

## **International labour flows: an export perspective**

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A recent article in the Lancet focused on the medical workforce 'brain-drain' and discussed a number of ways of tackling the problem including ring-fenced development aid to encourage professionals to remain in-country, an ethical recruitment code, in-country specialist training, restrictions on length of training in rich countries and incentives for staff to remain in their own countries (Eastwood, Conroy et al.). An editorial in the same issue focused on two key strategies: training more health professionals in richer countries and providing training exchanges and research collaborations with developing countries that ensure that training is imparted without need for permanent emigration. (The Lancet). The BMA has also highlighted the issue bringing it to the attention of the recent G8 summit in Edinburgh<sup>1</sup>. This was later reflected in the final G8 communiqué when leaders agreed that their nations would strengthen African health systems by, inter alia, "helping Africa to train and retain doctors, nurses and community health workers" (G8 2005).

### ***A slightly different take on the issue***

It is a mistake to believe that the attraction to developed countries is the only or even most important problem facing the retention of medical workers in developing countries. Health systems in many developing countries are faced with the situation where they are forced to pay wages that are low both by international standards and also by the standards of their own private sectors. Indeed in some countries the wages are below a basic subsistence level. Reasons for these low wages include a low total budget relative to staff employed and inflexible civil service rules that prevent wages rising above what other public sector workers receive. In some countries health sectors have been hit by falling real budgets resulting from poor macroeconomic growth and, in the case of some transition countries, the economic shock resulting from a loss of guaranteed export markets {FSU, Vietnam – refs}.

The consequences of these circumstances is that some public sector workers leave in order to work entirely in the private sector, usually once they have acquired training and basic experience in the public sector. Others remain in the public sector but establish their own private (dual) practices which they operate out of hours and during regular public hours (Berman and Cuizon 2004). Another option is to charge public patients unofficial fees, establishing a sort of quasi-private practice – a practice well recorded in both transition and low income countries (Killingsworth, Hossain et al. 1999; McPake 1999; Ensor 2003). The result of these practices is that the public sector is less productive than it would be if staff were able to devote all their working time to delivering public services.

What would happen if staff were prevented from emigrating to jobs in high income countries either through 'ethical recruitment', tighter immigration controls or by boosting domestic training? It seems unlikely that this would suddenly mean that skills shortages in the local public sector would be filled. Most likely the staff would seek opportunities to generate incomes from the domestic private or quasi-private sector. This would certainly have the advantage that skills would be available to local citizens. The problem is that because such staff are likely to want to focus their energies on relatively lucrative urban posts and devote much of their time to their

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<sup>1</sup> <http://news.bbc.co.uk/2/hi/health/4100892.stm>

private practice, it will be the relative rich of the country that predominantly benefit. The policy would also enable governments in low-income countries to continue to side-step the issue of paying low salaries (even by domestic standards) to government workers rather than being forced into addressing fundamental issues of civil service restructuring.

Further down the line, the lack of overseas opportunities may have second order training effects. Bright young students may, rather than choosing medicine or nursing, join other sectors that are more ready to reward their talents such as commerce or IT.

### ***Worth considering...?***

When medical workers travel from poor to rich countries to work it is a type of export. It is, however, an export that is not properly reimbursed because the full cost training, formal and on-the-job, is not passed on to the recipient country. This is rightly thought of a type of theft, similar in theory to the theft of intellectual property that occurs through international piracy of software or music but with consequences much more profound. Although controls over the movement of labour may assuage the ethical concerns of northern policy makers, it is not clear that this properly addresses the problem of helping health sectors in developing countries to address their long-term sustainability. Financial compensation and academic exchanges may help yet seems a rather passive response to what is in essence the international face of a fundamental a more problem.

An alternative route to addressing this issue is to encourage the development of a fully reimbursed market for medical human resources. Given that it is far cheaper to train doctors and nurses in many developing countries, why not pay these countries to provide training to students from developed and developing countries, at international market rates. Since the market rate that could be charged may well be substantially above the domestic costs it could become a way by which governments in developing countries could help subsidise their entire domestic medical education sector.

Naturally there are concerns about quality and medical training provided would undoubtedly have to be accredited to an international standard – another advantage since it could help to raise the standards of human resources and services provided in these exporting countries. It should also be observed that for some medical specialties, the quality of training could be a lot higher than in developed countries since the experience from a higher potential caseload would enable far more practice for staff in training.

There are undoubtedly dangers to this approach. One is that it would accelerate the skill drain from countries where the supply of graduates from secondary schools is extremely limited. This is an important concern and one to be monitored.

Another danger is that providing an international market for medical graduates, might also force public sectors to examine the opportunity cost of their own medical staff. Suddenly employing a new graduate has a price since it implies forgone income from exporting to a recipient country. This has the danger that it might restrict needed skills into the domestic sector. Yet it could also act to the advantage of the sector since current practice in many countries is to employ too many staff, pay them inadequately and then find they become unproductive. If this is the case forcing governments to look more carefully at the costs and benefits of employing highly qualified medical staff could help them to consider both ways to improve the

productivity of a scarce resource, including better incentives, and also ways of substituting for less highly trained staff in some circumstances.

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