplus of HCP (Forcier *et al.*, 2004), the potential benefits of migration for exporting countries are insignificant in comparison to the negative impact on their healthcare systems and their populations. The loss of HCPs represents a loss of intellectual capital which may also cause medical research institutions to crumple, thus impairing the training of new professionals (Ojo, 1990). In addition, the migration of just a few specialists can result in the complete loss of certain health services or the closure of entire health centers (Martineau *et al.*, 2004). Furthermore, it is estimated that as a whole, African countries lose over \$500 million of public funds annually in the training of personnel who leave to find work abroad (Chen & Boufford, 2005).

Emigration strains the financial and human resources of health systems in exporting countries, leaving many predominately rural regions underserved. Where health facilities do exist, they are usually grossly understaffed. The remaining workers are thus overworked and the delivery of healthcare services deteriorates: consultation times are decreased and the rates of misdiagnoses, prescription errors, inadequate treatment and abusive treatment of patients increase (Chikanda, 2005). Moreover, the continuing exodus of the HCPs poses a significant obstacle in the execution of several disease-reducing initiatives, leaving many individuals in developing nations vulnerable to devastating or avoidable illnesses (Zurn *et al.*, 2004; Kuehn, 2007; WHO, 2006b).

Effects of Migration on Importing Countries

a) Positive Effects:

Importing countries profit from a short-term relief of labor shortages and from savings in educational costs, although it should be noted that this is at the expense of the exporting nation. The swell of HCPs also translates into decreased costs for medical services, as well as greater quality and accessibility of these services (Forcier *et al.*, 2004). In addition, importing countries benefit from the compliance of migrant workers to accept work assignments that domestic HCPs are more hesitant to accept (i.e. working night shifts and in difficult locations).

b) Negative Effects:

While importing countries are the primary beneficiaries of the migration of healthcare providers, concerns regarding the unfavorable effects of the current migratory trends have been raised. Foremost, the development of the domestic healthcare workforce may be delayed by the continued dependence on migrant workers (Findlay, 2002). There are also concerns regarding the decreased quality of patient care that may result from a migrant worker's difficulty in communicating in a new language or from insufficient training due to differences in medical standards among nations (Forcier *et al.*, 2004). Furthermore, as wealthier countries deplete the pool of HCPs abroad, containing the global spread of infectious diseases, such as SARS, will become increasingly difficult (Chen & Boufford, 2005).

Possible Conflicts

The migration of HCPs from rural to urban areas and from developing to developed nations brings into question several key conflicts. We can divide these areas of conflict into themes that explore the background positions and prerogatives of both sides involved.

Healthcare Providers versus Policy Makers

As a basic human right, every person has the right to relocate for any reason they should choose. This right is enshrined in Article 13 of the Universal Declaration of Human Rights (UN, 1948). In response to the exodus of HCPs, governments may create policies limiting their ability to enter or exit a particular country, in direct conflict with this right. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their

Families (UN, 2003, Part III, Article 8) also mentions this right to relocate, but recognizes that it can be subject to restrictions in order to protect public health.

Healthcare Providers versus Community

HCPs are obligated to serve the healthcare needs of their community, be it a geographic community (a nurse serving as the only HCP in 100 square miles), a subspecialized medical community (a specialized doctor treating patients with a rare illness), a socioeconomic community (a HCP in a public system services a particular disenfranchised class's health needs), or other defined group. A community will depend on having accessible healthcare services, which entails a stable and adequate number of HCPs. Furthermore, when a government subsidizes the cost of their training, there is an expectation for the HCP to work in the communities that have contributed to government subsidies (through taxes paid by the public). Above all, every person has the basic human right to health (UN, 1948, Article 25). Governments often invest in and subsidize healthcare to satisfy this right.

The Provider-Community expectations are complex, pitting the right to relocate against the right to health. Furthermore, when HCPs leave the community that has subsidized their training, they deny the community access to the benefit of the resources invested in that training. Thus, the community loses not only its access to healthcare and its consequent right to health, but also the tremendous investment it made in training HCPs.

On an individual level, when making the decision to migrate, each HCP must balance their own interests with their obligations toward the communities that trained and need them.

