INTERNATIONAL DIALOGUE ON MIGRATION SEMINAR

MAKING MIGRATION OF HUMAN RESOURCES FOR HEALTH A WIN-WIN SITUATION FOR ALL

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It is estimated that the total number of migrants doubled from 75 million to 150 million between 1965 and 2000. Today, 120 million of these are thought to be labour migrants. While it is true that at the turn of the century there was more migration, the difference today is that it is affecting more countries, both as origin, transit and destination.

A number of factors have contributed to this rise in population movement, principally economic, political and cultural globalization, rapidly improved communications technology and cheaper international transport which, in particular, has led to migration becoming increasingly temporary and circular. Migration has also become a controversial issue, in many cases rising up the agenda of the political debate. This is because many powerful social and political issues are involved.

Economic opportunities in the health sector of more affluent countries are attracting health workers from developing countries. Despite rapid expansion in the number of medical graduates and health care personnel, many developed countries are not able to find enough doctors and nurses to meet their needs and hence consider engagement of graduates from other countries as an alternative. Some countries such as Canada and Australia have adopted successful points systems to attract these migrants to their countries. While it is true that migration of human resources for health from poor countries to rich ones puts enormous pressure on those who remain behind, the lure of a better life for the family, better employment conditions, opportunities for postgraduate education and research cannot be ignored. Medical personnel have also been forced to seek asylum in other countries due to instability. Since medical training has tended in most cases to be portable, they are able to get jobs and settle in the host countries. Most doctors from Uganda working in South Africa went there as refugees and have never gone back.

Moreover, the demographic situation in many developed countries has created a new demand for health care services. The ageing populations of many industrialized countries has meant that, as current fertility rates stand, they are not able to replace medical workers who go on retirement. Many more nurses are needed to provide care and support to those living in old peoples' homes. Fertility in most rich countries (in particular in Europe) is below the replacement level so their populations will age and shrink over the next 50 years. Without immigration, the population of the soon-to-be member states of the EU will drop from about 450m now to fewer than 400m in 2050. This means that some jobs in their health services sector will go unfilled and services unprovided.

The principal impact on the country of origin with the departure of medical personnel who tend to be the brightest and most skilled people, creates fiscal losses and has

demographic impacts along with the fact that fewer workers are left behind to cater for the health care needs of the country.

There can also be 'brain waste' which may occur in both origin and recipient countries when developing country labour markets cannot fully employ native-born medical workers who have been trained abroad in advanced technology. In this case emigration would pose little economic threat. Conversely, there may also be underemployment in host countries, e.g. when a doctor can only find work as a nurse.

While principally migration of health care professionals is negative on the origin country (apart from the issue of remittances), there are some benefits in out-flow. An exodus of the skilled may raise pay levels for those left behind, free up places in education institutions and trigger skill upgrading.

The possibility of emigrating to higher wage countries may stimulate individuals to pursue higher education in the medical field in anticipation of finding better-paid work abroad This has happened in Kenya where many private institutions are offering training courses for nurses.

Can we stop a genuine desire of individuals to look for a more fulfilling life for themselves and their families. In other words, should we use barriers to migration like increasing the time required for a medical graduate to be fully registered? How can we ensure that the countries that have borne the full cost of training retain their health professionals? What about the countries that have surplus labour like the Philippines and have established training institutions that cater for those seeking opportunities in the health care sector of more affluent countries? Shouldn't they be allowed to export their surplus labour under mode 4 of the WTO rules on movement of natural persons. Should more affluent countries adhere to a code of ethics in their recruitment practices where they only recruit health professionals from only those countries with a surplus?

In responding to the above issues, Governments have to be more open and honest about the reality of migration of human resources for health in the country. The principal challenge for them in this sphere is to develop migration policies that appear ordered – currently this is not the case in many countries.

Whichever policy responses are adopted by the origin or destination country, there is need to predict the health care needs of the country by taking into account demographic trends, health sector reforms, the balance between public and private healthcare. Employers do not think that the solution lies in seeking to limit mobility but in finding ways to meet health care needs of the country. It should also be remembered that there are inequalities not just between countries but within countries. Inner cities in developed countries and rural areas in developing countries tend to be less attractive to health professionals

POLICY RESPONSES

Given the choice most people would prefer, all things being equal, to remain in their home country. Consequently, in devising policy solutions to migration, making a country a good place to work and to live in must be the starting point: developing a culture where

advancement (in education or professional life) depends on quality, not on political affiliation, race, religion, national origin, etc.

If migration is to meet the requirements of the donor and recipient country – providing labour and capital respectively – then it should mainly be a temporary exercise. Cheap international transport and communications have made it easier for workers to go abroad for short spells and migration does not need have the 'finality' that it had in the past.

Developing countries need to try harder to entice their high skilled healthcare professionals back. This could be done, for instance, through schemes where top public officials in countries have their public sector pay 'topped up' through aid assistance schemes so as to encourage them to stay. Schemes could be developed were medical expatriates are brought back for a period of time to impart skills on the home population. However, any such schemes need to be sustainable in their own right and not create artificial situations that could dry up as soon as any funding ends.

New ways could be devised to draw on the experience of expatriates by truly developing the concept of dual nationality (possibly by internet use to maintain expatriate skills and contact).

Whether health professionals are permanent or temporary, backward linkages to their source country can increase the available knowledge and technology that meet health care needs. Diaspora arrangements such as expatriate organizations and e-based expatriate networks are important, as are means of facilitating remittances or investments in the health centres.

