"Brain drain" or ethical recruitment?

Solving health workforce shortages with professionals from developing countries

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ABSTRACT

- Recruitment by wealthy countries of health personnel from developing countries is threatening the viability of crucial health programs in poor countries, especially in sub-Saharan Africa.
- Australia has participated in this "brain drain", although the extent and impact of this on different countries has not been adequately assessed.
- Australia depends on overseas-trained doctors to fill vacancies in public hospitals and private practice, particularly in rural and outer suburban areas where locally trained professionals are reluctant to work.
- Australia should adopt national strategies to minimise harm and maximise benefits of skills migration; concerted international action will also be required.

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THE MIGRATION OF HIGHLY SKILLED PROFESSIONALS from poor to rich countries is not a new phenomenon. The losses attributed to this global migration, commonly referred to as "brain drain", have been recognised internationally since the 1960s.[1] This migration has had particularly serious ramifications in sub-Saharan Africa, where it severely limits the provision of even basic health services infrastructure.[2-5] One study has commented that "the haemorrhage of health professionals from African countries is easily the single most serious human resource problem facing health ministries today".[6] The Director-General of the World Health Organization, Dr Lee Jong-wook, has said 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.[7]

Has Australia played a significant role in the development of this ominous situation? A recent report published by the Australian Health Ministers' Advisory Council (AHMAC) emphasised Australia's continuing dependence on overseas-trained doctors.[8] The number of temporary resident overseas-trained doctors arriving in Australia to work in "areas of need", such as rural and remote areas, has increased over the last decade, from 667 in 1992–93 to 2899 in 2001–02.[9] There is indirect evidence that a considerable number of these doctors may be from the developing world: in 2001, 5.7% (2930) of the Australian medical workforce was born in Africa or the Middle East and 16% (8348) in Asia.[10] However, these statistics do not show where these doctors were trained or when they came to Australia. A more reliable indicator may be the permanent migration to Australia of overseas residents. Data from the Australian Institute of Health and Welfare show that the number of doctors permanently migrating from South Africa, for example, has steadily grown over the 1990s, with 12 (2.5% of total medical migrants) migrating in 1992–93, increasing up to 32 (6% of total medical migrants) in 1999–2000.[11] Migration from certain Asian countries, particularly China, has also grown significantly, with 186 Chinese doctors (30% of total medical migrants) migrating to Australia in 1995–96. Between four and five thousand overseas-trained nurses enter Australia annually; while many of these come from other wealthy countries such as the United Kingdom, New Zealand, Canada, Ireland and Norway, source countries in the developing world, such as the Philippines, South Africa and Zimbabwe, are also important.[12]

Australia's reliance upon overseas-trained doctors is unlikely to diminish in the foreseeable future. This situation reflects past decisions of politicians and their advisers, health service administrators, those responsible for the provision of medical education programs and, by no means least, expectations and aspirations within the current medical workforce. Announcing Medicare Plus on 19 November 2003, the Federal Government promised to increase the number of available doctors, in part by recruiting appropriately trained overseas doctors.[13]

We should not ignore the ethical aspects of this recruitment. Australia is an affluent country that, because of difficulties in attracting Australian doctors to work in rural and remote regions and shortfalls in the production of medical personnel, relies on skilled personnel from poorer countries — countries that can ill afford to lose their health professionals. Is this unethical? Or would it be unethical to prevent these health professionals from emigrating in search of better personal opportunities?

Some argue that skilled health personnel could be seen as an "exportable" asset for low-income countries, generating remittance income to the source country and thus offsetting, perhaps eventually outweighing, the costs of training and other losses. Remittances by migrant workers are the second-largest source (after foreign direct investment) of external funds for developing countries and are, in total, much greater than development aid funds.[14] Skilled health personnel

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

1. Develop, promulgate and implement a national code of conduct for ethical recruitment. Such codes seek to identify 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 here and in Box 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
   - Recognises 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
   - Recognises differences between countries as potential sources of imports (eg, 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

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 for developing countries losing 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 (Africa spends an estimated $4 billion a year on the salaries of 100 000 foreign development assistance experts,[15] 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[16]
   - 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

comprise a small proportion of these workers and remittances. However, remittances by health workers are not directly reinvested in human capital for the health system[14] and cannot, in the short term, match the losses resulting from the exit of experienced health personnel from a grossly understaffed health service.

So what should Australia be doing to prevent or mitigate the adverse effects of importing overseas-trained doctors, nurses and other health service personnel? In our review of the voluminous body of published material relating to "skills migration", from sources ranging from the World Bank, World Health Organization and World Medical Association to correspondence from migrant and "stay-at-home" health professionals, we found a relatively small range of proposals. Box 1 presents the most commonly suggested strategies to be adopted by individual countries; Box 2 draws attention to international cooperative strategies to address this issue.

As an actor on the international stage, Australia should be seen not only to pursue ethical policies relating to its own recruitment activities, but also to contribute to developing multilateral approaches to minimising the harm and maximising the benefits associated with the migration of health personnel from developing countries. Australia is well placed to play an exemplary role in the development of ethical but pragmatic approaches to the recruitment of overseas-trained health personnel, as well as contributing to the formulation of international cooperative strategies to address the ethical, economic and population health problems arising from migration of health personnel. More detailed analyses are required, and issues relating to the brain drain must remain high on the agendas of national and international health policy-makers if effective action is to follow.

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