Developed versus Developing Countries

Despite HCP shortages, many developed countries train fewer HCPs than needed because it is expensive to increase the number of training positions, while it is less expensive to procure foreign-trained professionals. Both governmental and non-governmental actors in many developed countries actively recruit HCPs from developing countries. Most developing countries have shortages of HCPs and are hard hit by sometimes predatory recruiting on the part of developed countries. Furthermore, the mass emigration of HCPs from developing countries occurs partly as a result of the greater socioeconomic and political power of developed nations and because of their HCP shortage.

Many developing countries also maintain practices that discourage or sufficiently limit HCPs in their medical practices in ways that encourage emigration. Working conditions may be below

acceptable standards, salaries may be unsatisfactory given the level of work, etc. These practices on the part of developing countries further contribute to the emigration of HCPs.

Solutions to the migration of healthcare providers should therefore take into account the following points:

- How far can organizations or governments infringe upon the right of individuals to relocate in order to improve the global healthcare situation?
- How can the right of HCPs to relocate be balanced against the communities' and individuals' right to health and accessible healthcare?
- To what extent can importing and exporting countries each be held responsible for the current trends in HCP migration? By extension, what role should they each play in solving the problems caused by the migratory phenomenon?

Possible Solutions

Strategies that can be used by Exporting Countries

a) Protection and Fair Treatment of Healthcare Providers:

Financial incentives are important: the problem of low salaries of HCPs must be addressed (Mathauer & Imhoff, 2006). Health budgets of exporting countries must increase in order to provide more competitive salaries, to recruit new HCPs and to provide equipment and supplies.

However, non-financial incentives and human resources management tools are also needed and may be of paramount importance where financial resources are severely limited. Overall, HCPs are strongly guided by their professional conscience (Mathauer & Imhoff, 2006). Indeed, many HCPs are demoralized and frustrated working in their native countries precisely because they feel unable to fulfill their professional duties due to an inadequate or inappropriately managed healthcare system, staff shortages, lack of equipment and supplies and a mounting workload ((Mathauer & Imhoff, 2006; Physicians for Human Rights, 2004).

HCPs often complain of feeling underappreciated in their native countries. Therefore, exporting countries could make an effort to strengthen leadership and supportive management in order to acknowledge healthcare providers' professionalism and to address goals such as career development, research opportunities and training for further qualification (Mathauer & Imhoff, 2006; Zurn *et al.*, 2005). Also, small incentives such as holidays, childcare or even benign

measures such as free tea for staff on night duty (Mathauer & Imhoff, 2006) can go a long way in making HCPs feel appreciated.

HCPs also need to feel safe: they need to be protected against violence, fraud, harassment, disease, etc (Physicians for Human Rights, 2004). Of particular importance in countries with a high HIV/AIDS burden, healthcare providers and their families should be assured access to complete healthcare.

b) Training Healthcare Providers Specifically for Local Needs:

HCPs often receive training that prepares them to work in conditions quite different from the settings in which they will actually practice. For example, their training typically focuses excessively on practice in tertiary facilities and on the use of advanced technology that will rarely be available in the settings in which they will practice (Physicians for Human Rights, 2004). This leads to HCPs feeling frustrated at not being able to practice the type of medicine for which they were trained. It also leads to more of them opting to work in urban areas instead of rural regions, thus exacerbating the shortage of HCPs in under-serviced areas.

Training institutions in exporting countries could therefore adjust their curricula to better prepare graduates for the conditions in which they will be required to practice (Physicians for Human Rights, 2004). This should include an emphasis on primary healthcare and common health problems, such as infectious diseases and HIV/AIDS care and treatment. Teaching methods in exporting countries could also be reoriented to include critical thinking and problem-solving to prepare graduates for working in settings with limited resources.

In addition, there exists a culture in certain medical schools in exporting countries that encourages graduates to practice abroad (Physicians for Human Rights, 2004). Where such a culture exists, faculty could be persuaded to encourage students to remain in the country and to provide them with the necessary skills to do so.

c) Policies that Facilitate the Return of Migrant Healthcare Providers or that Help the Exporting Country Benefit from the Advantages Gained by Migrant Healthcare Providers:

Many of the HCPs practicing outside their native countries have an interest in using their professional skills to assist their country of origin. These professionals could therefore be encouraged and allowed to return to their native countries, even if only temporarily or for only part of the year.

