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Health worker migration: what can be done?

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Contents

Summary

A shortage of health workers is one of the most serious challenges that health systems face in many areas of the world. Whereas the reasons for this shortage vary across regions, health worker migration is assuming an increasingly important role in the developing world. This issue has received great attention in recent years. Different perspectives have been adopted while looking both at the reasons and at the consequences of health worker migration; and different options have been proposed to address its negative impacts.

The aim of this study is to provide an in-depth presentation and discussion of health worker migration in general and in particular to present and discuss two policy options that have attracted increased interest in recent times: circular migration and policies for ethical recruitment of health workers. In addition, the study presents a short comparison of these two policies. The study looks at existing experiences of circular migration in Ghana and the Netherlands; and explores the experiences of England, who was one of the first countries to introduce a code of conduct for the ethical recruitment of health workers.

The methodology adopted to address these objectives is a review of literature. Theories of migration are also used in order to shed light on the potential driving forces of health worker migration, which will also determine which policy options are more likely to work. The policy triangle framework, proposed by Walt and Gibson for policy analysis in the health sector, is also used.

We found that both policies have their own advantages and disadvantages, and are unlikely to solve the problem of health worker migration in isolation. In addition, their success might be influenced by the contexts in which they are applied. A balanced solution requires that the interests of both health workers, as well as the interests of populations in sending and receiving countries are taken into due consideration, and thus will need the application of different strategies with the participation of all stakeholders.

We believe the study will contribute knowledge which can inform policy makers working towards achieving a balanced solution to the health worker migration.

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My sincere gratitude goes to all my family members for their support in everything I try to accomplish. My deepest appreciation goes to my husband for his continuing encouragement and my daughter Naomi for making my life so much more meaningful. I love you, Naomiye!

Dad, this one is also for you. May your soul rest in peace.

Abbreviations

AU	African Union
DH	Department of health
ILO	International labor organization
IOM	International organization for migration
MDG	Millennium Development Goals
MIDA	Migration for Development in Africa
MMI	Medicus Mundi International Network
NHS	National health services
UK	United Kingdom
US	United States
WHO	World Health Organization

1. Introduction

1.1. Health workforce crisis: an overview

A shortage of health workers is becoming an increasing problem in both developing and developed countries across the world. The world health organization (WHO) estimates that globally, 4.3 million more health workers are required to achieve the health-related Millennium Development Goals (MDGs). Some parts of the world are particularly affected: while carrying 25% of the world's disease burden, Africa has only 3% of the world's health workers (Robinson and Clark 2008). The situation is worst in Sub-Saharan Africa where 38 of the approximately 47 countries do not meet the WHO recommended minimum 20 physicians per 100,000 population; about 13 sub-Saharan countries have five or fewer physicians per 100,000 population (PHR 2004).

In developing countries, the major reasons for this shortage include a lack of training facilities, loss due to HIV, and migration of health workers (also referred to as brain drain) which is playing an increasingly important role (PHR 2004). In some countries like Ghana, half of all doctors and a third of nurses leave their countries after training (Robinson and Clark 2008). In addition, health professionals practicing in their country of origin are mal-distributed, further aggravating the situation in rural areas (Bach 2003, Stilwell et al 2004).

In developed countries, on the other hand, the major factors behind this shortage include demographic changes, an increased demand for quality health care on the side of service recipients, advancement in technology, an increase in chronic illnesses etc (Connell et al 2007, Ahmad 2005, Robinson and Clark 2008). The US, for example, will have a nursing shortfall of around 500 000 by 2015 (OECD 1997).This results in an increased demand for foreign health professionals in wealthier countries. Indeed, many developed countries make up for the shortage of health workers in their set ups by hiring health professionals from poorer countries. Although many of these health professionals apply themselves for their positions in the health sector, active recruitment of health professionals is also increasingly used (Stilwel et al 2004, Bach 2003). The aggressive recruitment of foreign health workers is viewed as a reflection of the failure of industrialized countries to address their recruitment and retention difficulties, and of

difficulties with workforce planning in health-care systems of developed countries (Bach 2003). These countries have been incriminated for taking advantage of health workers trained in their country of origin, with detrimental effects on the health systems of these countries, both at a micro and at a macro level (UNCTAD 2007, Stilwell et al 2004, Hooper 2008, PHR 2004, WHO 2006(2)). Worst affected by this lack of health workers is Sub-Saharan Africa, where Tuberculosis and HIV/AIDS are claiming the lives of a significant number of health workers and patients (Cooper 2009).

Poor countries are also losing a return on their investment (Patel 2003) and subsidizing the health systems of richer countries (Snyder 2009, Lopes 2008): according to the International Organization for Migration (IOM), developing countries spend 500 million dollars each year to train health workers who leave to work in developed nations (Lopes 2008). Country specific examples also show the detrimental financial losses incurred by source countries: South Africa, where training a physician costs about $61,000-97,000 and training a nurse costs about $42,000, is a country for which the loss for all health professionals practicing abroad may be as high as $1 billion (PHR 2004).

Ultimately, those who end up being highly affected are mainly health services (and their users) in the remoter rural areas, as they are the least favored locations of work by health workers. If a post in an urban area becomes vacant because of the overseas moving of a health worker, a reshuffle takes place and the post is taken over by someone from a rural area and so on. Since the poorest citizens usually live in the remoter areas, they are therefore most affected (Lowell and Findlay 2001). This kind of "domino effect" is also described in Western countries: richer countries in the West recruit health workers from poorer Western countries, which make up for their losses by recruiting from poor countries in the South (Cooper and Aiken 2006). Equinet, a Southern African NGO, has described the flow of health personnel in the following manner (PHR 2004):

> *"follow[s] a hierarchy of 'wealth' resulting in a global conveyor belt of health personnel moving from the bottom to the top, and resulting in a vicious cycle of increasing inequity."*

The IOM and the International Labour Office (ILO) recognize the advantages of managed migration, but nevertheless voiced concerns about possible detrimental effects of unmanaged migration, including the consequences of a brain drain of highly skilled workers, the dislocation associated with migration, the gender consequences of migration and the potential vulnerability of migrant workers (Bach 2003). On the other hand, others, such as the World Trade Organization (WTO), see the migration of workers as an integral and beneficial component of globalization and the liberalization of the service sector (Adlung 2002). Others also argue that migration has potential benefits for both the health worker and the health systems of poor countries because it results in brain gain through further training acquired abroad (Thomas 2000, Lien and Wang 2005).

In addition, remittances are presented as an advantage that source countries can get from migrant workers. Studies looking at remittances from health personnel in particular are lacking. Nevertheless, remittances from migrants in general constitute a large proportion of some countries' incomes, surpassing the total money that is gained through foreign aid (Stilwell et al 2003, Stilwell et al 2004). Doubts remain though about the value of remittances for economic development because it is unclear how they are utilized within the source community. There is an argument that such income is seldom used for productive purposes and does not benefit the poor. Nevertheless the sums of money gained from remittances are large and must not be ignored (Bach 2003).