Remittances to the host country can be considerable[1] and should figure highly in policy responses. For instance, there could be a key role for settled immigrants to help in the development of the health sector of the country of origin – i.e. channelling the remittance money into government-approved development health projects. Highly skilled workers may be more likely to invest in their home country. For example, the Indian government campaigns in the United States and elsewhere urging its professional emigrants to invest in Indian remittance-backed bonds. Indian banks market the bonds and they are capitalized on the flow of future remittance monies to India. Foreign currency accounts in developing countries with prime rates of exchange and prime/assured interest rates are another way to attract expatriate earnings.

The loss of highly skilled medical personnel is twofold for the origin country. First is the immediate loss of those skills to the economy and second is the loss of investment that the origin country has put into developing and paying for those skills. There are discussions on the possibility of placing a tax on these kinds of high-skilled migrants in order to try and recoup this loss for the origin country – although, without a proper framework, in practice this may be difficulty to put in place.

However, while education, training and targeted economic development paradoxically may increase skilled migration in the short to medium term, they are the best means of addressing developing country skill shortages in the health services sector in the long run. Some assistance could be provided to them to upgrade postgraduate education and research opportunities that meet the needs of their health systems. This would stop newly qualified

[1] 1989-2000 officially reported remittances were about 20% more than all official development aid

medical graduates from seeking for specialized training abroad which is usually the first phase of migration of health professionals

Circulatory migration

Guest worker schemes can be a means of circular migration for health professionals although in the past in many countries they have taken on more permanent characteristics. One of the key attractions of guest schemes from the origin country perspective is that remittances back are often, as a percentage, very high. This is mainly due to the fact that the family of a health care guest worker will remain in the origin country. In addition, this kind of migration is the classic circulatory type where a migrant goes to another country, develops new skills and transfers this knowledge gained back to his home country (along with increased financial capabilities). There is a direct convergence of interests in both the origin and host country when the issue is viewed through this lens.

There is strong empirical evidence that the longer the migrant worker stays abroad, the lower the likelihood is that he will return to his country of origin during his working life. Short-term work permits with a clear message that return is obligatory after the defined period of stay can be a mechanism to induce circulatory migration. For example, once the permit expires, the migrant is required to return home for a two-year period before applying for re-admittance to that country.

There have to be clear incentives, financial or otherwise, for health care migrants to return to their home country. Dual nationality or residency rights can play a role in helping migrants return, even for a short period. Many emigrants would be more willing to return home if they were assured they could retain residency rights in their adopted developed country.

One form of circulatory migration that is increasing is movements of skilled workers between developed countries; the so-called brain exchange. This can take the form of intra-company transfers between countries by employees of multinational corporations in the health care field.

Demographics

In many developed countries the demographic trends would indicate that these countries will in the coming decades face an unsustainable gap between future tax revenue on the one hand and commitments to spend and to service government debts, and above all in sustaining economic growth on the other[2]. For example, the Italian population is falling despite the arrival of around 70,000 immigrants each year. The solution from the EU does not lie East as data from the new EU accession states actually reveals a similar demographic pattern.

In the developing world the opposite is the case with rapid increases in population. The UN has estimated that the world's population could rise from 6.1 billion in 2000 to 10.9 billion in 2050 with half the growth in just six countries: India, China, Pakistan, Nigeria, Bangladesh and Indonesia.

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[2] According to EUROSTAT between 1975 and 1995 the EU population grew by just over 6% with this growth is expected to almost half to roughly 3.7% (between1995 and 2025) and the over-65 population to rise from 15.4% of the EU population in 1995 to 22.4% by 2025.

However, it is too simplistic to think that immigration can resolve the labour and welfare problems of developed countries and free up resources in the developing countries. Once migrants are settled they tend to adopt the fertility patterns of the country they move to and, consequently, more immigrants are then needed to support them in their retirement. In developing countries an exodus of young workers creates its own demographic problems in the origin country.

Solutions therefore need to be viewed in an integrated way. That means in developed countries other types of intervention such as changes to the retirement age for doctors, the pension system, measures to stimulate mobility of workers within the labour market, and enhanced productivity need to be an integral part of the overall solution. In developing countries this means implementing policies to make it attractive to convince the most skilled workers to stay.

Agreements

In the absence of any agreements at the international level addressing the recruitment of health professionals,, bilateral and regional agreements between origin and host countries can help to bring order to the process. However, bilateral and regional arrangements are probably more appropriate for a long-term relationship rather than meeting short-term requirements. These agreements could help identify where migrant health workers can play a role, but also where certain skills are important to the origin country, and try and maximize benefits for both origin and host countries.

Development agencies could target investment to health sectors losing the skilled workers in the origin country as a way of ensuring that the conditions are conducive to entice the migrants to return. Agreements should also be considered in a regional context. For instance, increasing the recognition of qualifications and skills across borders. It is wasteful to see highly qualified migrants working in menial jobs simply because their qualifications are unrecognized by the host country.

CONCLUDING REMARKS

Solutions are not easy – but migration of healthcare personnel can be a ‘win-win’ scenario given the right policy choices. Evidently, solutions have to be coordinated amongst countries. Analyzing the issue in such purely black and white terms will not lead to sustainable solutions. Immigration policies drawn up by rich countries without the active cooperation of poor countries are unlikely to work.

The priority task is therefore to adjust migration policies on healthcare professionals to respond to changing patterns and current realities in the sector, with policy responses taking into consideration the linkages between the economic, social, political, trade, labour, health, cultural, security and foreign and development aspects.

Crucially, policies need to be tailored to the distinct categories of migrant populations and, in doing so, involving all the relevant stakeholders.