Exporting countries could actively seek out their diaspora, in particular the alumni of local schools, and maintain a database of job openings that could be filled by members of this group. With the assistance of donors, exporting countries could establish top-quality “centers of excellence,” especially in under-serviced areas, in order to attract diaspora HCPs by guaranteeing that they will be able to continue their professional development or research in their native countries (Physicians for Human Rights, 2004).

Exporting countries that regularly provide their HCPs with the opportunity to study or train abroad could continue do so but with conditions. For example, workers’ training and travel expenses could be paid by their government only if they return to practice and make use of their new skills in their native countries.

Exporting countries could also permit dual citizenship if they do not do so already and in general avoid discrimination against HCPs who have trained and/or worked in foreign countries.

Strategies that can be used by Importing Countries

Besides protectionism and an increasing reliance on foreign professionals, importing countries have few incentives to stop the migration of HCPs due to their own shortage of personnel and the appeal of acquiring professionals without bearing the expenses to train them. However, importing countries must recognize the necessity to work with developing countries to establish policies and aid programs that address the issues related to the migration of HCPs.

To minimize their reliance on foreign professionals, importing countries must begin by addressing the domestic shortage of HCPs by developing strategies to improve the production and retention of HCPs (WHO, 2006d). To complement this, it is necessary that ethical recruitment policies be implemented through legislation, codes of practice, or other government mandates.

In addition, importing countries could provide professional and financial aid to exporting countries directed toward the healthcare system or HCPs in those countries. Health training institutions in high-income countries could develop partnerships with health training institutions in the developing world facing faculty shortages and offer intellectual resources and professors on a per semester or annual basis (WHO, 2006d). Assistance in the creation and management of healthcare systems should focus on the implementation of basic primary healthcare and the training of local HCPs, instead of funding disease-specific programs, as donors have tended to prefer in the past (Physicians for Human Rights, 2004).

Importing countries could promote and facilitate the temporary or permanent return of HCPs to their country of origin. For example, the United States could permit health professionals from countries experiencing critical HCP shortages to temporarily return to the health sector in their countries of origin without having the time spent away from the United States impede the naturalization process (Physicians for Human Rights, 2004).

Importing countries should not ignore the problems associated with the migration of HCPs. They must use their financial and political resources to create and implement policies and programs which address HCP shortages on both domestic and international levels.

Codes of Practice and International Agreements

The migration of HCPs is a feature of globalized labour markets. Ethical recruitment principles and mutually beneficial agreements are essential in mitigating the global crisis in human resources for health. Many international organizations have developed and advocated codes of practice. Bilateral and multilateral agreements form a framework for interaction between countries as they seek to meet the basic health needs of their populations. Such guidelines, policies and regulations aim at an equitable balance between the right of HCPs to migrate and the right of individuals to health care services.

a) Codes of Practice:

The *Commonwealth Code of Practice for the International Recruitment of Health Workers* codifies ethical principles to which member countries should adhere. Since its adoption in 2003, it has served as a model and reference for international HCP recruitment guidelines. Firstly, the *Commonwealth Code of Practice* encourages states to regulate the recruitment process via bilateral agreements. Secondly, it strongly discourages recruitment from regions with a shortage of HCPs or from countries without an agreement. Thirdly, it aims at ensuring the fair treatment of migrants and is sensitive to their migratory rights. Lastly, it encourages monetary compensation for exporting countries (i.e. reimbursing the cost of education, investment in healthcare systems) and educational partnerships between importing and exporting countries (i.e. temporary migration) (Commonwealth Code of Practice, 2003).

For almost two decades, associations of health professionals have been issuing codes of practice for the ethical recruitment of healthcare providers. Amongst them: physicians, nurses, midwives, dentists and pharmacists (Willets & Martineau, 2004). Governmental institutions can also issue codes of practice. For instance, the United Kingdom's National Health Service

international recruiters chose to adhere to a code of practice, similar to the one described above. Amongst other recommendations, it discourages recruiting advertisement in countries experiencing a health workforce shortage and lists 154 of them (Forcier *et al.*, 2004).