In addition to financial gains, skills transfer, and possible investment if workers return have also been mentioned as advantages to source countries (Regets 2001). However, all these are insignificant compared to the losses, including loss of public educational investment, loss of intellectual capital, reduced range of available services, chronic understaffing of health facilities, and poor healthcare services (Ahmad 2005). Despite a growing tendency to look at migration of the highly skilled as a positive phenomenon, the notion of "medical exceptionalism" is used as an argument which highlights the negative impacts of health worker migration on the health of populations in poor sending countries (Alkire and Chen 2006).

Several debates have also revolved around the issue of competing rights in the international migration of health professionals: the right to health of the populations in the source and destination countries; the right to leave one's country to seek a better life; labor rights including the right to work and the right to just and favorable conditions of work; the right to an adequate standard of living; the right to education (Ogilvie et al 2007, Chen et al 2004, Bueno de Mesquita and Gordon 2005). There is also an argument stating that, where healthcare workers are trained using taxpayers' money, they have an obligation to those taxpayers to provide a service to them. Poor people in developing countries pay taxes to train health workers so that these health workers provide them with services making use of the knowledge and skills they acquired, making this an issue of tax payers rights (Hooper 2008).

It is nevertheless the right to health of populations in source countries that has been given much emphasis in the formal debate on health worker migration.

1.2. Magnitude of the problem of health worker migration

The first important research conducted to assess the magnitude of the problem of health worker migration dates back to mid-1970's and showed that 6% of physicians and 5% of nurses live outside of their country of origin. The authors nevertheless pointed out that it had been difficult for them to ensure the reliability of the data (Meija et al 1979). This problem is shared by many, and it has been difficult to estimate the magnitude of health worker migration because of the lack of an adequate standardized manner of registration. Different sources are used by different bodies, making the reliability of data questionable and the comparability difficult. However, despite these limitations of data, one issue is clear, and it is that, in general, the number of people migrating has never been higher than it is now, and the majority of migrants are highly skilled (Carrington and Detragiache 1998).

In 2006, WHO estimated that one in four doctors and one nurse in twenty trained in Africa was working in OECD countries. There are differences between poor countries in the numbers of migrant health workers. For instance, Ghana saw over 60% of all its locally trained doctors in the 1980s emigrate by 1999.In 2001 alone, the country lost over 2972 nurses compared with 387

nurses in 1999 (Ahmad 2005). Similarly, WHO reported that 34% of Zimbabwean nurses were practicing abroad (WHO 2006).On the other hand, it is estimated that more than 20% of physicians working in Australia, Canada and the United States of America come from other countries (Diallo 2004). Figure 1 shows the significant differences in the density of health workers globally.

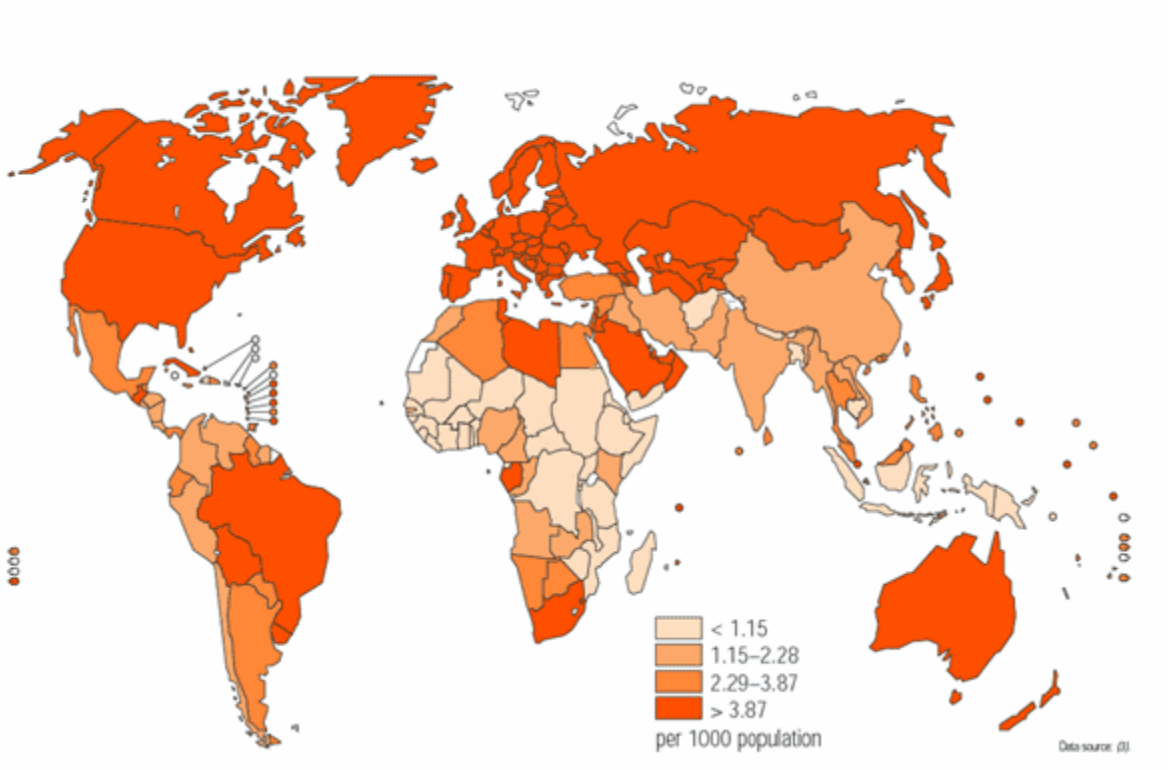

Figure 1. Health worker distribution worldwide (Source: WHO (2006). The world health report 2006 – Working together for health. Geneva, World Health Organization.)

1.3. Measures to tackle health worker migration

Several strategies have been developed to overcome the problem of health worker migration and address brain drain both in sending and receiving countries. In addition to the two policies that are our policies of interest, and will be discussed in detail below, other policies have also been developed and implemented.

In sending countries, several health worker retention strategies have been proposed and some adopted throughout the years. Provision of financial and non financial incentives is one measure. The impact of provision of non financial incentives such as training and study leaves were found to motivate health workers to continue their services in public facilities hence enhancing retention. Financial incentives were similarly found to play a pivotal role; although the feasibility of providing such incentives in some set ups might be questionable and thus might need targeting (Willis Shattuck et al 2008, Stilwel et al 2004).

Other strategies that have been implemented in some set ups include: stay or pay mechanisms whereby health workers who wish to leave the country pay a certain amount of money mainly intended to cover for the free education they have received, mandatory work requirements whereby health workers are obliged to provide services in the public sector for a certain period, training of health workers in local health problems making them less marketable in the global market; and training rural health workers who are believed to be more likely to remain and work in rural areas (Frehywot et al 2010, Grobler et al 2009, Wibulpolprasert and Pengpaibon 2003, Pang et al 2002).