International organizations have issued assertive position statements about ethical recruitment. Notably, the World Organization of Family Doctors (Wonca), an organization comprising member states of all major world regions, adopted *The Melbourne Manifesto* (World Organization of Family Doctors, 2002). This recruitment code of practice encourages the development of bilateral agreements between countries exchanging HCPs (Physicians for Human Rights, 2004). In addition, the WHO recently passed two resolutions that include recruitment code of practice clauses (WHO, 2004; WHO, 2005).

b) International Agreements:

International agreements can be aimed either at facilitating or discouraging movement of HCPs. Agreements can (i) address bureaucratic issues such as work visas and diploma recognition, (ii) aim at compensating the exporting country for its losses and (iii) create partnerships that facilitate the exchange of information and expertise through temporary migration.

(i) Many countries have entered into agreements imposing requirements that physicians must fulfill in order to work abroad. The legal clauses refer to nationality, citizenship requirements and procedure for issuing work permits (Stillwell *et al.*, 2004). Certain countries have eased immigration requirements for physicians. For example, Canada's recent changes to the Immigration Act Regulation favour the immigration of physicians (though they may encounter strife when seeking licensing). Australia and the United States have relaxed immigration requirements for those engaging to practice in rural areas. In Ireland, the option exists to fast track working visas for foreign physicians (Forcier *et al.*, 2004).

International agreements stimulating HCP migration are counterbalanced by the requirements licensing medical practice. On the one hand, the extensive process to obtain qualification equivalency in a given state aims at ensuring the quality of practice. On the other hand, it also serves to reduce competition in the host country and to raise the income of domestic physicians. Simplified licensing procedures exist for physicians trained in specific countries. For instance, following an agreement adopted in 2002, graduates of British medical schools are eligible to practice in New Zealand. There is also a Mutual Recognition Agreement between Australia and

New Zealand, providing for automatic recognition of primary medical qualification. Licensing provisions governing the migration of Canadian physicians to the United States have been simplified in that fewer visa restrictions apply and Canadian physicians do not have to pass the Clinical Skills Assessment exams (Forcier *et al.*, 2004).

The European Union has adopted a range of measures to simplify licensing provisions. In 1977, Member States adopted sectoral directives that facilitate the movement of physicians through the harmonisation and recognition of qualifications and diplomas (Forcier *et al.*, 2004). These directives entitle any European Union physician who has completed basic training in a Member State to be automatically registered in any other Member State. It is interesting to note, however, that the impact of these directives on the movement of physicians has been minimal: until recently such migrations have been small. This can probably be accounted for by the general absence of physician surpluses or by the failure to recognise the equivalence of qualifications.

The General Agreement in Trade Services (GATS) is binding for all World Trade Organisation (WTO) member countries and encourages the free movement of health workforce (WTO, 1994). Though it leaves the adoption of its clauses to each country, the GATS has been widely criticized by actors that try to mitigate the negative impact of 'brain drain' (Physicians for Human Rights, 2004).

(ii) Agreements between countries could specify that the importing country will invest in institutions in the exporting country. In effect, some countries will act as providers of health care personnel for other countries by training a surplus of health workers. This sort of system has been in place in the Philippines where private nursing schools train nurses who intend to migrate.

(iii) The United Kingdom and South Africa created a partnership on health education and workforce issues. Through the agreement adopted in 2003, opportunities have been provided for professional exchanges between the two countries (WHO, 2006b). The Caribbean Community (CARICOM) has adopted a similar scheme.

A drawback of international agreements is that their proper implementation may be lost in national bureaucracy. The problem with codes of practice is that they do not fall within any jurisdiction. It can also happen that legislations adopted on a governmental level do not reflect codes of practice. Furthermore, internationally adopted measures may control state inequalities

of access to HCPs; they do not, however, address disparities at a national level such as the push and pull from rural to urban environment and from public to private healthcare systems.

The Need for a Global Response

The migration of HCPs is driven by a global crisis in the health workforce that affects every country. The WHO predicts that the international migration of HCPs will continue to amplify disparities in health between developed and developing countries in the coming years. It has now become unrealistic to expect the UN Millennium Development Goals on health to be met by 2015, unless an urgent, coordinated and global response of unprecedented scale is initiated (WHO, 2006a; WHO, 2006d).

A global response implies collaboration and solidarity between countries at several different levels.

a) Sharing of Information on the Migration of Healthcare Providers:

The sharing of information and the coordination of research efforts on the migration of HCPs is needed. So far, available information is sparse and difficult to compare between countries (Diallo *et al.*, 2003). Agreements on research priorities, research tools and methodologies will help develop a firm foundation of knowledge, much needed for developing effective international policies to limit the negative effects of the migration of HCPs. International databases and networks are needed to share this information (WHO, 2006b).

b) Developing an International Strategy for Ethical Recruitment of Healthcare Providers:

Countries must realize the global implications of recruiting HCPs abroad. National governments need to develop and endorse regulations on ethical international recruitment. However, countries must coordinate their efforts. It is not sufficient for one country to limit recruitment of HCPs, as these migrants are likely to choose another destination, which would still produce the same negative effect on their country of origin. This situation was observed when the British government developed its code of practice, which limited the international recruitment of nurses. As a consequence, migration of South African nurses to other Commonwealth countries increased (Organization for Economic Co-operation and Development, 2004). International codes of practice could serve as a framework for coordinating national policies (Physicians for Human Rights, 2004).

c) Funding Healthcare Systems:

An extraordinary effort is needed to scale up health systems. Funding of infrastructures, equipment, salaries and training of additional staff will result in better working conditions for

HCPs, who will be less driven to migrate. Considerable funding can only be achieved by international solidarity. These funds will first need to be directed towards regions most in need, namely several of the sub-Saharan countries in Africa. Also, international funds need to be coordinated in such a way as to limit the administrative work of the countries that receive them, which in addition to missing HCPs, often also lack administrative personnel. Finally, funding needs to be sustainable and predictable, and donors need to meet their commitments (Physicians for Human Rights, 2004; WHO, 2006a).

d) Training More Healthcare Providers Worldwide:

To solve the global health workforce crisis, every country needs to train more HCPs. Some countries lack the infrastructures and human resources to train more HCPs. Academic institutions can assist other institutions by sharing expertise and through international training programs. International funding of training institutions in developing countries should be integrated in a global effort to strengthen health systems (Physicians for Human Rights, 2004; WHO, 2006c).

The Roles of International Organizations

International organizations, such as the WHO, have a crucial role to play in coordinating such an extraordinary international effort to address the causes and negative effects of the migration of HCPs.

a) The Central Role of the World Health Organization in Coordinating the Global Response:

The WHO plays several central roles in resolving this crisis, which include advocacy, improving information on HCP migration, issuing recommendations to develop and coordinate effective policies, and evaluating the effectiveness of international interventions.

To unite international players around these key issues, the WHO founded the Global Health Workforce Alliance (GHWA). This partnership between national governments, civil society, finance institutions, professional associations and academia produced a strategic plan to address the global workforce crisis (GHWA, 2006). General orientations of this plan will be discussed below.

b) Advocating for Workforce Issues at an International Level:

To draw the attention of the international community to the health workforce crisis, the WHO dedicated its 2006 World Health Report and World Health Day to the health workforce. In its report entitled “Working together for health”, the WHO emphasized the role of HCP

migration in the workforce crisis in several of the poorest countries (WHO, 2006a). To resolve this crisis, the WHO called for a global effort to scale up healthcare systems and asked all member states to develop and adhere to policies that aim to limit the negative repercussions of migrations on healthcare systems (WHO, 2004; WHO, 2005a; WHO, 2006c). The Health Workforce Advocacy Initiative (HWAI), a member of the GHWA, is the working group of the WHO dedicated to advocating internationally for health workforce issues.

c) Improving Information on the Migration of Healthcare Providers:

The WHO is presently coordinating through the GHWA several initiatives to improve the quantity and quality of information on HCP migration. The department of Human Resources for Health of the WHO promotes the use of standardized tools and methodologies for gathering information. Also, an effort in creating an international human resources database is underway (Dobson, 2003). This database should facilitate meaningful international comparisons, thus enhancing the ability of countries to learn from their counterparts and adapt successful practices to their own circumstances (Physicians for Human Rights, 2004).

d) Developing and Coordinating Effective Policy Responses:

The WHO works at developing evidence-based policies and strategies to improve retention of HCPs through collaboration with the member states. The GHWA serves to catalyze and coordinate these collaborations. It also compiles and develops technical frameworks, guidelines and best practices that national governments can use to strengthen their health systems. Some of these recommendations aim at improving planning and management of the health workforce and at exploring options for training mid-level workers, who are less likely to migrate (GHWA, 2006).