Recipient countries have also put some commitments to assist the loss of health personnel from poor countries: in Norway, for instance, there has been an advocacy towards including working towards self sufficiency through training of a higher number of health personnel as well as making more efficient use of existing personnel, better organization of the health sector and through qualification schemes for unskilled workers. There have also been efforts to support

health systems in developing countries who suffer from health worker shortage through assistance on matters such as research on human research issues, recruitment and training, incentives to promote retention etc. and through the provision of compensating sending countries for their loss. There has also been advocacy to provide compensation for countries from which health worker that come to Norway come from though either monetary or other forms of support such as transfer of know how, skills and technology (Norwegian directorate of health 2007).

It is worth noting that some developing countries such as Cuba and the Philippines intentionally train an excess of health professionals, many of whom will emigrate after completing their studies. This is done with the belief that the remittances that will be gained from these health workers will exceed the costs of training them in the first place (Hooper 2009, Ogilvie2007).

1.4. Objectives of the study

1.4.1. Major objective

The major objective of this study is to describe two policy options (circular migration and ethical recruitment policies) aimed at combating health worker migration (also referred to as brain drain) from countries with health worker shortage.

1.4.2. Specific objectives

The minor/specific objectives of the study are:

a. To provide an overview of the health workforce situation worldwide

b. To provide an overview of the global migration of health workers, the causes, and the consequences

c. To provide an overview of circular migration, its advantages and limitations

d. To provide an overview of policies for ethical recruitment of health workers, their advantages and limitations

e. To give country specific examples of these two policies

The description of the benefits and limitations of the two policies will also help the purpose of presenting a comparative reflection of these two policy options. In addition, a short comparison of the two policy options will be presented in a separate section.

2. Methods, data and theory

2.1. Methods and data

The methodology adopted in this study is a review of scientific/scholarly literature. Due to the time frame available, it was not possible to do primary data collection. Different search engines were used to identify relevant literature. These search engines included, but were not limited to PubMed, Google Scholar and Medline. I also searched references from the scientific articles we found. In addition, I visited the websites of different organizations such as the WHO, International Organization for Migration, International Labor Organization, Physicians for Human Rights and others. Although most of my data is from scientific papers published in scientific journals, I also used reports from the organizations referred to above, as well as from books dealing with our topic of interest.

I used both broad and more specific search terms, for e.g. migration, health worker migration, physician migration, nurse migration, circular migration, codes of practice, ethical recruitment policies, theories of migration, health worker retention policies, brain drain, brain circulation and others. For the specific countries that I wanted to draw examples from, I added the country's names to the search terms. Otherwise, I did not limit my data to a certain geographical location because the aim of the study is to look at the situation of health worker migration at the global level.

The data I used in this study is therefore secondary data. Both quantitative and qualitative studies were used. The literature was thoroughly read and necessary information extracted. I have tried to assess the validity and reliability of the data as much as possible, by critically assessing what the information put forward was based upon and how the authors have addressed these issues in their papers.

Theories of migration and in particular theories adapted to health worker migration are used for a better analysis and discussion of the data. The policy triangle framework developed by Walt and Gilson is also used, to shed light on the discussion of policies that could best address the problem of migration of health workers.

2.2. Framework for policy analysis

2.2.1. Defining policy

The word policy is a term commonly used in government documents, academic writings and daily conversations. Even though there are several attempts to define policy in the literature, it is also widely recognized that the concept of policy is complex and that achieving a definition is not easy (Rui 2005). Weiss defines policy as: "An officially accepted statement of objectives, tied to a set of activities that are intended to realize the objectives" (Weiss 1998).

Policy can cover a very broad arena, and there are various ways in which policy can be understood and used, including plans, decisions, documents and proposals. In addition to written forms (the most commonly defined forms), policy can include actions, practices and even the inactions of governments (Rui 2005). It is by taking this broad view of policy into consideration that I refer to circular migration schemes and codes of practice for ethical recruitment as policy options in this thesis.

2.2.2. The policy triangle framework

I will use the policy analytical model developed by Walt and Gilson to discuss aspects of the two policy options chosen. Walt and Gilson underline that, although there is increased focus on what health policies should be introduced by countries, less attention has been paid to how such policies should be introduced, and who is going to be likely to favour or resist such policies. They argue that there had been a wrong focus on *content* of policy reforms, and that the *actors* (at the international, national and sub-national levels) and *processes* involved and the *context* within which policy is developed have been neglected (Walt and Gilson 1994).

They suggest a simple analytical model (see figure 2) which includes the concepts of *context*, *process*, and *actors* as well as *content*. They point out that this is a highly simplified model of an extremely complex set of interrelationships. They stress the fact that these factors are interrelated and don't act in isolation: actors are influenced (as individuals and as members of interest groups or professional associations) by the context within which they live and work, at both the macro government level and the micro-institutional level. Context in turn is influenced by many factors such as instability or uncertainty created by changes in political regime or war; by political ideology; by historical experience and culture. The process of policy-making in turn is affected by actors' values and expectations, as well as the positions they hold in power structures (Walt and Gibson 1994).

In the case of policies involving health worker migration, the actors include first and most importantly the health professionals themselves, but also policy makers involved in the health workforce situation, civil society members, members of health professional recruitment agencies and others. These will all have their own interests in the matter and will have their own views towards health worker migration, which might be conflicting. These interests and views will influence which policies are likely to be implemented and to have effective outcomes.

The most important issue when referring to context, on the other hand, is that of globalization that is making international migration, global communication and training much easier, all of which influence migration of health workers. The globalization of markets and the development of free trade agreements have also facilitated international migration through the reduction of barriers to trade and mobility of services, products and people, including the skills of health professionals (Tim et al 2004).

I will use this model while discussing the advantages and disadvantages of circular migration and policies for ethical recruitment of health workers, as well as in the comparison of the two policies.