One of the GHWA working groups, the Health Worker Migration Policy Initiative was commissioned to develop a global code of practice for HCP migration and to seek high-level political support for its recommendations (WHO, 2007). Such a code of practice, although not legally binding, could serve to further provide minimal norms to which all countries should conform.

e) Initiatives by Other International Organizations:

Gathering information: In its efforts to gather information about the migration of HCPs, the WHO collaborates closely with other international organization such as the International Organization for Migration (IOM), the International Labour Organization (ILO) and the World

Trade Organization (WTO) (WHO, 2005b; WHO, 2006b).

Reversing the African ‘brain drain’: The IOM has developed a program to attempt to reverse the African ‘brain drain’. The Migration for Development in Africa (MIDA) initiative encourages and facilitates the return of African expatriates and families to their home country (Lowell, 2001). The NGO Physicians for Human Rights (PHR) suggested in their action plan that the IOM could also maintain a database of job openings in countries suffering from ‘brain drain’, as well as a database of diaspora health professionals interested in working in Africa (PHR, 2004).

Regulating international migrations: The International Labour Organization (ILO) and WTO developed guidelines for regulating international migrations of workers, including HCPs (ILO, 2005; WTO, 1994).

Funding Healthcare Systems – Responsibilities of the International Community

Developing countries will require significant external funding in order to develop health systems that can train and retain more HCPs. Developed countries, as well as international financial institutions, have several moral and ethical obligations in providing the necessary funds to achieve these goals.

a) Honoring Commitments for Development Assistance:

To ensure a sustained and predictable aid flow, donor countries should provide long-term commitments of foreign assistance for health systems and meet their commitments. An important first step for donor countries would be to respect their promise made at the October 1970 UN General Assembly to donate 0.7% of their Gross National Product (GNP) to development assistance. Although this target has since been frequently reaffirmed, official development assistance was only 0.25% of GNP in 2003. Official development assistance in 2003 from the United States was only 0.14% of their GNP (Physicians for Human Rights, 2004).

The Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccination and Immunization (GAVI Alliance) were created to dramatically increase resources to areas of greatest need. These partnerships between governments, civil society and the private sector strengthen health systems by allocating international aid. The NGO PHR suggests that countries that suffer a health workforce crisis also apply to the Global Fund to Fight AIDS, Tuberculosis and Malaria for help in paying the salaries of their health workforce. The Fund has made grants to 127 countries, and will be able to save millions of lives, provided it gets the funds

it was promised by donor countries (Oxfam, 2006 and the funds' official websites).

b) *Providing Debt Relief:*

Large external debts of many sub-Saharan African countries, primarily to Western nations and international financial institutions, constrain health and other public sector spending. Every year, large portions of government budgets are allocated to servicing these debts, thereby reducing the money available for health spending. Two initiatives, the Heavily Indebted Poor Country (HIPC) debt relief initiative in 1996, and the Enhanced HIPC initiative in 1999, have moderately improved the situation. However, much more extensive debt relief is required, and it should include more countries (PHR, 2004).

c) *Ending Constraints on Health Sector Spending:*

Constraints on health and public sector spending are also imposed on many sub-Saharan African countries by the International Monetary Fund (IMF), the World Bank, and other donors. Strategies include withholding loans or grants, suspending or canceling programs, or penalizing countries that break overall spending ceilings because of increased spending in health and other sectors needed to promote human development. Budget ceilings in health and education sectors should be more flexible (PHR, 2004; WHO, 2006a).

d) *Investing in Health to Promote Development:*

The international community is now realizing that development and economic growth cannot be achieved without health. The NGO PHR suggests that the WHO and the World Bank collaborate to educate finance ministries on the economic benefits of investing in health (PHR, 2004). Initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance are now showing concrete returns on their investment: in less than 4 years, these global financiers have saved over 2 million people from early death. These human gains will eventually translate into economic growth, as those who regain health can lead productive lives and care for others (Kazatchkine, 2008).

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See also the organization's website at <http://www.ghwa.org/>

Global Fund to Fight AIDS, Tuberculosis and Malaria,
<http://www.theglobalfund.org/en/about/how/>

HWAI : Health Workforce Advocacy Initiative
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