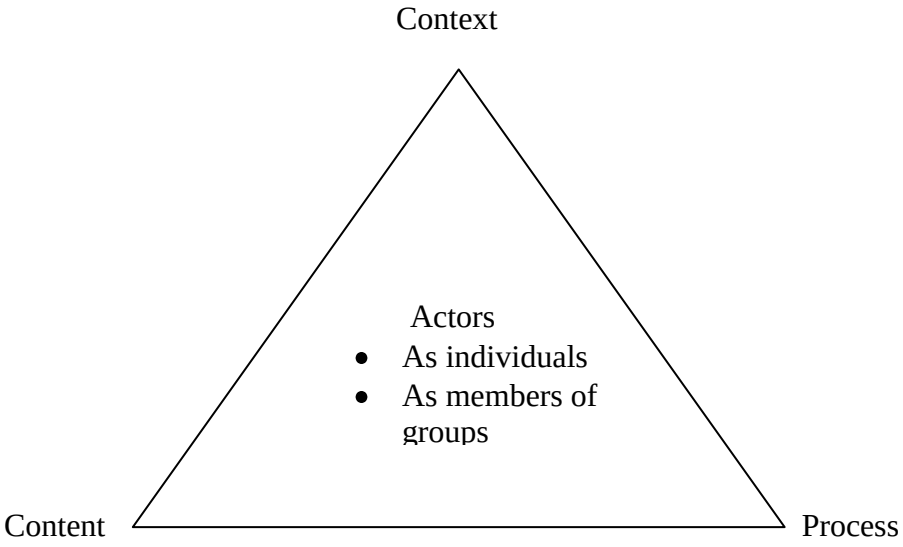

Figure 2 Policy triangle framework (source: Walt and Gilson 2004)

2.3. Theories of migration

An understanding of the major reasons why health professionals migrate is of paramount importance if any attempt to address the issue of health worker migration is to become successful.

Different theories of migration have emerged over the years. Although addressing different perspectives and levels, these theories are nevertheless not mutually exclusive and can rather be combined (Massey et al 1993). A comprehensive understanding of international migration would necessitate that influences beyond the level of the individual or the household be looked at, including the influence of the country as a whole and its policies and circumstances. The overall economic and social context in which decisions are made should also be looked at (Stilwell et al 2004, Bach 2003).

The most widely used approaches to explain migration are the push pull theories. According to this approach, labor flows are seen as an outcome of poverty and backwardness in the sending

areas. Push factors, such as economic, social and political problems in the poorest parts of the world, play against pull factors- comparative advantages in richer countries - to influence the decision of migration (Portes and Borocz 1989). For health workers, push factors in the sending countries include insufficient suitable employment, lower pay, unsatisfactory working conditions, poor infrastructure and technology, lower social status and recognition, and repressive governments. Pull factors in rich countries, on the other hand, include: higher living standards, training opportunities, better practice conditions and more sophisticated research conditions (Hagopian et al 2004). These factors appear to be homogeneous in the literature. Box 1 presents a summary of push and pull factors in health worker migration.

Based on a world system framework, more recent studies have associated the migration of highly trained personnel to broader global processes such as the global articulation of higher education and unequal development on a global scale (Ong et al1992). According to Ong et al, the very process of reproducing highly educated labor results in the creation of an international labor market because of similar training, shared universal values and transnational ties. That is because students from developing countries are either trained directly in developed nations, or curricula from developed nations used for those trained locally, often using instructors trained in developed nations. The articulation of the educational system further creates a common language and a global network of information and social connections. It also results in acculturation which eliminates some of the cultural barriers between countries. All these factors facilitate international migration. But, although the global articulation of higher education and the creation of an international class of labor act as preconditions for international migration of the highly educated, it is the global inequality through the creation of economic incentives that pushes individuals from a developing country to migrate to a developed country (Ong et al 1992).

In their attempt to develop a global integration framework to explain the migration of highly skilled, Cheng and Yang also found that economic and educational interactions between sending and receiving countries are important driving forces for migration. They again emphasized the vital role that global educational articulation plays in the migration process of highly trained individuals. They also showed that inequalities between countries, in particular inequalities in

living standards and in employment opportunities also have major influence in the migration of highly trained individuals (Cheng and Yang 1998).

Yet another theory, the network theory, underlines the importance of migrant networks in migration. These increase the likelihood of migration because they lower the costs and risks of migration and increase the expected net results to migration. These networks can include relatives, friends or community members (Massey et al 1993).

The question is then, what can be learned from these theories which can inform which policies are likely to work the best. Any policy trying to counteract the negative impacts of health worker migration should not only take the interests/motivations of health workers into consideration, but should also look at broader socio-economic and political factors that drive health worker migration. Some of the factors influencing migration such as those related to globalization with the creation of common training, common values etc are likely to get even stronger, indicating that the phenomenon of migration is likely to increase, unless attempts are made to address issues at all levels. Any attempt to solve the health workforce migration which does not take these factors into consideration is likely to yield unfruitful results.

Push and pull Factors:

The main push and pull factors relating to migration and recruitment of health workers

Push:

- Low pay (absolute or relative)
- Poor working conditions
- Lack of resources to perform work in an efficient manner
- Limited career opportunities
- Limited education and further training opportunities
- The burden of infectious diseases such as HIV/AIDS
- Unstable and dangerous working environment
- Economic instability

Pull

- Higher pay (and opportunities to send part of it home)
- Better working conditions
- Well-financed health systems
- Career opportunities
- Further education opportunities
- Political stability
- Travel opportunities
- Attractive career opportunities with NGO's and International agencies

Box 1. Push and pull factors in health worker migration (Source: Norwegian Directorate of Health. Recruitment of Health Workers: Towards Global Solidarity)

2.4. Ethical considerations

Since this study is based on a literature review involving secondary data analysis, it does not pose major risks in terms of research ethics. That is, there is no risk of breach of anonymity and confidentiality, and there is no problem with consent.

But it is important nevertheless to point out that other ethical aspects do exist and should be considered. These include the necessity to acknowledge the authors for the data extracted from their writings through proper referencing, and making every attempt possible not to misquote or misreport the ideas/perspectives of others.

We should be able to delineate clearly which perspectives are supported by literature and which ones are our own views and discussions of matters.

I do this study as a medical doctor myself from a country adversely affected by health worker migration. I have attempted to be as objective as possible while approaching the subject, and not allow my pre-understanding influence my view and analysis of data in an improper manner.

3. Circular migration and policies for ethical recruitment

In this chapter, I will present overviews of circular migration and of policies for ethical recruitment. I will give examples from specific countries to illustrate why and how these policies have been used and what the experiences with these policies have so far been in these specific set ups. I will then present a discussion of the advantages and limitations of these policies; giving a comparative reflection of these two policies. While presenting the advantages and disadvantages of the two policies, I will draw upon the facts presented throughout the thesis about health worker migration in general and the policies in particular, to present my own assessments of what the advantages and disadvantages of the particular policies can be. In addition, I will also point out to some specific advantages and disadvantages mentioned in the literature. I will conclude the chapter by giving a short comparison of the two policy options.

3.1. Circular migration:

A. Overview

Circular migration is a relatively new phenomenon in the international policy agenda, although not a new happening. It has attracted attention in recent years, because it is believed to provide a solution to the complex problem of health worker migration (Vertovec 2009). Although circular migration is given different definitions in the literature, in this study, circular migration refers namely to the temporary return of health professionals to their countries of origin for the purpose of providing professional work, which can be repeated at different times. This is referred to in some literatures as return migration/temporary migration/ temporary return.

The notion of brain circulation is also used in the literature. Brain circulation is achieved through circular migration, but also through the use of the internet for exchange of knowledge with source countries, for example through the use of telemedicine (Dodani and LaPorte 2005, Ogilvie et al 2007).

A number of policy makers at national and international levels are advocating for measures that would facilitate the movement of migrants from their foreign places of work to their country of origin and vice versa (Milliez 2009). The main idea is that this could allow for "win-win-win" results, that is, benefit to migrant health workers sending countries and receiving countries: migrants would make use of the opportunities for employment (by moving from Sierra Leone to the UK, a medical consultant will see the life expectancy of is children increase from 40 to 79 years of age, and his salary to exponentially increase from £300 to over £100 000 (Hooper 2010)), receiving countries would satisfy their labour market shortages (Vertovec 2007, Hooper 2010), and sending countries would benefit from remittances, in addition to the increased belief that there are increased possibilities for gains for these countries from returning or visiting emigrants because of enhance skills, ideas and technological advances (Ogilvie et al 2007, Hooper 2010).

The International Organization for Migration acknowledges the importance of circular migration and, together with sending and receiving countries, has launched a Migration for Development in Africa (MIDA) initiative in 2002 to facilitate technology and knowledge transfer through Internet communication, and through temporary return of skilled migrants to their countries of origin without the risk of loss of visa status loss in the destination country (IOM 1). A number of African countries, including Benin, Burkina Faso, Burundi, the Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Mali, Mauritania, Morocco, Nigeria, Rwanda, Senegal, Sierra Leone and Somalia, have set up MIDA programs. Through mobility based approach, this initiative is intended to assist African highly skilled nationals to contribute to the development of their countries of origin directly. The program was endorsed by the African Union (AU) in 2001 (IOM 1). The AU called on the IOM:

> *"to continue to help African countries to encourage and facilitate the return of their qualified expatriate nationals and promote the initiated Migration for Development in Africa (MIDA)."*

One of the receiving countries actively involved in the temporary return of health professionals is the Netherlands, which, together with the IOM, arranges for temporary placements of qualified

migrants, for periods ranging from few weeks to three months. In addition to this temporary return, the IOM facilitates virtual return assignments through internet or videoconferencing (IOM 2). Although this concerns skilled workers in general, specific programs for health workers in Ghana have been devised and will be discussed below.

B. The case of Ghana and the Netherlands

I present the case of Ghana and the Netherlands as an example for circular migration, because this is the case that I found during my search for an example for circular migration involving health workers. In addition, the case involves a developing country highly affected by migration of health workers, making it worthwhile for discussion in this thesis.

Ghana is one of the countries in the world worst affected by health worker migration. It has lost a big proportion of its locally trained doctors (29% of its physicians practice abroad) and nurses in recent years (Ahmad 2005, WHO 2006). The overall number of doctors in Ghana is nine per 100000 population.The country has made use of doctors from Cuba, often needing interpreters, thus creating a high cost to the system (Eastwood 2005).

Ghana's parliament passed the Dual Citizenship Act in 2002, and it was signed into law by the president. Ghanaians abroad are seen as partners in development and their participation encouraged. This act allows Ghanaians to work in Ghana or in their new country of settlement (Ogilvie 2007).

In an initiative supported by IOM, the MIDA Ghana Health project was started, in association with the Ghanaian Ministry of Health and the Dutch Embassy in Accra. The project aims at supporting the development of the health sector in Ghana. One of the ways in achieving this goal is to have temporary assignment in Ghana of Ghanaian and other African migrants living and working in the Netherlands, the United Kingdom, Germany and other EU countries.
MIDA Ghana I AND II are said to have been successful projects, and in 2008, IOM started MIDA Ghana project III, a project specifically targeted at strengthening the Human Resource Development in the health sector (IOM 3).

The active participation of Netherlands in such initiatives is very important and is an effort on its side to contribute to the well being of populations in poor countries. The project with Ghana so far has been described as successful (IOM3); but there is a need for research evidence to show how much the contribution of this project is, in view of the limited number of health personnel that is to be exchanged. The success of the project in Ghana might partly be related to the fact that the government is positive towards the participation of Ghanaians living abroad in assisting their country; the dual citizenship code further facilitates the process of temporary return. Thus, the context of Ghana might be one of the contexts where circular migration might be easier to implement; its implementation might be different and more complicated in other set ups.

C. Advantages of circular migration

Circular migration has a number of advantages. It is important to see circular migration in light of the theories of migration to evaluate its potential benefits. One of the advantages of circular migration, seen in the light of migration theories, is that it allows migrants to stay in their countries of choice, therefore allowing them not to be subjected to the push factors that in the first place pushed them to migrate. They would still enjoy the benefits of the "pulls" from rich countries.

Circular migration also allows for brain drain to be transformed into brain gain, and especially if targeted at those workers most in need, can allow for significant transfer of knowledge. Sending countries benefit by having a temporary return of workers who have acquired better skills and better training abroad, and they still get benefit from remittances (Ogilvie et al 2007, Hooper 2010).

The other issue, which we discussed in previous sections, is that of the right of health workers. Although migration is seen as a fundamental human right, the migration of health workers has been heavily condemned in the literature. Health workers have been subjected to criticism over their migration to an extent much higher than any other professional migrant (Snyder 2009). This could be partly justified because the risk involved is the health of populations in source

countries, and these populations have the right to health. Whose rights should predominate thus remains the question, in the conflict between the rights of health professionals come and that of the right to the highest attainable standard of health of people in their home countries (PHR 2004). This issue remains highly debated, but, if successful in other aspects, circular migration can provide a certain balance in this discussion.

If migrants experience temporary migration to their home countries with successful return, they might be motivated to go back again because they will have less fear of difficulties with return, and others might look at their experiences, making the process a success on the long term.

Seen from the angle of the policy triangle framework (Walt and Gilson 1994), the actors that are the most likely to support such a policy are the health workers themselves; since it is a voluntary process, it is likely to have proponents among health workers. Policy makers in different countries might also back this strategy. The context within which migration is happening, makes circular migration an attractive policy, both because globalization seems to make migration inevitable, but also because it facilitates the process of circular migration, due to easier means of communication and creation of global networks, easier transportation etc.

D. Limitations of circular migration

Circular migration might suffer from a number of limitations. For such a policy to be effective there is a need for strong collaboration between sending and receiving countries. Even if health workers agree to go back to their home countries temporarily, they have to be able to have a guaranty for keeping their posts in receiving countries, and of being able to return back after the completion of their stay. Thus, the practical and legal implications are many and complex. Thus, what is referred to as process in the policy triangle framework (Walt and Gilson 1994) will be a difficult process, influencing the implementation of such a policy.

It would also be difficult to implement such a policy in set ups where migrants do not trust governments. It would be unlikely that a significant amount of migrants would return if the unfavourable conditions in the countries of origin persist.

The other issue is that, since this is based on voluntarism, it is difficult to predict the sustainability.

The policy might encourage more health workers to migrate, once they become aware of the possibilities of circular migration

Circular migration might be more feasible for fields other than health that might not require the permanent presence of the worker, since it might be possible to follow up the work at long distance, for example through internet communication. If circular migration is to work in the health sector, it might mean that leaving health workers are replaced by others taking on their positions which might need a lot of programming and collaboration.

E. Conclusion

Circular migration is appealing in many aspects and one of the ways forward in view of the inevitability of migration in an age of globalisation, and this explains the attention it has recently attracted. There is a need for research to quantify the benefits of such a strategy versus the loss that countries incur in terms of loss of health workers. If only a small number of health workers participate in such a voluntary process, then the outcomes can be nearly negligible; but if a large number of health workers return, then it would have meaningful impacts (Hooper 2008).

Circular migration by itself is unlikely to compensate for the huge losses that countries incur due to health worker migration, both in terms of adverse impacts on health and health systems, and in terms of financial losses. As Hooper (Hooper 2008) points out referring to the so called win-win –win anticipated:

> *"Sadly, this mutually beneficial, symbiotic union hides a more malign, parasitic relationship".*

This is a strategy that can have positive impacts, but should not be considered in isolation, but together with other policies.

3.2. Policies for ethical recruitment of health workers

A. Overview

One of the factors driving health worker migration is believed to be active recruitment of health workers from countries with shortages of health workers (Willett and Martineau 2004, Stilwel et al 2004, Bach 2003). Recruiting countries include western countries but richer countries of Africa such as Botswana have also recruited from other poorer African countries. Active recruitment implies that the employer takes the initiative of stimulating interest and recruiting health workers from a foreign country (Buchan 2009). Exact data on the numbers of health workers recruited actively by different countries globally are lacking.

Some countries have worked towards limiting the negative impacts of such recruitment policies and have adopted codes of practice for ethical recruitment of health workers. These may have a number of objectives, including the protection of individual health workers in the process of recruitment and from dishonest employers, ensuring adequate preparation and support on preparation for the job, and the protection of sending countries from the aggressive recruitment of their health workers (Willetts and Martineau 2004). It is this last component which is the component of interest in this study.

One of the first countries to adopt such as code is England, the case of which will be discussed in detail below. Other codes include those adopted by remaining countries of the UK, and the commonwealth code of practice for the international recruitment of health professionals (Willett and Martineau 2004). A review of a total of 12 such codes conducted in 2004 indicated that, by the end of 2002, the strategies were generally effectively disseminated and in place; nevertheless, there was a weakness or lack of support systems, incentives and sanctions, and monitoring systems needed for effective implementation and sustainability of such strategies (Willett and Martineau 2004).

Nevertheless, concerted efforts had also been ongoing for some time to pass a global code of conduct, supported by countries such as Norway, as well as a wide range of civil society organizations, namely the Health Workforce Advocacy Initiative, which has member organizations from both sending and receiving countries. This organization is affiliated with the World Health Organization's Global Health Workforce Alliance; the later held in 2008 in Kampala the first global forum on human resources for health, an event that is believed to have incited international enthusiasm for a Code of Practice for ethical recruitment (MMI 2010).In May 2010, the WHO endorsed a global code of practice for international recruitment of health professionals (WHO 2009), a code that was described as historic, voluntary in character. Figure 2 summarizes the objectives of the code.

At this point it is unknown how many countries will eventually adopt this code. An initial draft of the code had already faced resistance from the side of the US, a country which imports 25 percent of its physicians from abroad (and two-thirds of them from lower income countries), and which argued for a weaker code than was preferred by African country delegates. The initial draft was subsequently revised during the World Health assembly meeting (MMI 2010).

The objectives of the WHO Code:
(1) to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel;
(2) to serve as a reference for Member States in establishing or improving the legal and institutional framework required for the international recruitment of health personnel;
(3) to provide guidance that may be used where appropriate in the formulation and implementation of bilateral agreements and other international legal instruments;
(4) to facilitate and promote international discussion and advance cooperation on matters related to the ethical international recruitment of health personnel as part of strengthening health systems, with a particular focus on the situation of developing countries.

Figure 2. Objectives of WHO Global code of practice (source: WHO)

B. The experiences of England

I have chosen the case of England for discussion because England is one of the first countries in the West to introduce a code of practice for ethical recruitment of health personnel. In addition, England is a country which receives a large number of migrant health professionals from developing countries, as will be discussed below.

England is one of the countries which have attracted large numbers of migrant health workers for several decades, facilitated, among other things, by colonial ties with Asian and African countries and because of the widespread use of English language in medical systems of several countries making integration within its medical system easier. In 2002, it was estimated that half of the new registrations with the General Medical Council were from non European Union countries ((Eastwood et al 2005); this figure had risen to more than two thirds in 2003 (Buchan 2005). Similarly, in 2002-2003, one in four nurses from non – EU countries was from countries identified as countries with severe shortage of health personnel (Eastwood et al 2005).

The high number of foreign health workers in the UK was partially driven by policies of active international recruitment by the Department of Health (DH) in England, in order to ensure adequate staffing in the National Health Service (NHS) (Buchan 2009). A first attempt at limiting the potential negative impacts of active recruitment was made by DH in 1999, with guidelines forbidding NHS not to actively recruit from two countries: South Africa and West Indies (Buchan 2009). This followed complaints from Nelson Mandela (South Africa) and from the Caribbean (Willetts and Martineau 2004).

The first code of conduct regulating recruitment of health workers was subsequently passed in England in 2001 in response to the controversies surrounding this recruitment (Department of Health 2001). It required National Health Service (NHS) employers not to actively recruit from low and middle income countries unless there is government-to-government agreement; and a list of 154 selected countries was made available in 2003. A revision was made to the code in 2004 with its extension to cover recruitment agencies working for NHS employers, temporary staff working in the NHS, and private sector health care organizations providing services to the NHS (Department of Health 2004). The code also has guidelines which cover aspects of

recruitment, selection and induction, as well as aspects relating to equal opportunities in employment, pay and career prospects (Buchan 2009).

Attempts have been made to assess whether the code of practice introduced in England a decade ago has had its intended effects. One such attempt was made by Buchan et al., who looked at the trends of migration of health workers to the UK. For this purpose, they used professional registration data and data on applications for work permits. They also conducted an in-depth overview of the situation in two countries: Ghana and Kenya. They found that there was a significant reduction in the inflow of health professionals. Multiple causes were said to exist for this reduction, among which a decline in demand in the UK. The country case studies similarly showed that there was a perceived significant reduction in active recruitment, although it was difficult to ascribe this to the Code, since it might have been due to a decrease in vacancies in the UK. The authors concluded that, with existing databases, it was difficult to assess the effect of the code (Buchan et al 2009), which can be assumed to apply to other set ups in view of existing data on migration and in particular health worker migration.

In England, the implementation of the policy and the monitoring of its execution are facilitated by the fact that there is one major public sector health care employer and a single point of entry for regulated health professionals. Thus, the code applied in England might not work in other set ups with dominant private systems or decentralized systems (Buchan et al 2009).

C. Advantages of the policy

A policy for ethical recruitment of health workers has a number of advantages: with such a policy, it is possible to have clear cut objectives and targets, a clear cut set of countries from which not to recruit. Thus, countries adopting this code can have monitoring systems with sanctions against those who do not follow rules and incentives for those who do. Although the code of practice suggested is voluntary in nature, if endorsed by a country, it becomes obligatory to use it in that set up.

If adopted by many countries, and applies to both government and private sector, ethical recruitment policies can have impacts of significant magnitude in terms of health worker loss averted.

A code for ethical recruitment has the potential to work quite well in set ups such as England where the health system is organized allows for centralized monitoring (Buchan 2009).

With the passage of a global code for ethical recruitment of health workers, with participation from both sending and receiving countries, there will be more awareness about the existence of such a code at the global level, allowing for its widespread implementation

Seen in the light of the policy triangle framework (Walt and Gilson 1994), what makes this policy appealing is that the process involved in its implementation might be relatively simple; although, as experience shows, there has been difficulty implementing some of the mechanisms necessary for such a policy to work adequately (Willett and Martineau 2004).

D. Limitations of the policy

Limiting the movement of health workers can be seen as a breach of their rights; there have been arguments that any policy aimed at limiting migration will also limit the freedom of choice (migration is a choice), and that this represents a threat towards visions for development (Clemens 2009). Again, the issue of competing rights comes into question, between the right to health of the populations in the origin and destination countries and the rights of the individual health worker to fulfill his/her ambitions (Ogilvie et al 2007, Chen et al 2004). Thus, actors in the policy who are likely to be adversely affected themselves and resist such a policy are the health workers themselves. In addition, this policy does not by itself reduce the push factors that incite health workers to migrate, unless other components accompany the implementation of such a policy that take this fact into consideration.

If the magnitude of active recruitment in a certain set up is limited, but instead other routes are widely used for migration, then focusing on such a policy and investing in its implementation

might not be cost effective, and might only serve political purposes of manifesting responsibility by governments. Thus, this should by no means divert attention from other more important strategies in such set ups. Buchan et al provide examples of these other recruitment means that will not be affected by a code of practice for ethical recruitment. These include: applying for recruitment by own initiative which is facilitated in an age of internet; health workers might be in the country for educational and training purposes and will be recruited while there; in addition, some international workers might have a refugee status (Buchan et al 2009).

If the rules apply for every health worker in the countries selected, no matter his/her experience, it would be unfair for those who have provided long years of services for their countries not to be able to aspire for a better life. Periods of service are taken into consideration in mandatory service schemes in different countries and should also apply here.

The success of voluntary codes of practice in influencing behavior had been limited in other areas and thus raises the question of whether it will work in the health field (Willett and Martineau 2004).

E. Conclusion

Codes for the ethical recruitment of health personnel can have a potentially good outcome if there is a centralized health system which makes implementation and monitoring easy and if the regulations apply to both private and governmental systems. Nevertheless, the number of people who come to the receiving countries through active recruitment should be well known, indicating the need for a standardized method of recording health worker migration data.

This will allow for the assessment of how much of the problem can be addressed through limiting active recruitment. This can help decide how much investment and effort should be put forward for such a policy versus other policies that can have higher impacts; and will help avoid unnecessary diversion of attention and resources against other more effective strategies. Whether many countries will endorse the global code of practice remains to be seen.

To achieve a balance in the rights issue, policies such as this one that make it more difficult for health professionals to emigrate, should be implemented in the context of improving working conditions, better salaries, and other advances in health professionals' ability to enjoy their rights (PHR 2004).

Again, this policy should be one of many other strategies and would not by itself have a significant impact even if fully implemented and endorsed by several countries.

3.3. Comparison of the two policy options

In this section, I will present a short comparison of the two policies described in the previous chapters. Although an attempt has been made in the previous sections to present the advantages and disadvantages of the two policy options in a manner that gives a comparative reflection, the aim of this section is to bring together some of the points of comparison in a more specific manner; most of the points/discussions presented in this section have thus been discussed in previous sections.

The intention of this comparison is not to show/discuss which policy is better than the other, but to compare the different dimensions of the policies which can potentially indicate similarities, differences, as well as the need for the use of these policies in a contextualized manner.

The comparison will be made in light of theories of migration; it will also be made making use of the policy triangle framework, comparing the policies in terms of context, process and actors.

The first point that can be made is that the two policies will have no direct impact on some of the factors mentioned in the theory of migration as being factors driving health worker migration, such as: the global articulation of higher education, shared universal values, transnational ties, the presence of network of family and friends abroad, etc. Neither do they directly address the push and pull factors of migration (see figure 2). One difference between the two approaches, which can be seen as beneficial to the individual health worker is that, in the case of circular

migration, the pull factors of migration, beneficial to the health worker, still remain. It can also be assumed that, since the decision to participate in circular migration is voluntary, the health worker is also in control of the push factors; able to assess the risks of the push factors, and to decide to participate in circular migration schemes or not. Thus, seen from a health worker perspective, circular migration appears more attractive/beneficial. Although codes of practice are also voluntary, the decision to adopt them lies on a number of stakeholders including government bodies, and not health workers (which can be one of the stakeholders through their unions); once adopted by a country, the health worker has no choice but to comply with the regulations.

From the perspective of the policy triangle framework, we can see that, in both cases, the *process* component of the policies has challenges. In the case of circular migration, there are practical and legal challenges associated with the implementation process, for example a necessity to change immigration laws, arrange temporary posts etc. The establishment of regulations restricting active recruitment also has its practical challenges, namely in decentralized health systems and in terms of implementation and monitoring, as evidenced in the literature (Buchan 2009, Willetts and Martineau 2004).

The socio-political environment or *context* will influence the success of the policy of circular migration, because a certain degree of harmony between governments and diaspora groups likely to work on circular migration schemes is necessary. Other factors in the context such as political instability, conflicts etc are likely to adversely impact on circular migration schemes. Similarly, elements related to globalisation are likely to favour circular migration as mentioned earlier. The influence of *context* on policies for ethical recruitment appears to come from different dimensions than those of circular migration. The socio-political environment at a local level will have less impact on this policy, but the international political and administrative structures will influence this policy more. For this policy to get an international attention, it has so far needed the collaboration of different bodies, both at a national and at an international level, and WHO has been the final decision maker as to the passage of a global code. Despite the adoption of such a policy by countries such as England over a decade ago, many countries which are heavy

recruiters of health workers have not worked towards the implementation of such a policy in their set ups so far. The presence of a Global Code of Practice will certainly put some pressure on countries. In both cases, governments will play central roles. In the case of circular migration, organizations such as the IOM and diaspora organisations will be important *actors*. In the case of policies for ethical recruitment, leaders in the health systems will play a central role as well, as will recruitment agencies, as their cooperation and compliance is what will make the policy successful. And the other *actors* are the health professionals themselves, who can act by themselves or through health professional organisations, and whose views on the policies will have an impact, namely when it comes to a voluntary process such as circular migration.

One question while trying to compare these policies is: What is the magnitude of the problem that they are likely to avert? For this, there is a need of data to assess the magnitude of active recruitment in specific set ups, and a need for research evidence about the willingness of health workers to participate in circular migration. These data are currently lacking. It would then be possible to assess what the magnitude of the impact the policies can have is. In set ups where active recruitment is limited, the policy that is likely to work better and yield better results will be circular migration and vice versa.

It is also possible to compare these two policies in terms of the highly debated rights perspective of health worker migration. If circular migration were likely to have significant impacts i.e. in an ideal situation where massive participation of health workers occurs and where planning, implementation and evaluation are easy, it could have been at least a partial solution to the rights discussion of health worker migration, one in which the right of the health worker, of the source country and of the recipient country are safeguarded. But in an actual world, circular migration will probably have more limited impacts, and the balance might shift to that of the right of the health worker and recipient country.

On the other hand, policies limiting recruitment of health workers can be seen as shifting the balance away from the individual health worker. Although most policies, including the WHO Code of practice against recruitment of health workers, do mention the need to preserve the right of the health worker to migrate (WHO 2009), their major objective is to limit active recruitment,

which can be seen as influencing the right of individual health workers to migrate; on the other hand protecting the right to health of people in source countries.

5. Discussion, Conclusion and recommendations

The thesis has provided an overview of the health worker shortage worldwide and discussed health worker migration as one of the forces contributing to this shortage. It has highlighted the reasons behind this shortage, and the solutions that have been developed so far. It has focused on two policy options: circular migration and policies for ethical recruitment of health workers. It has provided an overview of these policies, their advantages and limitations, and provided a short comparison of these policies.

The issue of health worker migration is complex, driven by a number of factors, many of which are not easy to deal with. The issue also presents a dilemma because health worker migration is seen very differently to migration of other groups of individuals. For the latter, migration is usually seen as a positive and unavoidable phenomenon in an age of globalization.

Migration of health workers is on the other hand largely seen as a negative phenomenon, and is widely condemned. Medical exceptionalism is justified in some aspects because of the involvement of the right to health of populations of different countries (Ogilvie et al 2007). Nevertheless, the interests of the individual health worker should also be maximized as much as possible.

It would be too naïve to assume that there is a single policy option that is likely to resolve the issue of health worker migration. Instead, efforts should be directed towards looking for different policy options, each of which might be more beneficial depending on the context where it is applied, and to use policies in combination.

There is a need to address the root problems of migration of health workers, a need to address the push factors that are precipitating health worker migration; and developed countries need to assist poor nations in their struggles to keep their health workforce, as well as to increase the number of their health workers and strengthen their health systems, in addition to participating in schemes such as circular migration schemes and policies against active recruitment of workers from countries with health worker shortage. These two later policies are positive strategies, but

there is a need to understand that their impacts in terms of magnitude might be limited and that they might have different impacts in different contexts. They should just be only part of the solution to the problem of health worker migration.

In addition, some of the assumptions behind circular migration revolve behind the belief that remittances are a "win" for the source country. But, as discussed in earlier parts of the thesis, the role of remittances in fostering development and benefiting the poor is still contested and it is unlikely that remittances will make up for the ill-health that will result from the lack of workforce in health. Nevertheless, the impact of remittances might be important for countries such as the Philippines who produce health workers in excess of the local need. Although attractive in view of the fact that it gives an opportunity for the health worker to migrate at the same time providing him/her with a choice to serve their country of origin, the limitations behind some of the assumptions of circular migration need to be understood.

Similarly, codes of practice for ethical recruitment will be most effective in set ups where active recruitment is widespread, where there is adequate coordination between different bodies and a system for accountability. Such codes nevertheless will need to address the rights of the health worker to migrate, and if possible should be targeted at a specific group of health workers, excluding workers who have already provided long years of service to their countries. There is a need for research on how health workers perceive their roles and obligations with regards to their own interests versus the interest of the collective. To my knowledge, such research is currently lacking

Similarly, some of available information on health worker migration is based on expert opinion and not on research evidence per se. There is thus a need to conduct more systematic studies to look at causes, patterns, responses to this phenomenon as well as other aspects of it. There is a need for research that looks into the willingness of health workers to participate in circular migration schemes, and research that looks at responses of different stakeholders (including health workers) towards policies for ethical recruitment including the recently passed WHO Global Code.

The assessment of the magnitude of health worker migration, as well as the assessment of the implementation and evaluation of effective policies to address the problem have both been hampered by a lack of data on migration in general and of migration of health workers in particular. Diallo indicates that data on health care migration are neither complete nor comparable, and limited in scope; in addition to being untimely. Although there is a wide range of sources from which data could be extracted, there is poor statistical evidence on the migration of health personnel (Diallo 2004). There is thus a need to develop standardized recording systems of health worker migration data.

Some strategies which have had research evidence for their effectiveness to increase health worker motivation and potentially decrease migration include the provision of incentives locally (Willis Shattuck et al 2008, Stilwel et al 2004). Although these might not be feasible in all set ups because of economic constraints of source countries, they provide a point where developed countries can support poor countries in their struggle against health worker migration.

The involvement of health workers themselves in strategies to combat health worker migration is likely to yield more sustainable results. It is important to have policies that do not end up demotivating not only currently practicing health workers, but also younger generations with aspirations to join the medical field.

Some developed countries are having national policies which conflict with policies against health worker migration. The increasing reliance on migrant health workers is believed to not just be a result of poor planning, but an integral part of health policy and labor policy. For example, in the US, international recruitment of heath workers is considered a way of keeping hiring costs down and improving retention; thus, immigration of the highly skilled, chief among those physicians and nurses, is made easier and even incentivized, and promoted by employers and industry organizations (Ahmad 2005).

These policies are in opposition to the struggle to deal with health worker migration, and need to be addressed, since it is only a global effort that will lead to successful results. These policies

also represent tensions between domestic policies of countries' and their policy on international development (Martineau 2004, Hooper 2008).

It can thus be concluded that, despite the fact that health worker migration is an old phenomenon, and despite the fact that many attempts have been made to limit its negative impacts, the experience to date is that health systems in many countries are detrimentally affected by the loss of health workers secondary to migration to richer countries. A concerted effort involving all stakeholders, and both receiving and source countries is necessary to tackle the impacts of migration of health workers. Different policies, among which circular migration schemes and policies for ethical recruitment need to be implemented in a systematic and contextualized manner to get satisfactory results. There is a need to understand that, in an age of globalization, policy decisions no longer have implications for the local setting alone, but will have impacts in other settings (Walt et al 2008); thus necessitating responsibility taking on policy issues more than ever from all governments.

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